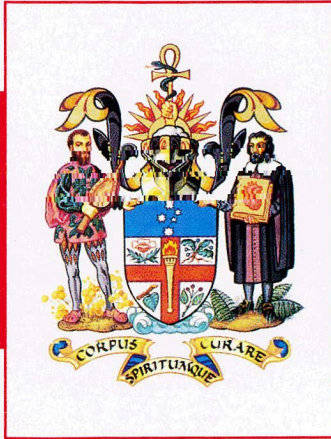


# Australian and New Zealand College of Anaesthetists

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 medicine'.*

## Inside...

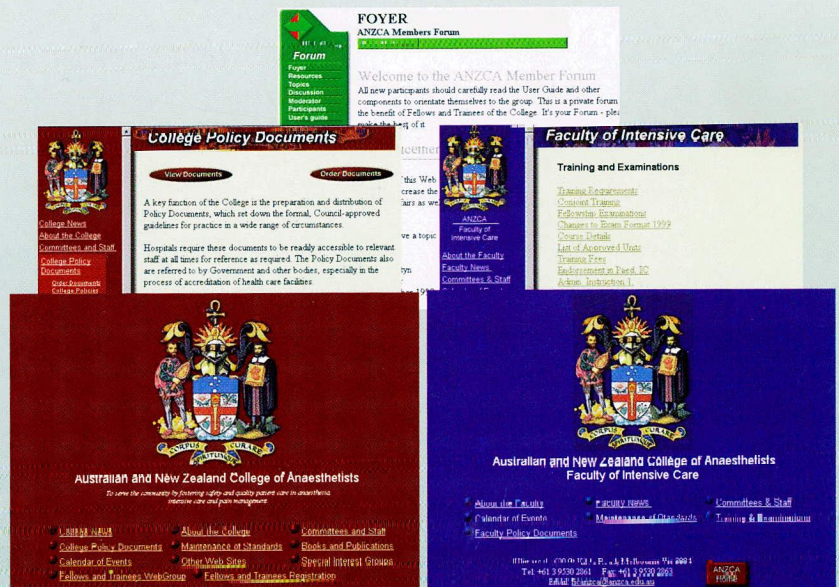
- President's Message
- Revised MOPS Program
- Research Awards
- ANZCA Website Update
- Postgraduate Education on the Internet
- Australasian Anaesthesia Launch
- Highlights of Council
- SIG Annual Reports
- Law Report –  
Medical Manslaughter Revisited  
Doctors to the Rescue

## Faculty of Intensive Care

- Dean's Message
- Examination Format Changes
- Items of Interest from Board Meeting
- Fellows' Survey – Single Body

## Faculty of Pain Medicine

- Update
- Foundation Diplomates
- Pain Management Certificate Overview



## CONTENTS

Page

|    |  |
|----|--|
| 1  | President's Message  |
| 2  | Revised MOPS Program   |
| 3  | Death of Fellows   |
| 4  | Director of Education – Advertisement  |
| 5  | 'Anaesthetists Care' – NAD 1999  |
| 6  | Law Report – Medical Manslaughter Revisted?<br>Doctors to the Rescue                     |
| 10 | Honours and Appointments   |
| 11 | ANZCA Website Update   |
| 12 | Admission to Fellowship by Examination<br>Award of Certificate of Pain Management        |
| 13 | Staff Profile – Mandy Williams<br>Policy Documents for Review in 1999<br>ANZCA Donations |
| 14 | Postgraduate Education on the Internet   |
| 17 | The Internet and Rural Practitioner Needs  |
| 18 | College Library  |
| 19 | Changes to Staff Nomenclature  |
| 20 | Highlights of October Council Meeting  |
| 26 | Primary Examination Successful Candidates  |
| 27 | Court of Primary Examiners   |
| 28 | Final Examination Successful Candidates  |
| 31 | Flinders Medical Centre – Specialist Anaesthetists                                       |

### Faculty of Pain Medicine

|    |  |
|----|--|
| 31 | Call for Foundation Diplomates                                       |
| 32 | Report – Chairman's Update   |
| 34 | Overview of Pain Management Certificate – Assessor's Reports         |
| 35 | ACHS – Clinical Surveyors  |
| 36 | 1999 Research Awards   |
| 37 | Research Awards for 2000   |
| 39 | 1998 Younger Fellows Conference Report                               |
| 48 | Special Interest Groups Annual Reports<br>Welfare of Anaesthetists   |
| 49 | Rural  |
| 50 | Cardiothoracic, Vascular and Perfusion                               |
| 51 | Day Care Anaesthesia   |
| 52 | Medical Education  |
| 55 | Obituaries<br>Dr Gwen Wilson MD                                      |
| 56 | Dr Kevin Merrett, Dr Bede Mooney<br>Dr Douglas Tabereth              |
| 57 | Prof. Gustav Fraenkel, Dr James Opie                                 |
| 58 | Emeritus Prof. Colin Shanks<br>Dr Sankarakurup Nair, Dr David Wright |

### Faculty of Intensive Care

|    |  |
|----|--|
| 59 | Dean's Message   |
| 60 | Obituary – Dr Kate Flynn   |
| 61 | Results of Survey – Single Body  |
| 62 | 1998 National Intensive Care Day Questionnaires<br>Admission by Election |
| 64 | Interests of October Board Meeting                                       |
| 66 | Admission to Fellowship  |
| 67 | Fellowship Exam – Changes<br>Policy Documents                            |
| 70 | IC-3 Guidelines for ICU Seeking Accreditation                            |
| 75 | Future Meetings<br>Policy Documents                                      |
| 81 | PS14 – Guidelines for Regional Analgesia in Obstetrics                   |
| 83 | TE16 – Requirements for Multidisciplinary Pain Centres                   |
| 85 | PS3 – Major Regional Anaesthesia and Analgesia                           |

## EDITORIAL

Mrs Joan Sheales, Editor  
 Dr R.G. Walsh  
 Dr M. Martyn  
 Dr I. Rechtman  
 Dr R.S. Henderson  
 Dr R.N. Westhorpe  
 Dr R.V. Trubuhovich  
 Mr E. Dean

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

Telephone: +61-3 9510 6299  
 Facsimile: +61-3 9510 6786  
 E-mail: ceoanzca@anzca.edu.au  
 Internet: <http://www.anzca.edu.au/>

Regional Committee offices can be contacted via email as follows:

VIC: victoria@anzca.edu.au  
 NSW: nsw@anzca.edu.au  
 SA: sa@anzca.edu.au  
 QLD: qld@anzca.edu.au  
 WA: Anaesthesia.WA@hcn.net.au  
 TAS: surgeons.Tas@hcn.net.au  
 NZ: anzca@actrix.gen.nz

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## PRESIDENT'S MESSAGE



I suspect that many Fellows and Trainees do not fully appreciate the many and diverse roles of the College and its leaders. The 'leaders' are not only members of the College Council and College Faculty Boards, but are also members of all Regional Committees and a great number of others who have volunteered for varied and vital functions of the College. All contribute enormous amounts of their time and energy to our professions of anaesthesia, intensive care and pain medicine. Many others apply their talents equally toward functions of the Australian Society of Anaesthetists (ASA), the New Zealand Society of Anaesthetists (NZSA), the Australian and New Zealand Intensive Care Society (ANZICS), the Australian Medical Association (AMA) and other professional bodies, noting that a large number have, or have had, important roles in several organisations over time or simultaneously. I also acknowledge those who contribute greatly to the status of our professions in their hospital departments or institutions, major and minor, public and private, working at the coalface in providing a high professional service to our patients.

The roles of the College, and more particularly its current activities, are reflected in part throughout the pages of regular issues of this and other publications. The College is primarily an educational body, which uniquely serves the community in its many functions, as well as having conjoint activities with other organisations. It is important to note that the College thereby must maintain an involvement in certain, very specific 'medico-political' and 'medico-legal' issues. These issues involve discussions with such bodies as hospitals and similar institutions, regional health authorities, other Colleges and related organisations, State and National governments, and any other relevant body which approaches the College with matters of concern pertinent to our professions as they apply to the College. Such organisations as the ASA and NZSA are fully informed of these College relations with outside bodies.

The October 1998 meeting of the College Council, a report of which follows in this edition of the Bulletin, accepted the reviewed Maintenance of Professional Standards Program. A draft version was published in the Bulletin earlier this year. Although it is voluntary, it must be noted that many hospitals throughout Australia and New Zealand see participation in a MOPS program as a requirement for

appointment or reappointment of any specialist. The College MOPS Program is made easy for all responsible and practising Fellows, and any others who wish to join, to participate and comply with its requirements. Read more about it in the pages to follow! The Council also formally established the Board of the Faculty of Pain Medicine with involvement of other relevant Colleges and Faculty. This marks a landmark stage in the development of pain medicine toward a belated and most deserving high status in overall health care for all over communities. It is of great note that our College has been able to lead the medical profession toward this development and it is a fine tribute to the leadership, tremendous efforts and skills of Professor Michael Cousins and his supportive colleagues.

