

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'*

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PRESIDENT'S MESSAGE



The issues confronted by the College are continuous and vital, and don't I know it! As a private practitioner, it is obviously difficult but personally rewarding to juggle family, College, clinical and administrative responsibilities at this time. I am greatly indebted to those many people who support me in this quest.

I continue to visit all Regions of the College for a variety of meetings in order to discuss concerns and issues as relevant. In particular, I mention my involvement and Executive membership of the Committee of Presidents of Medical Colleges (CPMC) whose current Secretariat resides at our College. The CPMC has an increasing influence as a representative voice of all Colleges on Australian national standards of health care in general. Each College maintains its independence on all issues whenever relevant. A similar Committee exists in New Zealand on which the College is represented. In Australia, the CPMC communicates with a variety of bodies at the highest of levels on matters as related to the Colleges. Such bodies include the Australian Medical Council, the Commonwealth Department of Health and its Minister, the Australian Medical Workforce Advisory Committee, State Medical Boards, the Australian Council on Healthcare Standards, the AMA, the NH&MRC and many others. I believe that the CPMC is currently working very well in the interests of the Colleges, particularly ANZCA and the professions our College represents.

While on "our professions", the College's Faculty of Pain Medicine has now been launched with the inaugural meeting of the Board of the Faculty held in February 1999. Professor Michael Cousins was elected as the Dean of the new Faculty, while other Board members who represent other participating Colleges hold key positions within the Faculty. It is a great tribute to Michael Cousins and his Board members that the specialty of Pain Medicine has been established in this way, particularly and rightfully within ANZCA. Foundation Fellows of the Faculty will be presented during the College Ceremony at the Annual Scientific Meeting in Adelaide in May 1999.

The rebuilding of the College Headquarters in Melbourne is about to commence. Accumulated funds of \$7 million will be invested into this

project which will establish a home of the future for ANZCA and all the specialties which the College and related bodies represent. The extensions to "Ulimaroa", an historic mansion on St Kilda Road in Melbourne, will be a much needed, significant and effective addition to the current site. More news will follow as the building proceeds!

The College and Australian Society of Anaesthetists (ASA) have now formally agreed to amalgamate the functions of their respective Asia-Pacific and Overseas Aid Committees. The New Zealand Society has been invited to also participate in this venture. In assisting development outside Australia and New Zealand, the College has traditionally been involved in Singapore, Malaysia and Hong Kong, with the ASA and NZSA in the Pacific Islands and some developing nations of Asia and other regions. Many individual anaesthetists from Australia and New Zealand have been outstanding, and most often insufficiently acknowledged, for their zeal and effectiveness in assisting developing countries, no matter how small. Names such as Haydn Perndt, Steve Kinnear, Hugh Spencer, John Hains, Karl Alexander, Chris Sparks, Garry Phillips, Kester Brown, David Mawter, Peter Armstrong and a great many others come to mind. I earnestly hope and trust that the combined efforts of all our professional bodies will renew enthusiasm, effectiveness, financing and participation in providing appropriate aid, education and increased health standards in our global region. Meanwhile, I welcome comments and suggestions on this issue in which I have a personal interest.

I note recent increased publicity, particularly generated from governments, on quality of healthcare as delivered to our patients. While this topic has achieved outstanding prominence in the political scene and therefore the media, it is in my view an issue on which the profession must show appropriate leadership. Old fashioned quality assurance programs now have many new acronyms and different points of emphasis, while the roles, for example, of evidence based medicine, clinical practice guidelines, critical incident monitoring, clinical auditing and clinical indicators are being evaluated and discussed, as are potential linkages between outcomes and health funding. All Colleges are fully involved in these developments and an unprecedented number of conferences, small meetings and consultations are occurring as a sensible and effective overall direction is being sought. ANZCA is heavily involved in this complex process of evaluation and debate and will of, course, closely liaise with all interested parties within our industry. Watch this space as the "quality debate" unfolds!

Finally, I remind everyone of National Anaesthesia Day on 7 July 1999, which will emphasise the peri-operative role of anaesthetists. It is in the interests of all anaesthetists to promote our profession as best we can, so please participate!

RICHARD G WALSH
President

THE MASTER TRIAL – A MILESTONE

Organisers of the Multicentre Australian Trial of Epidural Anaesthesia (the MASTER Trial) held a symposium at the Austin and Repatriation Medical Centre, Melbourne on Monday, 15 February, to update contributors from around Melbourne on the progress of the trial. The occasion was in part a celebration of the ARMC's recent recruitment of their 100th randomised patient.

Karen Collins, Principal Nurse Researcher for the Trial, attended from Perth to represent the Proincipal Researchers in the Department of Public Health, University of Western Australia, Associate Professors John Rigg and Konrad Jamrozik. She presented the Department of Anaesthesia at the ARMC with a certificate in recognition of their contribution to recruitment.

Dr Philip Peyton, Staff Anaesthetist at the ARMC, recapitulated on the aims of the trial and described the current status of recruitment. The MASTER trial is a randomised controlled trial of the influence of perioperative epidural analgesia on clinical outcomes after major surgery. To achieve sufficient power to detect a modest but important difference in perioperative complication rates between epidural and non-epidural groups, the trial selects a high risk patient population, and requires a multicentre base of recruitment.

Building on an initial grant from the Australian and New Zealand College of Anaesthetists, the MASTER trial secured further funding of over half-a-million dollars from the NHMRC in 1997 to randomise in excess of 800 patients. To date 450 patients have been recruited nationwide, with 20 hospitals in four States, as well as Hong Kong, Malaysia and New Zealand contributing. It is now larger than any other randomised trial looking at the influence of perioperative epidural analgesia.

Dr Paul Myles, Director of Research at the Alfred Hospital in Melbourne, presented data from a recent comparison of demographic data and complication rates between randomised patients and other eligible patients not recruited across the participating hospitals. The purpose of the analysis was to identify as early as possible any selection bias in the randomisation process. Results of this were encouraging with no significant differences demonstrable between the 200 randomised and 117 non-randomised but eligible patients studied. This suggests that the

results of the trial will have high external validity and will be generalisable outside the participating institutions.

An interim analysis of trial data was performed by biostatisticians at the Independent Data Monitoring Committee at the Department of Public Health, at n=260. This has indicated that at this stage no statistically significant differences exist between treatment groups and that recruitment should continue with a further interim analysis scheduled at n=460.

Dr Peyton concluded by commending the importance of the study to the audience both as a means of defining the place of epidural analgesia in perioperative management and as a new benchmark for the conduct of randomised controlled clinical studies in anaesthesia. A reminder was added of the need to maintain momentum in recruitment rates to achieve randomisation targets within the allowed time frame. The organisers extended their thanks to contributors from all over Australasia and offered congratulations on their efforts so far toward the successful completion of the MASTER Trial.



Dr Philip Peyton and Stephanie Poustie, Nurse Researcher at the Department of Anaesthesia at the Austin and Repatriation Medical Centre being presented by Karen Collins with a certificate in recognition of the ARMC's recent recruitment of their 100th randomised patient for the MASTER Trial.

DEATHS

Council noted with regret the death of the following Fellows:

Dr George Davidson, NSW – FFARACS 1953, FANZCA 1992
Dr George Robinson, Vic – FFARACS 1956, FANZCA 1992

NATIONAL ANAESTHESIA DAY

PERIOPERATIVE MEDICINE

WEDNESDAY, 7 JULY 1999

Mike Martyn
Communications Officer



How would you, as an anaesthetist, like to be remembered? As a technician (not a real doctor), working in seclusion in an operating theatre at the beck and call of others. Or would you like to be remembered as a leader amongst specialist medical practitioners in providing quality care to your patients?

National Anaesthesia Day in 1999 provides an excellent opportunity to highlight the leadership of anaesthetists in the development of perioperative services and our integral role of providing high quality, cost effective care before, during and after anaesthesia. Perioperative Medicine is a theme that emphasises our established training, skills and responsibilities.

Letters have been sent out to all hospitals and those on the National Anaesthesia Day mailing list in order to allow advance planning towards another successful Day.

Have you contacted your hospital management or public relations department? Their support should be able to enhance your own efforts in organising the National Day.

You may wish to mount displays in hospitals, local shopping centres or other public areas. Alternatively visits to schools, or school visits to hospitals, interviews on local radio or TV, articles in local newspapers or talks to GP meetings or other organisations are all proven techniques for broadcasting our message out to the community.

Once again kits will be supplied to support your activities in conveying your message to the community. A poster using photographs is being prepared along with a simple leaflet and accompanying stickers and a media support package. To book your kit please contact Mandy Williams at the College – more than 100 have already been ordered.

The concept of National Anaesthesia Day as a successful annual event is now well established and is also being planned by both UK and Canadian anaesthetists. However the ultimate success in further improving community understanding of our important specialty is very dependent on the enthusiasm, endeavor and actions of all anaesthetists.

Your input and suggestions are very welcome.

1999 YOUNGER FELLOWS' CONFERENCE

THEME: *STRIVING FOR A JOB WELL DONE*

Representatives to the Younger Fellows Conference to be held at
Chateau Yaldara Motor Inn, South Australia

6-8 May 1999

HONG KONG	Dr Simon Kin-Cheong CHAN Dr Bee Beng LEE
NEW SOUTH WALES	Dr David ELLIOTT Dr Sharon TIVEY
NEW ZEALAND	Dr Cameron BUCHANAN Dr Carolyn FOWLER
QUEENSLAND	Dr Gerard HANDLEY Dr Anton LOEWENTHAL
SOUTH AUSTRALIA	Dr Dave BARKER Dr Dave McLEOD Dr Brian SPAIN Dr Dave WILKINSON
TASMANIA	Dr Wendy FALLOON Dr Ruth MATTERS
VICTORIA	Dr Debra DEVONSHIRE Dr Colin IATROU
WESTERN AUSTRALIA	Dr Elisabeth AVRAAMIDES Dr Lindy ROBERTS

LAW REPORT

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

TESTING TIMES

A recent decision of the Supreme Court of South Australia confirms that doctors have a responsibility to ensure follow-up on tests ordered or reports requested, and should have a follow-up or checking system in place.

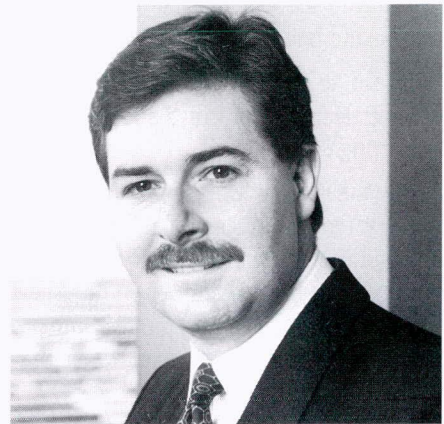
The decision in *Kite & Anor v Malycha (1998) 7602 SASC (10 June 1998)* continues the inexorable increase of doctors' obligations and reduction in patients' obligations.

