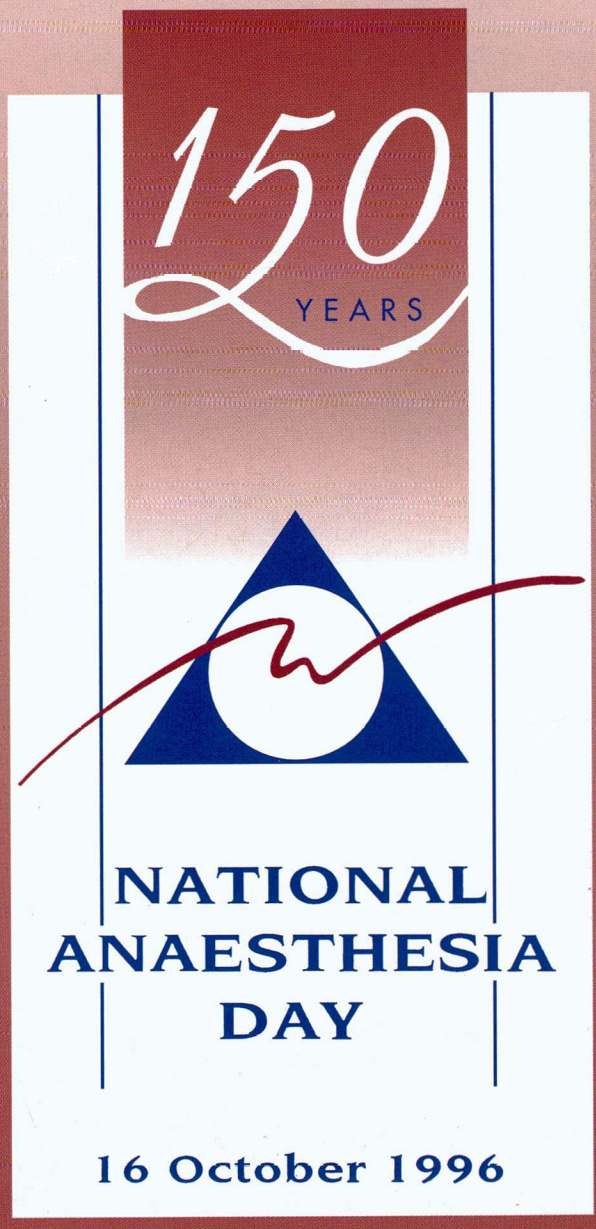
Australian and New Zealand
College of Anaesthetists
ACN 055 042 852
and Faculty of Intensive Care

Bulletin

Inside...



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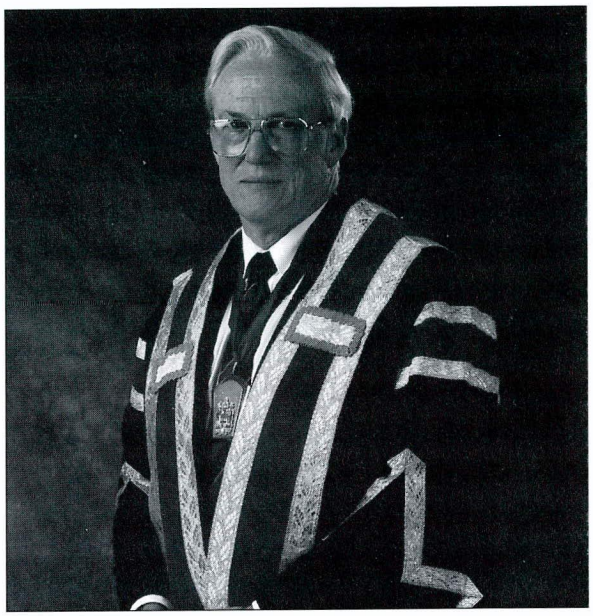
PRESIDENT'S MESSAGE



At the June Council Meeting, Neville Davis and David McConnel were thanked for their dedication and hard work on Board and Council over the past twelve years, as also was David Jones for his contributions as President of the New Zealand Society of Anaesthetists. Neville was congratulated on his appointment as President of the Committee of Presidents of Medical Colleges. Mike Martyn and Greg Knoblanche were welcomed to Council.

The Officers and Main Committees of Council appear inside the back cover of the Bulletin. Important changes have included incorporation of the Bulletin Editorial Committee into the Communications Committee, which has already established the College home page on the world wide web; establishment of the Pain Management Committee as a major Committee of Council, indicating the importance of this area of practice, and formation of the Asia Pacific Committee to develop and pursue College policy in the Region.

I raised three issues at the end of the Council Meeting and proposed that they be addressed over the next twelve months. The first was Asia Pacific Affairs for which Teik Oh's Committee has already prepared a strategic plan. The second was an internal review of College structure and function, to ensure that this is efficient and effective. The third is to review ANZCA/ASA relationships. A key component of this will be a workshop for Councillors, the College's "Board of Directors", to discuss the aims and objectives of the College, to be followed by consultation with Regional Committees and Fellows.

Many other issues require very serious consideration over the next twelve months, including provision of anaesthetic services for rural areas, career pathways for medical graduates unable to pursue specialist training, specialist registration of overseas trained doctors and the implications of the Competition Policy Reform Act 1995 which will extend the operations of the Trade Practices Act to the professions, and in particular, to Medical Colleges.

In relation to a number of the issues mentioned above, it will become increasingly important for the Colleges to co-operate with each other and with external bodies to ensure that high standards of clinical practice are maintained.

Two events which will be upon us shortly are National Anaesthesia Day, the 16th October, and the Combined Scientific Meeting in Perth less than two weeks later.

I would ask all Fellows to support the first activity and look forward to seeing those who can come to the second, in Perth.

G.D. Phillips

GARRY D. PHILLIPS

National Anaesthesia Day
Organising A Public Display

PLAN

Appropriate planning makes it happen. This should involve the whole Department staff, not just be the responsibility of one person. Throw ideas around the group, "brainstorm" - which may bring surprising results. A combination of talents, ideas and ownership is a good recipe for success. A project checklist is a good way to avoid forgotten steps and to allocate work.

WHERE

In most hospitals there is a 'standard' place for displays. Ideally a reasonable space with considerable traffic (both public and staff) is ideal. Foyers of hospitals or departments are ideal but consider access and security. For the really intrepid consider setting up in the local shopping centre! Remember to book the space early or you may be competing with the CWA ladies! Also if venturing outside the hospital check if Council permits are required.

WHEN

Ideally, the display should last the whole week of 14-19 October, provided it can be sustained and manned. Remember to allow time for setting up (and down) and try to be set up during the peak time(s) for traffic past the display.

WHAT

A display must attract people to it. Avoid being too technical or complex. A simple poster storyline with large photos may attract some people. This could include a sequence of pre-anaesthetic consultation, in-theatre preparation, induction, maintenance with monitoring, recovery and back in the ward. Most departments have access to medical photography and/or colour printers. Use National Anaesthesia Day Posters to highlight the display. A display of old equipment can provide for a good talking point to emphasise the improvements in techniques and safety. Illustrating the wide range of services that the Department provides is another good talking point. A mock display with anaesthetic machine, monitors, operating table and mannequin can provide for good fun. Generally people like to have a hands on involvement. Checking oxygen saturation, blood pressure, end tidal carbon dioxide and airway skills are all good public health and educational activities. Gimmicks to hand out to children such as stickers or helium filled balloons will attract family groups.

WHO

Choosing appropriate people to staff a display is a key factor and must be in line with the target audience. Outgoing warm personalities are generally best. It can be hard work so make up a roster. Unmanned displays playing endless videos are not all that attractive.

INFORM

Publicise your display beforehand. Create simple one-side flyers and distribute them a week or two in advance to shops (to put in windows), businesses (office noticeboard) and schools. The flyer only needs to state the EVENT (with some catching comment relating to the display), DATE and WHERE. Put some up around your hospitals. Inviting friends and family helps bolster numbers and can snowball interest and participation. Inform the local media in advance. Invite them to visit. A background Fact Sheet will be available to send to the media. Make use of any hospital newsletters.

LOOK

Look out for other opportunities. Ask around and see if relatives or friends are members of community groups and/or service clubs like Apex, Lions, Rotary, and the like. Talking to people can bring invitations to speak or make influential contacts. Promoting anaesthesia, your Department and/or hospital this way not only helps to build positive community perceptions, but may even attract unexpected support or useful feedback.

REVIEW

Debrief after the event. Make notes on what worked best or ideas for the future (such as Anaesthesia Day 1997). Let others know about any particularly successful strategies (or spectacular failures). A note to the College Bulletin could lead to an interesting collation of experiences.

MIKE MARTYN, Communications Officer
July 1996

JOIN IN ON NATIONAL ANAESTHESIA DAY

National Anaesthesia Day this year is a tremendous opportunity to further develop community recognition and understanding of the role and responsibilities of the anaesthetist.

Anaesthetists everywhere are invited to participate in marking possibly the single most significant development in medical history.

The Day - Wednesday, October 16 - coincides with the 150th anniversary of W.T.G. Morton's first successful public demonstration of an anaesthetic for a surgical procedure, in Boston, USA.

Comprehensive media coverage is planned to focus on the occasion at national, State and suburban level.

Support material will be distributed through Regional Committees and anaesthetic departments.

This is an opportunity for public displays about anaesthesia, wherever they can be arranged, to better inform the community about the specialty and its key role in medicine.

Displays of equipment, old and new, with an emphasis on today's high degree of sophistication and technology, and on improvements in safety would be highly appropriate.

Group practices and individual anaesthetists may also wish to mount a small display, or otherwise publicise the Day on their premises.

Such displays would ideally last for the week 14-19 October.

Another valuable communication channel is through local community and service clubs and groups.

Individual anaesthetists who feel so motivated may consider offering to give a talk about anaesthesia's history and its modern-day, complex and wide-ranging role in medicine. For example, few members of the public are aware of anaesthesia's role in intensive care, hyberbaric medicine and resuscitation.

An information package will be available as required by participating departments and Fellows.

The package includes a help-note on how to organise a suitable display, a National Anaesthesia Day poster, and basic historical information.

The poster features a new logo created specifically for National Anaesthesia Day from this year on. It will act as a focus for displays.

Already, 1996 has seen a much higher profile for specialty of anaesthesia. The National Day, and the CSE in Perth soon after, offer additional avenues to maintain the continuing programme of improved community recognition and appreciation.

This programme, initiated in 1994, is a long-term process, and new elements progressively will be put in place.

EDDIE DEAN, Communications Consultant

ANAESTHETISTS' WELLBEING AND WELFARE

"I observe the physician with the same diligence as the disease" - John Donne

Personal and professional dysfunction reflecting stress among anaesthetists is the focus of a group established following the Victorian Combined Continuing Medical Education Day on "Risks to the Anaesthetist", in August 1995.

Formation of the group follows increased awareness of the impact of deleterious life stresses which can affect the anaesthetist.

The interest shown by anaesthetists in relevant sessions at the World Congress in Sydney and in other recent meetings indicates growing interest in the need to address harmful stress.

Suicide is a highly visisble result of such influences. However, the group is looking at a wide range of factors that impact on an anaesthetist's working life.

The group is collecting information on such issues as substance abuse, psychological and physical health, the stresses of years of training, coping with patient mishap, planning for retirement, income protection, insurance, help for impaired colleagues and their families, and the development of mentor and "Buddy" systems.

Dubbed "Onions" because of its first meeting place, a restaurant in Melbourne, the group meets on a regular basis. It has a commitment to promote professional and personal wellbeing amongst anaesthetists, intensivists and their families by means of educational and other appropriate support methods. Colleagues in distress have been identified and helped since the group formed.

Planned strategies include consultation with appropriate experts, liaison with existing helping agencies (eg, the Doctor's Health Advisory Services), and moves towards education of both trainees and colleagues about potential problems during their professional lives.

A resource brochure is being prepared. Other aims include focus on the issues at national meetings of ANZCA, ASA and NZSA, and the development of a more formal structure.

JOHN GIBBS
Secretary/Treasurer

DI STRANGE KHURSANDI
Chair

For further information or to register your interest in the group, please contact:

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Central Otago, New Zealand
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At a recent meeting in Queensland, the group was renamed

"WELFARE OF ANAESTHETISTS"

PRESENTATION OF LABAT'S TEXTBOOK

Following the recent Final FANZCA examinations in May, one of the successful candidates, Dr Gerrit Reimers, presented the College with a copy of Labat's classic textbook, "Regional Anaesthesia: It's Technique and Clinical Applications", to the College library.

Gaston Labat, born in 1876, was an engineer and pharmacist prior to commencing the study of medicine in 1914. His interest in regional anaesthesia developed during his student days when he was working as a part-time surgical assistant. "Regional Anaesthesia: Its Technic and Clinical Applications" was first published in 1922, the first significant English language textbook on the subject. Labat's eminence is recognised by the American Society of Regional Anaesthesia (ASRA) with their most prestigious annual award, known as the Gaston Labat Award. The recipients of this award represent a Who's Who of regional anaesthesia and include Sir Robert Macintosh, John Bonica, Philip Bridenbaugh and Michael Cousins.