National Anaesthesia Day for 1999 will be held on Wednesday 7th July 1999 with a theme of peri-operative medicine. In choosing this theme, the College Council is further promoting all anaesthetists in their central role of peri-operative physicians, not ones who just 'pass gas'! Our consultant status will be lifted with the 1999 National Anaesthesia Day. It is incumbent on all of us to examine, reassess and sometimes lift our perceived performance as the highly trained professionals that we all are. This is a none too subtle message that we must all maintain our highest professional standards, pass these on to our trainees and ensure that all those with whom we work fully appreciate this. As a practitioner in both the public and private sector, I suggest that we sometimes could do better. I earnestly encourage all sectors of our anaesthesia profession to actively participate in National Anaesthesia Day 1999, further details of which will be widely circulated.

Further to the issue of promoting anaesthesia, the College recently wrote to all University Medical Schools in Australia, New Zealand and Papua New Guinea offering an annual prize to an undergraduate who topped the examination or assessment in anaesthesia subjects. The response from the Universities has been overwhelming and I believe this initiative will significantly increase undergraduate awareness, no matter how the careers develop, of the importance of anaesthesia, intensive care, pain medicine and related subjects.

Finally, recent wide publicity has been given to welfare issues of doctors, including hours of work, crisis management, fatigue, depression, drug abuse and suicide. The College, the ASA, NZSA, AMA and related bodies have all been actively addressing these difficult and serious issues for several years and will continue to do so in a collaborative manner. The Welfare of Anaesthetists Group (WOAG) has been incorporated as a formal Special Interest Group of ANZCA, ASA and NZSA with its secretariat based at the College. I can assure Fellows and Trainees that the College Council strongly supports active development of policies and infrastructures to manage this perceived increasing problem.

I wish all Fellows and Trainees a happy and productive 1999.

R.G. WALSH, President

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

# MAINTENANCE OF PROFESSIONAL STANDARDS

## REVISED MOPS PROGRAM

The introduction of the College Maintenance of Standards (MOS) program in 1995 included plans for a review of the program. This review was undertaken this year and Fellows' suggestions have been incorporated in a new program, now called Maintenance of Professional Standards (MOPS).

The principal objective of the College MOPS program is now stated, i.e. 'to foster continuing scholarship in order to maintain a high standard of clinical practice'. Thus **the principal role is educational** and the MOPS program validates continuous medical education (CME), quality assurance (QA), and other self-improvement educational activities. It is not intended as a confirmation of 'competence'. In order to certify clinical competence, all levels of competence must be reliably assessed, including knowledge, theoretical 'know-how', procedural skills and actual performance. Personal qualities such as clinical judgement, humanistic values, communication skills, fitness and conduct must also be judged. The MOPS program does not assess any of these qualities. Thus MOPS should not be acknowledged as a credential of 'competence', but there is some evidence to suggest that participation in CME and QA activities (i.e. MOPS) is associated with improved clinical performance. MOPS serves to foster professional development, and the program must be credible to realise the educational objectives.

The MOPS program should also not be misinterpreted as a recertification tool. ANZCA does not recertify Fellows for them to remain on the Register of Fellows, and the College does not initiate, encourage, or participate in recertification processes by other bodies. Licensing bodies and employing institutions may, however, wish to implement recertification independently. Some may choose the College's MOPS program as a qualifier for anaesthetists. This would be helpful to Fellows, and the credibility of the program would enhance its acceptance for this purpose.

The key elements of the new program are:

- The program places emphasis on CME and QA while recognizing the important contributions from other areas in enhancing clinical standards.

- There is flexibility and diversity in crediting educational activities to meet the varied needs of individual participants, especially those in rural and private practice. More activities are credited, including those relating to multi-media and self-initiated learning, and local activities organized by private practice or rural participants.
- Attention is given to feedback and self-analysis by peer comparison, and to recording outcome of each activity, so as to assess and enhance the educational value of activities. Deficient areas can be self-targeted for improvement.
- A prepared diary or logbook is used to record activities. This facilitates annual returns and self-reviews of one's activities.
- The program is not points-driven, although a basic level of CME and QA activities is required every year to achieve credibility. There is no incentive to creatively accumulate points, as any useful analysis involves self-comparison with peers.
- Activities of other Colleges and specialties are recognized, if they are relevant to one's particular practise of anaesthesia and related disciplines.

Enrolment is open to Fellows and all anaesthetists in Australia and New Zealand. **Participation is voluntary**, although the program encourages and facilitates all colleagues to participate, whatever the nature of their practice. The 5-year cycle remains (see below), but there is now no minimum total of 500 points to chalk up at the end of the cycle. Nonetheless, for the program to be credible participants need to expand some effort consistently; hence the requirement to attain modest minimum points every year for QA and CME activities. These minimum points are comparable with those of the current MOS requirements but the new MOPS program offers more flexibility. For example, the minimum 25 QA points per year can be attained by attending local QA meetings for a minimum of three hours every four months.

The new program requires participants to maintain a MOPS *Portfolio of Activities*, which is a logbook record of involvement in specified activities in anaesthesia and related disciplines. These may be recorded manually in supplied forms or on computer using a specially written program. Recording in the simple-to-use computer program is strongly recommended, as it will save participants considerable time and will facilitate number crunching for feedback. The recording of activities is extremely important because information processed will provide feedback to participants. Of course, all records will be kept in strict confidence.

This new MOPS program will start on 1 January 1999. Those already enrolled under the present program will continue with their 5-year cycle, but with using the new program from 1 January 1999. For example, if you enrolled in 1996, you will start the fourth year of your 5-year cycle on 1 January 1999 under the new program. New registrants enrolling in 1998 will enter their second MOPS year and the new program on 1 January 1999. The present program and its requirements will cease to apply from 1 January 1999. Participants will be deemed to have satisfactorily completed their MOPS for every year (before 1999) *that they have submitted an annual return.*

**Thus please submit any outstanding returns for past years by 30 June 1999 if you want your years to be credited.** This will be the final opportunity to submit missed returns. To date, submission of returns has been dismal (Table) and crediting a year without sighting a return will render the 5-year cycle implausible.

With the new program, all participants are required to submit returns at the completion of each MOPS year, before the end of February of the following year. Participants will be issued with a *Statement of Participation* for that completed year when their returns are received by the MOPS Office. **Participants who fail to lodge a return or do so past the closing date will not be credited for that year.** Submitting return forms on time is vital, because it generates feedback, the cornerstone of the program. At the completion of a cumulative 5-year cycle, participants will be awarded a *Maintenance of Professional Standards Certificate.*

Please remember to:

- **Submit all your past MOS returns by 30 June 1999**
- **Submit your new 1999 MOPS return before 28 February 2000**

**TEIK OH**  
QA/MOPS Officer

**Table of Nil Returns Submitted**

|  | 1995 | 1996 | 1997 |
|--|------|------|------|
| Registered participants who did not submit returns | 603  | 784  | 854  |
| Total number of participants                       | 1214 | 1364 | 1454 |

## **DEATH OF FELLOWS**

The death of the following Fellows is noted with regret:

Dr William Derek Wylie, UK – Honorary Fellow 1984

Dr T. John Watkins, NSW – FFARACS 1977, FANZCA 1992

Emeritus Professor Colin A. Shanks, USA – FFARACS 1969, FANZCA 1993

Dr Douglas G. Tabrett, NSW – FFARACS 1981, FANZCA 1982

Dr John A. Griffiths, NSW – FFARACS 1971, FANZCA 1992

Professor Gustav J. Fraenkel, SA – Honorary Fellow 1986

Dr Gwenifer C. Wilson, MD, NSW – FFARACS 1956, FANZCA 1992

# 'ANAESTHETISTS CARE'

## 1999 NATIONAL ANAESTHESIA DAY

WEDNESDAY, 7TH JULY

EDDIE DEAN

Communication Consultant

Planning is progressing for the next National Anaesthesia Day – to be held on Wednesday, 9 July 1999. Letters of invitation to participate in the 1999 Day have been sent out by the ANZCA, ASA and NZSA Presidents.

The objective on this occasion is to improve public knowledge about the role of anaesthetists in perioperative medicine, and to actively promote this role. The proposed message, 'Anaesthetists Care', is aimed at enabling a broad focus on our role before, during and after anaesthesia.

This is an excellent opportunity to focus community, media and government attention on the leadership of anaesthetists in the development of perioperative medicine services, the efficiencies it is bringing to the health system, and the benefits being enjoyed by an increasing number of patients.

There are many positive aspects of this burgeoning area of medicine which highlight the contribution to improving health care quality that is made by anaesthetists. Perioperative medicine is an area that emphasises the established skill-range of anaesthetists as well as our widening responsibilities.

National Anaesthesia Day is a successful annual event now well-established on hospital, community and media calendars. It provides a vehicle with which departments and individual anaesthetists can convey the theme message in many ways – as well as your hospital's particular expertise in the delivery of quality health care.