The case relates to a situation where a doctor, having taken a needle biopsy of a lump in the patient's left breast, failed to take proper steps in response to a pathology report indicating that the specimen was highly suspicious of an underlying carcinoma. It was suggested in the case that the doctor's shortcoming was in his failing to record in his notes and follow-up appropriately the procedure (a fine needle aspiration) which he performed on the patient in 1994. The carcinoma was finally detected in 1997.

In summary, the case suggests that the doctor examined the patient, who had previously benign conditions relating to sweat glands and lumpy breasts, and the doctor conducted a fine needle aspiration of the lesion detected. He gave some reassurance to the patient that it was unlikely to be a major problem.

Whilst the patient gave evidence that the doctor said that he would have the specimen tested and that if anything showed up he would be in touch with her, the Court was satisfied that the doctor in fact made a further appointment for the patient to return in one month to review the matter and that the patient was asked to ring the doctor later on the day of the fine needle aspiration to ascertain the result of the biopsy. The Court was satisfied that the patient did neither.

However, a report on the biopsy was alleged to have been sent to the doctor on the same day by fax, with a fax record indicating that the transmission was not in error, and that a copy was couriered to the doctor's rooms. The Court found, as a question of fact, that the fax was sent and received by the doctor's rooms, but was prepared to find that the hard copy was not couriered to the doctor's office. The Court concluded:-



“In summary, I find on the balance of probabilities, the report was faxed (to the doctor's) room, but that for some reason or another it was misfiled or mishandled, if in fact the facsimile machine in (the doctor's) room printed a copy of it, with the result that its contents were never read by (the doctor) and it was never placed in his file for (the patient). I find on balance that the hard copy of the report was not delivered to his room”.

The doctor sent correspondence to the referring practitioner confirming that a fine needle aspiration biopsy had been conducted and that he had given the patient some reassurance that the lump was unlikely to be serious.

The doctor gave evidence that he later reviewed the file, but did not detect that the report from the biopsy had not been received, seen or acted upon and did not recognise his failure to follow up.

There was competing medical evidence as to whether, even if the cancer had been detected in 1994 that the outcome for the patient would have been any different. The Court heard extensive medical evidence from both sides but concluded that if the cancer had been diagnosed in December 1994, and if properly treated then, it would have either been cured or the patient would have had a much extended life expectancy compared to the life expectancy now prevailing.

The Court concluded that the doctor was negligent:

"Having performed the fine needle aspiration, he owed a duty to record that he had done so in his notes. He did not do so. Furthermore, if perchance the cytology report was not brought to his attention, he should have made some enquiry to find out what had happened to it.

At worst, he should have become aware of it when (the patient) did not come in for the appointment on 3 January 1995. His review of his notes at that stage should have alerted him to the fact that he had taken a fine needle aspiration and had not seen the result of it.

Not only did he have no note of the needle biopsy but he missed the reference to it in the file copy of his letter to (the referring doctor).

Obviously the simplest of systems would have provided a more or less foolproof means of checking whether cytology reports had been forwarded to his rooms. All that would have been needed was a simple running sheet, recording that such a report had been requested, with provision for a particular entry to be ticked off when the report was received".

The Court did not accept that the doctor's liability should be reduced because of the patient's own "negligence" in failing to follow up the matter herself, by calling back to ascertain the results of the biopsy report and failing to maintain the subsequent appointment made for January 1995. The Court approved the statement that **"it is unreasonable for a professional medical specialist to base his whole follow up system, which can mean the difference between death or cure, on the patient taking the next step"**. In fact, the doctor in the course of examination at the trial admitted that it was his responsibility to follow up the report in order to obtain the result. In very telling language, the Court concluded that it is clearly the responsibility of doctors to advise patients of the outcome of tests and reports. The case extends the principles of "informed consent" which have followed the decisions in *Rogers v Whitaker* and *Kalokerinos v Burnett* in which doctors have clearly been found to be responsible to fully inform patients of all risks and the consequences of taking action, or in the latter case, the consequences of failing to take action.

The Court in this case conceded that the patient owed a duty to exercise reasonable care for her own safety and wellbeing, but that she was entitled to assume that if the outcome of the testing of the biopsy gave cause for concern, she would be informed by the doctor. The Court therefore did not reduce the liability of the doctor at all, merely because of the patient's failure to follow up or keep the appointment made.

IMPLICATIONS FOR DOCTORS

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

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

Doctors should also **emphasise to a much greater extent to patients the need for the patient to call back** to ascertain the results of tests and advise the patient of the implications of failing to follow up or failing to keep an appointment made by advising the patient in more detailed terms. There is then the possibility of the doctor placing some of the responsibility back on the patient. However, in the Kite Case, it can be seen that much more information must be given to the patient, before the Court is prepared to consider some liability or responsibility being placed on the patient (and the judgment being reduced accordingly).

On a broader view, the Case represents part of the continuing shift to place more responsibility on doctors, and less responsibility on patients. Other commentators have suggested that whilst there is an increasing push for greater patient autonomy and participation in decision-making, the Kite Case re-imposes "medical paternalism" by placing all of the responsibility on the doctor (Blomberg, "Australian Medicine", 21 September 1998, p.7):-

"The healthcare partnership is necessarily characterised by inequality. The sick patient relies upon the knowledge and skill of the doctor and it is precisely for that reason that the relationship will always remain an unequal partnership.

The partnership does not exist in a vacuum. It exists within circumstances of rapid technological change, increasing costs, growing medical litigation and media interest.

It is within this environment that the judgment in (the Kite case) must be read. It has been said that the case demonstrates a reigning-in of patient autonomy, of re-imposing medical paternalism by placing all responsibility on the doctor".

Others have suggested that the Kite case does not represent a significant departure from the existing liability required of doctors.

It merely exposes yet another facet of the complete burden doctors face as a professional. This is merely the first time that this particular issue has come to trial. Dr. Paul Nisselle, Chief Executive, Medical Indemnity Protection Society states:-

“The Kite Case does not break new ground; it is but another example of bad records leading to a tragic outcome and an indefensible claim. It does though point to the need to give patients clear advice, including a caution as to what might happen if he or she chooses not to follow that advice, and to have systems in place for tracking important referrals and investigations.” (Nisselle, “Vidoc”, September 1998, p.237).

SIGNING REQUESTS FOR TESTS OR REPORTS FOR OTHERS

Following the current case, concern has also been expressed as to the liability of other practitioners or health professionals who sign the forms to request tests or reports on behalf of the treating doctor. For example, it is not unknown for anaesthetists or nurses to sign request forms on behalf of a surgeon who is scrubbing or for a treating doctor who is otherwise engaged, in order to initiate the testing procedure. Who is liable? – the person requesting the test or the report who has signed the request form, or the treating doctor who has responsibility for the patient and has authorised the report or test to be requested?

Firstly, there may well be issues of misconduct arising from a practitioner who signs some request forms on behalf of another practitioner, particularly where billing arrangements may be involved. It would normally be the proceduralist who requests and signs the relevant form, rather than the anaesthetist. Whilst there may be some practical advantages in this regard, I believe that it is not a practice which should be encouraged.

Secondly, I do not believe that the Kite Case automatically guarantees that the anaesthetist or nurse will be liable for any complications arising in relation to the testing or request form. Clearly, even through the anaesthetist or nurse has signed the form, the surgeon has the responsibility to pursue the tests and the results. However, the risk to the anaesthetist, whilst not great, is not eliminated. There may well be circumstances where the anaesthetist is held liable to pursue the matter. For example, if the anaesthetist has requested the testing to be carried out, the results may well be forwarded to the anaesthetist, rather than the surgeon (whether intentionally or unintentionally). Under those circumstances, the anaesthetist is inexplicably linked to the possible complications which may arise, and may have some responsibility as a consequence.

If the form clearly states the name of the requesting doctor (and doesn't state the anaesthetist or other professional as requesting the test) and the anaesthetist merely signs or initials the form as agent for or on behalf of the surgeon/requesting doctor, with full authority to do so – in most cases – there is possibly little of concern.

However, there are very good reasons why anaesthetists and others should not engage in this practice, notwithstanding the practical difficulties that may accrue.

HONOURS

Congratulations are extended to the following Fellows honoured on Australia Day

Dr John E (Fred) Gilligan, SA – Officer of the Order of Australia (AO)

Dr Michael J Hodgson, Tas – Member of the Order of Australia (AM)

Professor Michael A Denborough, ACT – Member of the Order of Australia (AM)

COLLEGE AWARD

Dr W R (Bill) Fuller, SA has been awarded the ANZCA Medal which will be presented during the College Ceremony at the forthcoming Annual Scientific Meeting in Adelaide.

HIGHLIGHTS OF FEBRUARY 1999 COUNCIL MEETING

EDUCATION

In-Training Assessments

Council resolved to undertake a review of in-training assessments with a view to making the assessment a more structured process.

Objectives of Training

A review of the Objectives of Training is currently being carried out with Fellows and Trainees invited, via the College Bulletin, to provide input.

Definition of Training Experience Required – Period of Leave

Council has resolved that from the commencement of the 1999 hospital year, the maximum leave of any form will be 32 weeks in the first four years of accredited training for the purpose of defining years of training.

Directory of Training

A Directory of Training setting out accredited Provisional Fellowship Posts, contact telephone numbers and hospitals' particular areas of experience on offer is being promulgated and will be included on the College website. This initiative is aimed at improving information for prospective Provisional Fellows seeking such posts.

Younger Fellows' Representation on the Education Committee

The forthcoming Younger Fellows' Conference has been requested to nominate a Younger Fellow for co-option to the Education Committee for a trial period of 12 months.

Trial of Logbooks – Queensland

The Queensland Regional Committee has been invited to undertake a trial of logbooks for a specific time in the subspecialty areas, with the proviso that a set of clear objectives and desired outcomes with respect to College requirements is established.

Anaesthetic Skills Laboratories

Council resolved that institutions with anaesthesia simulators be encouraged to develop as Anaesthesia Skills Laboratories and that the simulator centres collaborate with their surgical and other local colleagues in developing skills laboratories.

INTERNAL AFFAIRS

Joint Consultative Committee (ANZCA and RACGP) on Anaesthesia

Paediatric Anaesthesia and General Practitioners

Council supported the resolution of the JCCA that endorsement for elective paediatric anaesthesia down to age 12 months be granted on an individual General Practitioner basis after demonstration of the need for such endorsement and assessment/accreditation by specialist anaesthetists nominated by the JCCA. Such endorsement to be related to the area of need and dependant on appropriate and accredited maintenance of professional standards participation.

Diploma of Anaesthetics for General Practitioners

It had been reported that the Council of the Royal Australian College of General Practitioners is supportive of a Diploma of Anaesthetics, or some form of recognition/accreditation of practitioners completing the JCCA program.