Labat's textbook is considered a prized possession by regional anaesthesia enthusiasts with his clear illustrations, many of his techniques and his descriptions of patient management being as relevant today as in 1922 when his book was first published.

The generosity of Dr Reimers is gratefully acknowledged.

RICHARD J WILLIS
Chairman of Examinations

PRESS RELEASE **18 July 1996**

NEW ZEALAND CRIMES AMENDMENT BILL

Legislation codifies standard of criminal responsibility

The Minister of Justice, Hon D.A.M. Graham, today introduced legislation which will change the level at which criminal responsibility is imposed for manslaughter and injuring by an unlawful act.

The Crimes Amendment Bill (No. 5) amends the Crimes Act as it relates to the degree of negligence required before a person can be held criminally responsible for a breach of certain legal duties.

Mr Graham said the changes result from a report he commissioned from retired Court of Appeal Judge, Rt Hon Sir Duncan McMullin, following concern about cases of medical manslaughter.

The Bill changes the standard of criminal responsibility from negligence in an ordinary civil sense to 'gross negligence', codifying the standard for legal duties for the purposes of Part V111 of the Crimes Act.

Mr Graham said manslaughter is an inappropriate crime for acts of mere carelessness as distinct from gross negligence or recklessness.

He said there are more appropriate mechanisms for dealing with persons who are careless. For example the Health and Disability Commissioner Act and the Medical Practitioners Act provide procedures for dealing with mistakes and errors falling short of gross negligence or recklessness. Other statutory provisions such as those in the Transport Act and the Arms Act are available to deal with other cases of negligence involving dangerous activities. There is also a general endangering offence in Section 145 of the Crimes Act.

At present New Zealand law differs from the law in comparable jurisdictions overseas with respect to the standard of care required to establish criminal responsibility for manslaughter involving a breach of legal duty, he said.

'Those amendments will bring us into line with Australia, Canada and the UK where something more than ordinary negligence is required to justify a conviction for manslaughter in such cases.

'In his report, Sir Duncan made the point that the law in its present form is counterproductive to the maintenance of good health because it may result in health professionals practising defensive medicine, may discourage some from practising in New Zealand and may result in a failure to report information that might assist in improving medical procedures.

'He also said anomalous results may arise from the two different standards of negligence required by the various provisions on preservation of life in the Crimes Act.'

The changes in the Bill apply to all persons, including the medical profession, who perform inherently dangerous activities and have control of inherently dangerous things.

For further information:

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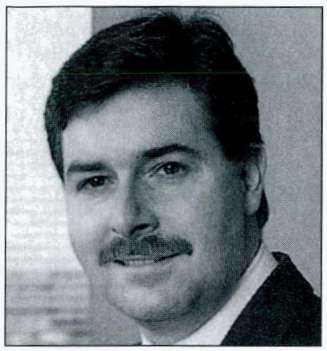

Disciplinary Action by Committees - The Need For "Natural Justice"

Michael Gorton - Honorary College Solicitor
Partner, Russell Kennedy, Solicitors

If someone had made allegations against you, how would you wish the College to deal with you in any proposed disciplinary proceedings?

When you were a trainee, or potential trainee, would you have expected the College to deal with you fairly in recognising your training or considering your removal from the training programme?

Obviously, decisions made by the College and its committees have dramatic and significant affect on the lives of individuals. Decisions made by the College affect the future and livelihood of individuals.

It is for these reasons, that the professions generally are seeing an increase in the threat of litigation against their decisions on matters of training and discipline.

Just as the Olympics have seen an increase in resort to legal action - whether it is drug-testing results or selection for particular events - so too, professionals are prepared to resort to legal measures where their career and livelihood are under threat.

There are a number of circumstances in which the activities of officers and committees of the College may be the subject of legal review. These include:-

1. The recognition of training;
2. The selection of trainees;
3. The removal of trainees from a training programme;
4. Discipline of Fellows in general.

Each of these procedures have particular bodies or committees to deal with them, and operate under different rules and regulations. For example, training is approved in accordance with the Regulations and criteria stipulated by the College in its handbook to trainees. The discipline of Fellows generally, is dealt with pursuant to the Articles of Association of the College and any regulations made by the College Council.

Any decision of the College, or an officer or committee of the College is also subject to review by the Appeals Committee, which has been established by the College pursuant to its regulations.

Each of these committees and bodies is, to some extent, subject to legal rules and principles, including the possible application of the rules of "natural justice".

It is not unusual, when an individual has had a decision made contrary to their interests, to have their lawyer scream that the decision was a "denial of natural justice". In many cases, the mere utterance of the words are intended to strike fear and terror into the hearts of the committee or body making the decision. In fact, there should be nothing mysterious about the rules governing "natural justice", since they accord with common sense and fairness. In addition, they do not always apply.

The rules of "natural justice" are likely to apply where some allegation is made against a particular individual, where some harm or disciplinary action is likely to be taken against an individual, or where some rights of a particular individual are affected.

The general principles underlining "natural justice" are as follows:-

Appropriate Notice

It would seem fair to most people that, where the rights of an individual are affected, the individual should have notice of any hearing and have the opportunity to put their view. This right is one of the fundamental principles underlining "natural justice".

Appropriate notice should be given to the individual, setting out in general terms the nature of the hearing or meeting, the substance of any particular allegations being made against the individual, and the evidence or factual material upon which the committee or body proposes to rely.

The notice should be given to the individual in sufficient time to enable the individual to consider the material and prepare submissions.

Obviously, the more damaging or important the allegations, or the more severe the likely punishment or consequences, then the more detail will be required of the allegations.

If the individual does not believe that he or she has had ample opportunity to prepare for a hearing, it may be important to adjourn the meeting for a period of time to permit the party to properly prepare their case.

In cases where trainees are being selected competitively, there may still be "allegations", or at least adverse material relevant to a candidate, upon which the relevant board or selection committee may base their judgement. It would be fair for the candidate to have any adverse material put to them, so that they could adequately respond and give any explanation that may be available.

Relevance

No matter what the particular activity of the board or committee, only material relevant to the actual decision required should be considered by the board or committee.

It will come as no surprise to some to hear of times past, where boards or committees, when selecting trainees, took into account a range of factors that many today would regard as completely irrelevant to the decision of whether to admit a trainee to a training programme. Certainly, in more recent times, legislation ensures that circumstances such as race, religion, gender and a range of other grounds can form no part of a decision regarding trainees, or in relation to any disciplinary action.

Whilst not covered by legislation, presumably we would also consider the chosen football team supported by candidates to be an irrelevant factor, as much as whether their hobbies included opera or macrame!!!

The simple principle is that the selection committee or the disciplinary committee should confine their considerations to material relevant to the decision at hand. They should not permit consideration of irrelevant material, and where irrelevant material is presented, it should be made clear that it is not being considered or relied upon in any way.

Bias

A selection committee or disciplinary committee must be free of bias. That is, the membership of the committee should not include any person previously having taken part in any substantive decision affecting the individual, and should not have any relationship with the individual (whether family or otherwise), which would preclude them dealing with the matter with an open mind.

Again, common sense would dictate that the relevant committee should operate impartially and without prejudice, and most importantly, to be seen to be so.

Pre-judgement

Similar to the question of bias, is the question of whether the committee, or any member of the committee, has previously made a decision about the individual, which would suggest that they have already pre-judged the issue. For example, a committee member who has carried out an investigation of an individual and may have prepared an investigative report and given a recommendation to the committee, could then not sit as a committee member to determine the committee's view of the matter.

This does not mean that the committee cannot delegate particular tasks of the committee to a smaller number, or to particular individuals. However, a committee member cannot have been part of a former process where some judgement was already made regarding the suitability or otherwise of a candidate, or whether disciplinary proceedings were warranted or not.

Procedure

Most of the procedures of these boards and committees remain relatively informal.

However, members of such committees should make themselves aware of any particular requirements, either under the College's rules or regulations, or the principles of "natural justice" generally, so that any necessary requirements can be observed.

There is nothing wrong with informality, so long as any required procedures have been adequately taken into account.

For example, it would be important for each board or committee to determine upon what criteria a decision is to be made before proceeding to deal with the matter.

Additionally, in relation to disciplinary procedures, it might be considered that the individual against whom allegations

are made, should be permitted professional legal representation. In most of the disciplinary procedures in which the College is involved regarding disciplinary actions, the individual has been permitted to have legal representation present to advise, but not to act as an advocate. The rules establishing the College Appeals Committee permit legal representation present to advise, but not to act as an advocate. The rules establishing the College Appeals Committee permit legal representation at the discretion of the Committee itself.

Obviously, the more important the outcome of the proceeding, the more formality may be required. For example, disciplinary proceedings which may remove Fellowship from an individual, or proceedings akin to a hearing by a medical board, where a license to practise may be removed, will require a greater degree of formality and structure.

Rules of Evidence

The College's committees are not bound by formal legal rules of evidence, unlike courts. They are entitled to hear material from any source, and determine themselves what weight to place on the material.

Obviously, committees should avoid placing any or too much weight on information from anonymous parties, or information which is second or third hand. Similarly, opinions should be regarded merely as such, unless the person forming the opinion is entirely qualified to have their opinion respected.

Again, without formal rules, evidence to be considered must nonetheless be relevant to the issue at hand, as previously noted.

Defamation

Normally, in relation to disciplinary proceedings particularly, the parties directly involved will not be subject to the ordinary laws relating to defamation. It is said that the protection of "privilege" against defamation applies to these proceedings. this would also extend to material prepared prior to and for the committee's deliberations, such as statements of witnesses and report providers.

However, statements made by individuals which go beyond what is strictly necessary for the proceedings, may lose protection from defamation, particularly if it is mischievous or malicious.

Thus, whilst there is some protection against defamation involved in these proceedings, participants should still deal only with relevant matters and not stray into character assassination or clearly irrelevant material.

Appeals

Because the College has its own appeal process, any decision of a selection committee or disciplinary committee may be subject to review by the Appeal Committee.

There are specific grounds upon which appeals can be made.

An appeal must be made within six months of being notified of the relevant decision against which the appeal is lodged. The appeal can only be made on one or more of the following grounds.

- *New material not available or considered when the original decision was made.*
- *An error in law or in process.*

The Appeals Committee consists of College Fellows, as well as distinguished non-Fellows.

The College Registrar and the Honorary College Solicitor assist the Appeals Committee with its hearings and processes.

The Appeals Committee can consider all relevant information which it thinks fit, and may invite any person to appear before it to provide information. The person lodging the appeal has the right to appear before the Committee and make submissions, but is not entitled to be legally represented, unless the Appeals Committee consents. Normally, the Appeals Committee permits legal representation to advise, but not to act as an advocate.

The Appeals Committee has a broad power to review a decision of a Committee or College Officer. The Appeals Committee may confirm the decision, revoke the decision, refer the decision to a relevant committee for reconsideration, or replace the decision with its own, as it thinks fit.

Once the College's appeal process is exhausted, of course, individuals have their ordinary rights at law to seek review before the courts.

ADMITTED TO FELLOWSHIP BY EXAMINATION

Andrew Myles BENNETT, Vic
Julie Robyn CLARKE, NSW
Shirley Lai Wah CHEUNG, Qld
Mark John Gifford FAMILTON, WA
Jose Andre Roger FERNANDEZ, New Zealand
David John KNOX, WA
Bee Beng LEE, Hong Kong
Janet LIANG, New Zealand
Kenneth Errol LEWIS, Vic
Bernard Henry NEGUS, NSW
William John O'REGAN, NSW
Peter David TOBIN, New Zealand

PERSONAL VIEW POINT

The success of the 11 WCA was splendid, in every respect; as always on such occasions the opportunity to meet old and make new friends, and to exchange information, views, plans, etc. was surely important and valuable to all present. Out of such conversations came at least one item of news which is not good - a practice which one may name 'poaching', though 'exploitation' may well be a more exact term.

(As it is apparent that there exists some inconsistency in the understanding and use of the terms 'developing' and 'developed' regarding regions of the world, the term 'Third World' is used here for developing regions, and 'First World' for developed countries).

In many parts of the Third World, the discipline of anaesthesiology is understaffed, often grossly understaffed, and this despite strong and continuing efforts to correct the problem. These efforts include in-country training schemes, often set up, run and funded by First World agencies or individuals, out-of-country schemes (regional and/or First World) or combined schemes. In some cases the costs are borne, wholly or in part, by the country of origin of the trainees, more often the funding is via a grant or similar arrangement with a foreign government or non-government agency and sometimes a First World hospital or health area undertakes to provide the training of particular individuals or series of individuals.

The number of people achieving specialist status in various parts of the world is significant. However many, if not most, of the areas of the Third World which should have benefited by such arrangements, are little if any better served, number-wise, than they were before such schemes began.

