Australian and New Zealand College of Anaesthetists

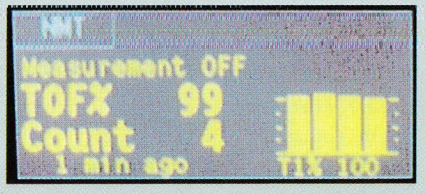
ACN 055 042 852

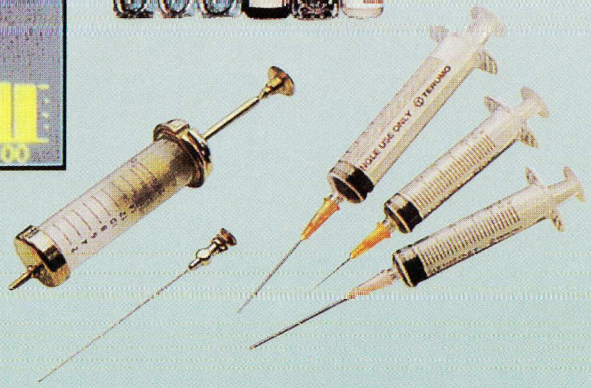
Faculty of Intensive Care
Faculty of Pain Medicine

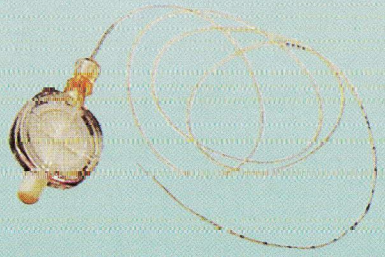
Bulletin

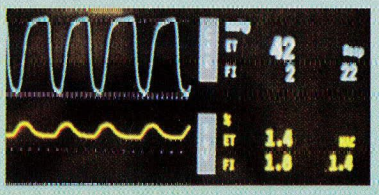
'To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain management'

Inside...









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CONTENTS

EDITORIAL

The Australian and New Zealand College of Anaesthetists' *Bulletin* is published four times per year by the Australian and New Zealand College of Anaesthetists, ACN 055 042 852, 630 St Kilda Road, Melbourne, 3004, Victoria.

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PRESIDENT'S MESSAGE

The recent Council meeting saw significant advances in educational roles of the College. For trainees, it was resolved that part-time training would become accessible throughout the whole period of training, rather than only after the first two years of training. A Working Party has been established to examine College initiatives to assist trainees with difficulties, while a new Policy Document has now been published (Advisors of Candidates for Anaesthesia Training – see full document in this issue of the Bulletin) in order to assist those candidates for anaesthesia training who do not occupy a recognised training position. A series of workshops will be established in the new year for College Supervisors of Training and Regional Education Officers, when greater emphasis and education will be given to the teaching roles of persons holding these positions in all training hospitals and regions ("training the trainer" seminars). The Council has almost completed its series of documents related to selection of trainees, an issue, which was addressed by the College both before and after the release of the Brennan Report. It is expected that a College booklet, delineating College policies of trainee selection principles, eligibility criteria, selection criteria, and due processes for selection, will be published in early 2000. Finally, the College will be offering scholarships (in terms of assistance with annual training fees) for trainees in severe financial hardship.

All the above initiatives have taken many months (sometimes years!) to achieve and I suggest they reflect a very progressive attitude on training of anaesthetists by the College. They will ultimately continue to ensure the highest standards of clinical care. On a similar matter, the College will be undertaking a project to produce Clinical Practice Guidelines on pre-anaesthesia assessment and management, a task expected to take up to twelve months. This follows the successful publication on acute pain management by the NHMRC, and the new document will be in accordance with the standards set by the NHMRC. Practice Guidelines are the way of the future for many reasons, but will only have their place when identified needs are apparent and where relevant. They are the cornerstones of evidence-based medicine; a growing but rational influence on the way medicine is practiced. The importance of practice guidelines and evidence-based medicine to anaesthesia, intensive care and pain medicine is still being assessed and developed and the College monitors this with interest, encouragement and concern.

Regional Committees in Australia (ie. State and ACT Committees) and the National Committee in New Zealand are a part of the vital infrastructure of the College. While the elected members of the College Council ultimately govern the College, the Council delegates considerable responsibilities to Regional and National Committees and these bodies are highly important to the functions of the College as defined in the College Constitution. The New Zealand Regional Committee was recently renamed as the NZ National Committee of ANZCA in recognition of its special role in negotiation with its national government and authorities. The NZ Committee may soon have its own Director of Professional Affairs to assist in this role, and the College Council is currently considering other restructuring of the College in New Zealand. As mentioned above, the College will hold workshops to improve understanding of College training but it will also convene regular seminars for Regional and National Committee Chairmen and other Officers to better introduce and familiarise them with processes of the College. The Council has also resolved to give greater recognition of Regional and National Committee Chairmen at such public occasions as the Annual Scientific Meeting of the College, especially at the formal College Ceremony. All these initiatives reflect the importance that the College Council holds in the appropriate functioning of these Committees. I should hope that all Fellows may thus not hesitate to support their Regional and National Committees, particularly through participation one way or another in elections for membership of them and feedback of concerns to members of these Committees.

I wish all Fellows the very best for the Christmas and New Year break, and look forward to further advancement of our professions in 2000 and beyond!

Richard Walsh

RICHARD WALSH
President

National Anaesthesia Day 1999

Report on Questionnaires

Juliette Mullumby

20 September 1999

172 Questionnaires were sent out
84 returned

Type of Activity

Display in hospital foyer	67	80%
Display in shopping centre	8	10 %

Other activities included: morning and afternoon teas, the ACT minister unveiled a plaque, lunch and quiz for staff, launch of pre-admissions clinic with Dr Brendan Nelson, display in an exhibition hall as part of a whole hospital expo, an education night and using a simulation centre.

Props Employed

Old/New equipment display	26	31%
Posters	79	94%
Leaflets	77	92%
Stickers	69	82%
Static Displays	27	32%

Media Advice Kit

Used	28	33%

Publicity	**Sought**	**Achieved**
Newspaper	33	21
Radio	19	15
TV	17	7

Public Relations

Used	44	52%

Comments

"favourable response from visitors in the hospital", "I'm still astounded that many people don't know how doctors become anaesthetists", "disinterested possibly at best", "competing with AFL roadshow in mall but steady numbers", "good response from staff, patients, relatives and friends who saw the display", "favourable, good interest from some but not a huge drawcard", "posters and leaflets were excellent", "staff asked 'why do anaesthetists need promoting?' ", "visitors impressed with video they recognised staff and the hospital."

Suggestions

"earlier and more widespread notification of individual anaesthetists rather than department or group practices, many did not know about it", "we would prefer if it wasn't in the holidays", "how about some media hype from the College?", "I believe the whole concept of NAD needs to be re-examined, especially in the light of Hugh Mackay's article", "materials should be supplied earlier to allow for better planning", "patients seem to love being given a sticker or a brochure", "similar, maintain awareness!"

Honours and Appointments

Congratulations were extended to the following Fellows:

Professor Tess Cramond, OBE, AO (Qld) – Hon.MD.*Qld* in recognition of an outstanding contribution to medicine in Queensland and distinguished service to the community.

Dr Michael J Hodgson (Tas) – President, Medical Council of Tasmania and hence membership of the Australian Medical Council.

Professor Michael J Cousins, AM (NSW) – Honorary Member, International Association for the Study of Pain.

Dr Deb Colville, FRACS (Vic) – Elected Councillor, Royal Australasian College of Ophthalmologists.

HIGHLIGHTS OF OCTOBER 1999 COUNCIL MEETING

WELCOME

The President welcomed to the meeting as observers Victorian and New South Wales Regional Committee Chairmen, Dr Mark Buckland and Dr Matthew Crawford; Dr Deb Colville, RACS Councillor and Dr David Chamley, President, NZSA.

AWARDS

Dr John Russell (SA) was awarded the Orton Medal.
Dr John Mainland (Vic) and Dr Patricia Mackay (Vic) were awarded the ANZCA Medal.
These medals will be presented during the College Ceremony of the ASM in Melbourne.

EDUCATION

Education Sessions for Supervisors of Training

Council has approved in principle the implementation of a Workshop for Supervisors of Training. It is anticipated that there will be two initial workshops with the first workshop to be held in Melbourne in early 2000. Topics will include In-Training Assessment, Selection of Trainees and Train the Trainer. A group of Regional Education Officers and Supervisors of Training will be invited in the first instance.

Anaesthetic Skills Laboratories

Council supported the establishment of a Working Party to investigate the further development and establishment of the Effective Management of Anaesthetic Emergencies (EMAC) course.

Part-time Training

As from the commencement of the 2000 hospital year Trainees will be eligible to undertake part-time training according to Regulations in any year of training. However, no further training will be recognised beyond two years of effective full-time training until the Primary Examination has been passed. Training must be completed within ten calendar years.

Clinical Guidelines

A Committee comprising of Professor Teik Oh, Chairman, and two representatives from each Region has now been established to produce clinical guidelines on pre-operative management in anaesthesia. It is anticipated that the topics will be finalised and tasks assigned by the end of October with the final document being available by the end of 2000. The Committee plans to produce a useful monograph for use by anaesthetists. Every recommendation on clinical guidelines will be accompanied by a reference and the level of evidence-base as used by the NHMRC. Any Fellows wishing to make suggestions for consideration will be most welcome.

Compulsory Intensive Care Training

Council resolved that compulsory Intensive Care training for anaesthetic Trainees under Regulation 15.5.5.2 may be undertaken in Intensive Care Units approved for training by The Hong Kong College of Anaesthesiologists.

EXAMINATIONS

Final Viva Examination

Following a review of aspects of the oral section of the Final Examination, Council has agreed that as from the first Final Examination in 2000 each viva will be reduced from 19 minutes to 15 minutes. This will mean 12 vivas each of 15 minutes duration.

Renton Prize

The Renton Prize for year ended 31st December 1999 was awarded to Dr Nicole Annette Healy (Qld).

Cecil Grey Prize

The Cecil Grey Prize for the year ended 31st December 1999 was awarded to Dr Shane Christopher Townsend (Qld).

INTERNAL AFFAIRS

Committee of Presidents of Medical Colleges Secretariat

The Secretariat of the Committee of Presidents of Medical Colleges has relocated from ANZCA to premises at Aikenhead Wing, St Vincent's Hospital, Melbourne.

New Zealand National Committee

The concept of a Director of Professional Affairs for New Zealand was accepted in principle, initially for 1-2 sessions per week.

Physical Facilities – Expansion of "Ulimaroa"

Council noted that excavation for the new building and underpinning of adjoining properties has commenced.

Training Workshop/Orientation Sessions for Regional Officer Bearers

Council resolved on the suggestion of the Western Australian Regional Committee Chairman, to hold an educational seminar for Regional/National Committee Chairmen, Honorary Secretaries and Treasurers. The purpose of this seminar is to provide details of College policies and activities for new Regional Office Bearers.

Rural Anaesthetic Recruitment Service

Following a grant from the Federal Government to establish a Rural Anaesthetic Recruitment Service in collaboration with the Australian Society of Anaesthetists, 60 expressions of interest have been received from Recruits seeking positions and 17 Principals seeking anaesthetic staff. At this stage most Recruits are interested only in locum positions but it is expected such experience may result in longer term placements.

College Mailouts on behalf of Outside Organisations

In view of the continual demand for College mailings, Council has agreed that, subject to approval of the information to be despatched, a fee of 50 cents per label plus postage will be charged for all future mailings.

Library Facilities

A web-catalogue interface has been purchased which will permit access to the College catalogue via the College website.

RACS Trauma Committee

Dr DJ Cooper, FANZCA, FICANZCA (Vic) has been appointed College representative to the RACS Trauma Committee.

RESEARCH

Research Awards for 2000

Recommendations from the Research Committee were noted by Council and details of the Research Awards for 2000 are published elsewhere in this Bulletin.

COMMUNICATIONS

Media Training

Council agreed to arrange continued media training for College personnel who may be required to speak to the media on College business.

National Anaesthesia Day 1999

Council noted the success of the Day in terms of activities and media coverage. Various activities had been arranged in the city and metropolitan areas including displays in hospital foyers, shopping centres, schools, interviews on talk-back radio and newspaper coverage.

National Anaesthesia Day 2000

National Anaesthesia Day 2000 will be held on Wednesday, 5 July with the theme "Anaesthesia". This topic provides a broad area for Fellows/departments to be involved and the opportunity to demonstrate the role of the anaesthetist in the operating theatre as well as in the pre and post operative process.

FINANCE

Subscription/Fees for 2000

Council resolved that there would be no increase in the fees for 2000.

Annual Subscription for 2001	$990 + GST where applicable
Examination Fee	A$1900
Register of Training Fee	A$950
Annual Training Fee	
Australia and Hong Kong	A$925
New Zealand	NZ$925 + GST
Singapore and Malaysia	$925 (local currency converted into Australian dollars)
Fee for Non-Fellows participation in MOPS Program	$300 + GST where applicable
Overseas Trained Doctors Assessment Fee	$500 + GST where applicable
Occupational Training Visa Assessment Fee	$75 + GST where applicable

Australia's GST is not payable on Training and Examination fees or Overseas Fellows' Subscriptions.

Daily Living Allowance

The Daily Living Allowance will remain at $230 for the first six months of 2000.

Scholarships for Trainees

Council agreed to offer up to 20 scholarships each year to assist Trainees to meet the cost of training. The value of each scholarship shall be half the Annual Training Fee normally payable by the Trainee. Consideration will be based only on severe financial hardship in meeting the costs of ANZCA training. Applicants must be registered Trainees of ANZCA, Faculty of Intensive Care or Faculty of Pain Medicine. Applications shall be submitted on the prescribed ANZCA application form with a closing date of 31 July and scholarships will be approved by Council at its October meeting, applicable to the next hospital year. ANZCA reserves the right to not award any scholarship in a particular year and it is agreed the funding for these scholarships will be provided from the Foundation Fund.

PROFESSIONAL

Goods and Services Tax

Information available to the College states that a GST of 10% will be payable on all post-Fellowship activities ie. subscriptions and CME meetings. Pre-Fellowship costs including Register of Training, Annual Training and Examinations Fees will be exempt. No Australian GST is payable on overseas subscriptions as this is regarded as an exported service.

Australian Council on Healthcare Standards

ANZCA has applied for membership of the ACHS Council.

Policy Documents

The following policy documents which are annexed to this report were reviewed, amended and accepted and are published elsewhere in this Bulletin.