In 1999, you may again choose to mount simple displays in the hospital, or take the message to local shopping centres or other public areas. Visits to schools, or school visits to the hospital; talks to local service clubs; meetings with local GPs; newsworthy items in local newspapers, interviews on radio, or television coverage (news and current affairs) of a topic-focused event are all proven techniques for conveying the message to your community.

As in past years, a kit will be supplied that includes display material, leaflets, stickers, and a media support package to supplement each hospital's National Day activity. To book your kit, please phone, fax or e-mail Mandy Williams at the College.

Feedback from previous National Anaesthesia Days shows that there is strong ongoing enthusiasm for the National Day. It provides excellent community relations and education values, and the opportunity to publicise relevant achievement of individual hospitals. As well, very real building of goodwill with the general public and government flows from the Day's information effort.

The success in making this Day another significant effort in further improving community understanding of the specialty is mainly dependent on the enthusiasm of anaesthetists and associated staff. Your input and any suggestions are welcome.

## LAW REPORT

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

### MEDICAL MANSLAUGHTER REVISITED?

A recent paper by my partner, Mr Victor Harcourt, a health law litigation expert, has raised the question as to whether 'medical manslaughter' may still be an issue in Australia.

In New Zealand, until recent legislative amendments, doctors could be guilty of the crime of manslaughter where patients died as a result of the doctor's simple negligence. In Australia and most other western countries, manslaughter could only arise in situations where there was gross or criminal negligence – a much higher standard. Since the passing of the *Crimes Amendment Act 1997* in New Zealand, legislative amendment in which the College was vitally involved, the standard for medical manslaughter has been raised to a similar standard that applies in Australia and other countries.

However, interpretation of coronial legislation in Australia now raises the prospect that doctors may be named in coronial investigations as having 'contributed to death' in situations of simple negligence or even where there is an adverse outcome or simple mis-adventure.

Whilst the situation is not nearly as grave as it once was in New Zealand – no doctor will be convicted of manslaughter as a consequence of this issue – a finding by a Coroner that a doctor has contributed to the death of a patient is nonetheless a serious accusation and can substantially adversely affect the reputation of the doctor. In most other states the Coroner has an ability to find that a doctor may have contributed to death, but is under no obligation to do so, particularly where simple negligence or an adverse event or outcome is involved. However, as Victor Harcourt's article suggests, there is now an onus on the Coroner to make findings about contribution. The provisions in the Victorian legislation to which the article relates also are similar to provisions in Western Australia, Tasmania and the Northern Territory.

I am grateful to Victor Harcourt for his contribution to this article –



#### The Coroner and the Meaning of Contribution

The Victorian coronial system was the subject of extensive reform with the introduction of the *Coroners Act 1985*. While reinforcing the primary function of the coronial investigation to ascertain the identity of the deceased, how the death occurred and the cause of death, the legislation introduced a mandatory requirement for the Coroner to identify, if possible, any person who may have contributed to the cause of death.

An adverse finding of contribution is a contentious issue at the best of times. In this legislation, the Victorian Parliament chose to make identification of any contributor a mandatory requirement, a unique provision at the time.

Controversy now surrounds the meaning of 'contribution' in section 19 (1) (e) of the *Coroners Act 1985*. A recent decision by the Victorian Court of Appeal re-defines the concept. This decision will force a Coroner to take a different approach when considering whether a finding should be made that a person (particularly a doctor) contributed to the death of a person.

The primary function of a coronial investigation, of which the inquest is part, is to make certain findings as to the identity of the deceased, how the death occurred, the cause of death and the identity of any person who contributed to the cause of

death. Although expressed differently, the previous legislation required a Coroner to make the same findings, except in respect of contribution. At the time the new Act commenced in 1986, the mandatory requirement of a Coroner to name any person who contributed to the death was unique in Australia and England.

In determining how a death occurred, it has always been open to a Coroner to name any person who caused the death. This exists in other jurisdictions in Australia, New Zealand and beyond. In various jurisdictions this ability is subject to restrictions about any comment that the person may have committed a crime or civil wrong. However, the Victorian legislation imposed upon the Coroner a duty to name a contributor, if the facts justified it. Why the Legislature saw this as necessary is not readily apparent from the debates in Parliament when the legislation was considered.

The scope and extent of the meaning of 'contribution' has been the matter of some consideration by the Victorian Supreme Court in a number of decisions. However, the decision of the Victorian Court of Appeal on 1 May 1998 in *Keown v Khan & West* has again sought to define the concept. The Court has upset the practice adopted until now by the State Coroner of not finding contribution, except in cases where there is some element of *blameworthiness*.

The *Keown v Khan & West* case concerned an inquest into the death of a person fatally shot by police in St Kilda. The Deputy State Coroner found that the police officer who fired the shot did not contribute to the cause of death. He further found that the deceased had contributed to her own death by ignoring the lawful directions of the police. On first hearing, the Supreme Court ordered a re-opening of the inquest, holding that the Coroner's finding was in effect that the deceased had solely contributed to the cause of death, and the evidence disclosed that the police officer had an opportunity to take action to avoid shooting.

On a plain reading, the Deputy State Coroner appeared to be in breach of the *Coroners Act* by not finding contribution against the police officer – as undoubtedly the shot caused the death in a very direct sense, whether or not there was lawful justification. On appeal the Court did not point to the obvious in declaring the findings void. That is, the Court did not state that as a question of fact, the police officer must have contributed to the death; thereby negating what was seen as the vice of the Coroner's finding that the deceased had contributed solely to her own death.

Instead the Court felt too constrained to analyse the facts and find 'some element of departure from the reasonable standards of behaviour ordinarily required' to base the

decision to open the inquest. This approach reflected the practice adopted by the Victorian Coroners of not making a finding of contribution simply because there is a mere causal connection between the act or omission and the death of the person. Generally there has also to be some degree of fault or blameworthiness.

This approach now needs to be considered by the State Coroner in light of the Court of Appeal decision. The Court of Appeal took the view that a person who kills must necessarily contribute to the cause of death, even if it is in lawful self-defence. The Court stated that the test of contribution is solely whether a person's conduct caused the death. In some circumstances, causation may be inextricably linked with the question of whether the contributor's conduct was in breach of duty. In those cases the Coroner will also need to look at culpability. Otherwise, the test of contribution is now one of fact only.

There are clear implications for doctors and other health professionals. Even though a patient may die of misadventure or as a result of the outcome of an adverse event, which might otherwise have occurred having regard to the illness or complication suffered by the patient, a doctor might be named as having contributed to the death. This is likely if there is an act or omission by a doctor or health professional which in some way is related factually to the death of the patient. Previously a Coroner would not make any statement in relation to the doctor or health professional, unless there was some element of blameworthiness or real degree of fault. Under this new interpretation, Coroners will now be required to name doctors and health professionals where there is merely factual connection of their conduct to the death of the patient.

Of course, Coronial inquests attract significant media attention. A finding of contribution is likely to be reported in the media without adequate regard to any comment by a Coroner concerning the fact that no blame could be found. There is therefore the potential to undermine public confidence in the Coronial process, the potential to damage professional reputations unnecessarily, and to hinder the Coroner's important role of preventing the re-occurrence of similar fatalities.

Interestingly, the Court stated that the duty of the Coroner to make findings as to how the death occurred and the cause of death would require the identification of any contributor. Thus the express requirement to name a contributor served no purpose other than to ensure that it was done. The Court noted that a person's reputation was protected if the relevant facts were brought out. Of course, the media is unlikely to be able to draw such subtle distinctions and therefore the public



is unlikely to appreciate that the naming of a doctor does not necessarily carry with it any blame or legal responsibility.

This approach is also likely to lead a review of the approach to inquests by parties against whom a finding of contribution might be made. Significantly, doctors, hospitals, health professionals are more likely to rely on formal legal representation and take a more adversarial approach to inquests and Coronial proceedings so as to avoid any significant impact upon the person's character, reputation and employment prospects which might arise from an adverse conclusion by the Coroner.

The reform of Coroner's legislation introduced in Victoria contains significant and welcome reform, and has otherwise proved to be effective in achieving its purposes. However, the

failure by Parliament to define the meaning of 'contribution' or to indeed give any clue as to its intent, has created unnecessary uncertainty as to its scope. This uncertainty, if permitted to continue without legislative reform, may create an unwarranted fetter on the effectiveness of the Coronial system.

Repealing the mandatory obligations to determine contribution may well resolve continuing controversy which has manifested itself in a number of decisions of Courts. However, it is clear that there is a need for legislative reform in relation to this issue.

(See 'Contribution to cause of death', Victor Harcourt, Partner, Russell Kennedy, *Journal of Law and Medicine*, Volume 6, August 1998, number 1).

## DOCTORS TO THE RESCUE

I have recently been asked on a number of occasions about the liability of doctors who attend emergencies or 'come to the rescue'. With the increased risk and fear of litigation and willingness of patients to initiate proceedings, doctors are becoming more worried about their legal liability in situations where they are asked to act in an emergency.