Why? Because the trainees did not return home on completion of training or did not long remain there if they did return, or, if training had been carried out entirely, or completed in the home country, went elsewhere after qualification. And the reason for this? In the first instance, and from the trainees' point of view, ***money*** - reflected in a better lifestyle for the trainee (and family?) together with a superior work environment - an understandable explanation, but an acceptable excuse? One could speak about 'honesty', 'integrity', 'justice', 'fair play', even 'patriotism'; some will also wish to invoke the concepts of individual freedom and rights. However another aspect of the matter must be considered. It is, has been, and will continue to be possible for Third World personnel to remain in, or move to, the First World, or other favourable location, rather than return to or remain at home, only if positions are offered, appointments made, and appropriate visa (or whatever) arrangements facilitated.

It is recognised that in a number of cases these things are done out of kindness to an individual (with no ethical consideration); but it is probable if not certain that, in the vast majority of cases, the employing body puts self-interest first. Indeed some reputations are well established in this regard.

If medical practice is an ethical matter, if duties and responsibilities are moral as well as legal, and if the world really is a global village as we (almost) 3rd millennium people like to think of it, then we, anaesthesiologists, our medical colleagues, our administrators, and our governments, have a very real obligation to stop this brain drain, this direct sabotage by anaesthesiologists (and others) of the often heroic efforts of fellow anaesthesiologists (and others) endeavouring to rectify gross inequalities in the global availability of medical services. In addition to thwarting and frustrating the efforts of trainers, this poaching, this exploitation, is surely a cause of increased morbidity and mortality in the Third World.

So there lies the challenge - effect a resolution of this matter. This challenge admits no exceptions, although, on the way to full resolution, some accommodations may be acceptable, and even desirable to soften the impact of the practice in question, while it still exists.

The unacceptable nature of this matter should be clearly set out by the WFSA, as well as each of its constituent elements, for the information of individual members and departments, health authorities, etc. Sanctions are undoubtedly necessary: eg. a levy on a department of (at least) $100,000 for each transgression (yearly/person) and $10,000/year on the overstaying (or absconding) trainee. Such monies should be used to address, in some way, the problem of inadequate, or entirely absent anaesthesia services.

A temporary, partially compensatory, procedure is provision of a replacement (of a least equal standing) in the Third

World department from the department accepting the Third World anaesthesiologist. Such an arrangement is 'partially compensatory' because a First World professional in the Third World is much slower or even less likely ever to adapt to the situation, than a Third World person in a First World department.

In order to forestall objections and misunderstandings, at this point, let it be understood that it is acceptable that properly arranged exchanges of suitably prepared personnel for limited and clearly defined periods, or, in appropriate circumstances, unilateral movements of personnel, again for limited and defined periods, are a useful and important element in many training schemes.

PATRICIA COYLE, FANZCA

Management of Complications Arising Following Discharge From a Day Surgery Unit

It is essential that Day Surgery Units make proper provision for the management of complications which occur following the discharge of patients from the Unit. Because of the possibility of complications such as haemorrhage, severe pain or intractable vomiting, it is recommended that patients undergoing outpatient surgery should reside no more than one hours travelling time from the nearest medical attention. Patients must have ready access by phone to their surgeon and anaesthetist during the postoperative period. While in principle it would be preferable for the patient to return to the Day Surgery Unit should a significant complication arise, many such units do not provide an after hours service. Under these circumstances the patient should go to a major hospital or seek the advice of their general practitioner. Where the patient resides more than one hour's travelling time from appropriate medical attention the advisability of having surgery carried out as a day patient should be fully discussed with the surgeon involved prior to the scheduling of the procedure.

Explanatory Note:
The above is a statement of general principle which may be varied according to the requirements of individual Day Surgery Units.

HIGHLIGHTS FROM COUNCIL JUNE 1996 MEETINGS

INTERNAL AFFAIRS

Election to Council

Associate Professor Greg Knoblanche (NSW) was welcomed to the Council as was Mr Kevin F. King (Vic) as the Royal Australasian College of Surgeons' representative.

Retiring Councillors

Associate Professor Neville Davis and Associate Professor David McConnel were farewelled from the Council. Professor Davis has been elected Chairman of the Committee of Presidents of Medical Colleges

Administration

The Committee Structure and function of the College will be discussed in some detail over the next 12 months.

Appointment of Part Time Archivist

Following the re-location of the College Archives from the Royal Australasian College of Surgeons, Council has agreed to engage the services of a part-time Archivist to organise and maintain the College Archives in addition to the appointment of an Honorary Archivist.

One Grand Chain

The launch of Dr Gwen Wilson's Book *"One Grand Chain - The History of Anaesthesia in Australia 1846-1962"*, Volume 1, at the World Congress in April was noted.

Review of Policy Documents

In future, at the time of reviewing policy documents, Fellows will be advised, via the Bulletin, and their comments and suggestions sought.

New Committees

Two new committees were established:

Pain Management Committee, Chaired by Professor Michael Cousins; and
The Asia Pacific Committee, Chaired by Professor Teik Oh.

Asia Pacific Committee

This Committee will co-ordinate activities with Asia Pacific Countries to realise objectives in the College's strategic plans for such countries.

Objectives:

1. To assist Asia Pacific Countries to improve their standards of Anaesthesia and Intensive Care.

2. To assist Asia Pacific Countries to establish local Training and Examination programmes in Anaesthesia and Intensive Care.
3. To promote Continuing Education in Anaesthesia and Intensive Care in Asia Pacific Countries.
4. To promote the status of Anaesthesia and Intensive Care in Asia Pacific Countries.
5. To enhance the relationship of the College with local Colleges/Academies in Asia Pacific Countries.
6. To increase the standing of the College in Asia Pacific Countries.

This Committee will co-ordinate and promote education (Teaching, Training and Continuing Education), Consultative Services and Research in Asia Pacific Countries with any existing relevant College Committees and will advise Council on such matters relating to these countries.

EMST Committee

Dr Alan McKillop (NSW) was nominated to replace Professor Phillips on the EMST Committee of the Royal Australasian College of Surgeons.

National Day Surgery Committee

Dr Andrew Bacon and Dr Glenda Rudkin will be the College representatives on the National Day Surgery Committee.

National Morbidity and Mortality Committee

The National Anaesthetic Mortality reporting was discussed and it was agreed that as the NH&MRC had withdrawn from this activity, it would be appropriate to be taken over by the College. Discussions are being held with the State Anaesthetic Mortality Committees.

New Committees for 1996/97

A list of the Office Bearers, Committees and College representatives on outside organisations for 1996/97 is published in the Bulletin.

PAIN

Retrospective Recognition of Training

Council resolved that the Certificate in Pain Management be available to participants fulfilling specified requirements from the commencement of the 1996 Hospital Year.

COMMUNICATIONS

National Anaesthesia Day - 16th October 1996

The 150th Anniversary of the first successful demonstration of ether anaesthesia for surgery, will be the subject of media exposure. On this day, Dr Gwen Wilson will be conferred with the honour of Inaugural Laureate of the Wood Library Museum of Anaesthesia History, in Boston.

A logo was accepted for National Anaesthesia Day which is distinctly separate from the style of any Crest or Logos already associated with anaesthesia organisations in Australia and New Zealand. The concept of the logo has strength and impact with capacity to gain the recognition and retention required over time.

The focus of Anaesthesia Day will be centred on how individual Hospitals or Departments can provide some form of patient focussed display to promote the specialty. An Open Day in an Operating Theatre has been considered one popular method. An article on the proposed events for this day appears elsewhere in the Bulletin.

Development of On-line Information Services

Council accepted in principle a proposal from Med-E-Serv for the development of On-line information services for the conduct of College business and for Fellows and Trainees of the College.

Fellows and Trainees of the College will be invited to participate as subscribers to this service with hands-on training for Fellows (at their cost) during the CSM in Perth.

EDUCATION

Equivalent Basic Science Criteria

A Sub-Committee consisting of the Assessor, Education Officer and members of the General Examinations Committee will be convened to determine the criteria for assessment of equivalence of basic science content in overseas qualifications.

Council further resolved that a mechanism be developed by the Sub-Committee for assessment of overseas trained specialists who may be considered for exemption from the Primary Examination.

Training in Medical Ethics

Council resolved that College trainees be exposed during their training to three areas of medical ethics, namely:

1. The ethics of individual practitioners, including:
   a) Practitioner/Patient relationships; and
   b) Relationships with Colleagues
2. Ethics in areas of contentious Medical Practice, e.g. Palliative Care; and
3. The ethics of Medical Research.

The Gilbert Brown Prize and Formal Project Prize

Council approved a document "Information for Presenters" in the Gilbert Brown Prize Session and Formal Project Session at Annual Scientific Meetings to be made available to candidates. This document includes the scoring system used for judging such awards and is published in this Bulletin.

College Role in Development of Clinical Practice Guidelines

Council resolved that, should the opportunity arise, the College should become involved in the continuing development of clinical practice guidelines for areas of professional interest to its Fellows.

Regulation 15.7 - Requirement for Trainees to complete one year in Australasia

Council resolved to amend Regulation 15.7 omitting the requirement for trainees who have completed training in approved training posts in Singapore, Hong Kong and Malaysia to complete one year in Australia or New Zealand prior to admission to Fellowship. However, such Fellows will not be supported for specialist registration in Australasia until they have completed a "Residential" year in either Australia or New Zealand.

The College will advise the Medical Boards in each State and Territory of Australia and the Medical Council of New Zealand that Fellows of this College seeking specialist registration must also have a letter of support from this College.

FINANCE

Workshop - Assessment of Clinical Competence

Funding was approved for up to four attendees from the appropriate College and Faculty Examinations Committees to attend the Australian Medical Council Conference on the Assessment of Clinical Competence from the 31st October to the 2nd November next.

Examination Prize for D. A. (Anaesthesia) in Fiji

Council approved expenditure to a maximum of $400 for the establishment of a prize for the candidate with the highest score in the Examination for the Diploma of Anaesthesia (Fiji) who has achieved a standard considered by the Examiners to be appropriate. The total cost of this prize will be shared with the Australian Society of Anaesthetists. The most appropriate form of a prize is considered to be a book voucher plus a suitably engraved medal to be known as the Sam Seruvatu Medal in memory of Fiji's first specialist anaesthetist and a Fellow of this College. The initial cost will involve the striking of a medal.

Annual Subscriptions - Concession for Fellows residing permanently overseas

Council resolved that Fellows residing permanently outside Australia, New Zealand and the areas in which the College is involved in training, must pay the full subscription for five years, following which time a 75% concession would be granted.

CONTINUING EDUCATION AND QUALITY ASSURANCE

1998 Annual Scientific Meeting - Newcastle

Dr Ross Kerridge has been appointed Convenor for the 1998 Annual Scientific Meeting. Professor Geoff Cutfield has been appointed Scientific Convenor (Anaesthesia) and Dr Phil Byth, Scientific Convenor (Intensive Care) to that Meeting.

Presentation of Examination Prize Winners

Council has resolved that Examination Prizes be presented during the College Ceremony at the Annual Scientific Meeting. Such recipients would be offered complimentary basic registration for that Meeting but would be responsible for funding their attendance at social functions.

1996 Younger Fellows' Conference - New Norcia, Western Australia

The following Fellows have been selected to attend the forthcoming Younger Fellows' Conference:

Dr Stephanie Davies, WA
Dr Glen Downey, Vic
Dr Mary Ann Fox, SA
Dr Clement Goh, Vic
Dr Peter van Heerden, WA
Dr Chris Johnson, WA
Dr Wilson Lim, WA
Dr Lisa McEwin, SA
Dr Bill Miles, Qld
Dr Michelle Mulligan, NSW
Dr William O'Regan, NSW
Dr Lyndall Patterson, Qld
Dr Megan Robertson, Vic
Dr Craig Sims, WA
Dr Morris Vaille, Tas
Dr Vida Viljunas, ACT

Dr Mike Martyn has been appointed the Councillor-in-Residence to this Conference. Dr Dennis Hayward is the Convenor.

Participation in Younger Fellows' Conference from Representatives of Other Disciplines

Council has resolved to invite up to four local nominees from other specialties to participate in the Younger Fellows' Conference each year, the cost of such participation to be borne by the respective Colleges.

Guidelines for the Conduct of Continuing Medical Education Meetings

Council approved Guidelines for the Conduct of Continuing Medical Education Meetings which have now been forwarded to the Australian Society of Anaesthetists for its acceptance.

PROFESSIONAL

Quality Assurance Prize - Commonwealth Department of Community Services and Health

Council supported the College participation in a Quality Assurance Prize of $1,000 being offered to each College by the Commonwealth Department of Community Services and Health. However, in view of the change in Federal Government, it is not certain whether the offer of this prize is still available.

Euthanasia

Following a request to the College from the Northern Territory Government to advise on prescribed mechanisms for Euthanasia, the College responded that it was unable to assist as its Fellows were not trained or experienced in Euthanasia. However, discussion is still ensuing as to whether the College should have offered a stand on this matter.

Policy Document P23 - Minimum Standards for Transport of the Critically Ill

Following the promulgation of a Policy Document by the Faculty of Intensive Care relating to the Transport of the Critically Ill, Council deleted this document from the College Policy Documents.