TE3 Supervision of Clinical Experience for Trainees in Anaesthesia (formerly E3)

TE7 Secretarial and Support Services to Departments of Anaesthesia (formerly E7)

PS10 The Handover of Responsibility During an Anaesthetic (formerly P10)

PS26 Guidelines on Providing Information about the Services of an Anaesthetist (formerly P26)

PS33 Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT) (formerly T4)

The following new policy document was promulgated:

TE17 Advisors of Candidates for Anaesthesia Training

A detailed letter will be forwarded to each Regional/National Committee in the near future, setting out requirements for these appointments.

AMA National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors

Following consultation with Regional Committees, Council supported the aims of this document which are particularly relevant to the practice of anaesthesia. There was support for a program of implementation testing and the development of Code implementation tools in the hospital sector, with a view to developing implementation guidelines for use by all hospitals. Council responded also that further study which influences work patterns of hospital doctors should take into consideration implications for all doctors with regard to hours of work, shiftwork and rostering.

Labels for Anaesthetic Drugs

The College has supported a request to Standards Australia for the development of a national standard for additive and line labels.

National Code for Classification in Health – Coding of Anaesthetic Interventions

Following a request from the College, it has now been confirmed that the NCCH has revised the current Australian Coding Standards (ACS 0031 Anaesthesia) and will include a standard which will take effect from 1 July 2000 for all hospital and day procedure in-patient episodes of care. The revised Standard instructs clinical coders in assigning codes for certain types of anaesthesia and provides guidance on coding multiple anaesthetics, sequencing of codes and correct codes where documentation may be incomplete.

ANAESTHESIA CONTINUING EDUCATION COORDINATING COMMITTEE

Health*Insite*

The College has accepted a partnership agreement with Health*Insite* to participate in a web-base facility funded by the Federal Government which will provide links to health information. This facility is being managed by a department within the NHMRC established for this purpose. Currently the three main information paths are Life Events (eg. birth, parenting, hospitalisation etc), Health Topics and Expert Views.

Obstetric Anaesthesia Special Interest Group

The Obstetric Anaesthesia Special Interest Group has been established under the revised structure approved by ANZCA, ASA and NZSA with ANZCA as the parent secretariat provider.

College Ceremony – Annual Scientific Meetings

Council has resolved that where accommodation permits, Regional Committee Chairmen be included in the Stage Party or, alternatively, in the front of the auditorium.

Virtual Congress

Council has agreed to enter an agreement with Med-E-Serv to provide a Virtual Congress associated with Annual Scientific Meetings, commencing with the 2000 Meeting in Melbourne. This concept includes papers and slides from presentations during the Annual Scientific Meeting. This will be the first anaesthesia on-line meeting in the world. It will have a world wide audience with special licenses planned for hospital departments.

ASM 2001 – Hong Kong

Professor Martin Tramer (Switzerland) has been appointed the Foundation Visitor and Dr Charles Minto (Sydney) appointed the Australasian Visitor to this meeting.

ASM 2002 – Brisbane

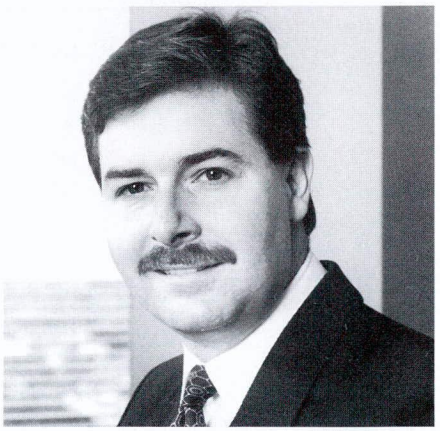
Dr Kerry Brandis has been appointed Convenor to this Meeting.

ADMISSION TO FELLOWSHIP BY ELECTION

Under Regulation 6.3.1(b) the following were admitted to Fellowship by Election:

Dr Lindsay S Barker	(Qld)
Dr Vanessa S Beavis	(NZ)
Dr Michael H Bennett	(NSW)
Dr Peter J Bruwer	(NZ)
Dr Mark A Josephson	(WA)
Dr Christopher Nixon	(NZ)
Dr Richard H Riley	(WA)
Dr Christopher J Smith	(NZ)
Dr Everhardus J Strauss	(NZ)
Dr Bronwyn E Williams	(Qld)

LAW REPORT



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

TRAINEES AND INFORMED CONSENT

The medical colleges are involved in extensive training programs for medical practitioners. Colleges and teaching hospitals must invariably ensure that trainees are adequately exposed to a range of practical situations involving the care and treatment of patients.

Teaching hospitals invariably have a "consent form", which discloses the fact that the hospital is a teaching hospital, and that occasionally trainees and junior practitioners may carry out some tasks. I am not aware of any hospital which has any more sophisticated arrangements to deal with the issues of trainees and "informed consent".

Consent

A doctor who carries out a procedure on a patient, without the patient's consent, is, in legal terms, guilty of assault or battery. The doctor can be sued for failing to obtain the patient's approval for the physical treatment undertaken. (This rule, of course, varies in emergency situations.)

Informed Consent

Since the decision of *Rogers v. Whittaker* in 1992, the Australian High Court has confirmed that simple consent is not enough. The law has recognised that a doctor has a duty to warn a patient of a material risk inherent in any proposed procedure or treatment. The Court has formulated the standard for doctors as follows:-

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

When considering the need to inform the patient of a particular risk, doctors should therefore consider two separate matters:-

1 Would a reasonable person, in the position of the patient, be likely to attach significance to the risk?

2 Is the doctor aware, or should the doctor be reasonably aware, that this particular patient would be likely to attach significance to that risk?

The Courts have placed a high burden on doctors to ensure that all material risks are considered, and that the particular circumstances of the patient are considered.

Delegation

Of course, doctors in busy hospitals do not act in a perfect world, and do not have unlimited time in which to properly consider all of the issues and risks, no matter how remote, that may affect the patient's decision.

Many doctors, unwisely, sometimes delegate the task of explaining the risks to patients to assisting doctors, trainees or other hospital staff. Doctors are entitled to delegate this responsibility to others, but they bear the liability if the others do not properly advise patients. Doctors, who leave "informed consent" to assisting or junior doctors, run the risk that the other doctors do not do the job properly.
It is clearly the responsibility of the treating doctor to obtain informed consent from the patient, and to advise the patient of all material risks. If this is not done properly, the treating doctor bears the legal responsibility.

Doctors who rely simply on consent forms, hospital administration or other bureaucratic processes, run a substantial risk. "Consent should be obtained by the person who will touch the patient. The doctor who delegates his responsibility to a hospital employee, such as a nurse, takes the risk that the consent obtained may be inadequate" *(Picard Legal Liability of Doctors and Hospitals in Canada (1994) pages 66-67.)*

Trainees

There is now sufficient case law to suggest that one of the material risks involved in any procedure, which ought to be advised to patients, is the fact that it may be undertaken by a trainee or inexperienced doctor, rather than the treating consultant or proceduralist. Several American and Canadian cases raise these issues:-

In *Buie v. Reynolds (Oklahoma)*, the Judge noted, *"A resident did perform the operation thereby engaging in a type of ghost surgery which is condemned by the law as malpractice and by the American Medical Association as a fraud and a deceit and a violation of a basic ethical concept. A surgeon may not, says the AMA article, permit surgery residents in training, to perform operations on private patients under the supervision of the patient's surgeon without the knowledge or consent of the patient."*

In *Guebard v. Jabbay* (Illinois), the resident appeared to have performed the majority of the surgery. The Court noted that, where an unauthorised surgeon operates, it is a battery upon the patient.

In *Pugsley v. Privette* (Virginia), a surgeon was held liable in battery for operating on a patient, despite the fact that the patient had signed a consent form. The patient had insisted that her own physician do the operation, rather than the actual surgeon involved.

In *Burk v. S and ors* (British Columbia), the Court refused to allow the "highly technical assault claim", where there was no damage or actual negligence in the treatment of the patient by the doctor, that the patient had not consented to.

A comment in *Consadine v. Camp Hill Hospital* (Nova Scotia) by the Court was that it was "*quite incredible*" that the operating surgeon had never spoken to the patient prior to the surgery - even though there was no actual negligence shown in the surgery performed.

The question arises; whether the fact that a trainee or inexperienced doctor was involved in the procedure, or may be carrying out some or all of the procedure, is a material matter which ought to be disclosed to the particular patient, in the particular case.

The recent decision of the High Court of Australia in *Chappel v. Hart* provides clear support for the proposition that such disclosure is required. *Chappel v. Hart* is a case in which it is alleged that Mrs Hart was not warned of the particular risks of a procedure. Mrs Hart said that, if warned of the risks, she would not have undergone the procedure. The case is very similar to *Rogers v. Whittaker*. It was alleged that the doctor was of average experience in relation to the particular procedure, and that more experienced doctors may have produced a better result. It seems implicit from the case, although it was not finally decided, that Mrs Hart should have been warned that the doctor was only of average competence in relation to this procedure, and that there were more experienced surgeons available.

It was stated:-

> *"If the foreseeable risk to Mrs Hart was the loss of an opportunity to undergo surgery at the hands of a more experienced surgeon, the duty would have been a duty to inform her that there were more experienced surgeons practising in the field."*

Later, it was stated:-

> *"Mrs Hart swore that if she had been told (by the doctor) of the risks to her voice, she would not have gone ahead with the operation by him. She would have sought further advice. She would have wanted the operation performed by the most experienced person available. Professor B was posited as such a person. The evidence showed that he had performed many more operations of this kind than (the doctor) had."*

Ultimately, the Court's decision did not determine this issue. However, it provides a telling argument for the suggestion that a doctor might have to warn of the fact that they are junior or inexperienced in relation to particular procedures.

If it is, therefore, material that a doctor may have to disclose their relative level of experience, then it can clearly be a matter for disclosure that a trainee or inexperienced doctor was to undertake some or all of a medical procedure.

Most of the community will accept that public hospitals are training hospitals, and that junior doctors and trainees must gain experience and learn under supervision. However, the Courts are likely to also require that patients be adequately informed when a trainee or junior doctor is performing a procedure, and probably the level of supervision involved.

It would not be sufficient that a general consent form indicated that the hospital was a training hospital, and that certain procedures would be undertaken by trainees from time to time. Such a general formulation or general advice would not satisfy the requirements for the informed consent to be specific to the patient in the particular circumstances.

Of course, patients can be advised in a way that it is non-threatening and does not jeopardise the training situation which applies in hospitals. Patients can be advised that a junior doctor will be undertaking the procedure, under close supervision of the consultant, and with the consultant available to monitor and step in when necessary.

As noted above, general consent forms are largely irrelevant to the process of informed consent itself. The form is merely a sign that a consent process has been undertaken. It is the verbal and other communication that goes on between doctor and patient which represents the informed consent, and not the form or any signature. (In many cases, the consent form is only worth the paper it is printed on!)

The requirement to inform patients when a trainee or junior doctor is involved will be greater in circumstances where the patient is clearly nervous about the outcome, requests more information about the procedures and who may be undertaking the procedures, or otherwise exhibits concern and interest. Other principles of informed consent should be considered:-

- Would the risk (of a trainee doctor being involved) influence the decision of a reasonable person in the position of the patient?
- Is the risk of the trainee's involvement so slight (because the procedure they are undertaking is so simple) that no reasonable person would be influenced by it?
- Obviously, the more drastic the intervention or procedure undertaken by the trainee or junior doctor, the more necessary it would be to inform of the risks and consequences.
- The desire for more information by a patient necessitates greater disclosure, even if the patient says they have no desire for such information.
- Obviously, the existence of emergency situations, or lack of opportunity for proper counselling or discussion can affect the obligations to disclose. In an emergency environment, the information that may be disclosed may be minimal or not possible at all.

Whilst the issue has not been finally determined by the Australian Courts, there is sufficient support in Australia and international cases for the requirement that patients be properly advised when trainees or junior doctors are involved in procedures. This is particularly so where the procedure is complicated, substantive, or where minimal supervision may be involved. The extent of disclosure required is still to be determined by the Courts. However, I believe it is now clear that where an inexperienced trainee or junior doctor is undertaking a procedure, it would be a "material risk" which should be part of and disclosed in the "informed consent" process, and the patient advised accordingly.

I recognise that this has substantial implications for the training programs of medical colleges and for procedures in training hospitals. However, these implications must be faced, and appropriate systems and adjustments developed to deal with this issue.

(I acknowledge the contribution of Patrick Joyce, Solicitor with Russell Kennedy, Solicitors, in the development of this article.)

OBITUARY

DR SIRI RAMA KARTHIGESU

New Zealand – FFARACS 1983, FANZCA 1992

Rama was educated in Ceylon, graduating MBBS in 1965, and it was in Colombo that he took up anaesthesia. He continued his anaesthetic training in England, gaining the FFARACS in 1973. From England Rama moved to Sweden, then in 1976 he moved to New Zealand, taking up a post in Greymouth. After two years he left for the sunnier climes of Northland.

Rama was devoted to his family, they were the focus and joy of his life, and when his son Ramesh entered school in Auckland, Rama and his wife moved their home down to Auckland. As Rama was still working in Whangarei, this involved the very considerable effort of the regular commute from home in Auckland to work in Whangarei. This was eased only by his enjoyment of performance motorcars, and continued until he took up a post at Middlemore in 1993. Rama worked as a full time specialist at Middlemore until his untimely and unexpected death.

Rama was a true gentleman. He never spoke ill of anyone, and he could never do too much for you. He was a superb colleague to work with. Nothing which didn't keep him away from family was ever too inconvenient, and he was always willing to provide cover and change duties to keep the roster going. He was very convivial, and hospitable. It didn't matter if you were colleague, or visiting foreign student, Rama's hospitality and generosity were the same to one and all.

Rama had a very wide circle of friends, both in and out of medicine. He clearly "had a life", and it was important to him. He was extensively involved in Rotary, and just prior to his death had arranged a substantial amount of rotary funding for hospital equipment.

His major interests within anaesthesia lay in Day Stay, and TIVA. While working in Whangarei, he was a major mover in developing a private Day Care facility, Primecare. The success of this was a source of considerable satisfaction to him. He was also involved in setting up the helicopter rescue service, even though he didn't enjoy flying in the helicopter. Whangarei Hospital's roof top helipad is one of his legacies.