ANZCA College Executive was of the view that emphasis should be on ensuring non-specialist practitioners are safe and proficient within their areas of practice and not in supporting a Diploma of Anaesthetics, which would result in two standards for qualifications in anaesthesia.

Subsequently, ANZCA Council resolved that a separate Diploma of Anaesthetics, in whatever form, is not supported.

Equal Specialist and GP Anaesthetist Representation

It has now been agreed that there will be four GP anaesthetists, two of whom will be representatives of the Australian College of Rural and Remote Medicine, and four specialist anaesthetists on the JCCA.

The ANZCA representatives to this Committee are Dr Richard Willis, Dr Wally Thompson, Dr Di Khursandi and Dr Frank Moloney.

ANZCA Mousemat

An ANZCA Mousemat which includes contact details for the College and Regional Committee offices will be distributed to all Fellows and Trainees with the forthcoming edition of the Bulletin.

Director of Professional Affairs – Appointment

The appointment of Professor Garry Phillips as Director of Professional Affairs was ratified by Council.

This is a part time position to assist the President, Deans of the Faculties, the Council and various College committees in response to correspondence, reports from internal and external bodies and in preparation of relevant submissions for consideration by the College Council.

CONTINUING EDUCATION AND QUALITY ASSURANCE

Annual Scientific Meetings – 2002 and 2003

There has been a change in the venue for following Annual Scientific Meetings:

- 2002 will be Brisbane, Queensland
- 2003 will be Hobart, Tasmania

PROFESSIONAL

Policy Document

The policy document was reviewed and promulgated:

TE 11 (1999) Formal Project Guidelines, has been reviewed and appears elsewhere in this Bulletin. This document will apply to all projects presented for approval.

Australian Incident Monitoring Study

Professor W B Runciman was appointed the College AIMS Officer within the Continuing Education and Quality Assurance Committee.

Australasian Anaesthesia

Council has agreed to publish *Australasian Anaesthesia 1998* on the College website.

LETTERS TO THE EDITOR

RE: PAEDIATRIC ANAESTHESIA OUTSIDE SPECIALIST HOSPITALS

I wrote a letter on the subject of paediatric anaesthesia for publication in *Anaesthesia and Intensive Care*.

However the Chief Editor felt that the contents of the letter may be critical of the College's policy document on the subject (it was not my intent) and suggested that my letter best be published in the Bulletin.

I am particularly concerned that babies are anaesthetised outside of specialist hospitals and on an occasional basis. The policy document suggests that two consultant anaesthetists working together can manage such cases. I do not feel that two consultants, who may not work together otherwise, are a satisfactory alternative to a hospital or unit specifically set up for infants.

Yours sincerely,

T G Coupland
FANZCA

We thank Dr Coupland for raising his concerns about the wording of the College's *Policy Document PS29 Anaesthesia Care of Children in Healthcare Facilities without dedicated Paediatric Facilities 1997*. There was considerable consultation with Regional Committees and with paediatric anaesthetists from many parts of Australia and New Zealand before the consensus document as published was agreed upon. As with any consensus, compromises were necessary and it is on some of these areas that Dr Coupland comments.

It was considered impossible to draw up firm statements that would meet all the needs of the widely varied hospitals in Australia and New Zealand which undertake paediatric surgical procedures. The strategy of suggesting that hospitals develop their own policies having regard to local factors was therefore adopted. We preferred not to suggest the actual amount of "hands on" experience which an individual might require to maintain competence as this can vary considerably from person to person. There could be difficulties when an anaesthetist considers that she/he requires more experience than that mandated by a College document. Within such a framework, we accept completely that smaller children presenting for emergency surgery in particular should, as a policy, be transferred to a paediatric centre. This is stated in para 2.1 of *PS29*.

Dr Coupland refers to two papers which mention Australian practices. We note that they were dated in 1990 and 1992 and question whether they accurately reflect current realities. Certainly the care of critically ill patients during transportation has developed greatly in recent years. This factor must be taken into account by any hospital in developing its own policies. Dr Coupland's main criticism of *PS29* appears to be that it is not sufficiently supportive of transfer policies. We consider that the document does not strongly support transfers in the circumstances of the final paragraph of his letter. If there is specific evidence that such transfers are not occurring

and that individual patients (and anaesthetists) are being jeopardised, we would ask that the College is informed so that the existing *Policy Document* can be strengthened.

John M Gibbs
Rod Westhorpe
ANZCA Councillors

I wish to formally acknowledge my personal thanks to the anaesthetist for both his professional expertise and caring nature, which I was fortunate to receive during my recent day surgery in St Andrews Hospital last week. In the last ten years, I have required a number of operations, and each time I have been very apprehensive about the anaesthetic as well as experiencing a real fear of the needles required to be inserted prior to anaesthesia. This is however, the second time that an anaesthetist has taken the time and trouble to allay my fear.

He visited me in the Day Surgery Suite and administered some medication (orally) prior to surgery, which relaxed me slightly, he then visited me just prior to going into theatre, and on realising I was still apprehensive, he inserted the needle (which was covered in Emla cream) in the Day Surgery Suite and gave me some form of relaxant intravenously. I can still remember being wheeled into the Theatre, but I can assure you I wasn't in the least apprehensive. I feel that this anaesthetist went beyond the call of duty of care in providing this service, but I am deeply indebted to him for doing so. I wish all his colleagues were as 'humane'.

Before writing this letter I felt it wasn't fair in thanking one anaesthetist and not acknowledging the other one, that I found to be just as caring. I therefore 'phoned my surgeon and enquired as to the anaesthetist that was present on that occasion. On looking up my records he informed me that it was the same anaesthetist.

In this day and age, when people are quick to criticise others, I wish to acknowledge my sincere thanks to this anaesthetist for his excellent 'customer service'.

Yours sincerely,

To the ANZCA Council and Fellows,

I am writing to thank you for your beautiful flowers after the death of my mother, Gwen Wilson. So many of your members have written kind notes and letters and I extend my gratitude to them as well.

Mum was not only devoted to her history of Anaesthetics but to the College and its past, present and future.

I am honoured for her that she was so well appreciated.

Yours faithfully,

Janet Johnston

Stress, satisfaction and 'burnout' within anaesthesia; a survey

Michal T. Kluger

Specialist Anaesthetist, North Shore Hospital, Auckland.

Anaesthesia has evolved into a specialty that spans many areas in medicine. The historical role of 'surgical assistant' has devolved into one of highly specialised consultant with expertise in acute medicine, clinical pharmacology, resuscitation and of course the administration of safe anaesthesia. It is however becoming apparent that there are some areas of the specialty which are less than ideal. Coffee room discussions over remuneration, lack of parity with our surgical colleagues, working conditions, lack of recognition of our specialist skills contribute to some job dissatisfaction. Moreover, some have commented on the stressful environment in which we work, potential litigation and 'burnout' within anaesthesia. Is this real? Does it matter? We don't actually know, as yet. A number of studies in other branches of medicine have highlighted areas of stress and job satisfaction, however little work has been done with anaesthetists, and none has been carried out in our region. The responses to such a study have important implications for individuals, institutions and the future of our specialty.

We are at present involved in a series of studies designed to look at all facets of anaesthetic practice. A pilot study designed by Dr. Di Strange Khursandi looking at personality profiles of Australian anaesthetists allowed a 'typical profile' of our specialists to be

generated. This study unfortunately had a 33% response rate. A further study from our NZ group, used a more sophisticated personality tool, and had a greater than 71% response rate. These have allowed us to gain a typical personality profile of our specialists and trainees. The next stage is to identify stressors and areas of our work that we find both satisfying and dissatisfying. This study has been deemed of sufficient importance from the College to have received a grant for NZ\$ 10,000 to support this work.

The next stage in this process is to send a questionnaire pack to a representative sample of Specialists (1000) and trainees (500) in Australia and New Zealand. This will contain three sections.

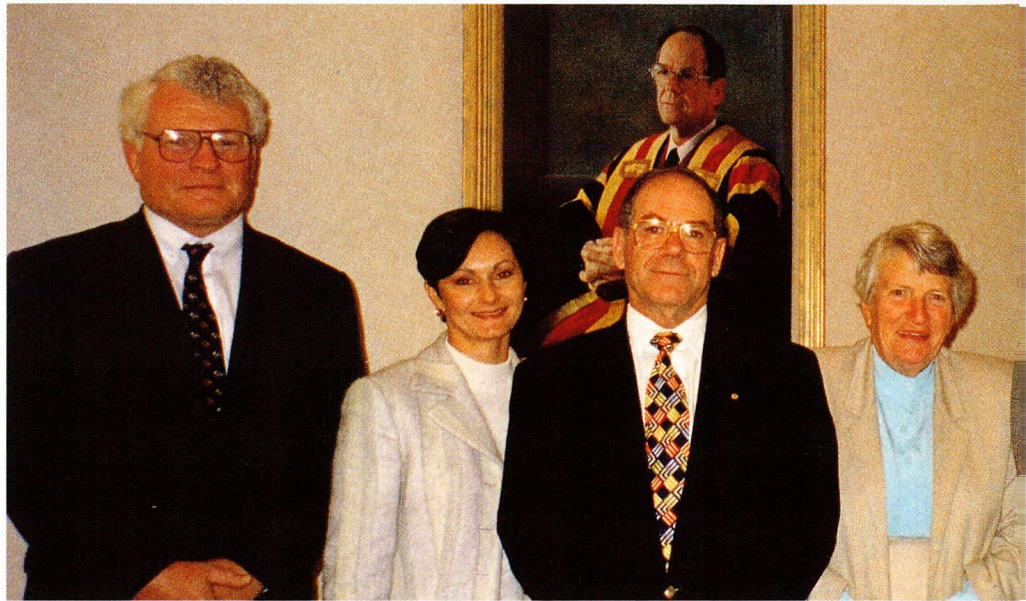
- (A) Job satisfaction – dissatisfaction survey.
- (B) Burnout questionnaire.
- (C) Stress questionnaire.

This will take about 20-30 minutes to complete, and will be totally anonymous. The validity of such a survey is entirely dependent on the response rate, which we need to be at least 70-75%. I would like to encourage you to take the time to complete this important survey and return it as soon as possible. It might just make a difference!