Guidelines for Autopsies Associated with Operative Deaths

The College has been requested to provide two representatives to join a Joint Committee with the Royal College of Pathologists of Australasia and the Royal Australasian College of Surgeons to produce Guidelines for Autopsies Associated with Operative Deaths.

COLLEGE AWARDS AND ELECTION

The Robert Orton Medal was awarded to Dr Geoffrey Clarke, WA, Dean of the Faculty of Intensive Care.

It is planned that this Award will be presented to Dr Clarke during the College Ceremony at the forthcoming Combined Scientific Meeting in Perth.

Admission to Fellowship by Election

Professor Pierre Coriat, France and Professor Bruce Cullen, USA were elected to Fellowship of the College under Regulation 6.2. These Fellows will be the Foundation Visitors to the forthcoming Combined Scientific Meeting in Perth.

WORKFORCE

AMWAC Report on the Anaesthetic Workforce

The AMWAC Report on the Anaesthetic Workforce in Australia was discussed. An increase in trainee numbers, as proposed in this Report, has already been put in place.

DEATHS

Council noted with regret the death of:

Dr Gwenda M. Lewis, New Zealand Fellow, FFARACS 1967, FANZCA 1992,

Dr Lucy MacMahon, (NSW) Foundation Fellow,

Professor Ross Hawker, Honorary FRACS, Queensland,
(Faculty of Anaesthetists Primary Examiner - Physiology 1966-1978).

COMMUNICATION SKILLS

Excerpt from Medical Board of Victoria June 1996 Bulletin

In the last six months, several Informal Hearings have been held into the professional conduct of doctors involved in medico-legal examinations, where multiple complaints have been received about the attitudes of doctors to patients.

The Board is aware that consultations for medico-legal reports are different from usual consultations. In these cases, the doctor is not in a treating relationship with the patient and is required in one visit, to take a detailed history and conduct an examination which might appear to the patient to be more searching than they would receive from their treating doctor.

The patient may also be anticipating an adverse report from the medico-legal examination. Nevertheless, it remains that only a small minority of doctors involved in medico-legal work are the subject of multiple complaints.

From the evidence of complainants and from the Board's assessment of these doctors, there appears to be several common features in complaints, including:

a) Insensitivity, sometimes amounting to impatience, rudeness and abruptness on the part of the doctor.

b) Inability on the part of the doctor to identify patient anxiety and concern.

c) Failure of the doctors to adequately introduce themselves and to explain the nature and purpose of the examination.

d) Doctors' lack of insight into their poor communication skills.

e) Undue roughness in the conduct of the physical examination

f) Doctors making inappropriate judgements about the rights of the patient to compensation. This would appear to be clearly usurping the role of the courts or tribunals to determine the matter.

g) Doctors failing to provide privacy for undressing, as well as gowns and sheets for patients. In this context, it should be noted that the practice of observing patient's capacity to perform certain tasks, other means of doing this must be found.

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PERIOPERATIVE CARE SATISFACTION

A College Fellow recently received a "Thank You" card from the mother of a 14 year old who had undergone a hip fusion. Anaesthetic care had included pre-anaesthetic education, intra-operative management on two occasions, and postoperative pain management.

To Dr .....

Both John & I would like to express our sincere thanks and appreciation for your assistance in helping our son Steve through his recent hip surgery and also for the T.L.C. you conveyed which, at times, was very much needed.

We realise it's all "part of the job" - so to speak, but some people do their job so much better than others...

We feel you most certainly fit into this category!!

Steve is doing very well, still crutching around with a week or so to go before that all important X-Ray!?

Thank you once again for everything.

Kind Regards

HONOURS AND APPOINTMENTS

Professor Roberta L. Hines, USA -
Professor and Chairman, Department of Anaeshesiology, Yale University

Professor Michael D. A. Vickers (Honorary Fellow), UK -
President, World Federation of Federation of Societies of Anaesthesiologists

Dr. Michael J. Hodgson, Tas -
Member, Federal Executive, Australian Medical Association

Professor Garry D Phillips, SA -
Officer of the Order of St. John (O St.J)

Dr. Agnes M. Day, Qld -
Member of the Order of Australia (AM)

Professor Teik Oh, Hong Kong -
Visiting Professor, University of Alberta, July 1996

Dr Richard J. Bailey, NSW -
Fellowship Wood Library Museum

Professor Lucien E. Morris, USA -
Fellowship Wood Library Museum

REGISTRAR SELECTION AND APPOINTMENT SURVEY

A questionnaire based survey of current registrar selection and assessment practices was undertaken by the Medical Education Special Interest Group in late 1994 and early 1995. I thank all those who returned the questionnaires. The data were collected in preparation for a workshop which took place as part of this SIG's involvement at the ANZCA ASM in Townsville, May 1995. The results are presented here because the data may be of general interest to all Fellows.

Questionnaires were sent to all 88 ANZCA Supervisors of Training in Australia and New Zealand and 38 completed questionnaires were returned. The questionnaire examined issues relating to clinical exposure in anaesthesia prior to entering a training programme and the requirements a prospective trainee would need to meet to be appointed and retained within a training scheme.

1 Clinical experience in anaesthesia prior to entering a training scheme

Medical students

Twenty eight of the hospitals were in geographical proximity to a Medical School. Most Medical Schools provided less than a two week block in anaesthesia and four provided no anaesthesia teaching. Concern was expressed about the low level of exposure to anaesthesia received by the medical students.

Weeks devoted to anaesthesia in undergraduate curriculum	Number of hospitals where this applied
0	4
<1	2
1	11
2	10
2.5	1

Pre-registrar appointments

Nineteen hospitals had formal House Officer or Resident Medical Officer (RMO) appointments within the Department of Anaesthesia, four other hospitals gave very short term training to interns e.g. 20 intubations.

Length of RMO post (months)	Number of hospitals where this applied
1.5	2
3	14
6	3

2 Usual requirements for appointment as a registrar

All hospitals took the best applicants available and in general gave preference to those with the Part 1 Examination. Four hospitals required the Part 1 Examination but two of these were specialist hospitals taking third year trainees. Enthusiasm, skill and good references were emphasized and one hospital gave value to any attempt at the Part 1, although another specifically gave no credit for failed attempt. The relationship between service needs and the number of applicants ultimately determined the appointees.

The amount of prior clinical experience varied between zero and 24 months.

Anaesthesia experience prior to training post (months)	Number of hospitals where this applied
0	5
3	6
6	10
12	9
24	3*

* (two were specialist hospitals)

3 Appointment process

Twenty-seven institutes interviewed prospective trainees, this being determined by the number of applicants in relation to the number of posts available. The nature of the interview ranged from formal and the usual process in some places to informal and ad hoc in others. The interviewing panel consisted of members of the Department of Anaesthesia or a panel representing the training scheme.

In most of Australia the selection process is coordinated by the training scheme, whereas in New Zealand this is hindered by the Privacy Act.

Interview Process

Formal Interview	15
Informal Interview	12

Who interviews applicant?	
Members of Department	19
Training Scheme Selection Panel	7
Unable to tell	1

4 Criteria for retention within training scheme

Apart from the College requirement to pass the Part 1 examination prior to entering the third year of training, there were very few comments regarding how to deal with unsatisfactory trainees.

5 Exposure to subspecialties

The adequacy of exposure to subspecialties was being addressed by the vast majority of the hospitals and 2/3 were specifically rotating their trainees through blocks of subspecialty anaesthesia.

Assurance of subspecialty training	
Formal rotation	22
Informal via roster	10
Computer database	2
Specialist hospital, N/A	2
No attempt	2

6 Do the registrars assess the quality of the supervision and teaching they receive?

Responses to this question were quite varied, some were quite positive, others extremely negative. Some hospitals had open systems in place , for example the right of reply on the In-Training Assessment form, or a registrar representative at staff meetings. Others had anonymous systems in place, including one where the registrars provided detailed written appraisals of the staff members, similar to the registrar assessment forms.

Is there an anonymous process? (comments offered)	
Yes	5
No (but interested in the idea)	7
No (with negative comments)	3
No (with no comments)	23

Summary

Thirty-eight questionnaires out of eighty-eight were returned. This limits the ability to generalise from these results.

There appears very limited exposure to anaesthesia for medical students and pre-registrar level junior doctors. Of those hospitals affiliated with a medical school, 2/3 reported that the medical student exposure to anaesthesia was one week or less. Only half of the hospitals had formal House Officer or RMO grade appointments in anaesthesia.

The selection process and level of prior experience required to be appointed to a training position was extremely variable and reflecting the competition for posts at different hospitals.

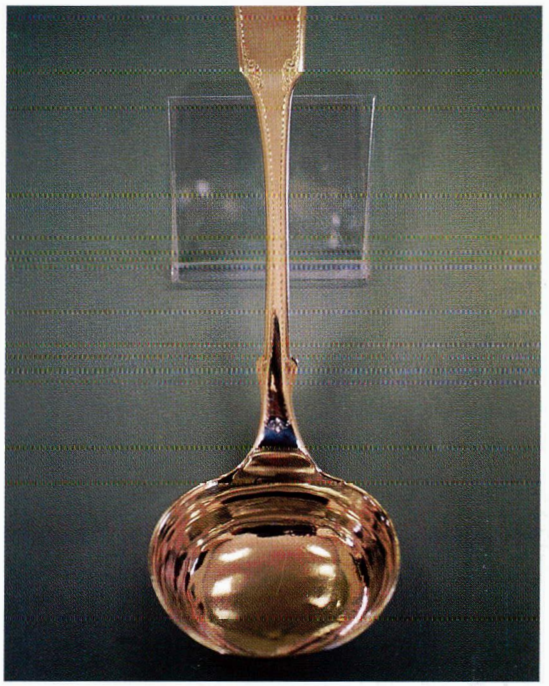
Most hospitals were attempting to ensure adequate subspecialty training. Only five hospitals had a process to allow trainees to comment upon the quality of supervision and teaching.

SANDY GARDEN
Chairman Medical Education SIG

PRESENTATIONS BY FORMER COUNCILLORS

at the completion of their terms of Office

Linton silver serving spoons presented to the College by Associate Professor Neville Davis



Austrian Hungarian solid silver soup ladle circa 1843 presented to the College by Associate Professor David McConnel

Three consecutive Foundation Visitors relaxing: left to right: Professors Paul White, Roberta Hines and Michael Roizen

Dr M J Hodgson at the unveilling of his portrait with the President, Dr N J Davis

FELLOWSHIP EXAMINATION IN INTENSIVE CARE

The Court of Examiners and Successful Candidates April/May 1996

Successful candidates of the Faculty Fellowship Examination May 1996:
Back row: Drs Mark Finnis, Athanasios Flabouris, Orlando Monteiro, Paul MacDonald
Foreground: Drs Florence Yap, Barbara Trytko, Ed Stachowski

REPORT FROM THE PRESIDENT TO THE FELLOWS OF THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAETHETISTS

AS AT THE 7TH JUNE 1996

It is my pleasure to report on behalf of Council on the affairs of the College since the last Annual General Meeting.

COLLEGE AFFAIRS

During the past year there has been considerable extension of the Library facilities. With the electronic advances, the Library is now far more accessible to Fellows from outside Melbourne than it was in the past. This has been reflected in the increase in use of the Library.

Two major events occurred in relation to the Primary Examination - the production of a Syllabus, and a change in the format of the Examination. This was the first real change in the Examination for ten years.

The Maintenance of Standards Programme is up and running with 1274 Fellows enrolled in the Programme. 341 have completed their first year's return.

This year we have strengthened our ties with South East Asia. The College is now formally appointing External Examiners for the local Examinations in Hong Kong, Malaysia and Singapore.

There has been strengthening of the training in Pain Management with the introduction this year of a Certificate in Pain Management which involves training in both acute and chronic pain. Pain has also been included in the College's Statement on Recommended Subspecialty Training.

The Australian Medical Workforce Advisory Committee (AMWAC), with significant input from the College, has included a document on workforce propositions for our specialty. The importance of this exercise is not just this document, but the ongoing monitoring of the workforce which will take place in co-operation with the College. This Committee was able to access data from various areas which has not been available in the past. The figures published in the AMWAC Report show a shortage of anaesthetists in Australia but the moves already taken by the College mean that we are ahead of a target figure which should abolish the shortage in approximately five years.

The College programme on improved communication is progressing in a satisfactory manner and already there is preliminary planning for National Anaesthesia Day on 16th October.

AWARDS, HONOURS AND APPOINTMENTS

During the past year many of our Fellows have been the recipients of Awards, Honours and Appointments.

Professor Michael J Cousins (NSW) and Dr Peter Brine (WA) were invested as Members of the Order of Australia (AM) in the Queen's Birthday Honours and New Year Honours Lists respectively.

Professor Teik E Oh was admitted by invitation to the New York Academy of Sciences.

Professor Michael D A Vickers (Honorary Fellow), Wales was elected President of the World Federation of the Society of Anaesthesiologists.

Associate Professor Robert A Boas (NZ) was elected to Fellowship of the Royal College of Anaesthetists.