As a result of his interest in Day Stay anaesthesia Rama became very interested in TIVA and was an avid promoter of this, not only to colleagues and juniors, but also as a presenter in many conferences he was invited to in the Asian region. He was always keen to develop new techniques and applications for drugs, and was indefatigable in his support of TIVA and ambulatory care. He was a great ambassador for Day Stay anaesthesia and for TIVA both in the local and the wider anaesthetic community.

Dr David Scott presenting gift to Dr Ed Loughman upon his retirement as Chairman, Final Examination Committee.

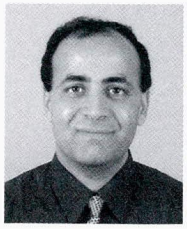
2000 Research Awards

The following Grants, recommended by the Research Committee, were awarded by Council at the October 1999 meeting:

Associate Professor Andrew Bersten (SA) $35,000
The dynamics of surfactant proteins across the alveolocapillary barrier in ARDS.

Dr Jamie Cooper (Vic) $35,000
Hypertonic saline in head injury – a multicentre, prospective randomised clinical trial.

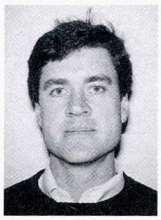
Dr Mark Fajgman (Vic) $20,000
Should pregnant patients have open or laparoscopic surgery? Effect of laparoscopy on fetal well being.



Associate Professor B Venkatesh (Qld) $16,000
Does hypertonic saline resuscitation of burn shock improve tissue oxygenation?

Professor Duncan Blake (Vic) $30,000
Interaction of alpha2 adrenoceptors and N-type calcium channels in the treatment of chronic pain.

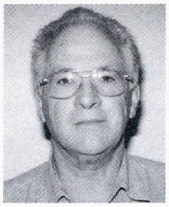
Dr Suellen Walker (NSW) $30,000
Effect of c-jun antisense oligonucleotides on nerve injury-induced allodynia.



Dr Desmond McGlade (Vic) $15,000
The comparative effects of two analgesia techniques on outcome from lower limb vascular bypass surgery.

Dr Tony Chow (Vic) $25,000
A prospective, double blinded, randomised controlled trial using ketamine and morphine to prevent chronic postoperative pain.

Clinical Associate Professor Alan Merry (NZ) A$16,000
Safer intravenous drug administration in anaesthesia – a pilot study.



Associate Professor David Crankshaw (Vic) $5,000
Development of a simulated infusion pump and a pharmacodynamic/ physiological model for use in drug infusion studies.

Dr David Cottee (NSW) $19,000
Evaluation of oesophageal electrode for stroke volume measurement using bioimpedance.

The **Harry Daly Research Fellowship** was awarded to ***Dr Andrew Bersten*** for his project *"The dynamics of surfactant proteins across the alveolocapillary barrier in ARDS".*

The **Florence Marjorie Hughes Research Award** was awarded to ***Dr Jamie Cooper*** for his project *"Hypertonic saline in head injury – a multicentre, prospective randomised clinical trial".*

PRIMARY EXAMINATION – SEPTEMBER 1999

Front L to R: Drs Harry Prevedoros, Matthew Crawford, Tony Quail (Chairman), Jo Sutherland, Yahya Shehabi, Miss Mandy Williams (Administrative Assistant, Examinations), Miss Cherie Wilkinson, (Administrative Officer – Assessments and Examinations).
Back: Prof Tony Gin, Drs Ian McKenzie, Steuart Henderson, Jim Love, Noel Roberts, David Cottee, Assoc Prof Greg Knoblanche.

FINAL EXAMINATION – SEPTEMBER 1999

Front L to R: Drs Glenda Rudkin, Roman Kluger, Penny Briscoe, Judy Branch, Maggie Bailey, Sandra Taylor, Pam Macintyre, Michael Paech, Brian Trainer.
Centre L to R: Michael Jones, Pat Farrell, Leona Wilson, Michele Joseph, Ed Loughman (Chairman), Graham Sharpe, Craig Morgan, David Scott, Doug Rigg, Kersi Taraporewalla.
Back L to R: Dr Chris Johnson, Prof. Tony Gin, Drs Wally Thompson, Tony Weeks, Dick Willis, Michael Kluger.

Special Interest Groups Annual Reports – 1999

Acute Pain

Standardised Audit for Acute Pain Management

This project has been completed and the final draft will soon be forwarded to the College Council for endorsement. The project has produced a set of pertinent and standardised assessment tools for acute pain management. This has the advantage of a common method to assess outcome from pain management and avoiding unnecessary duplication between centres. A future benefit can be the aggregation of this data from across Australia and New Zealand.

Change in Executive Membership

Dr Richard Halliwell has stepped down as the Chairman of the SIG after several years. The Executive has elected Dr Paul Christie from the ACT as the new Chairman.

Adelaide 1999 College Scientific Meeting Participation

A panel session on the clinical use of non-steroidal anti-inflammatory drugs for pain relief was held. The panel members included Foundation Visitor, Professor David Rowbotham. The format of the session was problem based with emphasis on the methods of evidence based medicine. The session was well attended and produced active and lively discussion from both the panel and audience.

Acute Pain SIG Continuing Education Meeting: 2000

The next Continuing Education Meeting is planned for November 2000, following on from the success of the last meeting in Leura, NSW in 1998, which was well attended. The venue, theme and format are yet to be decided.

Formation of the SIG under New Constitution

The SIG has agreed to adopt the new generic Constitution of ANZCA/ASA/NZSA and has chosen ANZCA to be the Parent Secretariat Provider. The SIG reports to the three supporting bodies through the Anaesthesia Continuing Education Coordinating Committee. The name "Acute Pain SIG" has been retained.

Paul Christie
CHAIRMAN

Cardiothoracic, Vascular & Perfusion

The Cardiothoracic, Vascular and Perfusion Special Interest Group is for the development of educational activities and communication amongst Fellows with interests in cardiac, thoracic or vascular anaesthesia as well as in perfusion. During the past 12 months we have held our biennial conference and contributed to the ASM program in Adelaide. There has been discussion on standards of practice for Perioperative Transoesophageal Echocardiography. One new member has been elected to the Executive.

Constitution

With the adoption by the CVP SIG of the new Constitution for SIGs, we have chosen the College to remain as our secretariat. Nominations for Executive positions took place this year (see below).

ANZCA Annual Scientific Meeting, May 1999

The ASM was held in Adelaide this year. A successful session on Risk Assessment for the patient with cardiac disease was organised by the CVP SIG with contributions from Dr. Michael Davies and Prof. Peter Moore.

A general Business Meeting was held during the conference, but the attendance was poor. Hopefully this reflected a general satisfaction with the directions that the group is taking.

Biennial CVP SIG Meeting, Noosa, July 1999

Our fifth Continuing Education Meeting was held at the Sheraton Noosa Resort from 9th to 11th July this year. We achieved a registration of over 180 Fellows, which resulted in good attendances at the sessions and active discussion. Session topics included cardiovascular risk, new cardiac surgical techniques,

echocardiography perfusion and cardiac complications. For the first time we had four non-fellow visiting speakers including two surgeons, a cardiologist and a hyperbaric physician. Their contributions increased the depth of the meeting in a number of key areas. Excellent contributions from the fourteen Fellows who presented ensured that the conference was well received.

Industry support was satisfactory and the specific sponsorship for our New Zealand and interstate, visiting speakers was welcome. Audio-visual costs continue to increase, but with the added complexity of data-projection and video-tapes as well as conventional slides and overheads it was money well spent. The conference still produced a surplus.

An Annual General Meeting was held during the conference with a very good attendance. In accordance with the new SIG Constitution, nominations for membership of the Executive had been called for prior to this meeting. Elections were not required as nominations filled available positions. In Victoria, one extra nomination was received and it was decided to use the flexibility allowed for in the Constitution to enable Dr. Paul Myles to join the Executive in addition to the reappointment of current members.

Future Meetings

The Executive is involved with the planning for the combined RACS-ANZCA sessions of Cardiac Surgery and Vascular Surgery at the ASM in Melbourne in May 2000. The critical issue of the venue for our next biennial conference (2001) has yet to be decided, but prime contenders are Port Douglas, Uluru or Broome.

CVP SIG Executive

The Executive of the CVP SIG has a representative from each State and New Zealand who were initially nominated by their respective Regional Committee. As a result of the recent call for nominations, all Executive members have been reappointed with the addition of Dr. Paul Myles. The current members of the Executive are: Dr. David Scott (Chairman-Vic), Dr. Malcolm Anderson (Tas), Assoc. Prof. Peter Klineberg (NSW), Dr Lisa McEwin (SA), Dr. John Murray (Qld), Dr. Paul Myles (Vic), Dr. Ken Williams (WA) and Dr. Leona Wilson (New Zealand).

The Executive meets four to five times per year to deal with issues arising and also organization of CME meetings. A considerable amount of work is performed by members of the Executive to ensure, that the main roles of the group are undertaken effectively. The current Chairman has been incumbent for three years, and the Constitution requires that the Executive elect a new Chairman after this time. This will occur at the forthcoming teleconference in September.

Transoesophageal Echocardiography

A Standards of Practice document for training and practice of diagnostic TOE, has been widely discussed amongst the membership. The main element of this is to establish a benchmark for training, which should enable an appropriate quality diagnostic examination to be performed. This document would not limit the use of TOE by practitioners who are developing their skills, but highlights the need for suitable training when diagnostic reporting is being undertaken. This document should be ready to be reviewed by Council and the Regional Committees by the end of this year.

Medical Perfusion

Due to the wide range of clinical practices in medical perfusion across Australia, progress on an updated Policy Document on Medical Perfusion continues to be slow.

I would like to thank the members of the Executive for their continued assistance with organising the SIG and also Ms Helen Morris for ensuring that everything gets done when it should.

David Scott
CHAIRMAN

Diving & Hyperbaric Medicine

The Diving & Hyperbaric Medicine Special Interest Group was formed in 1998 and held its first teleconference on 8 December 1998. All members who attended the ASM in Adelaide also met on 10th May 1999.

Currently, there are two bodies involved in diving and hyperbaric medicine, SPUMS (South Pacific Underwater Medicine Society) and ANZHMG (Australia & New Zealand Hyperbaric Medicine Group). SPUMS serves as an educational organisation for physicians and non-physicians interested in diving medicine and diving safety; whereas ANZHMG is a sub-committee of SPUMS and serves as a forum for Directors and other physicians working in hyperbaric medicine. In the absence of any other suitable body, SPUMS undertakes the administration of the Diploma of Diving and Hyperbaric Medicine. There is no academic institution, which oversees academic issues and maintenance of standards in Australia and New Zealand in this discipline.

The role of the SIG is seen primarily as a resource group to provide academic and educational guidance to the specialty and for the maintenance of standards.

Executive Members

The current Executive Members are Drs. Ian Unsworth (NSW), Chris Lourey (Vic), Chris Acott (SA), Margaret Walker (Tas), David Griffiths (Qld), Brian Spain (NT), Mike Davis (NZ) and Robert Wong (WA - Chairman). Drs. Mike Bennett and John Knight are co-opted members, representing ANZHMG (Australian & New Zealand Hyperbaric Medicine Group) and SPUMS (South Pacific Underwater Medicine Society) respectively.

SIG Constitution

The SIG abides by the Constitution of the ANZCA and ASA/NZSA with ANZCA as the Parent Secretariat Provider for its administration. Membership is open to all Fellows of ANZCA, or Ordinary Members of the ASA or NZSA who have a special interest in Diving and Hyperbaric Medicine. Associate Membership is open to people with a special interest in Diving and Hyperbaric Medicine who are not eligible to be full members. These may include Associate Members of the ASA or NZSA registered Trainees of ANZCA; allied health professionals or members of other related professional organisations.

Accreditation of Hyperbaric Facilities

Some members of the Executive Committee felt that the SIG should also play a major role in the accreditation of hyperbaric facilities. This latter role, however, comes under the jurisdiction of SF/46 Committee ("Tunneling and Non-diving Hyperbaric Facilities") of the Standards Australia. Drs. Knight, Bennett and Wong of the SIG are members of this Committee to review the accreditation of hyperbaric facilities. The Hyperbaric Oxygen Therapy Facilities Industry (HOTFIG) Document is used as the working basis. This is a document produced by the Hyperbaric Technicians and Nurses Association, which has been endorsed by the ANZHMG.

Hyperbaric Medicine Courses

Presently, for training in hyperbaric medicine, the only available courses in Australia and New Zealand are at the Royal Adelaide Hospital and at the Royal Australian Navy, both of which placed heavy emphasis in diving medicine (80%). The ANZHMG with the endorsement of the SIG has planned a hyperbaric medicine course to be conducted in February 2000 at the Prince of Wales Hospital, Randwick. This course consists of 80% hyperbaric medicine and 20% diving medicine. The course instructors will be drawn from the staff of the various hyperbaric departments.

Formal Qualification in Hyperbaric Medicine

There is no formal qualification in this growing discipline. The SPUMS diploma in diving & hyperbaric medicine only requires the attendance of an examinable course in diving and hyperbaric medicine; six months of hyperbaric medical training together with the submission of a formal project for publication. It was thought this is inadequate for unsupervised specialist work in a hyperbaric department and that a total of two clinical years of diving and hyperbaric medicine should be required before one is permitted to practise unsupervised.

ANZCA ASM

At the ASM in Adelaide this year, a session dedicated to hyperbaric medicine was well attended. It is the wish of the committee that a session in hyperbaric medicine be included at each ASM in future.

Robert M Wong
CHAIRMAN

DAY CARE ANAESTHESIA

Special Interest Group Constitution

The SIG adopted the new Constitution and nominated ANZCA as the parent secretariat provider. The methods of obtaining and then electing members of the Executive provoked significant discussion both within and outside the Executive. Nominations were called and the number of nominations received made elections unnecessary. The Executive was confirmed as:

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

The Rupert Hornabrook Prize for research in Day Care Anaesthesia

The SIG is promoting original research in the field of day surgery by offering a prize of A$300 for research presented in the forum of the ASMs of ANZCA, ASA or NZSA. One prize may be awarded each year to a paper of suitable standard. Details of the prize and its assessment are available on the SIG website and are currently under review.

SIG Internet site linked to College Home Page

The SIG has continued to attempt to promote this avenue for discussion and information dissemination. Although we are keen, we still have a long way to go to use this to its full potential.

MEETINGS

Day Surgery Conference of Australasia, Sydney, November 1998

This highly successful meeting at the Darling Harbour Convention Centre in Sydney brought together anaesthetists, surgeons and nurses. The DCA SIG was a supporting organisation and provided two speakers, Drs. Andrew Bacon and David Kinchington, in this excellent varied program. In the future we would hope to encourage more anaesthetist registrants to attend this type of meeting.