A case recently in Queensland highlighted the situation where a doctor assisted in an acute asthma attack, having to resuscitate a patient twenty times in the course of travel to hospital. The doctor was painted as a 'Good Samaritan' and the patient survived. However it was subsequently revealed that the doctor may have been impaired by alcohol after being charged with a drink driving offence relating to the same evening.

The Brisbane *Courier Mail* (16 July 1998) commented –

*"However the realisation that it could have been a different story points to the dilemma faced by off-duty doctors enjoying a few drinks when they are called to act in a medical emergency at a sporting event or dinner party or may be in a plane."*

On the lighter side, an airline recently reported a case where a patient suffered an attack on route and the pilot enquired over the loudspeaker whether a doctor was available. Over 20 cardiologists on board returning from an international convention immediately volunteered. (The outcome for the patient was not revealed).

A recent report of the Law Reform Committee of the Victorian Parliament ('Legal Liability of Health Service Providers')

confirmed that there has been no reported Australian case where a doctor has been held liable for providing assistance in good faith in an emergency situation or accident. However, the Committee also noted that it had been told 'that the fear of malpractice causes medical practitioners to avoid offering medical attention to people at the scene of an accident or in an emergency'.

Two questions arise:

1. Must doctors render assistance at the scene of an emergency?
2. If a doctor attends an emergency, what is his or her liability?

### Must doctors render assistance?

There is no general requirement at law for anyone to provide assistance in an emergency or accident, even where it may be clear or foreseeable that the failure to act may result in death or injury. The liability of a rescuer in such circumstances is much reduced from the ordinary liability for negligence. The duty in such cases is simply to ensure that the conduct of the rescuer does not increase the risk or peril of the person in danger.

There is a general duty for a person coming to the rescue to act reasonably, but this is interpreted at a reduced level, given the context of the emergency situation.

Additionally, at law, there is no legal obligation for **doctors** to give assistance at the scene of an accident or emergency. However, a positive duty to act does exist where the doctor is

in a particular role or part of a system, part of which is to deal with accidents or emergency situations. For example, a doctor in an emergency department clearly has a role to play in dealing with emergencies as they arise. However, even in these cases, even where a doctor is in a casualty department, the English Courts have found that there was not a general obligation to examine all patients who came to the Department. The doctor need not see every patient who calls at the department. The overriding determination by the Courts, is whether a doctor has acted reasonably in all of the circumstances.

The Courts also recognise the ability of doctors to carry out procedures, without informed consent if necessary, where treatment is reasonably necessary in the particular emergency situation. Clearly where treatment is necessary in an emergency to save life or prevent serious injury a doctor is entitled to act.

Apart from the law, the doctors might have a responsibility to attend an accident or emergency under ethical or professional obligations. General profession 'moral' obligations certainly recognise the requirement for doctors to render assistance where they are available to do so and such assistance is within their competence.

In New South Wales for example, the Medical Practice Act contains a specific ethical duty. It may amount to 'professional misconduct' if a doctor refuses or fails, without reasonable cause, to attend within a reasonable time after being requested to do so to render professional services, in any case where the doctor has reasonable cause to believe that the patient is in need of urgent attention by a doctor.

The recent decision in New South Wales of *Lowns v Woods* in 1996 confirmed that, if a doctor fails to respond to an emergency request for help, even if the victim is not an existing patient, the doctor would have responsibility if:-

- the request for assistance is made in a professional context;
- the doctor and the patient are in close physical proximity (such that the doctor could attend);
- the doctor is aware of the need for emergency treatment or attention for a serious medical case;
- the doctor is appropriately qualified to provide the treatment, has the equipment which may be necessary and is not otherwise at physical risk.

Obviously, any requirement to attend will depend on a range of circumstances:

- is the doctor able to attend?

- are there other patients requiring his attention?
- are ambulance or other medical services readily available?
- are the doctor's skills sufficient to deal with this situation?
- is he competent in the area of treatment or procedure that may be required?
- what is the nature of the illness or remedy required?
- is it a real emergency or merely perceived by those around to be an emergency?
- what are the circumstances of the emergency – is it a road accident in the bush? Is it a heart attack of a visitor in a hospital? What are the resources available?
- these principles obviously apply differently to other professionals such as nurses, paramedics, teachers, etc.

The medical legislation in other States is similarly broad enough to encompass a professional obligation on doctors to attend. For example, in Victoria the Medical Practice Act defines 'unprofessional conduct' to include conduct which is of a lesser standard than that which the public might reasonably expect or conduct which is of a lesser standard than that which might reasonably be expected of a doctor by his or her peers. In the Northern Territory section 155 of the Criminal Code provides that any person who, being able to provide rescue or treatment to a person urgently in need of it, and whose life may be endangered if it is not provided, callously fails to do so is guilty of a crime and liable to imprisonment for seven years. The Northern Territory legislation has been particularly applied in hit-and-run accident situations, where the driver fails to render assistance to the victim.

#### **What is the liability of doctors who render assistance?**

As noted previously, the law recognises a lesser onus or duty on doctors who render assistance in an accident or emergency situation. The law merely requires that a rescuer, particularly a doctor, acts reasonably, depending on the circumstances. Those circumstances include the fact that the usual medical equipment and supplies may not be available and that the doctor is acting under extreme, stressful situations. The law will only require a doctor to conduct procedures that are reasonably necessary in the emergency situation. Of course, the doctor may be liable where his or her own actions contribute to or exacerbate injuries.

The position at law in some states has been modified by legislation.

Queensland contains the most substantial legislation dealing with the situation of the 'Good Samaritan'. Section 3 of the Voluntary Aid in Emergency Act provides that:

*"Liability at law shall not attach to a medical practitioner or nurse in respect of an act done or omitted in the course of rendering medical care, aid or assistance to an injured person in circumstances of emergency:*

1. *at or near the scene of the incident or other occurrence constituting the emergency;*
2. *while the injured person is being transported from the scene of the accident or other occurrence constituting the emergency to a hospital or other place at which adequate medical care is available if:*
3. *the act is done or omitted in good faith and without gross negligence; and*
4. *the services are performed without fee or reward or expectation of fee or reward".*

To take advantage of this provision, the doctor must act without gross negligence, which goes beyond simple negligence or misadventure. The doctor would have to be so reckless or incompetent that it warranted the description of 'gross negligence'.

The doctor must also be acting in good faith. Clearly if the doctor was acting under the influence of alcohol, it is arguable whether the doctor is acting in good faith. If the doctor is clearly under the influence of alcohol and acts incompetently, it may also be that the doctor is grossly negligent. This raises interesting situations where doctors are at social functions, where clearly they have had a few drinks, but may be asked to act in an emergency situation. On the one hand, society would want doctors to intervene and exercise the skills and specialist knowledge that they obviously possess. On the other hand, an impaired doctor may not be of assistance and may in fact exacerbate the situation.

The situation was recognised in the recent *Brisbane Courier Mail* article (16 July 1998) in which the unique position situation of rural doctors was considered. A Queensland doctor explained that he had been a teetotaler for thirty years because, as the only doctor in the area, he had to be capable of delivering babies or helping people in road crashes at any time. "Most rural doctors, if not all, do put pretty severe restrictions on themselves", the doctor was quoted as saying.

Clearly other states in Australia and New Zealand should consider the Queensland legislative model, to clarify and reassure doctors and health service providers, and to encourage them to act in the case of emergencies or accidents.

Certainly the Law Reform Committee of the Victorian Parliament recommended that the Victorian Government should enact legislation based on the Queensland model to provide a limited defence for medical practitioners and nurses who provide medical assistance at the scene of an accident or other emergency.

Approaches by the medical colleges in recent months to other state governments have not been encouraging. Some other states rely on the fact that there is no evidence to indicate that their existing legal situation is inadequate or evidence of the fact that doctors may be resisting providing their services in an emergency situations. This is not, however, an answer. Clearly, the profession is concerned about the matter. Anecdotal comments suggest that doctors do indeed think twice before responding to an accident or request for emergency treatment. The fears and concerns of potential liability and litigation are real. If parliaments wish to encourage doctors and other health care professionals to provide their services in emergency situations, then legislation similar to that in Queensland should be considered.

Doctor Megan Keaney, National Claims Manager for United Medical Protection, was quoted in the *Brisbane Courier Mail* as saying that, "It will be a sad day when doctors stop intervening because of possible medico-legal consequences rather than following their instincts and assisting people in need."