Dr Chi Tim Hung (Hong Kong) was elected President of the Hong Kong College of Anaesthesiologists.

Associate Professor Neville Davis was elected Chairman of the Committee of Presidents of Medical Colleges (CPMC) and was awarded Honorary Membership of the Academy of Medicine of Malaysia.

Dr Gwen C M Wilson (NSW) was honoured as the Inaugural Laureate of the Wood Library Museum of the History of Anesthesia, USA for the period 1996 to 2000.

Dr Greg E Knoblanche (NSW) was appointed Associate Clinical Professor of Anaesthesia at the University of Sydney and Professor John M Gibbs (New Zealand) was appointed Emeritus Professor of Anaesthesia at the University of

Otago. Professor Tony Gin was appointed Professor of Anaesthesia at Christchurch School of Medicine, University of Otago and Dr John A H Williamson (SA) was appointed Associate Clinical Professor of Anaesthesia at the University of Adelaide. Professor Roberta L Hines (USA) was appointed Professor and Chairman of the Department of Anesthesiology at Yale University.

Dr Michael J Hodgson (Tas) was elected to the Federal Executive of the Australian Medical Association.

Deaths

It is with regret that I report the death of the following Fellows:

Dr Hilary J K Fisher, Qld
Dr R C Hallowes, Vic
Dr G M Lewis, New Zealand
Dr J G Lomaz, NSW
Dr T R Morely, WA
Dr M J Sullivan, Vic
Dr I A Waldie, Vic
Dr J Woodley, Vic

Research Grants for 1996

In the past year the College received applications for Research Scholarships and Grants totalling $572,201. College funds available for distribution and awarded in 1996 amounted to $158,739.

Scholarships were awarded to:

Dr John A. Loadsman (NSW) $30,000
Perioperative Sleep and Breathing

Dr Megan S. Robertson (Vic) $30,000
The Gut, Stress and Infection: Helicobacter Pylori In the Critically Ill Patient

Dr Christopher Hayes (NSW) $20,000
Special Project in Pain Management

Grants were awarded to:

Dr Anthony W. Quail (NSW) $21,000
Effects of exogenous nitric oxide donors on the distribution of regional coronary blood flow in the anaesthetised dog.

Dr Brian M. F. Lewer (NZ) $10,712
Late disturbance in ventilation following anaesthesia and surgery.

Dr Graeme K. Hart (Vic) $15,000
Continuous haemofiltration on the management of severe sepsis and early septic shock.

Dr John A. Loadsman (NSW) $ 7,000
Perioperative Sleep and Breathing

Dr Geoffrey A. Gutteridge (Vic) $12,960
Effect of high total volume ventilation on the local and systemic inflammatory response to gram negative pneumonia.

The Council 1996 - 1997

Membership of the Council to take office after the Annual General Meeting, its Office Bearers and Committees will be published as an addendum to this Report.

ADMISSION TO FELLOWSHIP BY ELECTION

Under Regulation 6.3.1(b)

Dr Stephen Charles Bentley, NSW
Dr John Berg, Vic
Dr Imelda Geraldine Bourke, Qld
Dr Patricia Heather Cosh, New Zealand
Dr Andrew Michael M Henderson, New Zealand
Dr John Stuart Henshaw, Tas
Dr Michal Theodore Kluger, SA
Dr Robin Iris Limb, SA
Dr Glenys Margaret Miller, SA
Dr Carl Theodorus Moller, Tas
Dr Marjorie Joan Pink, NSW
Dr Gayle Lynley Roberton, SA
Dr Tao John Slykerman, Qld

Under Regulation 6.3.1(c)

Professor Cindy Sui Tee Aun, Hong Kong
Dr Patrick Seow Koon Tan, Malaysia

Under Regulation 6.3.1(d)

Dr Samuel Wallace McVicker, Vic

Under Regulation 6.3.1(e)

Dr Judith Lyn Forbes, New Zealand
Dr Ramani Vijayan, Malaysia

PRIMARY EXAMINATIONS

July/September, 1995

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

The Oral Examination was held in Melbourne.

	Total No Candidates	Invited to Oral	Approved
MELBOURNE	154	124	81

March/April, 1996

The written section of the Examination was conducted in all capital cities in Australia, Cairns, Newcastle, Auckland, Christchurch, Dunedin, Wellington, Hong Kong and Kuala Lumpur.

Oral Examinations were held in Melbourne and Hong Kong.

	Total No Candidates	Invited to Oral	Approved
MELBOURNE	94	77	58
HONG KONG	15	10	9
TOTAL	**109**	**87**	**67**

The Renton Prize for the period ending 31st December, 1995 was awarded to Dr Kwok Wing Hong of Hong Kong and to Dr Anthony Neville Coorey of Queensland for the period ending 30 June, 1996.

FINAL EXAMINATIONS

August/September, 1995

The Written Examination was conducted in all capital cities in Australia, Newcastle, Townsville, Auckland, Christchurch, Dunedin, Wellington, Hong Kong, Kuala Lumpur and Singapore.

The Viva Voce and clinical examinations were conducted at Westmead Hospital, Sydney.

Seventy-four (74) candidates presented in Sydney and fifty-one (51) were approved.

SUCCESSFUL CANDIDATES

Names of successful candidates who had not completed training are listed in boxed section below.

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31st December, 1995 not be awarded.

Successful Candidates - who had not completed training

Dr. C. Arali	NSW	Dr. M.L. Harty	NZ	Dr. A. Purdon	NSW
Dr. D.L. Bain	VIC	Dr. W.C.T. Hui	HKG	Dr. M.C. Reddy	NZ
Dr. K.C. Baker	NSW	Dr. A.M. Lilley	VIC	Dr. G.M. Roper	NZ
Dr. H.K.T. Beh	HKG	Dr. G.C.B. Lloyd	NSW	Dr. D.A. Sidebotham	NZ
Dr. A.M. Brennan	VIC	Dr. S.M. Lockley	NSW	Dr. A.J. Silvers	VIC
Dr. G. Burgin	VIC	Dr. I. Lomas	QLD	Dr. N.R. Skjellerup	NZ
Dr. A.Cavdarski	QLD	Dr. W.C. Macaulay	NZ	Dr. M.G. Stewart	NSW
Dr. T.V. Chan	HKG	Dr. S.C. Maclaurin	NZ	Dr. P. Talbutt	QLD
Dr. Chew Tsong Huey Sophia	S'PRE	Dr. G.J. McHugh	NZ	Dr. K.H. Tan	NSW
Dr. P.T. Clark	NSW	Dr. A.D. McKee	NZ	Dr. N.M. Vandenriesen	WA
Dr. J.G.L. Cockings	SA	Dr. C.M. McKenzie	VIC	Dr. E.J. Visser	WA
Dr. B.T. Cook	NSW	Dr. S.D. Newell	QLD	Dr. D.C. Wilkinson	SA
Dr. F.J. Daday	QLD	Dr. Ngoh Ivan Hon Seng	MAL	Dr. I.R. Williams	NZ
Dr. A.B. Evans	VIC	Dr. S.R. Nicoll	NZ	Dr. P.A. Wilson	NZ
Dr. M.A. Featherston	NZ	Dr. N.B.T. Nor	MAL	Dr. Wong Ho Shan Steven	HKG
Dr. S.C. Fortey	NSW	Dr. T.E.A. Palmer	QLD	Dr. C.M.L. Wong	HKG
Dr. Goh Meng Huat	S'PRE	Dr. S.B. Parkes	QLD	Dr. D.W. Wrathall	NZ

April/May, 1996

The Written Examination was conducted in all capital cities in Australia, Auckland, Wellington, Hong Kong, Kuala Lumpur and Singapore.

The Viva Voce was conducted at the College Headquarters and the clinical examinations at the Alfred Hospital, Melbourne.

Eighty-eight (88) candidates presented in Melbourne and sixty-one (61) were approved.

SUCCESSFUL CANDIDATES

Names of successful candidates who had not completed training are listed in boxed section below.

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30th June, 1996 be awarded to Dr Cyrus Edibam of Western Australia.

Successful Candidates - who had not completed training

Dr. M C Anderson	VIC	Dr. K Kanji	NZ	Dr. G O Rooke	TAS
Dr. N Balis	VIC	Dr. Khoo Teik Hooi	MAL	Dr. C M Ryan	NSW
Dr. G R Barnes	NSW	Dr. D P Kibblewhite	NZ	Dr. P F Seal	VIC
Dr. S M Beath	NSW	Dr. M C Kilminster	NSW	Dr. D J Simmons	NSW
Dr. T C Branson	SA	Dr. H Kim	NSW	Dr. M F Sinclair	SA
Dr. B F Brett	QLD	Dr. K Lam	VIC	Dr. J A Smith	NSW
Dr. P W Browne	TAS	Dr. Leung Kit Hung Anne	HKG	Dr. K M Smith	NZ
Dr. R H Buckland	NSW	Dr. Lim Hong Joo	MAL	Dr. J G Speirs	NZ
Dr. A Cheng	HKG	Dr. D R MacKenzie	NZ	Dr. A H Stewart	NSW
Dr. A Czuchwicki	SA	Dr. E Malkoutzis	VIC	Dr. M V Stuart	NZ
Dr. A J Davidson	VIC	Dr. T J McCulloch	NSW	Dr. Suen Ka Lok Tommy	HKG
Dr. C Edibam	WA	Dr. R J McDougall	VIC	Dr. Tan Chin How	SING
Dr. B E Evans	SA	Dr. K F McManus	QLD	Dr. R M Thiruchelvam	NZ
Dr. R J Fitzgerald	NZ	Dr. A E Nicholson	VIC	Dr. J J Troup	VIC
Dr. A W Fock	VIC	Dr. A J Norton	SA	Dr. R J Turner	NSW
Dr. C G Fowler	NZ	Dr. S Pathy	SA	Dr. A Vartis	NSW
Dr. L M George	NSW	Dr. H R Playford	NSW	Dr. S A Watts	NZ
Dr. P R Hammer	NSW	Dr. R Popovic	VIC	Dr. H K Welch	WA
Dr. C A Hawke	QLD	Dr. A W Reid	NZ	Dr. D J Wilson	WA
Dr. Ho Pik-Yee Betty	HKG	Dr. G Reimers	NSW	Dr. A J Wyss	VIC
Dr. C C Iatrou	VIC				

ANNUAL SCIENTIFIC MEETING

Due to the World Congress being held in Sydney in April, there will be a Combined Scientific Meeting with the Australian Society of Anaesthetists this year in Perth from 26th to 30th October. The Foundation Visitors will be Professor Bruce Cullen of the USA who will deliver the Mary Burnell Lecture and Professor Pierre Coriat from France who will deliver the Ellis Gillespie Lecture. The Lennard Travers Professor, Associate Professor David Crankshaw, will be the Australasian Visitor to this Meeting.

Policy Documents

Council completed the promulgation of Policy Document E15 - *Guidelines for Trainees and Departments Seeking College Approval of Posts for the Certificate in Pain Management* and nine Policy Documents were revised after consultation with the College's Regional Committees.

The College's *Statement on Sub-Specialty Experience for Anaesthesia Trainees* was amended to include Pain Management. Council is aware that it may not be possible for all trainees to gain experience in all such sub-specialties, but it believed it important to highlight areas of experience.

Council

In accordance with the provisions of the Articles of Association, nominations were called for three vacancies on Council. N J Davis and D H McConnel retired from Council upon completion of 12 years as Board/Council Members and Dr Moira Westmore was eligible for re-election to Council.

The following is the result of the Ballot:

Votes Counted	939		
Less Informal	5		
	934		
	x 3	=	2802

M D Westmore	662
M Martyn	528
G E Knoblanche	495
D C S Khursandi	438
R D M Jones	347
A A Bishop	332

Retiring Councillor

Associate Professor David McConnel has completed his twelve years of Office, eight as a Member of the Board of Faculty and the latter as a College Councillor. David has been a great contributor to College activities over the years. He was a Member of the Queensland Regional Committee from 1974 to 1984 and Chairman from 1980 to 1983. He was a Member of the Panel of Examiners from 1976 to 1988 and Chairman of the Final Examination Committee for two years from 1986. David's contribution to Board of Faculty and College affairs covered Convenor of the 1988 Faculty's General Scientific Meeting in Brisbane, GSM Officer from 1989 to 1992, Protocol Officer from 1985, Member of the Executive Committee from 1989 to 1991 and Pharmaceutical/Technical Officer for the year 1988-89. David has chaired the Workforce Committee and has been a Member of the Anaesthetic Industry Liaison Committee since 1992. He has represented the College on the Joint Consultative Committee on Anaesthesia since 1993.

COLLEGE ADMINISTRATION

A number of staff changes have occurred during the past twelve months.

Miss Carol Cunningham-Browne was appointed Administrative Officer to the Faculty of Intensive Care and was replaced by Miss Lara Milvain as Administrative Assistant (Education). Lara is providing the secretariat for the Education and Hospital Accreditation Committees.