ANZCA ASM Adelaide Meeting

The SIG organised three sessions in this meeting: Preoperative assessment (Drs. Bill Shearer, Nicola Meares and Judith Killin), Postoperative morbidity assessment (Drs. Andrew Bacon, David Kinchington and Ruth Matters) and Day Case Tonsillectomy (Drs. David Baines, Robin Limb and John Ling). All sessions were well attended. Assessment of the sessions showed that participants enjoyed the sessions, which were relevant to ones practice and that new material was learnt. The Day Case Tonsillectomy was particularly successful and this style session will be utilised again. Important recurring features noted in session surveys were everyday issues of practical relevance with long discussion were popular. The Executive would like to thank all presenters for their work to make the sessions successful.

Day Care Anaesthesia Satellite Meeting to ANZCA ASM, Melbourne 2000

This satellite meeting "Day Care Anaesthesia: Now and Into the Future" will be held on Friday 5th May 2000 at the Hotel Sofitel, Melbourne. Dr Ian Smith, Senior Lecturer in Anaesthesia, Keele University, Stoke-on Trent, UK and Dr Glenda Rudkin, Anaesthetist, Adelaide will be the International and Australasian Visitors respectively. This one-day meeting will look at issues of where we are going in Day Care Anaesthesia, along with issues of common practice. Audience discussion will be a priority. Contact the Executive member in your State for further information.

ANZCA ASM, Melbourne 2000

Discussions are underway with regard to SIG input into this conference.

GENERAL COMMENTS

The last year has continued to be a busy one for the DCA SIG. Teleconferences have been well attended and considerable effort continues to be undertaken by all on the Executive. Changes in Executive personnel have continued with Dr Brent Donovan resigning and his place being taken by Dr Steve Watts from West Australia and Andrew Bacon resigning as the Victorian representative while maintaining his Day Surgery Council representation on the Executive. Dr Joe Novella is the new Victorian representative. The Executive thanks all retiring members and welcomes new members.

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

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

David Kinchington
CHAIRMAN

MEDICAL EDUCATION

This has been a quiet year for the group. There was some difficulty in arranging a time suitable to most members for a teleconference. There was a suggestion that email be used as an alternative means of communication, however it was acknowledged that teleconference meetings are still essential to progress matters. A teleconference was held on 6 July 1998 and a brief Business Meeting took place during the ASM in Adelaide, where nominations for the SIG Executive were endorsed.

Executive Members

There has been a change in the composition of the SIG Executive Committee. The current members are:

Cindy Aun	HK
Malcolm Anderson	TAS
Geoff Cutfield	NSW
Kerry Delaney	ACT
Patricia Goonetilleke	VIC
Vaughan Laurensen	NZ

Barrie McCann	QLD
Margaret Wiese	SA
Robert Wong (Chairman)	WA

The Executive Committee would like to thank outgoing Executive Committee Members, Dr Nick Gemmell-Smith, ACT and Dr Mark Fajgman, Victoria for their contributions to the Special Interest Group over a number of years.

Workshop

A Workshop on "Trainees with Difficulties" was held during the Annual Scientific Meeting in Adelaide and was well attended. Case histories were presented by Drs. Neil Maycock & Robert Wong, whilst Professor Teik Oh took the chair. Subsequently, the forum was open for discussion. Issues raised included selection of candidates; management of candidates who have difficulties with examinations/clinical skills or who are clinically inept, as well as candidates who have personality disorders. More importantly, discussion also focused on how to guide unsuitable candidates toward an alternative career path. Professor Oh agreed to raise these issues at the College Council.

Directory of Training

This has been formally adopted by the College and is currently on the Website.

In Training Assessment

This issue was raised and discussed at some length in the past. It was suggested that the importance of the topic merited broader discussion either at a workshop or a satellite meeting with invited speakers. No further action has been taken by the SIG to date.

Simulator

All trainees in Western Australia have had the opportunity to undergo a one-day Workshop in Anaesthetic Crisis Resource Management. These courses are also available to anaesthetists and non-specialists anaesthetists.

Robert M. Wong
CHAIRMAN

NEUROANAESTHESIA

The AGM in May was poorly attended. It was resolved that the Constitution, including amendments from the AGM be circulated for comment.

Most changes are either from discussions at the meeting at Lindeman Island, clarified the language, or attempted to clarify our relationship with the parent body (ANZCA). This new Constitution was forwarded to ACECC in May.

It is proposed that in the absence of any major objection that the new Constitution be adopted by the interim Executive at the next Business Meeting.

There was an interim Executive elected at the AGM, to ensure adoption of a new Constitution.

A successful scientific program was held during the October four day conference. It is intended that the next meeting be held in a major centre as a more specialised one day conference.

Ray W Cook
ACTING CHAIR

RURAL ANAESTHESIA

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

At the Adelaide ASM the Rural Special Interest Group was strongly represented at the Workforce Forum and the MOPS Workshop.

Rural training rotations have expanded with a WA rotation to Bunbury. Other rural training posts have also been established, with PFY posts accredited in Maryborough (Qld) and Whyalla (SA), amongst others.

Educational CME sessions continue in many rural areas. There are biannual meetings for non-specialists in Queensland to which many rural and city specialists contribute. The 1998 SA ANZCA/ASA weekend CME Refresher Meeting had a strong rural GP representation.

The JCCA, the triumvirate body for general practice and non-specialist anaesthesia comprises, ANZCA, RACGP and College of Rural and Remote Medicine. It is chaired by Dr David Merefield, and continues its valuable input into rural matters. 30 non-specialists have so far enrolled in its training program, and over 300 in the Triennial CME program.

The largest unresolved issue for all rural practitioners continues to be inadequate staffing levels and difficulty with locums.

In New Zealand the recent changes to registration is making it difficult to fill permanent positions due to the requirement to write the FANZCA exam. Some provincial areas are still finding it difficult recruiting Australasian graduates and have traditionally relied on overseas graduates. The threat to smaller hospitals seems to have temporarily abated with the government stating its intention to continue to fund existing services.

The Rural Anaesthetic Recruitment Service (RARS) is an initiative of the Rural SIG, following the successful granting by the Rural Health Support Education and Training (RHSET) organization of a substantial grant to ANZCA. This is a collaborative project with the ASA. Notices have appeared and will continue to appear in targeted journals and newsletters announcing the Service. It aims to improve all levels of staffing in rural areas from permanent to locum tenens. It also aims to raise the profile of rural practice within the profession. RARS wants to draw the attention of Younger Fellows and Trainees to the possible career path of rural practice.

RARS will survey rural practitioners to establish staffing levels and staffing needs. A dual database of potential recruits and of vacant positions is to be established. Contact between these two groups will then be facilitated. Because the grant used to establish the RARS has been from the Australian Government we will be restricted to the Australian rural setting. A Website will also be established, similar to other sites such as www.anesthesiajobs.com, a USA-based job page.

As the RARS becomes established its range of activities will also expand. This exciting project has so far received excellent support. RARS welcomes Ms Jennifer Ellis as the Project Officer who will be coordinating the Service. A Rural sub committee of the Committee of Presidents of Medical Colleges has been established but is still coming to grips with its brief.

The Rural SIG, like other SIGs has a new generic constitution; an important element of this is that membership is not limited to Fellows or doctors. The Rural SIG may now draw membership from both ANZCA and the ASA in an inclusive manner, as well as other interested parties. This inclusive nature of the Constitution will improve communication between all groups interested in rural anaesthetic practice.

In the last 12 months the Executive has seen the departure of Drs. Mark Radnor (Vic) and Ray Cook (ACT); their contributions have been much appreciated. Drs. Mark Tuck (Vic) and David Kinchington (ACT) have replaced them and their future contributions are welcomed.

D Catt
CHAIRMAN

WELFARE

In line with a general climate of increasing interest in the importance of doctors' health issues, the activities of the Welfare of Anaesthetists Group have continued to expand.

In March 1999 Drs. Rob Burrell, Roger Fitzgerald and John Walker organised a Saturday Seminar in Auckland (the venue, a beautiful old house in the Waitakeres, was generously lent by Tracey Walker's family). There were 52 attendees, mostly trainees and their partners. The five speakers were Dr Alan Merry, ANZCA Regional Committee Chair who introduced the day, Professor Paul Merrick, a clinical psychologist at Massey University, who spoke on examination techniques, John McEwan, another clinical psychologist specialising in stress, grief and trauma counselling, Dr Peter Leathem, a liaison psychiatrist involved in the alcohol and drugs program, and Robyn Paul, from Relationship Services. Both the program and the venue were excellent, and appreciated by all that attended.

In April, a second Queensland Seminar "Striving, Thriving and Surviving in Anaesthesia and Intensive Care" was held at the Holy Spirit Hospital, Brisbane. About 50 people attended, mostly specialists and partners. Feedback sheets indicated that all that attended considered the day very worthwhile.

The number of trainees attending was disappointingly small – leading to the suggestion that trainee issues might be covered in the Primary and Final courses. This idea will be trialed in Western Australia next year.

We are very grateful to all the speakers at these two sessions, who gave up their precious weekend time to help further the cause of anaesthetists' health.

At the ANZCA Annual Scientific Meeting in Adelaide in May 1999, several workshops of interest and value were held. The subject of one workshop was "Trainees with Difficulties" chaired by Professor Teik Oh. Stories of three trainees with various problems were presented. Much useful discussion occurred, and several resolutions were passed which will be referred to ANZCA for consideration. Jane Cowling, a psychologist and the sister of an anaesthetist, conducted a session on "Juggling work and family relationships"; participants were able to reassess their priorities in a series of fascinating exercises.

Drs. John Paull and Jack Warhaft jointly presented a session on "Doctors in recovery" and a "Re-entry program for ex substance abusing anaesthetists". A review of the session and this innovative program has previously appeared in the ANZCA Bulletin.

At the Welfare SIG Business Meeting in Adelaide, the formal election of the SIG executive was held. Each region had only one nomination, and the following were thus elected unopposed:

Di Khursandi	Qld (Chair)
Leona Wilson	NZ (Secretary)
Genevieve Goulding	NSW
Phil Ogden	Tasmania
Lindy Roberts	WA
Chris Acott	SA
Jack Warhaft	Victoria
Mary Cardosa	Malaysia
Phoebe Mainland	Hong Kong.

Our grateful thanks are extended to the two retiring members of the interim Executive, Professor John Gibbs and Dr Rod Westhorpe, whose unfailing support and hard work have been an essential part of the growth of the Welfare Group since its foundation in 1995. I would like to thank ALL members of the Group and the Executive for their enthusiasm and participation in the Group's activities.

In Bowral NSW the Australian Society of Anaesthetists (ASA) NSW section had held a weekend meeting on lifestyle issues, to which partners were invited. Topics at the meeting included cardiovascular stress, exercise, diet and an open forum discussing stress in anaesthesia. The meeting was highly regarded.

In October 1999, the ASA's National Scientific Congress in Cairns included two sessions on "Whistleblowing" and Competence Issues. Speakers included Dr Mal Morgan, President of the Association of Anaesthetists of Great Britain and Ireland, Dr Steve Bolsin (Geelong), Professor Jan Davies (Canada), Dr Jillann Farmer of the Medical Board of Queensland, and Dr Frank New, Vice-Chair of the Doctors' Health Advisory Service in Queensland.

The Welfare SIG Website continues to grow; it will include a list of regional and national speakers and resources, as well as Action Plans. A new Action Plan on Mentors is now available. At the Business Meeting in May, a resolution was passed to place the Welfare of Anaesthetists SIG material in the public domain of the ANZCA/ASA/NZSA websites.

Feedback on the Website material is always welcome.

An important document on fatigue issues, the Australian Medical Association's (AMA) "National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors" has recently been released. Members of the Welfare SIG have been asked for their comments on this document.

A welcome initiative of the Medical Board of Queensland has been the publication and distribution of a "Healthy Doctor" leaflet.

The first AUSTRALIAN DOCTORS HEALTH CONFERENCE will be held in Queensland in November 1999; this conference is one of the developments resulting from the formation, by the AMA in Queensland, of a Doctors' Health Advisory Committee. An anaesthetist, Dr Phil Harrington, chairs the Committee. The conference is organised by Ms Jacky Holt, one of the speakers at the Queensland seminar.

Several new books of interest to those concerned with the health of themselves and others have been acquired by the ANZCA library, and can be borrowed by any trainee or Fellow. Our thanks are due to the ANZCA library committee and the librarian Ms Shanti Nadaraja, for their help and co-operation.

Finally, we have been very lucky to have the services of ANZCA as our secretariat provider. Special thanks are due to all ANZCA staff, especially Ms Helen Morris and her new assistant, Ms Nikki Breheny, for their hard work, encouragement and support throughout the year.

Diana C S Khursandi
CHAIR

POLICY DOCUMENTS – UNDER REVIEW

In line with College policy, the following Policy Documents are due for review in 2000:

E6 *The Duties of an Anaesthetist* (to be renumbered TE6)

T1 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites* (to be renumbered PS30)

T3 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities* (to be renumbered PS32)

T5 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries* (to be renumbered PS34)

T6 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites* (to be renumbered PS35)

P4 *Guidelines for the Care of Patients Recovering from Anaesthesia* (to be renumbered PS4)

P15 *Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery* (to be renumbered PS15)

P18 *Monitoring During Anaesthesia* (to be renumbered PS18)

P19 *Monitored Care by an Anaesthetist* (to be renumbered PS19)

P28 *Policy on Infection Control in Anaesthesia* (to be renumbered PS28)

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

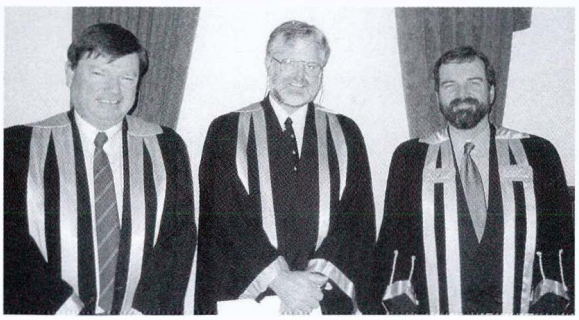
DEATHS

Council noted with regret the death of the following Fellows:

Dr Siri Rama Karthigesu, NZ – FFARACS 1983, FANZCA 1992

Dr John Ian Munckton, SA – FFARACS 1987, FANZCA 1992

RETIRING EXAMINERS



Drs Matthew Crawford, Tony Quail (Chairman – Primary Examination Committee) and Assoc Prof Greg Knoblanche.