## Honours and Appointments

Congratulations are extended to the following Fellows:

Dr Richard G. Walsh, NSW – Fellow, Academy of Medicine, Singapore,  
Deputy Treasurer World Federation of Anaesthesiologists

Dr Rod N. Westhorpe, Vic – President, Australian Society of Anaesthetists

Dr Michael J. Hodgson, Tas – Vice President, Australian Society of Anaesthetists

Dr David M. Chamley, NZ – President, New Zealand Society of Anaesthetists

Dr Chris M. Bolton, Vic – Commonwealth Championships Bronze Medal for Fencing

## ADMISSION TO FELLOWSHIP BY EXAMINATION

### MARCH-OCTOBER 1998

|                       |            |     |                  |              |     |
|-----------------------|------------|-----|------------------|--------------|-----|
| Bruce Craig           | ANDERSON   | NZ  | John James       | MATHESON     | NSW |
| Dinah Jane            | BLUNT      | QLD | Richard James    | MAYNARD      | NSW |
| Charles David         | BROOKER    | NSW | Paul John        | McMAHON      | SA  |
| Mary Elizabeth        | BROOKER    | NZ  | Kaye Frances     | McMANUS      | QLD |
| Derek Raymond         | BROWELL    | VIC | Pamela Stephanie | MEYER        | NZ  |
| Robert Hugh Barclay   | BUCKLAND   | NSW | Daniel Vincent   | MULLANY      | QLD |
| Alison Ruth           | CORBETT    | WA  | Anne Elspeth     | NICHOLSON    | VIC |
| Kelly Elizabeth       | DILWORTH   | WA  | Kevin Daniel     | O'CONNOR     | NZ  |
| Edward Ward Te Kanawa | DOUGLAS    | NZ  | Anthony Paul     | PADLEY       | NSW |
| Fiona Bronwyn         | DYALL      | WA  | Andrew Nathan    | PURCELL      | VIC |
| Bronwen Elaine        | EVANS      | SA  | Gerrit           | REIMERS      | NSW |
| Christopher John      | FISHER     | NSW | Gary Owen        | ROOKE        | QLD |
| Peter James           | HARMS      | QLD | David John       | SIMMONS      | NSW |
| Richard James Dunbar  | HARRIS     | SA  | Varjeet          | SINGH        | NT  |
| Catherine Anne        | HAWKE      | VIC | Julie Ann        | SMITH        | NSW |
| Drew                  | HEFFERNAN  | VIC | Karen Maree      | SMITH        | NZ  |
| Kwok Ming             | HO         | HKG | Wayne Michael    | SOROUR       | QLD |
| Ian Robert            | HOGARTH    | VIC | Rajivini Mohana  | THIRUCHELVAM | NZ  |
| Tania Jane            | HUNTER     | NZ  | Hugh Michael     | THOMAS       | TAS |
| John Bapoo Kottail    | JACOB      | SA  | Richard Iestyn   | THOMAS       | QLD |
| Steven Garth          | KATZ       | QLD | Thavarajah       | VISVANATHAN  | SA  |
| Haimee                | KIM        | SA  | Frederick Marc   | WALDEN       | QLD |
| Theresa               | LI         | HKG | Wilhelm Caspar   | WALDOW       | SA  |
| Elizabeth Ann         | MACKSON    | NSW | Angela Cameron   | WILKINS      | SA  |
| Ross Duncan           | MACPHERSON | NSW | Deborah Jane     | WILSON       | WA  |
| Maroun George         | MALLAT     | NSW |                  |              |     |

## AWARD OF CERTIFICATE OF PAIN MANAGEMENT

Dr Charles Brooker (NSW) and Dr Gajinder Oberoi (SA)

# POLICY DOCUMENTS FOR REVIEW IN 1999

In line with College policy, the following Policy Documents are due for review in 1999:

- E3 *The Supervision of Trainees in Anaesthesia*  
(to be renumbered TE3)
- E7 *Secretarial Services to Departments of Anaesthesia*  
(to be renumbered TE7)
- E14 *Guidelines for the In-Training Assessment of Trainees in Anaesthesia*  
(to be renumbered TE14)
- T4 *Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT)*  
(to be renumbered PS33)
- P10 *The Handover of Responsibility During an Anaesthetic*  
(to be renumbered PS10)
- P11 *Management of Cardiopulmonary Bypass*  
(to be renumbered PS11)
- P16 *The Standards of Practice of a Specialist Anaesthetist*  
(to be renumbered PS16)
- P26 *Guidelines on Providing Information About Anaesthesia*  
(to be renumbered PS26)
- P27 *Standards of Practice for Major Extracorporeal Perfusion*  
(to be renumbered PS27)

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

# POSTGRADUATE EDUCATION ON THE INTERNET

## Introduction

The internet<sup>1</sup> has now grown to the point where it can no longer be ignored. Starting from humble beginnings as a research project for the United States Department of Defence (where only a few sites were linked), it has now grown to the point where the majority of houses in Australia have at least one person who accesses the 'net' on a regular basis. Until the end of 1993, access to this network of linked computers was limited to people with an attachment to an academic institution. Around that time, a number of enterprising people started allowing dial-in access to computers running the Unix operating system, but that required learning Unix commands.

If one took the time and effort to do this, a number of applications were available. There were separate applications that enabled browsing documents on remote computers, downloading free (public domain) software to one's local computer, on-line interactive 'chatting' (using the keyboard) with a colleague anywhere in the world, electronic mail, newsgroups, and even searching the entire network of computers for an individual word, phrase or document.

The next step was to develop tools that would enable those of us using personal computers and no knowledge of Unix, to access this network. A number of enterprising people in CERN (the central European nuclear physics research facility) started developing these tools, and the World Wide Web<sup>2</sup> was born. Since that time, a number of companies have

developed multifunctional utilities to access the efforts made by the thousands of volunteer contributors to the web. The most recent and best known have been Netscape Communicator and Microsoft Internet Explorer. Many others preceded them. Microsoft was a latecomer to the World Wide Web (hereafter called simply 'the web').

## Range of material available

It is not possible in this brief overview to give a comprehensive listing with full commentary on all the resources available to the anesthesiologist or intensivist interested in postgraduate education. One simple way is to use one of the web browsers mentioned above to search the web for key words such as 'intensive care'. *Note: each web search engine has its own syntax for search commands. Choose one and learn its command syntax first, then explore using others.*

## Mailing lists

Mailing lists enable one to read comments by other members of the list. The lists are generally oriented around a particular interest. In order to post a message to the group, one needs to be a member of the list. A list may be joined by sending e-mail to a designated address for each list. In some cases, the process is automatic, in others it requires manual intervention. Closed lists generally require manual intervention on the part of the ListOwner. Do not abuse the ListOwner if there is a problem. They generally manage the lists in their spare time, and receive no payment for their services.

<http://gasnet.med.yale.edu/maillist>

The world's best known and busiest anesthesiology mailing list. Best subscribed to in digest mode

[aic-l@gasbone.herston.uq.edu.au](mailto:aic-l@gasbone.herston.uq.edu.au)

The Australasian anaesthesiology and intensive care mailing list. Low traffic, notices of meetings and hazard alerts.

<http://ccm-l.med.edu/>

American critical care medicine mailing list

[outcome@gasbone.herston.uq.edu.au](mailto:outcome@gasbone.herston.uq.edu.au)

Specialised list for those interested in supporting the development of a Global Intensive Care Database. Contact [p.cumpston@mailbox.uq.edu.au](mailto:p.cumpston@mailbox.uq.edu.au) if interested

## Anesthesia and Intensive Care Web Sites

<http://groucho.med.yale.edu>

The GasNet (*highly recommended*). Includes many educational resources, including video and audio presentations and a list of meetings

<http://www.anzca.edu.au/>

The Australian and New Zealand College of Anaesthetists

<http://gasbone.herston.uq.edu.au/>

The Royal Brisbane Hospital/University of Queensland Site. Includes many educational resources, including video and audio presentations.