Following Mrs Mary Crowhurst's resignation from the South Australian Office, Ms Sue Harrison was appointed in November 1995 to provide the secretariat for the College's Regional Committee.

I would like to express my sincere thanks to Members of Council and Regional Committees for all the work they have done for the College in the past year. The Council could not function however without the great effort put in by the College staff at Ulimaroa and in the Regions. I especially wish to thank Mrs Joan Sheales, the Registrar, who is untiring in her work for the Council and its many Committees. We owe her a vote of thanks.

NEVILLE J DAVIS
June 1996

ANZCA Council Elections
May 1996

Position on ballot		Votes	% of Votes
6	MOIRA WESTMORE	662	71%
5	MIKE MARTYN	528	57%
4	GREG KNOBLANCHE	495	53%
3	DIANA KHURSANDI	438	47%
2	DOUG JONES	347	37%
1	ASHLEIGH BISHOP	332	36%

1996 Council Ballot

Envelopes Received	963		
Less Invalid	24		
Votes Counted	939		
Less Invalid Votes	5		
	934	x 3 =	2802

Regional Breakdown of Votes

REGION	ENV. RECEIVED	NO. OF FELLOWS	PERCENTAGE
Victoria	203	469	43%
New South Wales/ACT	281	675	42%
Tasmania	26	47	55%
Queensland	162	302	54%
South Australia	70	211	33%
Northern Territory	4	6	67%
Western Australia	74	163	45%
New Zealand	82	274	30%
Hong Kong	14	95	15%
Malaysia	2	48	4%
Singapore	4	46	9%
USA & Canada	5	62	8%
United Kingdom	7	55	13%
Other Overseas Countries	5	30	17%
Invalid Envelopes	24		
** Figure does not include invalid envelopes or votes ***Total***	**963**	2483	38% **

COUNCIL OFFICE BEARERS AND COMMITTEES FOR 1996/97

President	G D Phillips
Vice President	R G Walsh
Assessor	J M Gibbs
Assistant Assessor	M D Westmore
Education Officer	R S Henderson
Chairman of Executive	R G Walsh
Chairman of Examinations	R J Willis
Treasurer	R G Walsh
Chairman of Hospital Accreditation Committee	I Rechtman
Pharmaceutical/Technical and Safety Officer (Australia)	M D Westmore
(New Zealand)	R S Henderson
Protocol Officer	I Rechtman
ASM Officer	R J Willis
Communications Officer	M Martyn
Maintenance of Standards Officer	G D Phillips

EXECUTIVE

Chairman	R G Walsh
President	G D Phillips
Assessor	J M Gibbs
Treasurer	R G Walsh
and such other Members as the Council may appoint	R J Willis
	T E Oh

EDUCATION COMMITTEE

Chairman (Education Officer)	R S Henderson
President	G D Phillips
Assessor	J M Gibbs
Chairman of Examinations	R J Willis
Chairman of CE&QA Committee	R N Westhorpe
Chairman of Hospital Accreditation Committee	I Rechtman
Faculty Education Officer	F H Hawker
and such other Members as the Council may appoint	M J Cousins

HOSPITAL ACCREDITATION COMMITTEE

Chairman	I Rechtman
President	G D Phillips
Assessor	J M Gibbs
Assistant Assessor	M D Westmore
Education Officer	R S Henderson
Member appointed by Council	G E Knoblanche

CONTINUING EDUCATION AND QUALITY ASSURANCE COMMITTEE

CE & QA Officer (Chairman)	R N Westhorpe
President	G D Phillips
Education Officer	R S Henderson
ASM Officer	R J Willis
MOS Officer	G D Phillips
Representative, Faculty of Intensive Care	R F Whiting
Representative from ASA	W R Thompson
Representative from NZSA	A L Garden
and other Members appointed by Council	M Martyn

WORKFORCE COMMITTEE

Chairman	M D Westmore
President	G D Phillips
Education Officer	R S Henderson
Assistant Assessor	M D Westmore
Faculty Education Officer	F H Hawker
and such other Members as the Council may appoint	G E Knoblanche
	M K Radnor

PRIMARY EXAMINATION COMMITTEE

Chairman	A W Quail
Deputy Chairman	M R Crawford
Chairman of Examinations	R J Willis
Chairman of Faculty Fellowship Examination	R P Lee
Councillor	R S Henderson
and three Members	R L Eyres
	N M Gibbs
	P Kam
Co-Opted Member	J B Love

FINAL EXAMINATION COMMITTEE

Chairman	P L Klineberg
Deputy Chairman	E Loughman
Chairman of Examinations	R J Willis
Council Representative	G E Knoblanche
and three Members	D A Pybus
	D A Scott
	A M Weeks
Co-opted Member	C A Morgan

GENERAL EXAMINATIONS COMMITTEE

Chairman of Examinations (Chairman)	R J Willis
President	G D Phillips
Education Officer	R S Henderson
Chairman of Primary Examination	A W Quail
Deputy Chairman of Primary Examination	M R Crawford
Chairman of Final Examination	P L Klineberg
Deputy Chairman of Final Examination	E Loughman
Chairman of Faculty Fellowship Examination	R P Lee

ASM COMMITTEE

ASM Officer (Chairman)	R J Willis
President	G D Phillips
Protocol Officer	I Rechtman
Communications Officer	M Martyn
Faculty Representative	R F Whiting
Registrar	J M Sheales

ASM SCIENTIFIC PROGRAMME COMMITTEE

ASM Officer (Chairman)	R J Willis
President	G D Phillips
CE & QA Officer	R N Westhorpe
Past Scientific Convenor (Queensland)	V I Callanan
Present Scientific Convenor (Western Australia)	N M Gibbs
Future Scientific Convenor (New Zealand)	R R Kennedy
Councillor & Deputy Convenor	M D Westmore
Representative of the Faculty of Intensive Care	R F Whiting

PAIN MANAGEMENT ADVISORY COMMITTEE

Chairman	M J Cousins
	J M Gibbs
	C R Goucke
	D Jones
	T F Little
	P E MacIntyre
College Representative on Board of Faculty of Intensive Care	R G Walsh
Gilbert Brown Prize Adjudicators	
Chairman (ASM Officer to select panel)	R J Willis
Formal Project Prize Adjudicators	
Chairman (ASM Officer to select panel)	R J Willis

COMPUTER SUB-COMMITTEE

Chairman	M Martyn
Treasurer	R G Walsh
Registrar	J M Sheales
Accountant	V M Lillis
and such other Members as the Council may appoint	M Martyn
	C A Morgan
Bulletin Editor	J M Sheales

COMMUNICATIONS COMMITTEE

Communications Officer (Chairman)	M Martyn
President	G D Phillips
ASM Officer	R J Willis
Registrar	J M Sheales
Communications Consultant	E Dean
Representative of Faculty of Intensive Care	D J Cooper
Other Members as appointed by Council	J M Gibbs
	I Rechtman
	M D Westmore

RESEARCH COMMITTEE

Chairman	M J Cousins
	J M Gibbs
	T E Oh
	T Gin
	D W Blake
Representative of the Faculty of Intensive Care	A D Bersten

HOUSE COMMITTEE

Chairman	R N Westhorpe
Councillor	G D Phillips
Member Board of Faculty	F H Hawker
Curator, Geoffrey Kaye Museum	R N Westhorpe
Registrar	J M Sheales
Librarian	S Nadaraja
Staff Representative	H Morris

LIBRARY COMMITTEE

Councillor and Chairman	R N Westhorpe
Councillor	I Rechtman
Members	C A Morgan
	B F Horan
	B Spain
Representative of Faculty of Intensive Care	J B Love
Librarian	S Nadaraja

VICTORIAN CHAIRS OF ANAESTHESIA ADVISORY COMMITTEE

G B Donnan
P A Lowe
I Rechtman
T C K Brown
P J Keast
R N Westhorpe

JOINT ADVISORY COMMITTEE OF COMBINED COLLEGES

President or
Vice President

AUSTRALIAN RESUSCITATION COUNCIL

V I Callanan
G A Harrison

COLLEGE HISTORIAN M G Cooper

ASSISTANT HISTORIAN A J Newson

GEOFFREY KAYE MUSEUM OF ANAESTHETIC HISTORY

Curator R N Westhorpe
Assistant Curator C M Ball

REPRESENTATIVES/NOMINEES TO OTHER OUTSIDE ORGANISATIONS

AUSTRALIAN SOCIETY OF ANAESTHETISTS

Executive President or nominee

ASA Joint Liaison Committee President
Vice President

Coordinator of Anaesthetic Representatives on External Standards Committees W J Russell

National Committee on Day Surgery A K Bacon
G E Rudkin

Anaesthetic Co-ordinating Committee for AMA Federal Conference President
Chairman of Executive

ANAESTHESIA AND INDUSTRY LIAISON COMMITTEE

President G D Phillips
ASM Officer R J Willis
R N Westhorpe

ASIA PACIFIC COMMITTEE

Chairman T E Oh
R G Walsh
J M Gibbs
R N Westhorpe
M J Cousins
Representative Faculty of Intensive Care TBA
Representative Australian Society of Anaesthetists TBA
Representative New Zealand Society of Anaesthetists TBA

JOINT CONSULTATIVE COMMITTEE ON ANAESTHESIA (JCCA)

R G Walsh
N J Davis
F X Moloney

Committee of Presidents of Medical Colleges President

Workforce Committee G D Phillips

Education and Standards Sub-Committee M J Cousins

RACS EMST Board A McKillop

RACS Committee on Infection Control G E Knoblanche

Conjoint Committee of the AMA and the Joint Advisory Committee of the RACP, RACS, RACOG, RACGP and ANZCA President

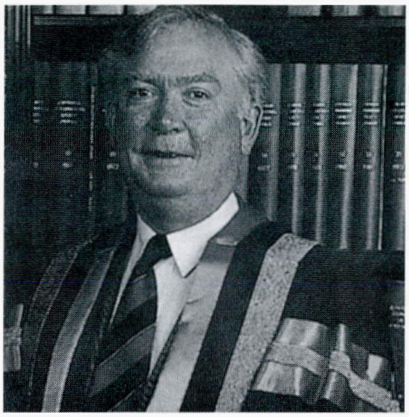
Australasian Board of Cardiovascular Perfusionists R G Walsh
A B Stewart

Observer to RACS Council President

WORKING PARTY

Anaesthesia Simulators
Convenor and Chairman R S Henderson
Treasurer R G Walsh
MOS Officer G D Phillips
R N Westhorpe
A L Garden
J Zelcer

DEAN'S MESSAGE



As the Faculty approaches its third birthday, it is interesting to review our current position. There are 192 Fellows of the Faculty and of these 124 are Fellows by examination. 176 are male and 16 female.

The distribution and designation of accredited training posts are set out in Table 1 (page 53). Currently there are 86 trainees (67 male, 19 female). 60 of the trainees are undertaking intensive care training alone (though many of these will have completed anaesthesia training) and there are 26 doing anaesthesia and intensive care training. The distribution of trainees by region is set out in Table 2 (page 53).

The Joint Specialist Advisory Committee dealing with all intensive care trainees (FIC, ANZCA and RACP) has already met twice this year. So far there are three trainees seeking dual certification of FRACP and FFIC, ANZCA.

Since the Maintenance of Standards Programme was offered in June 1996, 91 Fellows and 1 non-Fellow have registered.

It is clear that Australia and New Zealand are highly regarded by overseas graduates as having many centres of excellence for intensive care training. Currently between 40-50% of our training posts are occupied by overseas trainees. The Censor receives numerous requests from overseas doctors seeking support from the Faculty to gain Occupational Training Visas. The type of information provided by the Censor relates to whether or not the position for which they are applying is in an Intensive Care Unit recognised by the Faculty as a place suitable for training in intensive care. Many of these people do not go on to gain certification in intensive care. In many cases this would not be possible because of the time allocated to them in Australia. In response to similar situations affecting overseas surgical trainees, the Royal Australasian College of Surgeons issues a certificate acknowledging the period of training received (provided it is over one year) in a training institution.

Recently the Board has been looking at this same issue and has been seeking input from Regional Committees. It is not a matter the Board wishes to proceed with unless we perceive that there is support for this concept from our Fellowship. Any certificate issued to an overseas doctor spending a year or more in a unit which has recognised training posts in intensive care would be so worded that it could not be construed as implying Fellowship of the Faculty nor that the time spent would necessarily be recognised as training for the Fellowship. Its purpose would be to help those people who are trying to raise the profile and standard of intensive care in the areas to which they are returning. Remember that the proposed certificate would be only for overseas doctors who are returning overseas. If you have views on this or other Faculty related subjects, pass them on to your Regional Committee.

The convenors have constructed a very interesting and entertaining program for the October Combined Scientific Meeting. I hope to see many of our Fellows at this meeting.

G. M. CLARKE
Dean

THE FELLOWSHIP EXAMINATION IN INTENSIVE CARE

The aim of this article is to acquaint Supervisors of training, teachers and candidates with the current exam process and the expectations of the Examiners.