EXAMINATION PRIZE WINNERS

The Renton Prize for the period ending 31st December 1999 was awarded to:

DR NICOLE ANNETTE HEALY, Queensland

The Court of Examiners recommended that the Cecil Grey Prize for the half year ending 31st December 1999 be awarded to:

DR SHANE CHRISTOPHER TOWNSEND, Queensland

COUNCIL 1999

Back Row Left: Associate Professor Greg Knoblanche, Drs Mike Martyn, Wally Thompson, Steuart Henderson, Diana Khursandi, Rod Westhorpe, Mrs Joan Sheales (CEO), Dr Ian Rechtman

Front Row: Professors Michael Cousins (Dean, Faculty of Pain Medicine), John Gibbs, Teik Oh (Vice President), Dr Richard Walsh (President), Dr Alan Duncan (Dean, Faculty of Intensive Care), Dr Richard Willis

ANZCA SUBMISSIONS TO CONSULTANCIES/ENQUIRIES

The College is often consulted by organisations seeking College views on particular issues. Sometimes the issues have a focus on anaesthesia, intensive care or pain medicine, sometimes they seem peripheral but relevant. In each case a reasoned response is provided, based on College policy, supported by relevant published documents.

Fellows may be interested in knowing something of submissions made over the last few months.

(1) Australian Senate Community Affairs References Committee Inquiry into Childbirth Procedures.

This Committee is currently considering submissions made to it. There were ten terms of reference, the one most relevant to anaesthesia being "the variation in childbirth practices between different hospitals and different States, particularly with respect to the level of interventions such as caesarean birth, episiotomy and epidural anaesthetics".

(2) Federal Privacy Commissioner's Application of the National Principles for the Fair Handling of Personal Information to Personal Health Information.

The purpose of the Commissioner's information seeking is so he can inform the Attorney-General's Department which is drafting legislation to support and strengthen self-regulatory privacy protection in the private sector. Issues relevant to anaesthetists relate to collection of health data, confidentiality, consent to disclosure, data sharing among health professionals, disclosure in health emergencies, disclosure and law enforcement and disclosure for research.

(3) Consultation on the National Cancer Advisory Committee Ideal Oncology Curriculum.

The College submission emphasised the importance of including in undergraduate curricula the relevance of anaesthesia, intensive care and pain medicine as part of the team approach to care of the cancer patient.

(4) Consultation on the e-Health Model being developed for Government by Optus Health Solutions.

Sub-projects in this consultancy relate to electronic data recording, computerised patient records, automation of laboratory and radiology reporting and remote audiovisual applications.

Miss Karen Monette, receiving gift recognising her contributions to the Examination System from the Final Examination Committee.

Ms Carol Cunningham-Brown, Executive Officer of the Faculty of Intensive Care, with Dr Alan Duncan (Dean) and Dr Richard Walsh (President), following a presentation recognising her 10 years service to the College.

FACULTY OF PAIN MEDICINE
DEAN'S MESSAGE

First Examination:
The most important function of any professional body is the conduct of a high quality training program and examination system. The Faculty Examination Committee has been working hard to prepare for the **first examination** in November of this year. The details of the examination format were outlined in the August, 1999 Bulletin and are repeated in this Bulletin. It is very pleasing to report that there will be **twelve candidates** for this first examination. This compares very favorably with the inception of other professional bodies where often only a handful of candidates presented for the first examination. There is already a strong indication of a substantial number of candidates for next year's examination.

Short Course:
On 15th – 17th October a short course was conducted at Royal North Shore Hospital and ten of the twelve candidates for the first examination attended. Thanks are due to Dr. Suellen Walker who assembled a very high quality multidisciplinary Faculty at quite short notice. Feedback from candidates at the course has been extremely positive. The Faculty will soon need to initiate regional educational courses for trainees to complement their practical training.

Inspection of Pain Centres:
An encouraging number of requests for **inspection of Pain Centres** has been received from Directors of Centres, wishing their Centres to be considered as an approved Faculty training centre. The Hospital Accreditation Committee (HAC) will expedite requests for reviews, particularly for Centres which hope to appoint a trainee in the year 2000. I would like to underline the fact that reviews of a number of Centres to date has invariably resulted in the responsible institution correcting any deficiencies which were identified by the HAC review team.

Election of Board:
The initial Board of the Faculty will complete its term early in the year 2000. A "voting slate" for the Board will have specific Board positions for the participating specialities, however there may be more than one candidate for each position. All Fellows of the Faculty will vote for all positions. This will ensure that all participating specialities continue to have representation on the Board.

Research:
Research in the field of Pain Medicine is already receiving support from the ANZCA Foundation for Research in Anaesthesia, Intensive Care and Pain Medicine; four of the eleven project grants awarded in 1999 were for research of relevance to Pain Medicine. All Fellows of the Faculty are eligible to apply for such research support. The Wills' Report has major implications for the future of medical research and Fellows are encouraged to consider the overview of this report that appears in the August 1999 edition of the Bulletin.

In conclusion 1999 has been a pivotal year for the Faculty, with the induction of Foundation Fellows, election of a number of Fellows and Honorary Fellows, approval of Training Programs, and holding of the first examination for Fellowship. I would like to take this opportunity to wish all Trainees and Fellows a restful holiday season and a happy and productive year 2000.

MICHAEL J COUSINS AM

Faculty of Pain Medicine Highlights from Board Meeting held on September 30, 1999

EDUCATION

Manual on Training

The Education Committee is making progress with updating the Manual on Training and Reading Reference List. At a recent Committee meeting further areas identified which are required in the reference material are headache, musculoskeletal, medicosocial, psychiatry/psychology and imaging.

NHMRC Document *"Acute Pain Management: Scientific Evidence"*

Dr Suellen Walker, Dr Pam Macintyre and Dr Penny Briscoe have been nominated from the Faculty to a joint working party with the Acute Pain SIG to revise this document.

EXAMINATION

Examiners have been appointed for the first examination. Preparations for the examination on November 25 and 26 are progressing well.

HOSPITAL ACCREDITATION

Review of Units

The Committee has received requests from a number of Directors of Pain Centres for a review of their units with a view to accreditation in accordance with ANZCA approved Policy Document TE16 "Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine. Inspection of these Pain Centres", as well as reviews of existing accredited pain centres will commence shortly.

ANNUAL SCIENTIFIC MEETING

Melbourne 2000

The Faculty program for the Annual Scientific Meeting has been finalised and will be held over the weekend of May 6 and 7, 2000. Foundation Visitor will be Professor Dan Carr from the New England Medical Centre, Boston, USA.

PAEDIATRIC PAIN MEDICINE PRACTITIONERS

Dr Suellen Walker has commenced discussions with Fellows active in Paediatric Pain Medicine with a view to establishing a working party on Paediatric Pain Medicine Practitioners.

MAINTENANCE OF PROFESSIONAL STANDARDS PROGRAM

Fellows of the Faculty are expected to participate in the ANZCA MOPS Program or the equivalent program of their Specialist College/Faculty.

FORMAT OF THE FELLOWSHIP EXAMINATION

NOVEMBER 25 AND 26, 1999

Written Section
This will consist entirely of short answer questions, with the duration of the examination being 2½ hours. Candidates will be required to answer 10 out of 15 short answer questions. Five of the ten questions to be answered will be from a compulsory set of five questions. The remaining five questions can be chosen from ten questions which are optional and which provide candidates with an opportunity to choose questions that may be aligned with their particular areas and/or knowledge. In developing a bank of short answer questions, the examination committee has identified questions which they regard as being relevant to "core knowledge" which all candidates must possess; the five compulsory questions will be relevant to this core knowledge. The short answer question section of the examination will be held on Thursday morning 25th November.

Long case
Candidates will have one hour with a patient for history and examination. Twenty minutes will then be provided for making notes and organising the material. There will then be a 30 minute viva with a pair of examiners.

Short cases
There will be five stations, three of which will have patients and two of which will have diagnostic imaging, test results and other materials. Each candidate will visit each of the five stations and will spend ten minutes at each station. At the three stations with cases, there will be a mixture of "cold" cases with patients who have an established condition that has been previously diagnosed and treated. There will be at least one "hot" case which may be a patient brought from a ward or recent clinic who has a condition about to be treated, or currently under treatment.

Structured Oral Vivas
Each candidate will do three structured oral vivas 10 minutes each. The structured oral vivas will follow a predetermined format with a scenario previously developed and scrutinised by the Examination Committee. One of the three vivas will be aimed at acute, chronic and cancer pain respectively.

Court of Examiners Meeting
The Court of Examiners at the conclusion of the examination. Results will be posted and the successful candidates presented to the Court of Examiners.

ELECTED TO FELLOWSHIP

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

Peter COX, NSW,FANZCA
Robert DELCANO, WA, BDSc
Hilton FRANCIS, VIC, FRACP
Benny KATZ, VIC, FRACP
Robert LARGE, NZ, FRANZCP
Gajinder OBEROI, TAS, FANZCA
Michael POLLACK, NSW, FAFRM (RACP)
Ian POWER, NSW, FRCA
John QUINTNER, WA, MRCP
S Raj SUNDARAJ, NSW, FANZCA

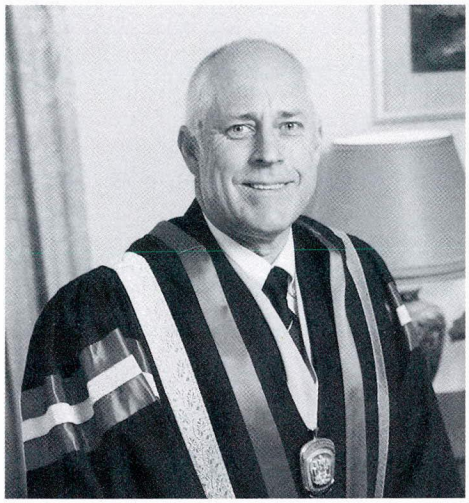
Dr Judith and Mr Michael Lynch (NSW) at the Neuroanaesthesia SIG Meeting, Lindeman Island.

ADMISSION TO FELLOWSHIP BY EXAMINATION

OCTOBER 1999

Allysan	ARMSTRONG-BROWN	NSW	Keith	REES	VIC
Timothy James Bernard	O'BRIEN	QLD	Kathryn Elizabeth	WEARNE	TAS
Elizabeth Joyce	PEMBERTON	VIC	Chandini Tikiri Kumarihamy	LIYANAGAMA	VIC
Leah Margaret	POWER	WA			
Stephen Nicholas	PRINEAS	NSW	Alex Harry	KONSTANTATOS	VIC

FACULTY OF INTENSIVE CARE
DEAN'S MESSAGE



An Independent College of Intensive Care Medicine – If and When?
I believe that the two bodies involved in Training and Certification in Intensive Care, namely the Royal Australasian College of Physicians and the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists, now have sufficient information to allow them to plot the course forward with this important issue. In July this year, a Discussion Document and Survey were circulated to all intensive care specialists and registered trainees. By early September 243 completed surveys had been returned. This represented a response rate of 45% for intensive care specialists and 12 % for trainees. Although there is no way of knowing, it is hoped that intensive care specialists who felt most strongly about the College issue took the opportunity to have input. It is unknown why few trainees availed themselves of the opportunity to be involved in this process.

The survey, whilst not producing a mandate for a particular direction of change, did indicate a desire for change and progress. Approximately 60% of specialists and trainees indicated that they considered the lack of a single pathway for certification in intensive care as important or very important. Of those offering an opinion, 67% of specialists and 83% of trainees also indicated that the lack of single academic body for intensive care was important or very important.

Only 17% of those who responded indicated that maintenance of the status quo was acceptable. Thirty one percent of respondents favoured formation of an independent College of Intensive Care Medicine de novo. Fifty percent favoured expansion of the Faculty by election to Fellowship of "bona fide" RACP intensivists in the first instance with the understanding that the Faculty of Intensive Care would ultimately evolve to form an independent College of Intensive Care Medicine. Not surprisingly, the Faculty option was most strongly favoured by Fellows of the Faculty and our College. Interestingly, however, RACP intensive care specialists were evenly split between the three options. Ninety two percent of respondents who do not currently hold FFICANZCA indicated that they would accept Fellowship of the Faculty if offered.

Eighty percent of respondents indicated that irrespective of the changes agreed upon, they should take place within five years.

In addition to the statistical information, a large number of comments were offered reflecting the spectrum of opinion on the various options. The survey results and comments are reproduced elsewhere in the Bulletin.

In further considering this matter it is worth noting that the Faculty now has 251 Fellows and 150 registered Trainees.

What then is the next step?
The Board believes that the pathway forward is becoming clear. It supports evolution of this issue in an orderly and co-operative manner. Fellows and trainees can be reassured that the interests of the intensive care specialty and the quality of services we provide will be paramount in these discussions.

A liaison meeting between representatives of the RACP, the Faculty and ANZICS was held recently to consider the Discussion Document, the results of the Survey, and problems perceived with the current intensive care programs and the respective roles of the Colleges and ANZICS.

The meeting was harmonious and there was strong agreement for the formation of a Joint Faculty of Intensive Care Medicine co-sponsored by ANZCA and the RACP. The model by which this occurs is yet to be determined and awaits the view of the two Colleges. This is an exciting development which would allow a further evolutionary approach for the specialty and provide a 'level playing field' available to Fellows of both the Faculty and the RACP Representatives of ANZICS also supported this model.

RACP Observers
The October Board Meeting was an historic event with RACP Intensive Care Specialists joining the Board as Co-opted Observers for the first time. The RACP has nominated Drs Raymond Raper and Jonathan Gillis as their representatives to the Board. The Board is delighted with this development and looks forward to the contribution that RACP Intensivists will make to our activities. This move comes on top of RACP involvement in the Fellowship Examinations, Regional Committees and Faculty hospital accreditation teams. Every attempt is being made by the Board to foster an inclusive environment.

Maintenance of Professional Standards
The revision of our Maintenance of Professional Standards Program has been completed and comes into effect in January 2000. The changes and format are modelled on those introduced by the College. Like the College, we are in the process of producing an electronic form of the diary. A summary of the revised program is published in this issue of the Bulletin.

Alan Duncan

A.W. DUNCAN, DEAN

ITEMS OF INTEREST FROM THE OCTOBER 1999 BOARD MEETING

EDUCATION AND TRAINING

Workshops for Supervisors

Plans for workshops which will enable Supervisors of Training to improve their management and training skills are being considered in association with other medical bodies. ANZCA will hold its first workshop in January 2000 and Faculty Supervisors are invited to attend.