ADMISSION TO FELLOWSHIP BY EXAMINATION

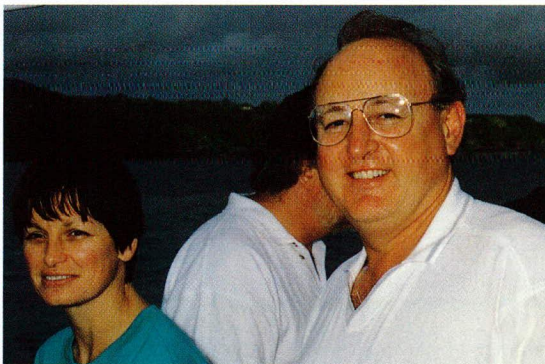
NOVEMBER 1998 – FEBRUARY 1999

Marion Irene	ANDREW	SA	David Earl	LINHOLM	VIC
Stephanie Elizabeth	ARMSTRONG	SA	Hendry Khetjang	LIU	NSW
Henry	AU KWOK-HENG	HKG	Mark Andrew	LOVELL	NSW
David Lancelot Hugh	AUSTIN	NZ	Benjamin Richard	MA	NSW
Michael John	BARRINGTON	VIC	Janet Anne	MacPHERSON	NZ
Susan Mary	BEATH	NSW	Andrew Thomas	MARSHALL	VIC
Kerrie June	BENFIELD	VIC	John William	MARTYR	WA
Alan Gregory	BENNETT	NSW	David Robert	MATTHEWS	WA
Andrew Ulrich	BUETTNER	VIC	Sarah Louise	McCRACKEN	NSW
Sesto Antonio	CAIRO	VIC	Warren Paul	McINTOSH	QLD
Ian Lachlan	CAMERON	QLD	Radha	McKAY	NSW
Ian St. John	CARTER	NSW	Wayne William	MORRISS	VIC
Eugene Israel	COHEN	VIC	Kenneth Kwong Keit	NG	VIC
Ian Maxwell	COOPER	QLD	Aeneas Francis	O'LEARY	VIC
Michael Anthony	CORKERON	WA	Brendan	ORR	NSW
David John	DALY	VIC	Olivia Solange Marie	PAGE	QLD
Debra Jane	DEVONSHIRE	VIC	Fabian Edward	PURCELL	VIC
Giuseppe	DIBARTOLO	NZ	Roberto Vincenzo	RADICI	WA
Catherine Susan	DOWNS	NSW	Lynne	RAINEY	SA
Cyrus	EDIBAM	WA	Stephen John	REID	TAS
Mary Anne	FAIGAN	NZ	Sharon Irene	ROCHE	NZ
Paul Emery	FERRIS	NSW	Mark Ivan	RUDELIC	VIC
Grant James	FREEAR	SA	Gary Neil	RUSSELL	NSW
Nicholas Paul	GAN	NSW	Craig Andrew	SCHWAB	NSW
Lenore Margaret	GEORGE	NSW	Robert Scott	SIMPSON	SA
Michael David	GOLDBLATT	SA	Philip Campbell	SOET	WA
Marianne Emma	HACK	QLD	John McKinnon	TORRANCE	NZ
Alexander Charles	HANCOCK	SA	Gerald Robert	TURNER	TAS
Jackson Nesbitt	HARDING	SA	Thomas Michael	VAUGHAN	VIC
Peter William James	HARRIGAN	WA	Freda	VOSDOGANIS	NSW
Christopher John	HIGHAM	SA	Mark Jeremy	WARDILL	NZ
David Si Hao	HO	NSW	Grant Alan	WATERS	NZ
Andrew Craig	HOGAN	QLD	Paul Stephen	WILKINS	NZ
Thomas David	JAENSCH	SA	Robert Ivor	WONDERS	NSW
Gerard Thomas	JOYCE	VIC	Andrew John	WYSS	VIC
Daryll John	KOCH	QLD	Florence	YAP HIU YI	HKG
Mary Patricia	LEVESTAM	NZ	Biing Lin	YIN	NSW



**Neuroanaesthesia SIG Meeting
"Anaesthesia problems and the CNS"**

College Mortality Committee (left to right): Dr Brian Horan (NSW), Mrs Carolyn Davis (WA), Associate Professor Neville Davis (WA), Dr Patricia Mackay (Vic), Dr Richard Williams (NSW), Professor Tess Cramond (Qld), Dr Peter Gartrell (SA)

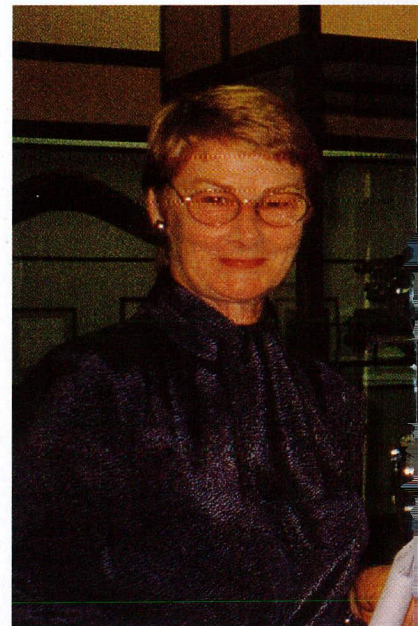


Dr and Mrs Michael Lynch (Qld)

Members of the Hornabrook family were delighted to have Dr Michael Hornabrook as a full-time anaesthetist in Australia, appointed in 1998.



*Back row: Dr Ray Cook, Mrs Diane Cook, Dr Rosemary Craen
Front row: Dr Gaylene Heard, Mr Greg Sue-A-Quon, Dr Bobby Sadhu*



Left: Ms Meg Hornabrook, Mr Michael Hornabrook



*Dr John Handley (Committee Administrator),
Dr John Paul (ANZCA President and Committee Chairman),*

GIFT TO THE COLLEGE



Dr John Paul recently presented the College with a sherry decanter, glasses and Ley Pewter tray and decanter coaster previously given to him by the late Dr Geoffrey Kaye. The tray, coaster and decanter label were crafted by Dr Kaye. Ley Pewter is a composition of 80% tin and 20% lead.

Dr Paul was delighted to visit the *Geoffrey Kaye Museum* which includes photographs of the late Dr Rupert Hornabrook. Dr Hornabrook was the first anaesthetist to be employed at the Royal Melbourne Hospital in 1909.



Dr Rupert Hornabrook, Ms Carolyn Rawlins, Ms Jean Thompson and Mrs Ann Rawlins



Jobson Professor 1999, Dr Stephen (Butch) Thomas, USA

with

*Drs Ross Kennedy, New Zealand
and Chris Thompson, Sydney*

ELECTION TO FELLOWSHIP

The following were invited to accept Fellowship of the College by Election:

Under Regulation 6.3(b):

Dr A M Phillips, NZ
Dr A R Molloy, NSW

Under Regulation 6.3(d):

Dr E C Morley, NZ

OBITUARIES

DR DEREK WYLIE, UK

Honorary Fellow – FARACS 1984, ANZCA 1993

Derek Wylie was one of the best known British anaesthetists in a generation of giants of our specialty. Born in Huddersfield, he was educated at Cambridge and St Thomas' Hospital Medical School, graduating in 1943. He commenced anaesthetic practice in 1948 and quickly established himself as an innovator as new drugs, techniques and ideas for patient care emerged. He recognised the importance of teaching these skills and taught and practised these with enthusiasm, whilst his spare time was taken up with limited clinical research.

He lectured and wrote extensively. With Dr Harry Churchill-Davidson he produced a major textbook, "A Practice of Anaesthesia" which became one of the gold standards for anaesthetic reference works.

It was translated into several languages and is still published under different editorship.

Derek Wylie had a distinguished role in the development of our specialty. He was Dean of the Faculty of Anaesthetists, RCS from 1967 to 1969 and President of the Association of Anaesthetists from 1980 to 1982. He was President of the European Congress held in London in 1982 and latterly became President of the Medical Defence Union, a body he served for over 25 years.

Derek Wylie was a man of great charm and gentleness, who was liked by all for his open and approachable nature. He claimed to have no interest in any political matters, either medical or otherwise, yet he achieved greatness on both national and international levels.

DR GEORGE MADGWICK DAVIDSON

New South Wales – FFARACS 1953, FANZCA 1992

Dr George Davidson, distinguished anaesthetist, friend, mentor and teacher to hundreds of anaesthesia trainees, died peacefully on 10th February 1999 after a short illness, aged 74.

He was educated at Newington College, graduating as Dux of the school in 1942. He graduated MBBS at the University of Sydney in 1948 and obtained the Diploma of Anaesthesia in 1953. He was awarded Membership of the Faculty of Anaesthetists in 1954 and awarded Fellowship in 1956.

George completed his residency at Sydney Hospital and in 1954 entered private practice, appointed to Sydney Hospital, St Luke's Private Hospital, Concord Repatriation and the Royal Alexandra Hospital for Children. In 1958 he was appointed Honorary Anaesthetist and ASA part time research officer at the NSW State Cancer Hospital. Subsequently, he became a visiting research fellow at the Mercy Hospital in Pittsburgh and the Montefiore Hospital in New York.

In 1963 George was appointed Director of Anaesthesia and Resuscitation at the Prince of Wales Hospital. He was appointed Chairman of that Department in 1967, a position he held until

1986. He was also Director of Anaesthesia at Prince Henry Hospital from 1967 to 1973 and an Honorary Consultant Anaesthetist at the Royal Hospital for Women and the Royal South Sydney Hospital.

In 1986 he returned to private practice as a VMO at the Prince of Wales Hospital until 1990 when, at the age of 65, he retired from the public system. He continued in limited private practice anaesthesia until 1995 when, at the age of 70, he took up the pursuit of his many and varied leisure activities on a full time basis.

George Davidson was a senior lecturer in the School of Surgery at the University of New South Wales from 1963 until 1987. He served as a member of the New South Wales Regional Committee from 1956 to 1975, its Secretary from 1956 to 1961 and its Chairman from 1967 to 1969. He was involved with the ASA from 1952 onwards and was the Treasurer of the NSW State Section from 1955 to 1958. He also made a vital contribution for many years as a member of the New South Wales Special Committee Investigating Deaths Under Anaesthesia.

George was no stranger to honours and awards. He was a Fulbright Scholar (Senior Category) and a Burroughs Wellcome Research

Fellow. In 1991 he was awarded Membership of the Order of Australia.

George's well recognised work in sustained hydration and fluid losses during surgery led to his involvement in lectures at the Part 2 Faculty of Anaesthetists' courses and to the preparation of a series of papers and presentations. He showed genuine interest in his trainees. Each would be invited to his office on an annual basis to discuss their progress through the program. They would be informed of their assessments, either positive or negative.

His door was always open for senior or junior staff to air their grievances. He consulted widely and listened patiently to advice given. In the end he would always have his own way, but his mastery was that everyone would feel that in the end they had had a fair hearing and that George had made the best possible decision under the circumstances.

George and his wife Barbara invited the whole department to their home annually. In this way he made them feel part of his family and this may well be why he earned the nickname of "Uncle George". Many registrars will remember him as a true gentleman – never too busy to give extra advice and encouragement. He was ever our wise counsellor and enthusiastic supporter.

Should one of his surgical colleagues unfairly treat one of his trainees during a procedure he would make a point to take the surgeon aside at the end of the day to privately "discuss" the matter. The offending surgeon would always be wise enough not to commit the transgression again. Should he feel that a surgeon was not performing satisfactorily in terms of patient care or outcome, he had ways of "rectifying" the problem in an unobtrusive but very effective fashion. His connections and influence within the organisation were truly remarkable.