The Fellowship Examination (Intensive Care) is an integral part of the Intensive Care Training and Certification Programme of the Faculty. This programme consists of:

1. A training period in approved posts.
2. In-training assessment.
3. The Primary Examination or equivalent.
4. The Fellowship Examination.

The Objectives of Training in Intensive Care are in the latter stages of a major revision.

The first exam was set in 1979. Since that time there have been several modifications and refinements. The examination process is continually reviewed.[1, 2] Pre-conditions for sitting the exam are set out in Administrative Instruction 1.

Currently the Examination consists of written and oral sections and covers the theory and practice of Intensive Care, including relevant aspects of the basic sciences, anaesthesia and clinical medicine.

WRITTEN SECTION

The written section consists of two papers. 15 short answer questions to be answered in two and a half hours and two long answer questions to be answered in two hours.

1. **The Long Answer Questions** comprise 20% of the total mark. They generally aim to assess the candidate's ability to handle a clinical problem, critically evaluate equipment, understand disease processes, intensive care organisation or practical issues of patient management. When a clinical problem is set, the candidate is expected to show an ability to plan a course of action, gather clinical information, develop a hypothesis, choose and justify investigations and reasonable treatment options.

   A creation of perfect copperplate prose is not expected, but the writing should be legible and understandable. Lists and diagrams are encouraged if they improve communication. Mindless lists (e.g. of tests) without explanation, rationale and justification do not accrue marks.

   A practical approach to a problem is expected as originally outlined in the Objectives of Training and the level of knowledge expected is best illustrated by reading recent reports of the exam. When a management plan is requested, the examiners are seeking a description of the whole process which should include resuscitation, assessment, establishment of diagnosis, definitive treatment. Candidates are expected to approach problems as a Specialist and to highlight contentious issues of management.

2. **The Short Answer Questions** comprise 20% of the total mark. They cover medical and surgical problems, procedures, equipment, pharmacology, anatomy, physiology, metabolic disorders and paediatric topics.

   Approximately 10 minutes is allocated for each question so lists, outlines, tables and brief discussions are sought.

   When a list is requested the common examples should be listed first. Marks are deducted for irrelevant information and a failure to show priority setting in lists and the relative importance of the constituents. When asked to critically evaluate for example, a drug, the candidate is expected to describe the pros and cons of that drug and its role in intensive care, assessing all aspects of its pharmacology. It is not sufficient to list without comment on its features.

ORAL SECTION

The oral section consists of Clinical, Investigation and Cross Table Vivas.

The Clinical Section consists of one hour of encounters with a mixture of patients:

1. acute intensive care unit cases and
2. non-acute cases (medical or surgical) in the presence of two Examiners.

This section comprises 30% of the total mark.

The candidate may be asked to examine:

(a) a system (e.g. respiratory or cardiac)

(b) a part of the body (e.g. a limb)

(c) parts of the body in a local or general problem

The case may be introduced as a clinical problem relevant to Intensive Care with a short history e.g. "increasing breathlessness" or "difficulty walking".

Emphasis is placed on an orderly, efficient and purposeful assessment. The candidate is then expected to derive an acceptable diagnosis (not necessarily the correct diagnosis) and generate differential diagnoses. The candidate may also be asked to suggest and interpret relevant investigations and discuss a general plan of management. Stress is placed on the comprehensive examination, determination of reliable signs and competent problem solving in acute medical and surgical cases. Candidates are cautioned not to jump to a diagnosis unless it is obvious.

Most candidates choose to remain silent until ready to discuss the findings but may explain the findings while examining the patient. It is important that the candidate displays courtesy and consideration for the patients and staff at the bedside. Where stimulation is required the candidate should explain the procedure and use increasing intensity of stimulation.

Any equipment which the candidate might require will be provided at the bedside but the candidate may bring a familiar kit.

It is possible that medications or equipment encountered at the bedside will be briefly discussed.

The Investigation Section lasts 30 minutes and accounts for 10% of the total mark. The candidate is asked to assess a range of radiological, haematological, biochemical, nuclear medicine and other investigations relevant to regular intensive care practice. This usually includes X-RAYS, ECG's, CT scans, MRI scans, biochemical profiles, blood films, respiratory function tests and arterial blood gas results.

The candidate is expected to recognise the pattern, discriminate between normal and abnormal features and suggest the cause of the abnormality. A brief general management plan may be discussed but this is not the aim of the section.

The investigations will necessarily be in various formats but the candidate will be assisted with normal values and given time to familiarise.

The Viva Section comprises 20% of the total mark and consists of two encounters, each of 30 minutes duration, with two separate sets of two examiners.

The candidate can expect to be asked to discuss any facet of intensive care practice, including medical/surgical/obstetric/paediatric problems, equipment and procedures.

The initial questions are at a basic level, and once the candidate has demonstrated an adequate safe level of competence, more esoteric questions will be asked.

Suggested Reading:

1. G.M. Clarke, G.A. Harrison. The Training/Examination Programme in Intensive Care, Australian and New Zealand College of Anaesthetists. 1. Training. Anaesthetics Intensive Care 1993; 21: 848-853

2. G.M. Clarke, G.A. Harrison. The Training/Examination Programme in Intensive Care, Australian and New Zealand College of Anaesthetists 2. Examination. Anaesthetics Intensive Care 1993; 21: 854-860

Table 1: Accredited Training Posts

	Core	Elective	Total
	101	26	127
By Region:			
NSW	30	3	33
VIC	19	4	23
QLD	12	6	18
SA	12	2	14
WA	7	2	9
ACT	2		2
TAS	1	2	3
NZ	14	3	17
HK	4	4	8

Table 2: Trainees by Region

ACT	2	NSW	24
QLD	14	SA	11
VIC	7	WA	5
HK	7	Malaysia	1
NZ	8	UK	2
Other	1		

ITEMS OF INTEREST FROM THE JUNE 1996 BOARD MEETING

EDUCATION

In-Training Assessment

In discussion, the Board emphasised the principles of in-training assessment as a prospective process of assessment. Assessments covering the 24 months of core intensive care training are compulsory in order to have this training recognised and are the responsibility of both the trainee and supervisor. In-training assessment for other periods of training are encouraged but are optional. It is recommended that prospective assessments are conducted for non-Faculty trainees occupying Faculty-approved posts for six months or more. This is to enable the possibility of this period of training being recognised should the occupant of this post later decide to register for intensive care training.

Formal Project

The Board resolved that trainees commencing approved vocational training from the commencement of the 1997 Hospital Year will be required to complete a Formal Project. The details of this requirement will be finalised following further consultation with the Joint Specialist Advisory Committee in Intensive Care.

Appointment of Supervisors of Training

The Board resolved that Policy Document IC-6 'Supervisors of Training in Intensive Care' will be amended to clarify the procedure for the appointments of Supervisors of Training. The Supervisor will be nominated by the Director of the Department. Following ratification by the Board, the Director and Hospital Administration will be notified of this appointment.

TRAINING AND EXAMINATIONS

Guidelines for Examiners

Documents currently under review include 'Guidelines for Appointment and Training of Examiners' and 'Rules for Observers'.

Dates for Examinations in 1997

The Board ratified the proposed dates for the Fellowship Examination in 1997. These are published elsewhere in the Faculty section of the Bulletin.

Training and Certification in Paediatric Intensive Care

The Board adopted a proposal for a training and certification programme in Paediatric Intensive Care. The programme allows provision for endorsement of the Faculty Diploma which can be obtained either through the Faculty of Intensive Care or through the Royal Australasian College of Physicians/Australian College of Paediatrics training scheme (both), with all trainees being supervised by the JSAC-IC. Successful diplomates fulfilling requirements for dual certification will emerge with a

FFICANZCA (Endorsed in Paediatric Intensive Care) and an FRACP (Paediatrics) in a minimum of seven years from graduation.

The five year programme is composed of three and a half years of core training, and one and a half years of elective training. Of the core period, two years must be spent in intensive care posts approved for core training, at least eighteen months of which must be spent in a paediatric intensive care unit with core approval; one year must be spent exclusively in anaesthesia with at least six months in paediatric anaesthesia, and six months must be spent in a paediatric medical post. The remaining eighteen months may be spent in any combination of adult or paediatric posts approved for elective training.

Exemption from the Primary Examination

The Board resolved that exemption from the Primary Examination may be granted to trainees who have passed a Primary Examination recognised by the Board as of comparable standard or who possess a Degree or Diploma obtained by examination, which satisfies the Board. Trainees who have passed the written and clinical FRACP Examination will be exempt from the ANZCA Primary Examination for the purpose of gaining certification in intensive care only. Under special circumstances, it may grant a trainee exemption from the Primary Examination following assessment of documentary evidence. Interviews and/or other assessment may be required.

Review of the System of Accreditation

A major review of the nature of accreditation by the Faculty was commissioned. A working party will consider the general philosophy of approving training posts as opposed to programmes; issues such as limiting the number of approved posts within accredited intensive care units will be considered, along with the level of the post.

Amendment to Administrative Instruction 1 - Training and Examination

Administrative Instruction 1 was amended to incorporate the provision for endorsement in paediatric intensive care. Reference to the terms 'compulsory' and 'optional' were deleted. These periods of training are now described as 'core' and 'elective'.

PROFESSIONAL

Clinical Indicators

Draft Clinical Indicators have been developed and will now be trialed in a number of hospitals. The Board confirmed that Faculty involvement in the continuing development of clinical indicators will occur through its representatives on the Intensive Care Medical Liaison Committee.

Joint Specialist Advisory Committee - Intensive Care

The Board resolved that the title of the document 'Administrative Instruction 2 - Joint Specialist Advisory Committee' be deleted and renamed the 'Terms of Reference' for that Committee. Following a recommendation from the JSAC-IC, the Board resolved that the Chairman of this Committee will hold tenure for a period of two years, eligible for re-election for a subsequent term of office.

Policy Documents

The draft policy document 'Statement on Patients' Rights and Responsibilities' is in preparation. A working group is currently reviewing Policy Document IC-1 'Minimum Standards for Intensive Care', which will also be discussed by the ANZICS-chaired Intensive Care Medical Liaison Committee.

CONTINUING EDUCATION

Combined Scientific Meeting - Perth 1996

The Board noted a registration fee for the Faculty component of the forthcoming Combined Scientific Meeting in Perth, which will allow for attendance from the afternoon of Saturday 26th October up to and including the morning of Monday 28th October.

Annual Scientific Meeting - Christchurch 1997

A suggested programme for the proposed meeting in Christchurch in 1997 to be held conjointly with the ANZICS Regional meeting was noted.

Annual Scientific Meeting, 1998 - Newcastle

Dr P.L. Byth was ratified as the Faculty's Scientific Convenor for this Meeting.

Maintenance of Standards Program

The Board resolved that the Maintenance of Standards Programme will be circulated to Fellows of the Faculty.

INTERNAL AFFAIRS

Honours and Appointments

The Board congratulated Professor Garry Phillips on his election as President. Board members proudly acknowledged the recent award by Council of the Robert Orton Medal, to Dr Geoff Clarke.

Board of Faculty

There was no requirement for an election this year. In view of the lack of an elected representative from New South Wales, the Board has co-opted Dr Gillian Bishop upon the recommendation of the New South Wales Regional Committee as a representative from that region.

Election of Office Bearers

The following office-bearers were elected:

Vice-Dean	R.V. Trubuhovich	Censor	A.W. Duncan
Education Officer	F.H. Hawker	Treasurer	D.J. Cooper

Finance

A review of training fees is underway.

CHANGES TO FACULTY REGULATIONS

3.3 The Chairman of each principal Committee will be a Member of the Board with the exception of the Joint Specialist Advisory Committee in Intensive Care where the Chairman may or may not be a Member of the Board. (Refer the Terms of Reference, Joint Specialist Advisory Committee in Intensive Care.)

5.10 Candidates admitted to Fellowship of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists who have satisfied the training and examination requirements in Paediatric Intensive Care will be issued with a Certificate of Endorsement indicating that the Fellowship is awarded in Paediatric Intensive Care.

12.3 Notwithstanding Regulation 12.2, exemption may be granted from the Primary Examination to trainees who have passed a Primary Examination recognised by the Board as of comparable standard or who possess a Degree or Diploma obtained by examination, which satisfies the Board.

12.3.1 Trainees who have passed the written and clinical FRACP Examination will be exempt from the ANZCA Primary Examination for the purpose of gaining certification in intensive care only.

12.3.2 The Board may, under special circumstances, grant a trainee exemption from the Primary Examination following assessment of documentary evidence. Interviews and/or other assessment may be required.

CHANGES TO ADMINISTRATIVE INSTRUCTIONS

1.3.1 Fellowship Examinations in Adult and Paediatric Intensive Care will be held at times to be determined by the Board.

1.3.3 The examinations will comprise written, oral and clinical sections.

1.3.3.1 The written examinations may be taken in any capital city in Australia, Auckland, Wellington, Christchurch, Dunedin, Singapore, Kuala Lumpur or Hong Kong, or in other centres at the discretion of the Board of Faculty.