Formal Project

The requirements for the Formal Project were reviewed and further consideration will be given to the merits of prospective registration and guidance of projects, and a broadening of the types of projects accepted.

Selection of Trainees

The Board approved a set of recommendations for Hospitals regarding Trainee Selection and Registration. A document including a statement of principles, eligibility and selection criteria will be promulgated to accredited hospitals in 2000.

Review of Intensive Care Training Programs

Restructuring of the intensive care training program offered by the Faculty will be one of the topics for discussion at a meeting with representatives of the RACP and ANZICS.

Review of Documentation Relating to Training

The Board supported amendments to the documentation required for accreditation, to streamline information required from trainees undertaking dual certification.

EXAMINATIONS

The Board ratified the appointment of Dr Rob Young to the Faculty Panel of Examiners.

Report of August/September 1999 Examination

Six of eleven candidates presenting for this examination were successful:

P.S. Kruger, Qld	Y.T. Leong, Vic
C.L. McCalman, NZ	A. Purdon, NSW
D.W. Wrathall, NZ	V. Yeo, HK

Paediatric Intensive Care Examination, August/September 1999

All three candidates presenting at this Examination were successful:

M.P. Clifford, Vic
S.J. Erickson, WA
M.J. Hayden, WA

The G.A. (Don) Harrison Medal

The Board resolved to award the G.A. (Don) Harrison Medal for 1999 to Dr Mark John Hayden of Western Australia.

PROFESSIONAL AFFAIRS

Credentialling of specialists for intensive care positions

A proposal for formalising the process of Faculty involvement in credentialling for hospitals was supported by the Board and will be developed further by JSAC-IC. Such requests will be handled by the Regional Committee.

Liaison with the Royal Australasian College of Physicians and ANZICS

A meeting with representatives of the RACP and ANZICS will take place in November to consider issues relating to an Independent College of Intensive Care Medicine, a review of the intensive care training programs, specialty recognition and the role of ANZICS and the Colleges.

A separate College of Intensive Care Medicine

The Board noted the survey undertaken by JSAC-IC of intensive care specialists and trainees, and discussed the results of the survey (see elsewhere in this issue).

Policy Documents

The Board endorsed the following College policy documents as joint Faculty/College documents:

- Draft College Policy Document "Intrahospital Transport of the Critically Ill"
- Policy Document PS40 "Guidelines for the Relationship between Fellows of the College and Healthcare Industry".

Representation on RACS Trauma Committee

The Board noted Dr Jamie Cooper has been appointed as the Representative of ANZCA and the Faculty on this Committee.

Maintenance of Professional Standards

The Board noted that the revised MOPS program will be introduced in January, 2000, which will include the option of a paper or electronic diary.

FINANCE

The Board resolved that fees for 2000 would not be increased. The following fees for 2000 apply:

Faculty Registration Fee for trainees	A$950

Faculty Annual Training Fee and once-only Faculty Training Fee for conjoint trainees for 2000:

- Australia and Hong Kong - A$925
- New Zealand - NZ$925 + GST (payable to NZ office)
- Singapore and Malaysia - $925 (local currency converted into Australian dollars)

Examination Entry Fee	A$1900
Non-Fellows' participation in the Faculty MOPS Program	A$300
Annual Subscription	A$990 +GST
Overseas Trained Specialist Assessment Fee	A$500.

INTERNAL AFFAIRS

The Board welcomed the attendance of Drs Raymond Raper and Jonathan Gillis as Co-opted Observers for the Royal Australasian College of Physicians.

The Board congratulation A/Professor Andrew Bersten for his splendid achievement of organising an effective scientific program for the intensive care section of the Annual Scientific Meeting in Adelaide.

The next National Intensive Care Day will be held in 2001, to be timed with the World Congress.

RESEARCH

The Board congratulates A/Professor Andrew Bersten, SA, Dr Jamie Cooper of Victoria, and A/Professor B. Venkatesh on their recent research grant awards (detailed elsewhere in the Bulletin.

Faculty of Intensive Care
ANZCA

REVISED MOPS PROGRAM

Fellows are reminded that at the beginning of the year 2000 the Faculty Maintenance of Standards Program will change in line with the ANZCA MOPS Program. Key changes will be:

Program Structure

The new program has a 5 year cycle. Those already enrolled will continue with their 5 year cycle but use the new program from 1st January 2000.

It will not be necessary to accumulate a certain total number of points over 5 years. There is a minimum number of points each year for CME (50 points) and QA (25 points).

Many more activities are included eg. clinical audit projects, distance learning, writing books, chapters, and papers. Practice peer review, hospital attachments and simulator courses are also included.

Returns must be filed by February of the next year, otherwise the MOPS points will not be credited.

Returns may be submitted in a paper or electronic diary.

Random Review

5% of all returns will be audited to verify accuracy of returns and relevance of activities. Documentation related to MOPS activities such as meeting programs, receipts, papers, audits etc should be kept.

Feedback

Feedback will be given to all participants each year to enable them to compare their MOPS activities with their peers in a similar practice.

Confidentiality

The Faculty MOPS Program has been declared under the Australian Commonwealth Insurance Amendment Act 1992 as a Quality Assurance activity to ensure protection of collected information. Currently the New Zealand National Committee is applying to the Ministry of Health seeking registration of the Faculty MOPS program as a declared QA activity under Part VI of the Medical Practitioners' Act 1995.

A new MOPS kit will be mailed to all Fellows in December and any enquiries should be directed to Dr Gil Bishop, the Faculty MOPS Officer.

Admission to Fellowship
of the Faculty of Intensive Care, ANZCA

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

Leung Hit Hung	Anne	HK	Antony Hugh Lawrence	Stewart	NSW
Francis Brigid	Colreavy	WA	John Raymond	Awad	NSW
Ross Michael	Calcroft	HK	Derek	Lai Ki Chu	Qld
Cheung Po	Wa	HK	Stephen John	Fletcher	UK
John McKinnon	Torrance	NZ	Peter Hamilton	Sharley	SA

FACULTY FELLOWSHIP EXAMINATIONS

September 1999, Sydney

The second Paediatric Intensive Care Fellowship Examination was held at the New Children's Hospital on 14th September. All three candidates who presented were successful.

Pictured are the successful candidates with the Paediatric Court of Examiners.

Rear: Drs Jim Tibballs, Tony O'Connell, Neil Matthews, Chairman Dr Richard Lee, Bruce Lister, Steve Keeley
Foreground: Candidates Drs Simon Erickson WA, Mark Hayden WA and Mike Clifford Vic, and member of the Court Dr Martin Rowley

The General Fellowship Examination was held at the Liverpool Hospital on 16th and 17th September. Six of the eleven candidates who presented were successful: Drs Peter Kruger, Qld, Tim Leong, Vic, Craig McCalman, NZ, Adam Purdon, NSW, Wayne Wrathall, NZ and Victor Yeo, HK

Rear: Drs Ron Trubuhovich, Les Galler, Neil Matthews, Martin Rowley, John Myburgh, Richard Lee, Jim Tibballs (hidden), Prof Ken Hillman
Foreground: Candidates Drs Craig McCalman, Peter Kruger, Wayne Wrathall, Victor Yeo and Adam Purdon

AWARD OF THE G.A. (DON) HARRISON MEDAL FOR 1999

The Board is pleased to announce that Dr Mark John Hayden, (WA), as the candidate achieving the highest mark in the Fellowship Examinations held during 1999, is the recipient of the G.A. (Don) Harrison Medal for 1999.

SURVEY OF AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SPECIALISTS AND TRAINEES

REPORT ON RESULTS OF THE SURVEY CIRCULATED ON 7 JULY 1999

The Survey was circulated to 648 ANZICS members and Faculty Fellows who are not members of ANZICS, and registered intensive care trainees of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians. As of 9 September 1999, 243 forms had been returned (a response rate of 37.5%).

A. Characteristics of Respondents

Fifty one percent of respondents were full time intensive care specialists, 39% were part-time intensive care specialists (48% > 50% part-time; 52% < 50% part-time), and 10% were trainees (79% FICANZCA, 4% FRACP and 17% both).

Of the intensive care specialists, 51% had > 10 years specialist experience, 22% had 5-10 years experience and 27% had < 5 years specialist experience.

Forty seven per cent of respondents held the qualification FFICANZCA (72% of these by examination), 16% were FANZCA only and 31% were FRACP (44% of these were JSAC-IC and 17% paediatric). Nineteen per cent held another specialist qualification. Only 142 (58%) answered that they had specialist recognition in intensive care with the HIC.

Fifty two replies were received from NSW, 41 each from Victoria and Queensland, 17 from WA, 15 from NZ, 13 from SA, 5 each from Tasmania and Hong Kong, 4 from ACT, 2 each from Northern Territory, UK and USA and one from India.

B. Results of the Questionnaire

Question 1

Comments on the problems are summarised at the end of this report.

Question 2

The data is based on 222 specialists and 18 trainees.

How important do you consider:

(a) Lack of single pathway for certification in intensive care?

Category	Nil Response	Very important	Important	Unsure	Of little importance	Of no importance
Specialists	9	56	73	22	53	9
Trainees	1	3	7	1	4	2

(b) Lack of a single academic body for intensive care?

Category	Nil Response	Very important	Important	Unsure	Of little importance	Of no importance
Specialists	9	59	84	23	39	7
Trainees	1	5	9	2	–	1

Question 3

Which of the options presented in the discussion paper do you prefer?

Option 1. (Status Quo)	45	(17%)
Option 2. (Independent College de novo)	74	(31%)
Option 3. (Expanded Faculty)	119	(50%)

(Includes all respondents)

Question 4

If you indicated Option 2 or 3 as first preference, what time frame would you consider appropriate?

0-2 years	30%
2-5 years	56%
5-10 years	14%

Question 5

Assuming that Option 2 (Independent College de novo) progressed:

(a) If offered, would you accept Fellowship of Intensive Care?
(b) Would you maintain your current Fellowship?
(c) If you answered YES to 5(a) and 5(b), would your acceptance of Fellowship be contingent upon a discounted Fellowship subscription for either your current Fellowship(s) or your new Fellowship of the College of Intensive Care?
(d) Which would you consider to be your main Fellowship? Current *or* College of Intensive Care

Overall, 94% of respondents said they would accept Fellowship of a College of Critical Care Medicine if offered, but 88% said they would maintain their current Fellowship. Just less than half (45%) stated that a discounted subscription would be necessary before they would accept a new Fellowship. Forty four percent said they would see their current Fellowship and 56% a Fellowship of a College of Critical Care Medicine as their main Fellowship.

Question 6

(Only respondents who did not currently hold FFICANZCA responded to this question).

Assuming that Option 3 (Expanded Faculty) progressed:

(a) If offered, would you accept Fellowship of the Faculty of Intensive Care?

(b) Would you maintain your current Fellowship?

(c) If answered YES to 6(a) and 6(b), would your acceptance of Fellowship be contingent upon a discounted Fellowship subscription for either your current Fellowship(s), or your new Fellowship of the Faculty of Intensive Care?

(d) Which would you consider to be your main Fellowship? Current *or* Faculty of Intensive Care?

Ninety two per cent of respondents indicated they would accept Fellowship of the Faculty of Intensive Care if offered. However, 97% said that they would maintain their current Fellowship. A discount on one or other Fellowship would be necessary before an additional Fellowship was accepted in 43% of respondents. Sixty one percent said they would see their current Fellowship and 39% the Faculty of Intensive Care Fellowship as their main Fellowship.

Question 7

The amount beyond the current subscription that respondents indicated they would be prepared to pay was $300 or less in 20%, $500 in 28%, $1000 in 41%, $1500 in 12% and $2000 in 9%.

C. Analysis of Responses with Respect to the Characteristics of the Respondents

(a) Analysis of responses to the questionnaire with respect to the State, Territory or Country of origin of the respondent is shown in the following Table.

STATE/TERRITORY/ COUNTRY	OPTION 1	OPTION 2	OPTION 3
NSW	11 (21%)	19 (37%)	22 (42%)
VIC	9 (22%)	11 27%)	21 (51%)
QLD	4 (10%)	16 (39%)	21 (51%)
WA	2 (12%)	5 (29%)	10 (59%)
NZ	3 (20%)	5 (33%)	7 (47%)
SA	1 (8%)	5 (38%)	7 (54%)
TAS	2	1	2
HONG KONG	0	2	3
ACT	1	0	3
UK	0	1	1
USA	0	0	2
NT	0	0	2
INDIA	0	0	1

(b) Analysis of responses with respect to the specialist status of the respondent is shown in the Table below.

SPECIALIST STATUS	OPTION 1	OPTION 2	OPTION 3
Trainee	2 (9%)	5 (22%)	16 (69%)
Specialist - full time	14 (12%)	42 (39%)	55 (49%)
Specialist - part time >50%	6 (14%)	15 (36%)	21 (50%)
Specialist - part time<50%	17 (38%)	9 (20%)	19 (42%)

(c) Analysis of responses with respect to the duration of specialist experience of respondents is shown in the Table below.

SPECIALIST EXPERIENCE	OPTION 1	OPTION 2	OPTION 3
< 5 years	12 (20%)	16 (26%)	33 (54%)
5 – 10 years	8 (17%)	19 (40%)	21 (44%)
> 10 years	24 (21%)	35 (31%)	53 (47%)

(d) Analysis of responses with respect to the qualifications of respondents is shown in the Table below.

QUALIFICATIONS	OPTION 1	OPTION 2	OPTION 3
FFICANZCA - all	15 (13%)	36 (32%)	61 (54%)
FFICANZCA - by examination	10 (12%)	26 (32%)	45 (56%)
FANZCA only	8 (21%)	7 (18%)	24 (61%)
FRACP – all	19 (28%)	24 (34%)	28 (39%)
FRACP – SAC-IC	7 (16%)	19 (43%)	18 (41%)
Other	10 (21%)	19 (40%)	18 (38%)

Of the respondents who said they would not accept Fellowship of a College of Intensive Care, 4 were FFICANZCA, 5 were FANZCA and 5 were FRACP.

Of those who responded that they would not maintain their current Fellowship, 23 were FFICANZCA, 4 were FRACP and none were FANZCA only.

The percentage of respondents who said that acceptance of Fellowship of a new College would depend on a discount was 47%, 44% and 43% for Fellows of FFICANZCA, ANZCA and RACP respectively.