<http://anzics.herston.uq.edu.au/>

The Australian and New Zealand Intensive Care Society

<http://www.palmer.net.au/talks/Default.htm>

Dr Allan Palmer's web site of CME material

<http://www.sccm.org>

American Society of Critical Care Medicine

|   |  |
|---|--|
| <a href="http://pedscm.wustl.edu/ORG-MEET/SCCM-PEDS/SCCM_Pediatrics_Section.html">http://pedscm.wustl.edu/ORG-MEET/SCCM-PEDS/SCCM_Pediatrics_Section.html</a> | American Society of Critical Care Medicine Paediatric home page  |
| <a href="http://www.usyd.edu.au/su/anaes/anaes.html">http://www.usyd.edu.au/su/anaes/anaes.html</a>   | The Australasian Anaesthesia Web Site  |
| <a href="http://www.usyd.edu.au/su/anaes/VAT/VAT.html">http://www.usyd.edu.au/su/anaes/VAT/VAT.html</a>   | The Virtual Anaesthesia textbook ( <i>highly recommended</i> )   |
| <a href="http://www.invivo.net/bg/index2.html">http://www.invivo.net/bg/index2.html</a>   | IN-Vivo anaesthesia and critical care emergencies, medical images  |
| <a href="http://gasbone.herston.uq.edu.au/gasbone.html">http://gasbone.herston.uq.edu.au/gasbone.html</a>   | GASBONE - Anesthesia education on the internet   |
| <a href="http://www.cme.net.au">http://www.cme.net.au</a>   | CME-Net (a web site dedicated to the development of online CME for rural and remote medical practitioners) ( <i>highly recommended</i> )                                       |
| <a href="http://www.pain.com">http://www.pain.com</a>   | Worldwide Congress on pain   |
| <a href="http://biomednet.com">http://biomednet.com</a>   | BioMedNet – The Internet Community for Biological and Medical researchers with links to annotated medline (including full text and citations), access to on-line medical texts |
| <a href="http://www.ncbi.nlm.nih.gov/PubMed">http://www.ncbi.nlm.nih.gov/PubMed</a>   | Public access Medline searches   |
| <a href="http://www.manbit.com">http://www.manbit.com</a>   | This site features a modified Internet version of 'The Hypertextbook of Obstetric Anaesthesia', and the St George Hospital MCQ's for anaesthesia.                              |
| <a href="http://www.asa.org.au">http://www.asa.org.au</a>   | Australian Society of Anaesthetists Inc.   |
| <b>ftp archives</b>   |  |
| <a href="http://gasbone.herston.uq.edu.au/ftp">http://gasbone.herston.uq.edu.au/ftp</a>   | Shareware computer programs of interest to anaesthesia and intensive care  |
| <a href="ftp://anzics.herston.uq.edu.au:21">ftp://anzics.herston.uq.edu.au:21</a>   | ANZICS ftp site  |
| <a href="http://gasnet.med.yale.edu/software">http://gasnet.med.yale.edu/software</a>   | Fully Functional and Demonstration Software  |
| <b>electronic journals</b>  |  |
| <a href="http://gasbone.herston.uq.edu.au:8080/esia">http://gasbone.herston.uq.edu.au:8080/esia</a>   | Educational Synopses in Anesthesia and Intensive Care (Australian Mirror)  |
| <a href="http://www.aaic.net.au/home.html">http://www.aaic.net.au/home.html</a>   | Anaesthesia and Intensive Care   |
| <a href="http://www.macmcm.com/sccm/sccm.htm">http://www.macmcm.com/sccm/sccm.htm</a>   | Society of Critical Care Medicine 25th Educational and Scientific Symposium Highlights   |
| <a href="http://www.ispub.com/journals/ijeicm.htm">http://www.ispub.com/journals/ijeicm.htm</a>   | The Internet Journal of Emergency and Intensive Care Medicine  |

### Discussion Groups

The browsers mentioned in the introduction are capable of allowing users to monitor and participate in discussion groups. Those of relevance to anaesthesia and intensive care include:

- alt.med.equipment
- bionet.diagnostics
- bionet.diagnostics.prenatal
- bionet.neuroscience

A variation on this scheme is the establishment of electronic 'Bulletin Boards', where notices of interest may be posted and read on-line. An example is the ANZICS online critical care discussion group ([http://anzics.HERSTON.UQ.EDU.AU/Discussion/Discussion\\_welc.htm](http://anzics.HERSTON.UQ.EDU.AU/Discussion/Discussion_welc.htm))

### Videoconferencing

Dr Allan Palmer and I broadcast the proceedings of the plenary session of the World Congress of Anesthesiology held in Sydney a few years ago. This was the very first time that a major medical conference was broadcast over the Internet. Since then, a number of lectures, seminars and conference proceedings have been broadcast in this way, and the

technology for doing this is improving all the time.

We originally used CuSeeme software, but a number of innovations to RealAudio and video have enabled real-time streaming of audio, video and multimedia presentations from a web page. (See <http://www.real.com>). This is an example of what may be developed for on-line postgraduate education.

### Telemedicine

There is an active telemedicine project for Intensive Care and rural medical practitioner support in Queensland. The contact e-mail address is [tardis@gasbone.herston.uq.edu.au](mailto:tardis@gasbone.herston.uq.edu.au). The purpose of this project is to develop partnerships across locations so that patient management may be optimised in real-time.

### Internet Relay Chat (IRC)

Interactive discussion can be managed on a one-to one basis, or can be set up in such a way as to allow large numbers of people to participate in an on-line interactive discussion on any topic. This can be done by joining an IRC server, and then setting up a chat room that people can attach to. The conversation is typed on the keyboard and appears on all computers attached to the chat room at the same time.

IRC servers are found in all countries participating in the internet, and anything typed is relayed to all those joined to the chat room. Specialised software exists to facilitate this process. The most popular being mIRC, published by Khaled Mardam-Bey (*khaled@mardam.demon.co.uk* – homepage at *http://www.mirc.co.uk/khaled*)

There are equivalent audio and video means of communication. References for these and a large number of other windows-based public domain software programs can be found by searching TUCOWS (*http://www.tucows.com/australia.html*)

#### Where now?

A number of people are trying to capitalize on the internet. The idea is that resources will be provided, and people pay to access those resources. This goes against the original tenet of the internet, which has developed as a world wide community of people providing resources in their own time, for others to share. In return, they ask only that others contribute to their efforts by donating time or expertise.

So, we can sit back and wait for others to provide postgraduate education resources, web sites, interactive discussions over the net and pay for the privilege of joining in, or we can all contribute to the efforts that have so far been made by a few individuals in anaesthesia and intensive care, and support them in their endeavours.

As the technology becomes simpler, as people grasp the implications of being able to hold videoconferences around the world using a few thousand dollars worth of personal computer equipment, I see formal and informal postgraduate education sessions being scheduled on a regular basis. I see the development of formal course material for Primary and Second part candidates in both anaesthesiology and intensive care, supported by the Colleges and government bodies.

It will be important, however, for those involved in such endeavours now to grasp the opportunity to understand the technology, and to use it themselves. Failing that, we will be reliant upon others to process our ideas, concepts and information, with their own agenda.

**PHILIP H.V. CUMPSTON**

(*p.cumpston@mailbox.uq.edu.au*)

Staff Specialist/Senior Clinical Lecturer

The Royal Brisbane Hospital/The University of Queensland

Internet

A worldwide network of thousands of computer networks, made up of millions of commercial, educational, government, and personal computers. The software running on those machines enables the

- 1 Internet to appear like an electronic city with virtual libraries, storefronts, business offices, art galleries, and so on.
- 2 World Wide Web  
The World Wide Web is a system for exploring the Internet by using hyperlinks. When you use a Web browser, the Web appears as a collection of text, pictures, sounds, and digital movies.



# THE INTERNET AND RURAL PRACTITIONER NEEDS

DARYL CATT

Chairman, Rural Special Interest Group

The Web has grown, developed and spread so Points of Presence (POP) are readily available in most, if not all centres – if not directly then by 1800- type telephone numbers.

Non-capital city ANZCA Fellows alone number 441 in Australia. Consequently significant numbers of Fellows are to some extent isolated from mainstream tertiary 'Centres of Excellence'. Great scope therefore exists to develop an inclusive communication system. The Web and the growing sophistication of software presentation systems make the Internet an obviously attractive medium for such a communication network.

Rural Fellows in isolated regions suffer from the vagaries of distance, cost and time problems when trying to maintain professional contact for CME purposes. Often a critical mass of local Fellows is lacking in rural and remote regions to make a viable local CME framework feasible. Discussion of common problems and the support it brings is hard when your local number is small.

When looking at the possible uses for these technologies we really are only limited by our understanding of the technological potential. As we get more experience with the technology more options will open up exponentially.

Options available for rural practitioners include narrow-cast (as against broadcast) of seminars/tutorials/conferences/lectures either directly or of digitized videotapes. Interactive virtual workshops are already underway in other disciplines.

This interactive format could easily become video-linked using inexpensive video cameras attached to PCs via a dedicated server. Morbidity and Mortality Meetings over extended regions could easily provide a Q/A involvement, which is difficult for the solo practitioner or for small clusters of Fellows.

Short interactive computer generated tutorials or learning packages which may be undertaken at leisure would be ideal, lets face it, none of us like to demonstrate our ignorance in public!

Importantly, this medium offers the diversity that is needed. We all learn at different rates and have different interests and needs. Variety is the key to enhanced learning.

This communication network has the capacity to serve all Fellows but particularly rural Fellows whose problems of professional isolation and distance with the consequent problems of cost and time simply will not go away.

The Rural SIG is developing various initiatives to address the needs of rural anaesthetists. These include seeking funding for the generation of pilot virtual CME modules on the Internet.

Input from Fellows is welcome – visit the ANZCA Website to view the Expressions of Interest submissions for Commonwealth Government Funding (in the Rural SIG Resources) and make any comments in the Rural SIG 'topic of discussion area' in the Web Group.

## COUNCIL 1998



*Rear: Drs Ian Rechtman, David Chamley (President NZSA), Di Khursandi, Michael Martyn, Prof. Michael Cousins, Drs Stewart Henderson, Wally Thompson, Assoc. Prof. Greg Knoblanche and Mrs Joan Sheales (Chief Executive Officer).*

*Front: Dr Rod Westhorpe (President ASA), Prof. John Gibbs, Drs Alan Duncan (Dean), Richard Walsh (President), Prof. Teik Oh (Vice President) and Dr Richard Willis.*

## HIGHLIGHTS OF OCTOBER 1998 COUNCIL MEETING:

### PROFESSIONAL

#### Policy Documents

The following Policy Documents were reviewed and approved:

TE16 Requirments for Multidisciplinary Pain Medicine Centres Offering Training in Pain Medicine.