The George Davidson Medal, named in his honour, was established to give appropriate recognition to the all round "best" trainee registrar within the department each year.

The hallmark George Davidson's career was his ability to gently but surely control his environment whether the task was an anaesthetic, a pain management procedure, a meeting he was chairing, a patient he was assessing preoperatively or a trainee he was counselling. He was a man of unshakable principle and indestructible integrity, his standards were simply not negotiable.

He took over the department in troubled times, but managed in a very short period of time to pioneer intensive care and pain management services. He attracted high profile anaesthetists with special expertise to develop paediatric and neonatal anaesthesia as well as paediatric intensive care. In addition, he developed a strong research and teaching program. Many of the novel concepts used in the construction of the intensive care and recovery units in the Parkes Block, Prince of Wales Hospital, were well ahead of their time thanks to the steadying hand of George Davidson.

His leisure activities included gardening, golf, bridge, bushwalking and skiing. He attacked all these activities with gusto and verve.

George was not only sincere, loyal and unselfish but exceedingly reliable. He was dedicated and totally committed to securing the highest possible standard of patient care. His superior sense of humour, quick smile and first class jokes will long be remembered.

George was a pioneer in many aspects of his life, including work and leisure. In anaesthesia he was a pioneer in the three aspects of anaesthetic practice now recognised by our College, Anaesthesia, Intensive Care and Pain Management. He was truly an "all rounder". Although his passing leaves anaesthesia in Australia the poorer, we are much richer for having known "Uncle George" and being part of this extended family.

STEPHEN GATT
MATTHEW CRAWFORD

FACULTY OF INTENSIVE CARE

DEAN'S MESSAGE



Preliminary discussions regarding a College of Intensive Care Medicine occurred at the November meeting of the Joint Specialist Advisory Committee in Intensive Care. Members of JSAC acknowledged the crucial nature of these deliberations and began to plan a way forward.

The Learned Medical Colleges are first and foremost bodies that develop and operate training programs for medical graduates with specialist aspirations. These bodies also foster continuing education, the development of standards, recertification programs and research. It is a fact that many Fellows of Medical Colleges, whilst maintaining pride in their training body, have little direct involvement in the running of college affairs once Fellowship has been conferred. It is therefore essential that the interests of trainees are paramount in our deliberations. Although the existing training programs could have been developed with greater commonality, Australia and New Zealand and indeed many other parts of the world have been well served by the high quality of graduates from both programs. The recent decision by the Board to open a pathway for emergency medicine specialists and surgeons to undertake supra-specialty training has now further ensured participation of practitioners from diverse backgrounds.

In order to progress this matter, a spirit of cooperation, camaraderie, flexibility and compromise will be required. JSAC has therefore commissioned a Working Party of two Faculty and two RACP members to develop a further discussion document. The document

will be written for all intensive care specialists. It will include an analysis of the business case for a separate body with projections based on a range of Fellowship numbers. The discussion document will be considered by the June meeting of JSAC. When all parties are satisfied with the document, it will be circulated to all intensive care specialists for consideration. It is again planned to include a survey that will canvass opinions on a range of options including attitudes to the subscription levels that would be required to support a viable body.

In the meantime, the Board of Faculty has approved in principle the appointment of an RACP representative to attend Board meetings. It is hoped that this move will further strengthen the bonds between the RACP and the Faculty and will aid negotiations. The mechanism for choosing this representative will be decided after discussions with the RACP.

Finally, Fellows should by now be aware that the College is to embark on a major redevelopment at "Ulimaroa". It has been determined that the Faculty will occupy a significant amount of office space on the top floor of the existing building. This welcome support by the College guarantees the Faculty's profile and will cater for our needs for the foreseeable future. The Faculty will continue to have access to all of the other shared facilities within the College that we require.

A W DUNCAN, DEAN

ITEMS OF INTEREST FROM THE FEBRUARY 1999 BOARD MEETING

HONOURS AND APPOINTMENTS

Dr J.E. Gilligan has been awarded the Order of Australia, as an Officer in the General Division (AO). An article outlining Dr Gilligan's achievements is featured elsewhere in the Bulletin.

Dr R.V. Trubuhovich has been awarded a Priority Vote of Thanks from the Order of St John of Jerusalem (in New Zealand).

EDUCATION

Supervisors of Training in Intensive Care

The Board ratified the following appointments as Supervisors of Training in Intensive Care:

Dr Sundaram Rachakonda, Wollongong Hospital

Dr Nigel Rankin, Middlemore Hospital

The Board is keen to provide more support and help to Supervisors of Training, eg. with communication skills.

Review of Accreditation

Following the recent re-classification of units accredited for training, the Board considered feedback from its Regional Committees, and from individual units. A number of units will be re-assessed following requests for a review of their classification.

Rather than regulate trainees to require them to work in more than one unit during their core training, or to restrict maximum core time in one unit (for instance to 18 months), the Board prefers the flexibility possible with the current system. There is however, a degree of responsibility for trainees to arrange their core training to maximum advantage through choice of workplaces and by planning rotational schemes. Input from Supervisors of Training will be very valuable in providing guidance to trainees.

The Board will further develop a survey form for trainees to provide feedback regarding supervision and training programs, and the quality of training information.

EXAMINATIONS

The Board noted that the next Fellowship Examination to be held in April/May will see the introduction of the OSCE section.

ADMISSION TO FELLOWSHIP

Dr Simon Finfer MRCP, FFARCS, of the Royal North Shore Hospital was elected to Fellowship of the Faculty under Regulation 5.3.

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

Myrene Carol Kilminster, NSW

Michael James O'Leary, NSW

Clive Bernard Jonathan Woolfe, NSW

Hugh Richard Playford, Qld

Ai Yu Claudia Cheng, HK

Manivannan Gopalakrishnan, NSW

PROFESSIONAL***High Dependency Units***

The Board is developing a Policy Document to define the minimum requirements for High Dependency Units seeking accreditation for training time for Faculty trainees.

Intensive Care Workforce

The final report from the Australian Medical Workforce Advisory Committee (AMWAC) is now completed and awaits acceptance by the Australian Health Ministers Advisory Committee before release.

Hours of Work for Hospital Doctors

The Board received the AMA's Overview of Consultations on the Draft National Code of Practice and will forward a submission. There needs to be balance established between fair and safe working hours and the need for training experience.

Co-option to the Board

The Board agreed in principle to co-opt a representative of the Royal Australasian College of Physicians to the Board of Faculty.

**CONTINUING
EDUCATION*****ASM 1999 Adelaide***

The Board approved the final program for the intensive care section of the ASM. An interesting program featuring the Faculty Foundation Visitor, Professor Rick Albert, has been arranged by Dr Andrew Bersten. A synopsis of the curriculum vitae of Professor Albert is provided elsewhere in the Bulletin. Following the ASM, Professor Albert will visit New South Wales.

The Board noted that the College's Gilbert Brown and Formal Project Prizes are available to Faculty trainees at the ASM.

ASM 2000 – Melbourne

Planning for the ASM 2000 in Melbourne is well advanced under the enthusiastic guidance of Dr Megan Robertson as Scientific Convenor.

Younger Fellows

The following were approved to represent the Faculty at the Younger Fellows Conference in association with the ASM 1999:

Dr Michael O'Leary, NSW
 Dr Dianne Stephens, NT
 Dr Michael Corkeron, WA
 Dr John Evans, Qld
 Dr Helen Opdam, Vic
 Dr Tony Smith, NZ
 Dr Mark Finnis, SA

Maintenance of Professional Standards

The Board resolved that the revised MOPS program will be introduced in 2000. Details of the new program are outlined elsewhere in the Bulletin.

The Board welcomed the gazetting of the Faculty MOPS Program as a Quality Assurance Activity recognised by the Australian Commonwealth Insurance Amendment Act 1992.

INTERNAL AFFAIRS***Dean-Elect***

Dr Alan Duncan was voted as Dean-elect and will continue a further term as Dean following the Annual General Meeting in June.

Regulations and Administrative Instructions

The Faculty's Regulations and Administrative Instructions relating to training are being revised to accord with recent changes introduced by the Board.

COMMUNICATIONS***Website***

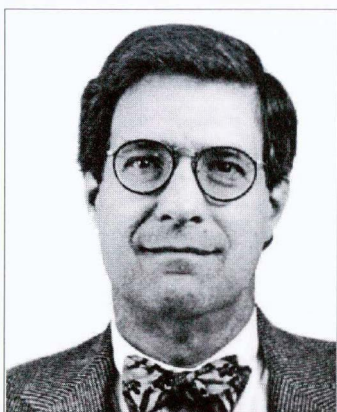
The Board anticipates further development of the Faculty's Website with the assistance of Dr Mark Finnis, SA, who has been appointed Website Officer.

National Anaesthesia Day

With a theme of "Perioperative Medicine", National Anaesthesia Day this year offers opportunities for Intensive Care Units to once again be involved in the College's National Day. How frequently National Intensive Care Day should be renewed is currently under review, with enthusiastic suggestions from several regions.

FACULTY OF INTENSIVE CARE FOUNDATION VISITOR, 1999

PROFESSOR RICHARD ALBERT



Professor Richard Albert is the 1999 Foundation Visitor. Following a Fellowship in Pulmonary Medicine in Denver, Colorado, he moved to Seattle, Washington in 1976 as the Director of the Medical Intensive Care Unit at the VA Medical Center. In 1990 Professor Albert was appointed as the Section Head of Pulmonary and Critical Care Medicine at the University of Washington Medical Center, and in 1997 he moved back to Denver as the Chief of Medicine at the Denver Health Medical Center.

During the last 20 years Professor Albert has made a very significant contribution to the literature including 58 original articles, 28 book chapters, 2 books and 32 review articles or editorials. His research has led to unique insights into the formation of pulmonary oedema, the role of surfactant in acute lung injury and pulmonary blood flow in the prone position. Most recently he has turned his attention to lung volume reduction surgery and airway inflammation. Over this period he has had continuous NHLBI funding as Principal Investigator, and has served on numerous Editorial Boards including the Journal of Applied Physiology and the American Journal of Respiratory and Critical Care Medicine.

Professor Albert has also served on numerous committees within the National Institutes of Health, the American Thoracic Society, the American College of Physicians, the American College of Chest Physicians, the American Heart Association and within his own institution. He is an extremely accomplished and stimulating speaker, and given his expertise, a predominantly lung orientated scientific program has been selected. He is visiting Australia with his wife Linda, and will travel on to Sydney following the ASM.

A. BERSTEN

DR J E (FRED) GILLIGAN AWARDED AO

Many Fellows will be aware of the recent award of Member in the Order of Australia (AO) to Dr John Eugene ("Fred") Gilligan, in honour of his service to medicine. Dr G M Clarke, inaugural Dean of the Faculty of Intensive Care, was awarded the AO in 1998.