Thirty seven per cent of FFICANZCA respondents said they would see their current Fellowship as their Main Fellowship compared with 43% of FRACP respondents and 71% of FANZCA respondents.

Other individual comments are summarised below.

Summary of Comments

Comments grouped under Option 1 - Status Quo

The major themes were:

1. Cost of a new College
2. Insufficient numbers for a new College
3. Present system works well

4. A variety of backgrounds is important to the Specialty
5. Importance of a second specialty as an 'escape route'
6. JSAC-IC does a good job

More minor themes:

1. No-one should be awarded the FFICANZCA if they have not earned it
2. Recognition of benefits of being part of the RACP
3. New College would be too anaesthesia based
4. A number of 'non-qualified' intensivists actually trained those who are now shouting the loudest to keep their Faculty exclusive!

Comments grouped under Option 2 - New College

The major themes were:

1. A new College would provide:
   a. a level playing field, it would be equitable
   b. a unified single voice
   c. a sense of identity for Intensive Care
2. The financial options could be re-examined with more modest goals
3. A degree of anti ANZCA/FICANZCA sentiment
   a. JSAC is dominated by FICANZCA
   b. FICANZCA fees are too high
   c. Need to distance ourselves from anaesthesia
   d. Faculty and ANZCA are a bloody nuisance
4. If Emergency Medicine can why can't we?
5. Existing training programs not optimal
6. Intensive Care seen as an add-on specialty - not a primary specialty
7. Sufficient resources (people) exist now
8. Would only accept FFICANZCA if definite plans to split from ANZCA made up front
9. Evidence of considerable difference of opinion among proponents of a new College
   a. should be inclusive/must be exclusive
   b. training should be longer/current training is too long
   c. training should have more/less anaesthesia/medicine

Comments grouped under Option 3 - Expanded Faculty

Major themes:

1. Feasible, achievable way to evolve into College in time
2. De novo College not financially viable
3. New College not viable unless RACP, FICANZCA stop ICU training
4. Lack of uniformity with current training

More minor themes:

1. The College issue is led by a vocal minority
2. FFICANZCAs reluctantly prepared to accept election of FRACPs for common good
3. Impracticability of full-time ICU practice in rural and remote areas
4. Option 3 has a 'take-over' feel
5. Many should aim for dual specialty practice

FELICITY HAWKER
Chair, JSAC-IC
September 1999

BOARD OF FACULTY

June 1999

Rear: Executive Officer Ms Carol Cunningham-Browne with Drs Rob Barnett, Ron Trubuhovich, Jamie Cooper, Richard Lee and Gil Bishop
Foreground: Drs Neil Matthews, Felicity Hawker (Vice Dean), Alan Duncan (Dean), Professor Teik Oh (Vice President, ANZCA) and Dr Peter Thomas

FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

POLICY DOCUMENTS

IC-1	(1997)	Minimum Standards for Intensive Care Units *Bulletin Aug 94, pg 44*
IC-2	(1994)	The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin Aug 94, pg 49*
IC-3	(1998)	Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care *Bulletin Nov 98, pg 70*
IC-4	(1994)	The Supervision of Vocational Trainees in Intensive Care *Bulletin Aug 94, pg 54*
IC-5	(1995)	Duties of Regional Education Officers in Intensive Care *Bulletin Nov 95, pg 50*
IC-6	(1995)	Supervisors of Training in Intensive Care *Bulletin Nov 95, pg 46*
IC-7	(1994)	Secretarial Services to Intensive Care Units *Bulletin Aug 94, pg 57*
IC-8	(1995)	Ensuring Quality Care - Guidelines for Departments of Intensive Care *Bulletin Mar 95, pg 32*
IC-9	(1997)	Statement on Ethics and Patients' Rights and Responsibilities *Bulletin Nov 97, pg68*
IC-10	(1996)	Minimum Standards for Transport of the Critically Ill *Bulletin Mar 96, pg42*
IC-11	(1996)	In-Training Assessment of Trainees in Intensive Care *Bulletin Mar 96, pg 46*
IC-12	(1996)	Examination Candidates Suffering from Illness, Accident or Disability *Bulletin May 96, pg 66*
PS38	(1999)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*

POLICY DOCUMENTS

Review PS10 (1999)

THE HANDOVER OF RESPONSIBILITY DURING AN ANAESTHETIC

1. INTRODUCTION

During an anaesthetic, the major responsibility of the anaesthetist is to provide care for the patient. This requires the continuous presence of an anaesthetist. In certain circumstances, it is necessary for the anaesthetist to hand over that responsibility to a colleague. Such handovers will not compromise patient safety provided that appropriate procedures are followed. In prolonged anaesthetics, handover may be advantageous to the patient by preventing undue fatigue of the anaesthetist.

2. PROTOCOL FOR TRANSFER OF RESPONSIBILITY

The following matters must be considered by both the primary and the relieving anaesthetists:

2.1 The primary anaesthetist must be satisfied as to the competence of the relieving anaesthetist to assume management of the case.

2.2 The relieving anaesthetist must be willing to accept responsibility for the case.

2.3 Review of the patient's health status having regard to past history and the present condition.

2.4 A description of the anaesthetic including drugs, intravascular lines, airway security, fluid management, untoward events and any foreseeable problems.

2.5 Observations of the patient according to College Policy Document P18 *Monitoring During Anaesthesia* as shown by the anaesthetic record.

2.6 A check to ensure correct functioning of the anaesthetic machine, monitoring devices in use and any other equipment which is interfaced with the patient.

2.7 Notification of the handover to the consultant anaesthetist (in the case of a trainee) and to the operating surgeon.

3. TEMPORARY RELIEF OF THE ANAESTHETIST

This is necessary when the primary anaesthetist must leave the patient but will return to resume management of the patient.

3.1 The primary anaesthetist will only leave while the patient is in a stable state and no potential adverse events are likely to occur.

3.2 The relieving anaesthetist must have had all facts relevant to safe management adequately explained.

3.3 The relieving anaesthetist should not substantially change the anaesthetic management without conferring with the primary anaesthetist except in an emergency.

3.4 The primary anaesthetist must be available to return at short notice.

4. PERMANENT HANDOVER OF RESPONSIBILITY FOR CARE

This is necessary when the primary anaesthetist must leave the patient under the care of another anaesthetist for the remainder of the anaesthetic.

4.1 The primary anaesthetist will only hand over responsibility at a time when the clinical status of the patient is appropriate and the relieving anaesthetist is willing to accept responsibility for the patient.

4.2 The handover procedure will include a detailed discussion of all the items listed in 2.1-2.7, including the plan for the further intraoperative and postoperative management.

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Promulgated (as P10): 1985
Revised: 1991, 1994
Date of Current Document: Oct 1999

Review PS26 (1999)

GUIDELINES ON PROVIDING INFORMATION ABOUT THE SERVICES OF AN ANAESTHETIST

Patients and/or their relatives are entitled to know the implications of anaesthesia, sedation or other treatment before it is administered and to seek clarification of any issues which may be of concern. They must be free to accept or reject advice.

1. PRINCIPLES

1.1 Information about the proposed management should be provided in such a way that the particular patient (and where appropriate, their relatives) is able to understand the process.

1.2 Where real alternatives exist, options should be outlined, together with their advantages and disadvantages.

1.3 The patient should be aware of the financial implications of the medical service to be provided.

2. PRESENTING INFORMATION

2.1 Information should be provided during the initial consultation in a form the patient is likely to understand.

2.2 Basic information about anaesthesia or other treatment should be provided, even if the patient requests no information. Where the patient clearly does not wish for further information and states this wish, the anaesthetist should record this fact in the notes and should not force further information upon the patient.

2.3 Questions should be encouraged and answered clearly.

2.4 An interpreter should be used wherever necessary.

2.5 Where blood products may be required, discussion should take place concerning the advantages, disadvantages and alternatives to blood products.

3. RISKS

3.1 Known risks should be disclosed when either an adverse outcome is rare but the detriment severe, or an adverse outcome is common but the detriment is slight.

3.2 The uncertainty of adverse outcomes/events should be explained, as should the difficulty of relating the incidence of such events to the particular patient. (See Appendix).

3.3 Discussion of risks should be based upon the anaesthetist's assessment of the best anaesthesia management, the seriousness and nature of the patient's condition, the complexity of anaesthesia, the questions asked by the patient, and the patient's attitude and apparent level of understanding.

4. EMERGENCIES

It may not be possible or sensible to provide information when immediate intervention is necessary to preserve life or prevent serious harm. Attempts must be made as soon as possible, to provide information to appropriate members of the patient's family.

5. INCOMPETENT PATIENTS

As full an explanation as possible should be given, appropriate to the patient's understanding. Adequate information cannot be given to small children, the intellectually disabled, the mentally ill and the unconscious. Appropriate consent must be sought in these situations - e.g. from parents, relatives, guardians, or legitimate carers, unless it is an emergency situation.

6. RECORDS

A summary of the discussion and of the patient's understanding should be recorded in the patient's anaesthesia record or hospital file.

APPENDIX

Examples of risk might be:

a) Common adverse effects of general anaesthesia include fatigue, altered mental state, sleep disturbance, nausea, vomiting, sore throat, bruising from venipuncture.

b) Less common, but not rare adverse effects such as spinal headache.

c) Rare adverse effects which are unpredictable, such as anaphylaxis, awareness, neurological damage or death in healthy people.

d) Adverse effects which are related to the pre-existing disease, such as death in a patient with recent myocardical infarction undergoing emergency surgery.

RELATED DOCUMENTS

PS7 The Pre-Anaesthesia Consultation

P20 Responsibilities of the Anaesthetist in the Post-Operative Period

P22 Statement on Patients' Rights and Responsibilities

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Promulgated (as P26): 1994
Revised: 1999
Date of Current Document: Oct 1999

Review PS33 (1999)

RECOMMENDED MINIMUM FACILITIES FOR SAFE ANAESTHETIC PRACTICE FOR ELECTRO-CONVULSIVE THERAPY (ECT)

The safe provision of anaesthesia for ECT requires appropriate staff, facilities and equipment as specified in this guideline document.

1. PRINCIPLES OF ANAESTHETIC CARE

1.1 Anaesthesia should be administered only by medical practitioners with appropriate training in anaesthesia or by trainees supervised according to College Policy Documents TE3 *The Supervision of Clinical Experience for Trainees in Anaesthesia* and P2 *Privileges in Anaesthesia.*

1.2 Every patient presenting for anaesthesia should have had a consultation by a medical practitioner who has appropriate training in anaesthesia. See College Policy Document PS7 *The Pre-anaesthesia Consultation.*

1.3 Appropriate monitoring of physiological variables must occur during anaesthesia. See College Policy Document P18 *Monitoring During Anaesthesia.*

2. STAFFING

2.1 In addition to nursing staff required by those carrying out the procedure, there must be:

2.1.1 An assistant for the anaesthetist. See College Policy Document PS8 *The Assistant for the Anaesthetist.*

2.1.2 Assistance to enable safe positioning of the patient whenever this is required.

2.1.3 Appropriately trained staff to recover patients from anaesthesia. See College Policy Document P4 *Guidelines for the Care of Patients Recovering from Anaesthesia.*

2.2 There should be Technical assistance to ensure appropriate availability and servicing of all drugs and equipment used.

2.3 There should be a designated anaesthetist with overall responsibility for the ECT anaesthesia services.

3. REQUIREMENTS FOR AREAS IN WHICH ECT IS ADMINISTERED

3.1 **Anaesthetic Equipment**

3.1.1 There must be a breathing system capable of delivering 100% oxygen for both spontaneous and controlled breathing. An alternative breathing system should be immediately available. Where the same system is used for a group of patients, the breathing circuit must include an in-line filter. See College Policy Document P28 *Policy on Infection Control in Anaesthesia.* A fully equipped anaesthesia machine is not normally required for ECT.

3.1.2 An oxygen failure warning device is essential. An independent emergency oxygen delivery system must be available.

3.1.3 Suction apparatus with appropriate accessories must be available for the exclusive use of the anaesthetist at all times. This apparatus should comply with the current requirements of the relevant national standards. Provision must be made for an alternative system in the event of a primary suction failure.

3.1.4 Available apparatus must include:

3.1.4.1 Appropriate protection for the anaesthetist against biological contaminants.

3.1.4.2 Monitoring equipment complying with College Policy Document P18 *Monitoring During Anaesthesia.*

3.1.4.3 A stethoscope and a sphygmomanometer.

3.1.4.4 An appropriate range of facemasks.

3.1.4.5 An appropriate range of airways.

3.1.4.6 Two laryngoscopes with a range of appropriate blades.

3.1.4.7 An appropriate range of endotracheal tubes with fittings as specified in College Policy Document T1 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites.*

3.1.4.8 Vascular tourniquets and intravenous infusion equipment as specified in College Policy Document T1 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites.*

3.1.4.9 Provision for the safe disposal of "sharps", waste glass and items contaminated with biological fluids.

3.1.4.10 A cardiac defibrillator.

3.1.5 Other requirements for safe anaesthesia include:

3.1.5.1 Appropriate lighting for the clinical observation of patients which complies with the current requirements of the relevant national standards.

3.1.5.2 Emergency lighting and power.

3.1.5.3 Telephone/Intercom to communicate with persons outside the anaesthetising location.

3.1.5.4 Refrigeration facilities for the storage of drugs and biological products.

3.1.5.5 An adjacent area for the recovery of patients from anaesthesia according to the requirements of College Policy Document P4 *Guidelines for the Care of Patients Recovering from Anaesthesia.*

3.1.5.6 Contingency plans for the emergency transfer of patients from the area under adequate medical supervision.

3.2 **Drugs**

3.2.1 In addition to drugs commonly used in anaesthesia, medications necessary for the management of conditions which may complicate and co-exist with anaesthesia must be readily available. Examples of relevant conditions include:

Anaphylaxis	Cardiac arrhythmias
Cardiac arrest	Pulmonary oedema
Hypotension	Hypertension
Bronchospasm	Hypoglycaemia
Adrenal dysfunction	Malignant hyperpyrexia

3.2.2 The selection of appropriate drugs is the responsibility of the senior anaesthetist noted above in paragraph 2.3.

3.2.3 Systems for the regular replacement of these drugs after use or their expiry date must be in place.

3.2.4 A basic supply of dantrolene should be readily available with further doses obtainable on request.

3.3 **Routines for Checking, Cleaning and Servicing of Equipment**

3.3.1 Regular cleaning, checking and sterilising routines for all equipment must be established.

3.3.2 Documented servicing of equipment including that for medical gases must be carried out at least twice a year by an appropriate organisation. Any modification to the gas distribution system requires proper documented checking of function prior to its use.