PS14 Guidelines for the Conduct of Major Regional Analgesia in Obstetrics.

These Policy Documents are published in this Bulletin.

### PAIN MEDICINE

Council approved the Regulations for the Initial Board of the Faculty of Pain Medicine and, following the admission of Foundation Fellows, the Regulations governing the elected Board of the Faculty. These Regulations have now been forwarded to the Council of The Royal Australian and New Zealand College of Psychiatrists, the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons and the Australasian Faculty of Rehabilitation Medicine, RACP for approval and nomination of a representative of each College to the Board of the Faculty of Pain Medicine.

Council appointed the following Fellows as the six ANZCA representatives to the Initial Board:

Professor Michael Cousins, NSW

Dr David Jones, NZ

Dr Pam Macintyre, SA

Dr Roger Goucke, WA

Dr Terry Little, Vic

Dr Suellen Walker, NSW

The ANZCA Council member is Professor John Gibbs.

*Subsequently the Executive accepted the nominations of Dr Graham Rice, FRANZCP, Dr Milton Cohen, FRACP, M Leigh Atkinson, FRACS and Dr Ben Marosszeky, FACRM.*

#### **Acronym for Fellows of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists**

On the recommendation of the Joint Advisory Committee on Pain Management, Council agreed that the acronym for Fellows of the Faculty of Pain Medicine be FFPMANZCA.

#### **Current holders of the Certificate in Pain Management - Eligibility for Fellowship by Examination**

Council agreed that current holders of the Certificate in Pain Management will be eligible to present for the initial examination for Fellowship of the Faculty of Pain Medicine and resolved that:

- (i) Current holders of the Certificate in Pain Management be eligible to present for the initial examination in Pain Medicine provided they have remained in a multi-disciplinary pain centre in a substantial pain medicine practice for at least one year.
- (ii) Trainees enrolled in the Certificate in Pain Management in 1997 will be eligible to present for the initial examination provided they have remained in substantial pain medicine practice in a multi-disciplinary pain centre from completion of their year of training in 1998 up to the time of the first examination.

**EDUCATION**

- (iii) The review of Pain Certificate candidates' eligibility to present for the first examination will be undertaken by the Pain Medicine Committee and recommendations made to Council.

**Workshop on Trainee Supervision**

Dr Stuart Henderson, the College Education Officer, attended a Committee of Presidents of Medical Colleges Workshop in Melbourne on trainee supervision. Presentations were made from all Medical Colleges highlighting the difficulties experienced with regard to supervision of trainees. ANZCA Provisional Fellow, Dr Andrew Buettner gave an excellent presentation on supervision from a trainee's perspective.

**Director of Education**

The position of Director of Education was established and will be advertised. Council also resolved that an Education Unit be developed without delay.

**Younger Fellows Appointment to the Education Committee**

Following a recommendation from the Younger Fellows' Conference in 1997 with regard to greater involvement of Younger Fellows in College affairs, Council resolved that the 1999 Younger Fellows' Conference be requested to nominate a representative to join the Education Committee on a twelve month trial basis. This representative should be a Fellow of not more than three years standing.

**Undergraduate Teaching in Anaesthesia**

Following the survey of levels of undergraduate training in anaesthesia, Council resolved that:

- (i) ANZCA recommends a core curriculum and an elective curriculum in anaesthesia and related disciplines (such as Intensive Care and Pain Medicine) for undergraduate medical education.
- (ii) ANZCA recommends that the duration of the course of core and elective curricula be at least four weeks.
- (iii) ANZCA recommends that the core curriculum comprise practical clinical skills, principles of anaesthesia and peri-operative medicine and principles of critical care and pain medicine.
- (iv) ANZCA recommends that the elective curriculum comprise a choice of topics relevant to acute medicine, anaesthesia, intensive care and pain medicine; examples include anaesthesia techniques, multi-organ failure and cardiac and trauma life support.

These resolutions will be communicated to the various Australasian Medical Schools.

**Selection of Trainees**

Following consideration of the Brennan Report, Council passed the following resolutions with regard to the selection of College trainees:

- (1) **That employing institutions continue to select trainees using ANZCA's selection principles, criteria and procedures but each selection panel must include a representative of ANZCA.**

(2) **That a Statement of Principles for selecting Trainees be adopted as follows:**

The Mission Statement of the Australian and New Zealand College of Anaesthetists is:

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

The College strives to realize its mission through the advancement of education, professional standards, and the science and practice of anaesthesia, intensive care, and pain medicine. The following principles of selecting trainees for the College's vocational training programs are based on the commitment of the College to realize its mission.

- (i) That ANZCA supports a selection process that will result in enrolling the best possible candidates into the College's vocational training programs.
  - (ii) That the selection process is based on equal opportunity without prejudice, regardless of gender, race, religion, age, pregnancy, or other personal attributes if they do not impair the candidate's clinical performance.
  - (iii) That the selection process follows documented procedures, with candidates having access to published criteria on eligibility and selection, and to an avenue of appeal.
  - (iv) That the selection process is subject to on-going evaluation.
  - (v) That the selection process is an integral part of ANZCA's endeavour to produce the best possible specialists in anaesthesia, intensive care, and pain medicine.
- (3) **That the Eligibility Criteria for selecting trainees be adopted as follows:**

The Australian and New Zealand College of Anaesthetists considers as eligible candidates for selection into its vocational training programs, any medical practitioner:

- (i) Who is registrable with the medical licensing authority of the region in which accredited ANZCA training will be undertaken, *and*
  - (ii) Who has completed two years of general hospital training after graduation, according to ANZCA regulation 15.1.7, *and*
  - (iii) Who is free from alcohol or chemical abuse, *and*
  - (iv) Who is willing to comply with the rules and procedures of ANZCA.
- (4) **Selection Criteria**
- Details of the Recommended Criteria for Selection have been referred to the College Executive for approval.

**HOSPITAL  
ACCREDITATION  
COMMITTEE**

**Skills Laboratories**

Council resolved:

1. That institutions with anaesthesia simulators be encouraged to develop as anaesthesia skills laboratories
2. That the simulator centres collaborate with their surgical and other local colleagues in developing skills laboratories.

**CONTINUING  
EDUCATION AND  
QUALITY ASSURANCE**

**Duration of Training in Single Hospital**

Council resolved that the Hospital Accreditation Committee inform hospitals that upon re-inspection, approval will be given for a maximum training period of three years in any one institution in Years 1-4.

**Credentialling Committees - ANZCA Representatives**

Council resolved that College Office Holders do not participate in consideration of appointees to their own hospitals while there may be a conflict with College Regulations and policies.

**Accreditation of Hospitals rather than Posts**

The Hospital Accreditation Committee was requested to examine the principle of accreditation of hospitals as opposed to posts, as referred to in the Brennan Report.

**1999 ASM**

Mr Graham Richardson will deliver the oration during the College Ceremony of the 1999 ASM in Adelaide.

**National Anaesthesia Day 1999**

Perioperative Medicine is the agreed topic for National Anaesthesia Day 1999. Preparation for the Day (7 July 1999) is now underway.

**Maintenance of Professional Standards Program**

The revised Maintenance of Professional Standards Program was approved and will commence from 1st January 1999. The program will be available in both a manual and electronic form for the convenience of Fellows. Currently, floppy discs encompassing the program are being developed and Fellows will be requested to identify whether they wish to continue using the manual form or utilise the computerised version. The new Program is published elsewhere in this Bulletin.

**Access to College Website**

Council agreed that non-Fellows registered with the College for the MOPS Program be granted access to the College restricted website.

**1999 Younger Fellows Conference**

Professor Teik Oh, Vice President, was nominated as the Councillor-in-Residence to the forthcoming Younger Fellows' Conference. The theme of this meeting is 'Striving for a Job Well Done'.

**Welfare of Anaesthetists Special Interest Group**

Council established the Welfare of Anaesthetists Special Interest Group. This is the first Special Interest Group to be established under the combined Constitution with the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

**INTERNAL AFFAIRS****College Bulletin**

Council supported the principle of recognising, in the College Bulletin, Fellows additional academic qualifications from recognised institutions.

**Information Technology Committee**

Council resolved to rename the current Computer Committee to Information Technology Committee. The responsibilities of this Committee will include:

- (i) advising Council on matters relating to the management of electronic information by the College
- (ii) advising Council on the purchase and maintenance of electronic information equipment for the College
- (iii) providing a forum for coordinating ongoing planning and implementation of information technology
- (iv) such other relevant matters which Council may determine

**Rural Health Support, Education and Training Program Funding*****Rural Anaesthetic Recruitment Service***

The College has made a submission for Commonwealth Government funds to establish a Rural Anaesthetic Recruitment Service to provide a centralised service for the provision of long and short-term anaesthetic services in Rural Australia. This service is a project of the College in liaison with the Australian Society of Anaesthetists.