Born in 1936, Fred Gilligan began his career at the Royal Adelaide Hospital in 1961. He did his specialist training in Anaesthesia in Adelaide, qualifying as a specialist in 1967. Following this he became the Director of Intensive Care Services, a position he held until 1991 when he took on his current position as Director of Retrieval and Resuscitation within the Department of Anaesthesia and Intensive Care at the Royal Adelaide Hospital.

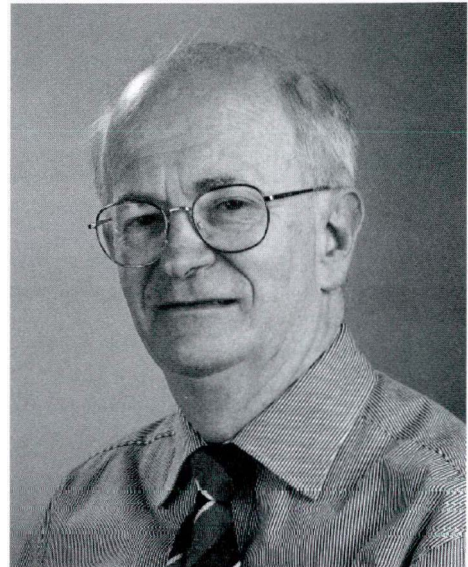
In the late 1960s and early 1970s he became aware that there were medical problems in remote Australia due to what John Flynn had described as the "tyranny of distance". There were patients who were often many miles from the nearest medical practitioner, let alone the nearest major hospital.

After consultation with country practitioners and much consideration, he originated the first medical retrieval service in 1973. This has subsequently been seen as an important pioneering move in Australia and the world in the field of aeromedical transport.

The service now comprises retrieval of patients by road ambulance, helicopter, fixed wing aircraft, modified executive jet and/or commercial aircraft. The retrieval system has now spread to involve all the teaching hospitals in Adelaide, although the majority of adult retrievals are still done by the Royal Adelaide Hospital with approximately 500 cases in 1998. Paediatric retrievals are primarily done by the Women's and Children's Hospital, with neonatal shared between the Women's and Children's Hospital and Flinders Medical Centre. Rescue capability is also present with medical rescue missions being a joint effort between Police, SA Ambulance and retrieval staff depending on the individual needs of the patient.

The international reputation of the Service is such that overseas Medical Assistance companies will regularly ring the Royal Adelaide Hospital to request assistance with assessing or managing one of their patients in the South East Asian or South West Pacific area. Dr Gilligan, along with Dr Griggs from the Trauma Service, provides the organisational support for these companies when required.

The RAH Retrieval Service is able to provide a number of retrieval teams at short notice with up to four teams having been simultaneously deployed. There have also been responses to a



number of mass casualty incidents over the past few years, including the O'Bahn Bus crash, the Redhill train crash, the Coober Pedy bus crash, the Cleve circus stand collapse, as well as a number of multi-victim road crashes.

The rapidity of possible response is indicated by the response to the NCA bombing incident. The bomb exploded at 0916, the first ambulance arrived at 0922, retrieval was at 0924, and two Retrieval Teams entered the building at 0932, only 16 minutes after the initial explosion. Currently there is a 24 hour a day rapid response capability.

This service, founded by Dr Gilligan, has been responsible for countless saved lives over the last 25 years.

In 1994, Dr Gilligan was awarded the AMA Award for Individual Contribution to Health Care in Australia. Dr Gilligan has been asked to speak on retrieval and aeromedical services at overseas international conferences on a number of occasions. He is recognised as an international expert in this field of "mobile" intensive care medicine.

P.D. THOMAS

FACULTY OF PAIN MEDICINE

DEAN'S MESSAGE



Thursday 4th February, 1999 was a historic day for pain medicine in Australia and New Zealand. At 'Ulimaroa', headquarters of the Australian and New Zealand College of Anaesthetists, the initial face-to-face Board Meeting of the Faculty of Pain Medicine was held. This meeting marked the beginnings of specialist training and specialist qualification in the field of pain medicine and undoubtedly heralds in a new level of professionalism in pain medicine in Australia and New Zealand. The events leading up to this Board Meeting represent an extraordinary degree of cooperation among the four participating Colleges and Faculty, namely ANZCA, RACP, RACS, RANZCP and AFRM (RACP). It has been a rewarding process for those involved to see the rapid evolution of the Faculty of Pain Medicine. This would appear to be a unique event in specialist training programs in Australia and New Zealand.

At the February 5 meeting of ANZCA Council, Council ratified the appointment of the following Board Members and Foundation Fellowship of the Faculty of Pain Medicine on Members of the appointed Board:

R L Atkinson	FRACS	Qld
M L Cohen	FRACP	NSW
M J Cousins AM	FANZCA	NSW
C R Goucke	FANZCA	WA
D Jones	FANZCA	NZ
T F Little	FANZCA	Vic
P E Macintyre	FANZCA	SA
J E Marosszeky	FAFRM (RACP)	NSW
G I Rice	FRANZCP	Qld
S W Walker	FANZCA	NSW

As a result of the appointment of the initial Board of Faculty, and their induction by ANZCA Council as Foundation Fellows, successful applicants for induction as Foundation Diplomates will be admitted as Foundation Fellows of the Faculty of Pain Medicine.

Criteria for *Election to Fellowship* were discussed at the initial Board Meeting and it was resolved to amend the Regulations of the Initial Board to include a Regulation dealing specifically with *Admission to Fellowship by Election*. This Regulation is reproduced in the accompanying material which summarises items of interest from the initial Board Meeting. The Board intends that **Foundation Fellows** will be those who meet the criteria set out in the 'call for applications' as advertised in the November Bulletin, which emphasises participation in a multidisciplinary pain centre and practice in accordance with ANZCA Policy Document TE16. It will be evident from the Regulation for **Admission to Fellowship by Election** that this provides for the election of additional individuals who have made a *substantial* contribution to the practice and/or science of pain medicine, but who may not fully meet the criteria for induction as Foundation Fellows.

With respect to holders of the ANZCA Certificate in Pain Management, the Board unanimously resolved that such individuals are eligible to apply for induction as Foundation Fellows, provided they have remained in pain medicine practice since obtaining their Certificate.

Trainees who have enrolled in the Fellowship Training Program in 1999 will be given credit for up to one year of training towards the two year training program, upon application and description of their prior experience relevant to pain medicine. The Board has

agreed, that during this initial year of training, there will be a liberal approach to approval of prior training so that it is anticipated that most, if not all, candidates will receive a year of credit and thus be eligible to present for the first examination in November 1999. Candidates should be aware that they may submit the materials for their treatise as each of the four required case reports are completed. It is anticipated that the examination will be held during the second week of November and precise dates will be notified in the near future.

The Board is very fortunate to have secured the services of Margaret Benjamin as Executive Officer to the Faculty of Pain Medicine. Margaret has an excellent background in professional college administration having worked for some years as assistant to the Chief Executive Officer at the RACS.

It is a privilege and an honour to serve as Foundation Dean of this new Faculty of Pain Medicine. There is much to be done to establish a first class training program and examination process. However, the Foundation Board is an extremely cohesive and energetic group of individuals who have already made substantial progress. This includes the formulation of a Training Manual, the development

of a supplementary reading list, to complement the IASP curriculum, and other essential materials for the training and examination process. Foundation Fellows and those elected prior to May 1999 will be awarded their Fellowship during the College Ceremony of the Annual Scientific Meeting on Saturday, 8th May 1999 in Adelaide. The Faculty of Pain Medicine will also have a segment of the Scientific Program on Wednesday morning the 12th May, 1999. Following the closing date for induction as Foundation Fellows on 28th February, 1999 the Board has met to deliberate on all applications received by the closing date. It is planned that successful applicants will be notified as soon as possible in order to permit them to present the ceremony in Adelaide.



MICHAEL J COUSINS AM

FACULTY OF PAIN MEDICINE

Office Bearers and Officers of the Faculty of Pain Medicine

Dean	Professor M J Cousins AM FANZCA
Vice Dean	Dr C R Goucke FANZCA
Treasurer	Mr R L Atkinson FRACS
Education Officer	A/Professor M L Cohen FRACP
Censor	Dr D Jones FANZCA
Chairman of Examination Committee	Professor M J Cousins FANZCA
Chairman of Hospital Accreditation Committee	Dr T F Little FANZCA

Examination Committee:

Professor M Cousins AM FANZCA	Dr J Corry FAFRM
Dr G Mendelson FRANZCP	Dr P Briscoe FANZCA
Dr R Chye FRACP	Dr T Little FANZCA
Professor P Reilly FRACS	

Education Committee:

A/Professor M Cohen FRACP	Mr R Vaughan FRACS
Dr S Walker FANZCA	Dr G Rice FRANZCP
Dr P Macintyre FANZCA	Dr R Large FRANZCP
Dr B Marosszeky FAFRM	

ADMISSION TO FELLOWSHIP

BY ELECTION REGULATION

4.3 *Admission to Fellowship by Election*

- 4.3.1 Persons who are registered medical specialists in Australia or New Zealand may be elected to Fellowship under the Board Regulations using the following criteria:
- 4.3.1.1 The candidate must hold Fellowship of a participating College or Faculty or an equivalent specialist qualification relevant to Pain Medicine that is acceptable to the Board.
 - 4.3.1.2 Substantial involvement in multidisciplinary pain centres or equivalent Pain Medicine practice acceptable to the Board. Substantial = commitment equivalent to three sessions weekly (including in and out of hours) in current clinical practice.
 - 4.3.1.3 Independent confirmation is required by the relevant health care facility of involvement in specialist Pain Medicine practice.
 - 4.3.1.4 Participation in Continuing Medical Education and Quality Assurance in the field of Pain Medicine.
 - 4.3.1.5 Contribution to the field of Pain Medicine by development of professional activity in this field.
 - 4.3.1.6 Contribution to the field of Pain Medicine by:
 - (i) Regular contributions to undergraduate and/or postgraduate education in this field
and
 - (ii) Publications in scientific journals and/or contributions to scientific meetings.
- 4.3.2 The Board of Faculty may elect to Fellowship without examination persons who are not registered medical specialists in Australia or New Zealand and who in the opinion of the Board have made notable and distinguished contributions to the practice and science of Pain Medicine.
- 4.3.3 Nominations for admission to Fellowship under this Regulation will be made on the prescribed form by two Members of the Board, or one Member of the Board and five other Fellows.
- 4.3.4 Nominations for election to Fellowship under these Regulations may be considered at any meeting of the Board provided that nominations are submitted to the Faculty Executive Officer at least 30 days prior to the meeting.
- 4.3.5 Each nomination will be accompanied by a curriculum vitae.
- 4.3.6 Nominations for election to Fellowship, on the prescribed forms and with supporting documentation, will be sent to each Member of the Board at least fourteen days before the day of the Board Meeting.
- 4.3.7 The Board will vote on nominations by secret ballot.
- 4.3.8 No award of Fellowship will be made at a meeting of the Board unless three quarters of the Members of the Board present vote in favour.
- 4.3.9 Nominations rejected by the Board may be reconsidered if formally proposed and seconded at a subsequent Meeting of the Board.
- 4.3.11 Those admitted to Fellowship by election will pay the entrance fee as prescribed by the Board in addition to the annual subscription.
- 4.3.12 The Board at its discretion may remit the entrance fee and annual subscription of any Fellow admitted under Regulation 4.3.1.