1.3.3.2 The oral/clinical examinations will be held in Sydney and/or Melbourne and may be held in other centres at the discretion of the Board of Faculty.

1.3.4 Candidates may apply for admission to the Fellowship Examination who comply with Administrative Instruction 1.1.1 and who have:

(a) passed the Primary Examination of the College, or

(b) passed a Primary Examination recognised by the Board as of comparable standard, or

(c) been granted exemption from the Primary Examination by the Board. Practitioners who have passed the written and clinical FRACP (adult or paediatric) examination will be exempt from the ANZCA Primary Examination for the purpose of gaining certification in intensive care only.

1.3.4.5 From the commencement of the 1996 Hospital Year, all trainees will have their training supervised by the Joint Specialist Advisory Committee (Intensive Care).

1.4.1.5 For trainees seeking Endorsement of the Fellowship in Paediatric Intensive Care:

(a) At least eighteen months of the two years core intensive care training (Administrative Instruction 1.4.1.1) must be spent in a paediatric intensive care unit approved for core training. Twelve months of this period must be spent in a unit with unrestricted approval for training.

(b) At least six months of the twelve months of core training in anaesthesia (Administrative Instruction 1.4.1.2) must be spent full time in paediatric anaesthesia.

(c) The six months of clinical medicine (Administrative Instruction 1.4.1.3) must be spent in an approved paediatric post that is not an Intensive Care post.

(d) The remaining eighteen months may be spent in any combination of adult or paediatric posts according to Administrative Instruction 1.4.1.4.

1.4.6 For trainees commencing approved vocational training from the beginning of the 1996 Hospital Year, no further Vocational Training will be recognised after the completion of the second year of training, until the trainee has passed or has been exempted from the ANZCA Primary Examination.

1.5.1 The Board will approve Intensive Care Units for training in Intensive Care as suitable for core and/or elective training. A limitation may be imposed on the number of posts and/or the duration of training recognised. Approval may be as follows:

1.5.1.1 For the two core years of Intensive Care training (Administrative Instruction 1.4.1).

The core years of Intensive Care Training must be spent in Intensive

Care posts approved by the Board for core training.

One core year of Intensive Care training must be continuous.

The second core year of Intensive Care training may be spent discontinuously in two periods of six months each. A period not less than three months may be approved when it is part of an approved training program. For attachments less than six months, prior approval must be sought from the Censor.

1.5.1.2 For the elective period of Intensive Care training (Administrative Instruction 1.4.1.4).

The elective period of Intensive Care training may be spent discontinuously, in periods of not less than three months in any unit recognised by the Board for elective training.

1.5.3 The Board will approve posts in medicine as follows:

1.5.3.1 For the core six months of medicine for Intensive Care training, posts must be in hospitals approved for training by the Royal Australasian College of Physicians. The post must not be in an Intensive Care Unit.

1.5.3.2 For the elective period of medicine for Intensive Care training, posts must be in hospitals approved for training by the Royal Australasian College of Physicians.

1.5.3.3 The Board may approve other posts in medicine.

Administrative Instruction 2 - Joint Specialist Advisory Committee in Intensive Care (JSAC-IC) has been deleted and replaced by a JSAC-IC document entitled 'Terms of Reference'.

REPORT FROM THE DEAN TO FELLOWS OF THE FACULTY OF INTENSIVE CARE, ANZCA AS AT 20TH JUNE 1996

It is my pleasure to report on behalf of the Board of Faculty on the affairs of the Faculty since the last Annual Meeting.

AWARDS, HONOURS AND APPOINTMENTS

The Faculty congratulates Professor Garry Phillips on his election as President of the Australian and New Zealand College of Anaesthetists. As the Council representative on the Board of Faculty, Professor Phillips has been replaced by Dr Richard Walsh, Vice-President. On behalf of all Fellows I wish to acknowledge the valued contribution Professor Phillips has made to Faculty affairs, particularly in relation to the establishment of the Faculty.

At its June meeting the Council awarded Dr G.M. Clarke the Robert Orton Medal for distinguished service to anaesthesia.

Associate Professor N.J. Davis was appointed Chairman of the Committee of Presidents of Medical Colleges from 1996.

Carol Cunningham-Browne was appointed as the Faculty Administrative Officer in October, 1995.

FELLOWSHIP

Since June 1995, 17 new Fellows have been admitted to the Faculty.

Admitted to Fellowship by Examination since June 1995:

Dr M.B. Anderson, Vic
Dr K.W. Au Yeung, SA
Dr N.A. Barnes, NZ
Dr J.G.L. Cockings, Qld
Dr C.L. Cole, NSW
Dr D.A. Cook, Qld
Dr R.C. Freebairn, NZ
Dr P.R. Hicks, NZ
Dr M.D. Landy, Qld
Dr P.C. Laussen, USA
Dr C.J. Joyce, Qld
Dr B.J. Marsh, Dublin
Dr A.G. Puddy, SA
Dr M.S. Robertson, Vic
Dr R.A. Smith, NZ
Dr Y.V. Tran, NSW

Admitted to Fellowship by Election since June 1995:

P.D. Crone, NZ

The Fellowship now totals 188 Fellows. 172 of these are male and 16 female.

EXAMINATIONS

April / May 1995

All five candidates who presented at the Fellowship Examination held in Sydney on Thursday 18th May 1995 were approved.

Successful candidates who have completed training:

Dr C.L. Cole, NSW
Dr P.R. Hicks, NZ

Successful candidates who have not completed training:

Dr K.W. Au Yueng, SA
Dr B.R. Marsh, WA
Dr K.K. Young, HK

August / September 1995

At the Fellowship Examination held in Melbourne on Thursday 28th and Friday 29th September 1995 at Royal Melbourne Hospital, a total of eleven candidates presented and nine were approved.

Successful candidates who have completed training:

Dr M.B. Anderson, SA
Dr R.A. Smith, NZ

Successful candidates who have not completed training:

Dr Ho Kwok Ming, HK
Dr Koo Chi Kwan, NSW
Dr A.G. Puddy, SA
Dr A.P. Whaley, NSW
Dr C.J. Joyce, Vic
Dr M.D. Landy, Qld
Dr M.S. Robertson, Vic

April / May 1996

The written section was held in Adelaide, Brisbane, Sydney and Hong Kong. The Viva section of the Examination was held at The St.George Hospital, Sydney. Eleven candidates presented and eight were approved.

Successful candidates who have completed training:

Dr P.T. Clark, NSW
Dr E.R. Stachowski, NSW

Successful candidates who have not completed training:

Dr M.E. Finnis, SA
Dr P.A. MacDonald, NSW
Dr B.E. Trytko, NSW
Dr A. Flabouris, SA
Dr O.A. Monteiro, NSW
Dr H.Y. Yap, HK

The G.A. (Don) Harrison Medal Winner 1995

The winner of the G.A. (Don) Harrison Medal winner for 1995 is Dr Ho Kwok-ming, from Hong Kong.

TRAINEES

The Faculty currently has 79 registered trainees. 58 of these are undertaking intensive care training only, whilst 20 are doing both intensive care and anaesthesia training.

ACCREDITATION OF UNITS

The matter of accreditation of Intensive Care Units was closely examined over the past year. Views were sought from Regional Committees on a number of interrelated issues, such as approval of training programmes as opposed to posts, the criteria for limiting numbers of training posts, and the potential for 'rotations'. In view of the varied responses, the Board is continuing to examine this issue.

The monitoring of accredited Intensive Care Units continued with the Faculty's programme of inspecting units in relation to requests for accreditation of new or additional training positions, and reviewing units due for periodic review.

A total of 123 training posts are currently approved. 97 posts are approved for core training and 26 for elective training.

EDUCATION

A working party composed of members of the Board is continuing to review the Objectives of Training in Intensive Care.

In-Training Assessment was introduced for Faculty trainees in 1996.

A Short Course was again successfully held by Dr L.I.G. Worthley in Adelaide in March and attended by 24 registrants.

A database is currently being established to detail academic posts in intensive care and individuals undertaking postgraduate study.

Professor Don Harrison has commenced his third survey of successful trainees in intensive care, which commenced in 1985.

CONTINUING EDUCATION

Annual Scientific Meeting, 1995

The intensive care component of this meeting was conducted over the first three days of the ASM and was considered a great success. The Faculty's Inaugural Foundation Visitor, Dr Charles Hinds of St.Bartholomews Hospital, London, made a valued and interesting contribution to the Meeting.

Maintenance of Standards Programme

A Maintenance of Standards Programme has been developed and will be available to Fellows in 1996. It is closely based on the Programme recently introduced by the Australian and New Zealand College of Anaesthetists, with a certificate of participation being awarded every five years, based on provision of evidence of quality assurance, continuing education and other activities, provision of evidence of current registration at an institution of practice and a declaration that a minimum of 30% of professional life has been spent in clinical intensive care.

INTERNAL AFFAIRS

Board of Faculty 1995-96

There was no requirement for an election of the Board.

Regional Committees

Elections were conducted by Regional Committees where necessary for the period commencing June 1996. The Faculty continues to have representation in the ACT, Tasmania and Hong Kong.

PROFESSIONAL

Policy Documents

In the previous year, the Faculty has reviewed the following policy documents:

IC-5 (1995) "Duties of Regional Education Officers in Intensive Care"

IC-6 (1995) "Supervisors of Training in Intensive Care"

IC-10 (1996) "Minimum Standards for Transport of the Critically Ill". This is a conjoint document published jointly with the Australasian College for Emergency Medicine and was previously published as College Policy Document P23 (1992).

The following new policy documents were promulgated:

IC-11 (1996) "In-Training Assessment of Trainees in Intensive Care"

IC-12 (1996) "Examination Candidates Suffering from Illness, Accident or Disability"

The Board is considering a draft Statement on Ethics and Patient's Rights and Responsibilities, and has commenced a review of IC-1 "Minimum Standards for Intensive Care Units".

Joint Specialist Advisory Committee in Intensive Care

Following a series of meetings between representatives of the Faculty, the Royal Australasian College of Physicians and the Australian and New Zealand Intensive Care Society, the inaugural meeting of the Joint Specialist Advisory Committee in Intensive Care was held in February 1996. The Faculty and the RACP have approved terms of reference for this Committee, whose role is to supervise intensive care training on behalf of the Faculty and the RACP, to define the training requirements of individual trainees and to advise both bodies on matters relating to education and specialist recognition. It has replaced the former Specialist Advisory Committee in Intensive Care of the RACP. The Committee meets three times a year.

This is a major achievement for all involved parties (Faculty of Intensive Care, Royal Australasian College of Physicians, Australian and New Zealand College of Anaesthetists).

I am pleased to report that a number of physician trainees are currently seeking dual qualifications of FRACP and FFIC,ANZCA. In accordance with Faculty Administrative Instructions, they will be exempted from sitting the Primary Examination of the College in view of their success at the RACP Part I Examination. They will be required to fulfil all other Faculty training requirements.

Training and Certification in Paediatric Intensive Care

A draft proposal for a training programme in Paediatric Intensive Care is being considered by the JSAC-IC and the Board of Faculty. All trainees, whether training via the RACP or the Faculty, would be supervised by the JSAC-IC. It is envisaged that trainees would be able to undergo a training program that allows them to obtain the FRACP (Paediatrics) and FFICANZCA (Endorsed in Paediatrics) in a minimum of seven years from graduation.

Intensive Care Medical Liaison Committee

This Committee continued to discuss interests common to the Faculty, the RACP and ANZICS. These included:

- Definitions of intensive care for the Australian Health Information Agreement
- Faculty Policy Document Minimum Standards in Intensive Care
- ANZICS Brain Death and Organ Donation
- Manpower in intensive care
- Clinical Indicators in Intensive Care

Criteria for Specialist Recognition in Intensive Care

Via the JSAC-IC, the Board of Faculty and the RACP accepted a set of criteria for the basis of assessment of individuals as specialists in Adult Intensive Care. This document was also ratified by ANZICS.

I would like to express my sincere thanks to all of the Fellows who have contributed so much of their time to support the Faculty, whether it be as a Regional Committee member, an Examiner, a member of a Hospital Accreditation Team or in supervising trainees and maintaining standards within our Hospitals.

My gratitude is also extended to members of the Board, for their contribution to what has been a challenging year for the Faculty.

A special thanks goes to Carol Cunningham-Browne who is doing an excellent job in her role as Faculty Administrative Officer. Ms Cunningham-Browne also runs the secretariat for the JSAC-IC.

Overall it has been a very good year for the Faculty. Progress continues to be made in all areas where we are involved.

Regional Committees have played a very significant role during this past year and it is hoped that their activities will continue to increase.

G.M. CLARKE
Dean, Faculty of Intensive Care

ADMISSION TO FELLOWSHIP BY EXAMINATION

Brian James MARSH, Ireland

David Howard Francis BUCKLEY, NZ

Peter Telford CLARK, NSW

Edward Richard STACHOWSKI, NSW

Karl Kang YOUNG, HK

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 005 042 852

POLICY DOCUMENTS INDEX

E = educational. P = professional. T = technical. EX = examinations.