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Promulgated (as T4): 1984
Revised: 1989, 1994
Date of Current Document: Oct 1999

TE17 (1999)

ADVISORS OF CANDIDATES FOR ANAESTHESIA TRAINING

The Advisors of Candidates for Anaesthesia Training are the College's representatives on training to assist doctors who have registered their intent to train or who wish to continue to train in anaesthesia, but who do not currently hold a College-approved training post. These candidates are likely to fall into one of the following categories:

- candidates who have registered with the College but have yet to secure an approved training position or have voluntarily stepped aside from the training program.
- candidates who have been in an approved training position but are temporarily ineligible to continue with training (e.g. they have not passed the Primary Examination after two years of approved training).
- candidates who have interrupted their training for any reason.

Where a candidate has an association with a training hospital, he/she may wish to maintain contact with the hospital Supervisor of Training. However, the College Advisor should be their College contact person.

The College Advisors of Candidates for Anaesthesia Training have an important role and must have a broad understanding and experience in College affairs. They provide liaison between these potentially isolated candidates, Regional Education Officers and the central administration of the College.

1. APPOINTMENT AND TENURE

1.1 The Advisor(s) of Candidates for Anaesthesia Training in each region shall be nominated by the Regional Committee according to the requirements of that region. The appointment will be ratified by the Education Committee on behalf of the College Council.

1.2 The appointee shall hold the Diploma of FANZCA or an equivalent qualification acceptable to the College Council and must not be a candidate for any College examination.

1.3 An Advisor of Candidates for Anaesthesia Training shall be appointed for an initial term of five years with a review by the Education Committee after two years. Advisors will be eligible for reappointment by the Council after advice from the Education Committee.

2. DUTIES OF ADVISORS

2.1 To advise potential and currently registered candidates who do not have a specified Supervisor of Training on their registration and training requirements, fee payments and examination preparation.

2.2 To refer any difficulties in respect of planned training programs or Candidates to the Regional Education Officer.

2.3 To be aware of appropriate training courses, the calendar of examination dates, and dates of closure for entries, and to ensure that Candidates receive this information.

2.4 To be familiar with the College's Regulations on Training, Examinations and Registration of Trainees.

2.5 To establish and maintain liaison with the Regional Education Officer and with Supervisors of Training. With the assistance of the College's Training and Examinations Administrative Officer, Advisors shall provide a list (on Form R2) to the Regional Education Officer and the Education Committee with the names of all candidates for anaesthesia training not in College approved posts. This list should be forwarded to the Regional Education Officer and the Education Committee within four months of the start of the hospital employment year.

2.6 To notify the Regional Education Officer of any changes to the list referred to in 2.5 caused by candidates joining or leaving training schemes during the hospital employment year. It is particularly important that the date of such changes are noted to allow for subsequent independent verification of training by the Assessor.

2.7 To be a member of the Regional Education Sub-committee.

3. RESOURCES

The Regional Committee Office shall provide each Advisor with the resources needed to fulfil his or her responsibilities.

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Promulgated: 1999
Date of Current Document: Oct 1999

Review TE3 (1999)

SUPERVISION OF CLINICAL EXPERIENCE FOR TRAINEES IN ANAESTHESIA

Supervision of trainees is performed by anaesthetists who possess the Diploma of FANZCA or a qualification acceptable to the Council.

1. LEVELS OF SUPERVISION

There are four such levels, viz.:-

1. Supervisor rostered to supervise one trainee and available solely to that trainee.
2. Supervisor rostered to supervise two trainees who are in anaesthetising locations in close proximity. The supervisor must be fully conversant with the nature of the patients in both locations and able to provide one-to-one supervision of each as appropriate.
3. The supervisor is available in the medical institution but is not exclusively available for a specific trainee.
4. The supervisor is not in the medical institution but is on call within reasonable travelling time and is exclusively rostered for the period in question. This level of supervision applies mainly to out of hours cases. Consultation must be available at all times.

2. MINIMUM SUPERVISION LEVELS

2.1 *General*

2.1.1 In order to ensure adequate supervision of trainees, Departments must employ at least one full-time equivalent (FTE) specialist anaesthetist for each trainee. There should be no more than two non-specialist anaesthetists (including trainees) for each FTE specialist anaesthetist employed.

2.1.2 Supervision at level 1 or 2 may be appropriate at any stage of training. It provides the best opportunity for teaching and for learning new techniques.

2.1.3 Supervision at level 1 and 2 should average at least 25% of all work done by trainees during the first four years of training.

2.1.4 Supervision at level 4 must not average more than 30% of all work done by trainees during the first four years of training.

2.1.5 Out of hours work should comprise between 25% and 50% of any trainee's workload during the first four years of training.

2.1.6 Trainees must be encouraged to seek advice and/or assistance as early as possible whenever they are concerned. This applies both in and out of hours. At all stages of training, a supervisor must

attend an anaesthetic whenever a trainee requests assistance. Conversely, a supervisor should attend an anaesthetic whenever this is deemed desirable.

2.1.7 Before being permitted to practice anaesthesia beyond level 1 supervision, all trainees must achieve a satisfactory standard in a structured assessment of competence by at least two appropriate designated consultant anaesthetists. This applies to new trainees as well as more experienced trainees who are working in unfamiliar subspecialty areas. This process is the responsibility of the Supervisor of Training.

2.1.8 As trainees become experienced, more independent practice should be encouraged by less close supervision. Guidelines are presented in items 2.2 to 2.6. The Supervisor of Training must advise on appropriate levels of graduated supervision for individual trainees.

2.1.9 All trainees must be supervised at level 1 in any working area with which they are unfamiliar.

2.1.10 Supervision of trainees must extend beyond the operating theatres to pre- and post-anaesthesia consultations, pain rounds, clinic assessments and related activities in other remote locations.

2.1.11 Trainees should be encouraged to discuss their progress on an informal basis with their Supervisors at frequent intervals throughout their training. This is in addition to the structured In-Training Assessments (College Policy Document E14 *Guidelines for the In-Training Assessment of Trainees in Anaesthesia*).

2.1.12 Supervision in a defined subspecialty area must be provided by a supervisor with appropriate experience in that area.

2.2 *First Year Trainees*

2.2.1 Supervision at level 1 must be provided for all cases during an initial period varying in length according to the trainee's previous experience and their development of skills and judgement. For trainees without previous anaesthesia experience, this will need to be for at least three months.

2.2.2 Supervision at levels 1 and 2 should be provided for most of the in-hours cases for the rest of the year.

2.2.3 After the initial period, the supervisor should be notified of all out of hours cases. At least 25% of out of hours cases should be supervised at level 1 or 2 . The supervisor should attend for all patients with conditions such as the following:-

2.2.3.1 Patients requiring major resuscitation.

2.2.3.2 Patients with serious medical illness.

2.2.3.3 Debilitated patients.

2.2.3.4 Children under the age of ten years.

2.2.3.5 Pregnant patients.

2.2.3.6 Surgery which poses special anaesthesia problems.

2.2.3.7 Any other high risk patients.

2.2.3.8 Any patient who the trainee does not feel competent to anaesthetise.

2.3 *Second Year Trainees*

2.3.1 Supervision at levels 1 and 2 should be provided for about half the in-hours case load.

2.3.2 Supervision at levels 1 and 2 should be provided for at least 20% of the out of hours case load.

2.3.3 The supervisor must be advised of all young children, all seriously ill patients and any patients posing special problems for the anaesthetist.

2.4 *Third Year Trainees*

2.4.1 Supervision at level 3 may be appropriate for many of the in-hours cases except where new areas of practice are encountered. In areas such as cardiothoracic, obstetric and major paediatric anaesthesia, level 1 supervision is normally appropriate.

2.4.2 For out of hours work, the supervisor must be advised of all young children, all seriously ill patients or those providing special problems for the anaesthetist.

2.4.3 It should be the supervisor's decision whether to attend the anaesthetic or not. Attendance on trainee request remains obligatory.

2.5 *Fourth Year Trainees*

2.5.1 Supervision at level 3 is appropriate for all work previously encountered but it may still be necessary for supervision to be at level 1 in unfamiliar environments or where necessary experience is lacking.

2.5.2 For out of hours work, consultation can be at the discretion of the trainee although consultation (and where necessary supervision) remains essential for unfamiliar clinical situations.

2.6 *Provisional Fellows*

2.6.1 Consultation and appropriate supervision must be available at all times.

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Promulgated (as E3): 1989
Reviewed: 1994
Date of current document: Oct 1999

Review TE7 (1999)

SECRETARIAL AND SUPPORT SERVICES TO DEPARTMENTS OF ANAESTHESIA

INTRODUCTION

All Departments of Anaesthesia require assistance from secretarial and support services to allow the medical, nursing and technical officers within the Department to perform their duties effectively. For those Departments approved for College trainees, the secretarial, administrative and educational support needed will require the appointment of appropriate staff within the Department.

DUTIES OF SECRETARIAL AND SUPPORT STAFF

The duties of secretarial and other support staff will fall into three main areas: individual support, departmental administrative support and departmental educational support.

1. INDIVIDUAL SUPPORT DUTIES INCLUDE:
   Provision of general secretarial services to individual specialists, trainees and other members of the Department, including the handling of correspondence, filing, appointments, telephone answering and mail.
   Assistance with the operation of computer based information and data processing services.

2. ADMINISTRATIVE SUPPORT DUTIES INCLUDE:
   Preparation, circulation and updating of departmental duty rosters, maintenance of departmental and medical records and general administration.
   Preparation and distribution of operating lists and facilitation of the deployment of medical officers for their service and other requirements.

3. EDUCATIONAL SUPPORT DUTIES INCLUDE:
   - 3.1 Co-ordination of the administrative aspects of continuing medical education, clinical review and quality assurance activities.
   - 3.2 Preparation and distribution of material for departmental meetings, including tutorials, peer review, clinical audit and quality assurance meetings.
   - 3.3 Facilitation of correspondence between the College, trainees and Supervisors of Training. See College Policy Document TE5 *Supervisors of Training in Anaesthesia*.
   - 3.4 Maintenance of the departmental library including books, journals, slides and other audio-visual material and preparation of visual display material.

4. OTHER RESPONSIBILITIES:
   Depending on other facilities and support at the hospital, secretarial assistance may be required for performance of literature searches, photocopying and circulation of documents from within the department, other departments of the hospital and other libraries.

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

POLICY DOCUMENTS

E = Educational P = Professional T = Technical EX = Examinations

PS = Professional Standards TE = Training and Examinations PM = Pain Medicine

E1	(1996)	Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
TE3	(1999)	Supervision of Clinical Experience for Trainees in Anaesthesia *Bulletin Nov 99, pg 67*
TE4	(1997)	Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg 88*
TE5	(1997)	Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
E6	(1995)	The Duties of an Anaesthetist *Bulletin Nov 95, pg 70*
TE7	(1999)	Secretarial and Support Services to Departments of Anaesthesia *Bulletin Nov 99, pg 69*
TE9	(1999)	Quality Assurance *Bulletin June 99, pg 94*
TE11	(1999)	Formal Project Guidelines *Bulletin Mar 99, pg 70*
E13	(1996)	Guidelines for the Provisional Fellowship Year *Bulletin Nov 96, pg 66*
E14	(1994)	Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, pg 62*
TE15	(1998)	Guidelines for Trainees and Departments seeking College Approval of Posts for the Certificate in Pain Management *Bulletin Mar 98, pg 70*
TE16	(1998)	Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin Nov 1998, pg 83*
TE17	(1999)	Advisors of Candidates for Anaesthesia Training *Bulletin Nov 99, pg 66*
EX1	(1996)	Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 96, pg 70*
T1	(1995)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites *Bulletin Nov 95, pg 52*
T3	(1995)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities *Bulletin Nov 95, pg 56*
T5	(1995)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries *Bulletin Nov 95, pg 65*
T6	(1995)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites *Bulletin Nov 95, pg 61*
P1	(1997)	Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin May 97, pg 81*
P2	(1996)	Privileges in Anaesthesia *Bulletin Nov 96, pg 72*
PS3	(1998)	Major Regional Anaesthesia and Analgesia *Bulletin Nov 98, pg 85*
P4	(1995)	Guidelines for the Care of Patients Recovering from Anaesthesia *Bulletin Aug 95, pg 64*
P6	(1996)	Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
PS7	(1998)	The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
PS8	(1998)	The Assistant for the Anaesthetist *Bulletin Mar 98, pg 75*
P9	(1996)	Sedation for Diagnostic and Surgical Procedures *Bulletin Nov 96, pg 73*
PS10	(1999)	Handover of Responsibility During an Anaesthetic *Bulletin Nov 99, pg 62*
P11	(1991)	Management of Cardiopulmonary Bypass *Bulletin May 91, pg 43*
PS12	(1996)	Statement on Smoking as Related to the Perioperative Period *Bulletin Nov 97, pg 78*
P13	(1992)	Protocol for The Use of Autologous Blood *Bulletin Aug 92, pg 49*
PS14	(1998)	Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin Nov 98, pg 81*
P15	(1995)	Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Aug 95, pg 62*
P16	(1994)	The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 94, pg 45*
PS17	(1997)	Endoscopy of the Airways *Bulletin Nov 97, pg 80*
P18	(1995)	Monitoring During Anaesthesia *Bulletin Nov 95, pg 68*
P19	(1995)	Monitored Care by an Anaesthetist *Bulletin Nov 95, pg 60*
P20	(1996)	Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 96, pg 52*
P21	(1996)	Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
P22	(1996)	Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
P24	(1997)	Sedation for Endoscopy *Bulletin May 97, pg 78*
PS26	(1999)	Guidelines on Providing Information about the services of an Anaesthetist *Bulletin Nov 99, pg 63*
P27	(1994)	Standards of Practice for Major Extracorporeal Perfusion *Bulletin Nov 94, pg 46*
P28	(1995)	Policy on Infection Control in Anaesthesia *Bulletin Mar 95, pg 38*
PS29	(1997)	Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin Nov 97, pg 82*
PS31	(1997)	Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg 84*
PS33	(1999)	Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT) *Bulletin Nov 99, pg 64*
PS36	(1997)	Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg 93*
PS37	(1998)	Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 98, pg 79*
PS38	(1999)	Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
PM1	(1999)	Guidelines for Trainees and Departments Seeking College Approval of Posts for Training in Pain Medicine *Bulletin Mar99, pg 73*