FACULTY OF PAIN MEDICINE

ITEMS OF INTEREST FROM BOARD MEETING

FEBRUARY 1999

APPOINTMENT OF EXAMINERS

Criteria for Appointment of Examiners were approved by the Board and appear on the following pages. As indicated in the criteria, Examiners will largely be drawn from Fellows of the Faculty but there will also be a small number of Examiners who are non-Fellows and have particular expertise in the science and/or practice of pain medicine.

ANZCA CERTIFICATE

Holders of the ANZCA Certificate in Pain Management

The Board resolved that "holders of the ANZCA Certificate in Pain Management who have remained in pain medicine practice since gaining their Certificate be eligible to apply for induction as Foundation Diplomates".

FELLOWSHIP

Induction of Foundation Fellows

It is planned to induct Foundation Fellows and those elected to Fellowship of the Faculty of Pain Medicine during the College Ceremony on Saturday 8 May, 1999 at the Annual Scientific Meeting in Adelaide.

Regulation for Admission to Fellowship by Election

The Board approved a Regulation for Admission to Fellowship by Election and this appears in the following pages.

Manual on Training

Trainees have already been informed that the "IASP Core Curriculum" will form the basis for reading material. However the Board of Faculty has now completed work on a supplementary reading list which will complement and update the IASP Core Curriculum. This will be provided to all trainees by the Faculty Executive Officer. One of the recent key sources of scientific evidence is the NHMRC document "Acute Pain Management: Scientific Evidence" (NHMRC 1999). This document is now available on the NHMRC website <http://www.health.gov.au/nhmrc/publicat> and is also available in hard copy via the Faculty office.

POLICY DOCUMENT

Policy Document

PM1 (formerly TE15) Guidelines for Trainees and Departments seeking College Approval for Posts for Training in Pain Medicine is published in this edition of the Bulletin and may be obtained from the Faculty Executive's Officer.

Fellows are always at liberty to discuss the content of documents and the Faculty of Pain Medicine would be happy to have their input.

AWARDS

Certificate in Pain Management

The Certificate in Pain Management ceased in 1998. All trainees commencing in 1999 will be registered for training for the Fellowship in Pain Medicine. The small number of candidates who are completing their Certificate in Pain Medicine will be overseen by the Board of Faculty. At the February Meeting of the Board the following candidate was approved for award of the Certificate in Pain Management:

Dr. Mary Cardosa (Kuala Lumpur, Malaysia)

Barbara Walker Prize for Excellence in Pain Management

Mr. R J Walker AO CBE, Chairman of the Microsurgery Foundation, St. Vincent's Hospital, Victoria wrote to the Chief Executive Officer of the College indicating financial support for the above prize. The Board is holding discussions with Mr. Walker to determine appropriate arrangements for the award of the prize.

BOARD MEMBERS — FACULTY OF PAIN MEDICINE



*Back Row: Drs S M Walker, J E Marosszky, P E Macintyre, D Jones, G I Rice, T F Little, Prof. J M Gibbs,
Front Row: Assoc. Prof. M L Cohen, Dr R G Walsh (President ANZCA), Prof. M J Cousins (Dean),
Dr C R Goucke (Vice Dean), Mr R L Atkinson, Ms M A Benjamin (Executive Officer)*

SELECTION CRITERIA FOR EXAMINERS

FELLOWSHIP IN PAIN MEDICINE, FINAL EXAMINATION

Definition: In the following, "Fellow" means Fellow of the Faculty of Pain Medicine

PRINCIPLES

1. To provide fair access to the Examination Panel for all Fellows who may wish to participate in the formal assessment process.
2. To promote fair and appropriate assessment of examiner applicants.
3. To provide the best quality examination process for the assessment of candidates.

CRITERIA FOR EXAMINERS

1. **Must** satisfy the Faculty of Pain Medicine criteria for clinical practice in Pain Medicine in Australia or New Zealand.
ESSENTIAL
2. **Should** have significant experience of specialist practice in Pain Medicine practice for at least five years.
PREFERABLE
3. **Must** be participating in and meeting the requirements of a MOPS program.
ESSENTIAL
4. **Must** be respected by his/her peers, have a commitment to professional development in Pain Medicine and have good communication skills. These attributes will be supported by the provision of the names of at least three referees, at least one of whom is a present or past examiner of participating Colleges and Faculty. Other written references may be sought by the Chairman of the Final Examination Committee from Fellows who have knowledge of the applicant.
ESSENTIAL
5. **Should** be familiar with the Pain Medicine practice environment in Australia and New Zealand and have recently practised in this environment.
PREFERABLE
6. **Must** be willing to make a commitment to the "duties and responsibilities" of an examiner. Be prepared to make regular commitment to the examination process, including preparation and marking of examination material and being available for oral examinations.
ESSENTIAL

GENERAL CONDITIONS OF APPOINTMENT

7. Initial appointment for three years will be made by ANZCA Council following recommendation by the Board of Faculty of Pain Medicine.
8. Re-appointment after the first three years will be made by ANZCA Council following recommendation by the Board of Faculty of Pain Medicine and evaluation of performance.
9. Under normal circumstances, examiners may be re-appointed for a maximum of twelve years.

NON-FELLOW EXAMINERS IN PAIN MEDICINE

1. Must have a high level of expertise in basic scientific and applied aspects of Pain Medicine.
ESSENTIAL
2. Must be familiar with aspects of the practice of Pain Medicine and the role of his/her field of expertise in the specialty of Pain Medicine.
ESSENTIAL
3. Must be respected by his or her peers, and have a commitment to professional development in Pain Medicine and have good communication skills. These attributes will be supported by the provision of the names of three referees, at least one of whom is a present or past examiner from participating Colleges and Faculty. Other written references may be sought from the Chairman of the Pain Medicine Examination Committee from Fellows who have knowledge of the applicant.
ESSENTIAL
4. Must be willing to make a commitment to the "duties and responsibilities" of an examiner. Be prepared to make regular commitment to the examination process, including preparation and marking of examination material and being available for oral examinations.
ESSENTIAL
5. Must possess a higher research degree and/or postgraduate specialist qualification in their specialised field.
ESSENTIAL

POLICY DOCUMENTS

Review TE11 (1999)

FORMAL PROJECT GUIDELINES

1. INTRODUCTION

Every trainee registered with the College is required to complete a Formal Project before the Diploma of FANZCA can be awarded. This project is not a prerequisite for presenting for either the Primary or the Final examinations and may be undertaken at any time. To avoid delay in awarding the Diploma of FANZCA, the trainee must submit the project well before the completion of approved vocational training.

A trainee should prospectively register the project with his/her Regional Committee (or Training Committee in South East Asia) Formal Project Officer and seek advice **prior to commencing work on the project**. This Policy Document relates to all Formal Projects presented from the commencement of the 1999 training year.

2. OBJECTIVES

The objectives of the Formal Project are:

- 2.1 To advance skills in self-directed continuing education and scientific enquiry
- 2.2 To develop an understanding of evidence-based medicine

The objectives are intended to advance skills in trainees by requiring them to gain experience, for example, in how to:

- Develop an idea or concept into a topic for evaluation
- Derive a question or hypothesis on the topic for the project to answer
- Perform a literature search on the topic using libraries, books, journals, the internet, *Index Medicus*, Medline, and other forms of information technology
- Evaluate what information is useful and relevant to the question or hypothesis
- Collect data from the literature search and relevant investigations
- Analyse information and data collected, and apply relevant statistical analyses
- Review past work and publications on the topic, especially with respect to the question or hypothesis

- Determine one's results with reference, where applicable, to evidence-based reports.
- Decide how to best present one's findings – if publication is intended, decide on the most appropriate journal
- Write up the project to demonstrate scholarship, i.e. clear, logical, critical and analytical thinking.

3. THE FORMAL PROJECT

The Formal Project is the submitted material of the trainee's work. With the exception of published papers and written dissertations for a qualification (see below 5.3.1 and 5.3.3), a project must include a written report of at least 1,500 words (excluding references) on the work undertaken. This will include a critical review and an evidence-based approach to the specific topic. The trainee should show that he/she has assessed background data relating to the project and objectively weighed up the validity of relevant information obtained from the scientific literature and other sources. The project must be conducted in major part by the trainee.

Examples of Formal Projects are:

- 3.1 A case report of interest or clinical significance.
- 3.2 A review of a topic relevant to anaesthesia, intensive care or pain medicine.
- 3.3 A meta-analysis of published work on a topic relevant to anaesthesia, intensive care or pain medicine.
- 3.4 A research project.
- 3.5 Documentation of activity resulting from a period of research prospectively approved by the Assistant Assessor. In general, this will require a period equivalent to three months full-time research. The trainee must have an appropriate supervisor. A statement from the supervisor to validate the trainee's work must be submitted with the trainee's written report.
- 3.6 Any other project which has value from a clinical, scientific or educational perspective, such as a quality assurance project, a project submitted for a higher qualification

relevant to anaesthesia, or an instructional video or computer program.

4. GUIDELINES ON COMPLETING A FORMAL PROJECT

The usual steps undertaken to complete a Formal Project are:

- 4.1 Decide on a topic and propose a question, problem or hypothesis to analyse
- 4.2 Define terms used in discussions on the topic
- 4.3 Search for published and other relevant literature on the topic
- 4.4 Collect other information or data if the project is a research study
- 4.5 Analyse the scientific evidence in published and/or collected data that is relevant to the question, problem or hypothesis
- 4.6 Derive conclusions from the analysis of one's information and data
- 4.7 Propose solutions and answers to one's question, problem and hypothesis
- 4.8 Complete the project, e.g. record videos, finish posters, prepare graphics etc.
- 4.9 Write up work undertaken.

5 ASSESSMENT OF PROJECTS

- 5.1 Each Regional Committee and Training Committee in South East Asia will appoint a Formal Project Officer, who will certify to the Assessor that each trainee has completed a Formal Project. Except for projects deemed to have met the requirements of the Formal Project (see below 5.3), all projects must be assessed by at least two people nominated by the Formal Project Officer, one of whom may be himself/herself.
- 5.2 For projects which need to be assessed, the Formal Project Officer may accept a project, may require it to be revised or may reject it. The Formal Project Officer will refer rejected projects to the Assistant Assessor. The Assistant Assessor will chair a Formal Projects Panel appointed by Council to reassess these projects.
- 5.3 Completion of the following projects will be deemed to have met the requirements of the Formal Project without requiring further assessment:
 - 5.3.1 A paper published in a refereed journal listed with *Index Medicus*. Letters to Editors are excluded.
 - 5.3.2 A qualification relevant to anaesthesia conferred by an educational or professional institution, which

requires examination of a written dissertation. Diplomas of FFICANZCA and FPPMANZCA are considered as approved Formal Projects. A qualification relevant to anaesthesia awarded before the trainee commences vocational training may also be accepted as a Formal Project. Acceptance of pre-vocational training and other qualifications requires approval by the Assistant Assessor.

- 5.4 An oral or a poster presentation at an ANZCA ASM, ASA NSC, Regional ANZCA/ASA CME Meeting, CECANZ Meeting, ANZCA Registrars Meeting, or a meeting approved by the Assistant Assessor, may be accepted as a Formal Project without further assessment. However, a written report must be submitted as stated in 3 for any oral or poster presentation submitted as a Formal Project.
- 5.5 Formal Project assessors should consider the following aspects when reviewing a Formal Project:
 - 5.5.1 The project's topic is relevant to anaesthesia, intensive care or pain medicine.
 - 5.5.2 The report has a minimum of 1,500 words.
 - 5.5.3 The trainee conducted a major part of the project.
 - 5.5.4 The trainee achieved the Formal Project objectives or demonstrated an awareness of the objectives.
 - 5.5.5 The trainee derived a question, problem, or hypothesis for the project to resolve.
 - 5.5.6 The trainee conducted an up-to-date critical review of the project's topic from published and other relevant literature, using an evidence-based approach.
 - 5.5.7 The trainee used a valid approach or relevant methodology.
 - 5.5.8 The trainee objectively analysed information derived from the project with reference to evidence contained in the literature.
 - 5.5.9 The trainee, where relevant, followed conventional standards applicable to scientific work (e.g. research ethics, honesty of reporting and authorship)
- 5.6 Formal Project Officers should consult the Assistant Assessor on problems with any project. A trainee whose Formal Project is rejected by a Formal Project Officer and the Assistant Assessor may lodge a formal appeal to the College.

6 CERTIFICATION

Upon compliance with the above, the Formal Project Officer will certify to the Assessor that the trainee has completed an

appropriate Formal Project. The College will notify the trainee of its acceptance.

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

Policy documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Policy documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have

regard to any information, research or material which may have been published or become available subsequently.

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

Promulgated: 1989

Reviewed: 1992, 1997

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FACULTY OF PAIN MEDICINE

PM 1 (1999)

GUIDELINES FOR TRAINEES AND DEPARTMENTS SEEKING COLLEGE APPROVAL OF POSTS FOR TRAINING IN PAIN MEDICINE

1. INTRODUCTION

- 1.1 The College offers training in Pain Medicine on the basis of one year of experience in a Multidisciplinary Pain Centre fulfilling the requirements of TE16 and approved for training by College Council and a year of training applicable to Pain Medicine during initial specialist training of participating specialist bodies (See ANZCA Manual of Training in Pain Medicine).
- 1.2 Training in Pain Medicine will be available to Trainees of participating Colleges.
- 1.3 Multidisciplinary Pain Centres recognised by the College for training purposes will be reviewed in respect of that recognition on a three yearly basis.
- 1.4 The number of posts approved within a Multidisciplinary Pain Centre will be specified. Additional posts will not be recognised without the prior approval of the College Council on the recommendation of the Board of the Faculty of Pain Medicine.
- 1.5 An application for recognition of post(s) will require the submission or resubmission of data as outlined in College Policy Document TE16 *Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine*, and the Pain Centre Questionnaire. An inspection of the Centre may be part of the recognition process.

2. THE TRAINEE

- 2.1 Will ordinarily be a Trainee or Provisional Fellow or Fellow of the Australian and New Zealand College of Anaesthetists or at similar stages in participating Colleges (see ANZCA Training Manual). Trainees will be approved by College Council on the advice of the Board of the Faculty of Pain Medicine.
- 2.2 Must be registered prospectively for training in Pain Medicine and must pay all appropriate fees.
- 2.3 Must work in a post approved for Training in Pain Medicine. In the case of an ANZCA Provisional Fellow, normal training

and administrative requirements must be met (see College Policy Document E13 - *Guidelines for the Provisional Fellowship Year*). Part time training may be approved upon application to the Assessor.

- 2.4 One of the two years of required training must be allocated exclusively to the Pain Medicine training program. The program will have a balance of work in the areas of acute pain, chronic non-cancer pain and cancer pain management.
- 2.5 Out of hours duties should be predominantly Pain Medicine.

3. FORMATIVE ASSESSMENT

- 3.1 Quarterly in-training assessments will be made by the Medical Director in conjunction with candidates and with College policy. A final report (10% of assessment) will be made by the Medical Director in association with all senior staff of the Approved Unit. The reports should confirm candidates' satisfactory performance with regard to:
 1. applied knowledge
 2. history taking and physical examination
 3. patient and staff interactions
 4. development of appropriate skills in communication with patients
 5. technical skills (if appropriate)
 6. other attributes appropriate for multidisciplinary pain medicine
- 3.1.1 Corrective Action by Directors at the Time of Quarterly Reports
Inadequacies in any area(s) of the quarterly reports should be discussed in detail with the candidate; where appropriate, other senior staff of the centre should participate in this discussion. A corrective plan should be developed by the candidate and director, and agreed upon. At the next quarterly report, the director should document whether or not the candidate has satisfactorily corrected the previously identified inadequacies. In the event that

residual problems remain, a further plan must be developed and agreed upon.

- 3.2 Submission by the trainee of a Pain Medicine log book (40% of assessment). The log book will include information on: diagnoses and treatment plans for each patient managed; multidisciplinary case discussions attended; diagnostic and therapeutic nerve block and other procedures performed.
- 3.3 Documentation in the log book will include confirmation by quarterly signature of the Medical Director and Supervisor of Training of cases logged, and final confirmation of:
1. 300 patients with chronic non-cancer pain. This must include a minimum of 50 patients in either category (i.e. at least 50 patients with cancer pain and 250 patients with non-cancer pain or vice versa).
 2. 200 patients with acute pain. The majority of cases in this category would be post-operative or post-trauma, but should include acute exacerbations of cancer pain and acute presentations of medical conditions. Obstetric analgesia is a valuable component of this category but should not constitute more than 10% of the total 200 patients.
 3. Performance of at least varied diagnostic or therapeutic pain management procedures for procedural pain specialists. Non-procedural trainees should witness, assist or participate in, and record in their log book, at least 50 varied procedures. Procedural and non-procedural trainees must be conversant with the indications, effects, side-effects, complications and interpretation of diagnostic and therapeutic pain management procedures and be able to discuss these issues in the examination.
 4. Non-procedural and procedural specialists should participate in psychiatric and psychological in-depth interviews in sufficient numbers to enable discussion of assessment and management of patients with chronic pain in the examination.
 5. Participation in at least 40 multidisciplinary case conferences

The log book should be divided into *three separate sections* for logging acute pain, cancer pain and chronic non-cancer pain. Space is provided at the top of each page for recording case type. Some patients may need to be logged in more than one section. A sequential record of patients should be regularly logged to ensure inclusion of all patients seen.

In addition, in order to demonstrate continuity of care, approximately 10% of each group of patients (acute, cancer, chronic non-cancer) should be logged with respect to multiple visits. Visits after the 10th may be logged as 10+. A separate page of the log book should be used for each such patient. Supplementary notes may be appropriate to record experiences of an interesting case.

Log books should also indicate direct involvement with other specialist disciplines in the management of patients, and show evidence of liaison with the referring practitioner and primary care physician.

- 3.4 Submission of a typed "Treatise" (50% of assessment) describing and discussing:
1. one patient with acute pain
 2. one patient with cancer pain
 3. two patients with chronic non cancer pain, one of which must be a case where no intervention by a proceduralist is appropriate, and involvement of other disciplines is required

The discussion section in two of the above cases must be expanded to the level of a "mini-review" with appropriate referencing. Cases and mini-reviews should be presented in the same format and to the same standard as for the Journal *Anaesthesia and Intensive Care*. In evaluating the literature for cases and mini-reviews, candidates should consult the levels of evidence table in the NHMRC Report. *Management of acute pain: Scientific Evidence (NHMRC 1999)*, and determine which level of evidence is appropriate for each reference quoted. Emphasis should be directed to the multidimensional aspects of pain and the interdisciplinary approach to its diagnosis and treatment. Wherever possible, candidates should use pain terms and diagnoses from the IASP taxonomy. The length of the "Treatise" should not exceed: 1,500 words for each case and 5,000 for each mini review with associated cases, including references, illustration etc. It should be double spaced on A4 pages, using 12-point type.

- 3.5 The Assessment will be reviewed by three Pain assessors appointed by the Board of the Faculty of Pain Medicine. Following receipt of all assessments by the College, assessors will confer through the mechanism of a formal meeting or teleconference in order to reach a joint recommendation for referral to the Board of the Faculty of Pain Medicine and will forward its recommendations to College Council for approval. In the event the Diploma of Fellowship of the Faculty of Pain Medicine assessors are unable to make a recommendation, further assessment may be obtained on the advice of the Board of the Faculty of Pain Medicine.

4. SUMMATIVE ASSESSMENT

An exit examination consists of written, clinical and oral sections (see Pain Medicine Training Manual).

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

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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 Year of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
- E3 (1994) The Supervision of Trainees in Anaesthesia *Bulletin Nov 92, pg 41*
- TE4 (1997) Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
- E6 (1995) The Duties of an Anaesthetist *Bulletin Nov 95, pg 70*
- E7 (1994) Secretarial Services to Departments of Anaesthesia *Bulletin Nov 94, pg 43*
- E9 (1993) Quality Assurance *Bulletin Mar 93, pg 38*
- TE11 (1999) Formal Project Guidelines *Bulletin Mar 99, pg 70*
- E13 (1996) Guidelines for the Provisional Fellowship Year *Bulletin Nov 96 pg 66*
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, pg 62*
- TE16 (1998) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin Nov 98, pg 83*
- 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*
- T4 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT) *Bulletin Nov 94, pg 59*
- 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 (1993) 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*
- P10 (1994) The Handover of Responsibility During an Anaesthetic *Bulletin Nov 94, pg 44*
- 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*
- P26 (1994) Guidelines on Providing Information about Anaesthesia *Bulletin Aug 94, pg 61*
- 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, pg82*
- PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg84*
- PS36 (1997) Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg93*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 98, pg 79*
- PM1 (1999) Guidelines for Trainees and Departments seeking College Approval of Posts for Training in Pain Medicine *Bulletin Mar 99, pg73*