***Virtual Anaesthetic Workshops for Rural and Remote Anaesthetists***

A consortium comprising the Australian and New Zealand College of Anaesthetists and The Royal Australian College of General Practitioners, with Med-E-Serv as project consultants, have lodged an expression of interest for Commonwealth Government funding to develop a pilot program of interactive electronically based distance learning packages aimed at rural and remote anaesthetists.

**Invitation to Regional Committee Chairmen to attend Council**

Council agreed to invite two Regional Committee Chairmen to Council, on a rotational basis, for a two-year trial period. It is anticipated that such participation will assist regions in the understanding of Council deliberations.

**Regional Committee Annual Reports**

In an endeavour to establish a structured annual report for publication in the Bulletin, a template has been approved and distributed to the Regions for future utilisation.

**Staff Nomenclature**

Following a review of the staff structures by independent consultants, the nomenclature of staff has been revised and reclassified to reflect their duties and responsibilities. In particular, the Registrar is now the Chief Executive Officer of the College. A list of staff and their titles is published in this Bulletin.

**New Zealand Regional Committee Chairman's Attendance at Council**

Dr Alan Merry attended the meeting to discuss matters relating to College activities in New Zealand. In particular, the following issues were considered: GST, payment of fees and Fellows' subscriptions in New Zealand, the Council of Medical Colleges in New Zealand, the New Zealand Healthcare Procedures Assessment Committee (NZHPAC) Perioperative Deaths Survey (PODS) and the assessment of overseas trained doctors.

**RESEARCH**

**1999 Research Awards**

Nineteen applications were received, totalling \$686,543 with \$250,000 available for allocation. All applications were considered by the Research Committee according to the guidelines applied by the NH&MRC. Each application was reviewed by three to four external Reviewers with recognised expertise in the area of the project. The Research Committee then evaluated all Reviewers comments and Applicant's comments on their Reviewers Written Reports, and applications were ranked accordingly.

Details of the awards for 1999 are published in this Bulletin.

**The Harry Daly Research Fellowship for 1999**

The Harry Daly Research Fellowship for 1999 was awarded to Dr David Scott, Victoria, for his project 'Spinal application of  $\omega$ -conotoxin GVIA in modulation of hyperalgesia and neuropathic pain'

**The Florence Marjorie Hughes Research Award**

The Florence Marjorie Hughes Research Award was awarded to Dr Mark Fajgman, Victoria, for his project 'Should pregnant patients have open or laparoscopic surgery? Effect of laparoscopy on fetal well being'.

**Lennard Travers Professor**

The Lennard Travers Professor for 1999 is Dr Guy L. Ludbrook, South Australia, who will pursue neuropharmacological research.

**Academic Anaesthesia Enhancement Grant**

On the unanimous recommendation of the Reviewers, this Grant was not awarded for 1998.

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

**Under Regulation 6.3.1(b)**

- (i) Dr F E Muller, New Zealand
- (ii) Dr Karla Karel, Victoria

**Under Article 22**

- (i) Professor G. Graham, NSW

**ELECTION TO FELLOWSHIP**

**FINANCE**

Following consideration of the budget for 2000, Council set College Fees as follows:

|  |  |
|--|--|
| <b>Annual Subscription for 2000</b>                          | A\$990   |
| <b>Examination Entry Fee for 1999</b>                        | A\$1900  |
| <b>Register of Training Fee for 1999</b>                     | A\$950   |
| (for all trainees)   |  |
| <b>Annual Training Fee for 1999:</b>                         |  |
| (a) Australia  | A\$925   |
| (b) New Zealand  | NZ\$925 +GST   |
| (c) Singapore and Malaysia                                   | \$925 (local currency converted into Australian dollars) |
| <b>Fee for Non Fellows participation in the MOPS Program</b> | A\$300 per year  |
| <b>Occupational Training Visa Fee</b>                        | \$75   |
| <b>Daily Living Allowance for 1999</b>                       | \$230  |

Paid for overnight stay on College Business



# PRIMARY FELLOWSHIP EXAMINATION

## AUGUST/SEPTEMBER 1998

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

The Viva Examination was held at College Headquarters in Melbourne.

Successful candidates were:

|                     |     |                             |     |                       |     |
|---------------------|-----|-----------------------------|-----|-----------------------|-----|
| Kevin D Arthur      | NZ  | Maria Hondronicola          | NSW | Michelle K Olsen      | QLD |
| Gregory W Baker     | NZ  | Lisa J Horrell              | NZ  | Ranjan C Perera       | NSW |
| Joanne M Berkahn    | NZ  | Christine A Huang           | NSW | Anne Rasmussen        | SA  |
| Catherine G Bernard | NSW | Hui Ki-Ling                 | HKG | Michael C Reade       | NSW |
| Suzanne R Bertrand  | WA  | Justin J Imrie              | NZ  | Jamie D Salter        | WA  |
| Roslyn O Breadsell  | QLD | Mike Lambros                | NSW | Christopher W Smit    | NZ  |
| Michael J Bremner   | WA  | Bernard H S Lee             | WA  | Robert H Solly        | VIC |
| Mark J Caporn       | QLD | Keat C Lee                  | NZ  | Boudewijn B Stolk     | NZ  |
| Richard W C Chin    | NSW | Lee Maurice Kong Lim        | NZ  | Minh D Tran           | NSW |
| Yien L Chin         | WA  | Lee Mei Ling                | NZ  | Geoffrey M Tweeddale  | NSW |
| Brian S Cowie       | VIC | David T H Lim               | HKG | Deborah S B Watson    | NZ  |
| Adriana Davis       | NSW | Frederick W Lombard         | NZ  | Paul N Wieland        | NZ  |
| Cyrus I Desouza     | NSW | Neil P McKinley             | QLD | Angel O K Wong        | HKG |
| Siobhan A Dobell    | VIC | Martin J McNamara           | QLD | Carolyn M Wood        | SA  |
| Richard S Emmett    | SA  | Chinthamuneedi Meher prasad | SA  | James D Woodfine      | NZ  |
| John G Faris        | NZ  | Jennifer M Morgan           | VIC | Tasoula Zafiroopoulos | VIC |
| Nadia J Forbes      | NZ  | Danielle D E Moses          | QLD | Amir R Zimmermann     | NZ  |
| Jonathan M Graham   | VIC | Priya Nair                  | NSW |                       |     |
| Robert A G Gray     | QLD | Chiu B Oh                   | VIC |                       |     |

## EXAMINATION PRIZE WINNERS

The **Renton Prize** for the year ended 31st December 1998 was awarded to

**Dr Brian S. Cowie (Vic).**

The **Cecil Gray Prize Winner** for the August/September 1998 Examination was awarded to

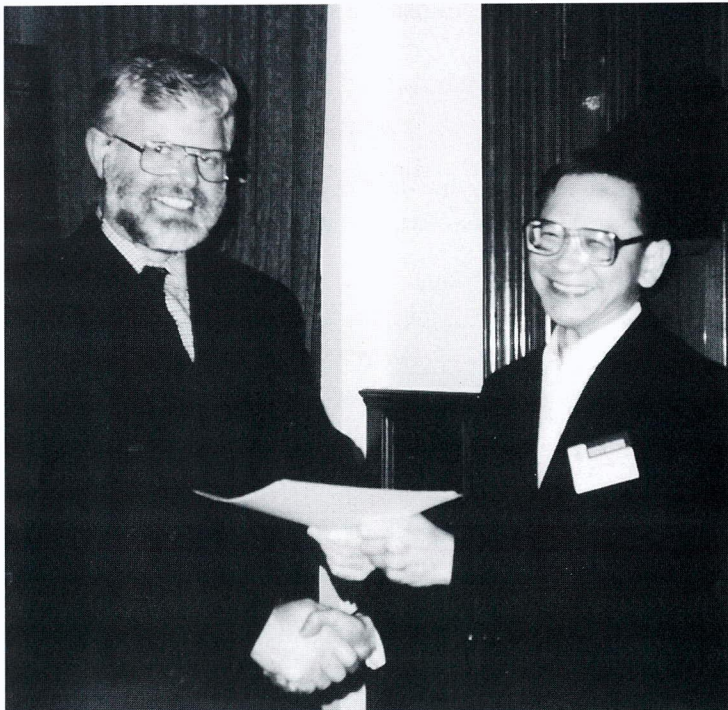
**Dr Hugh W. Douglas (SA).**

## COURT OF EXAMINERS – SEPTEMBER 1998 PRIMARY EXAMINATION



*Front Row: Drs Peter Kam, Gill Bishop, Renald Portelli, Noel Roberts.*

*Back Row: Prof. Duncan Blake, Drs Tony Quail (Chairman), Harry Prevedoros, David Cottee.*



*Retiring Examiner, Dr Peter Kam (right) being acknowledged by Chairman of Primary Examination, Dr Tony Quail.*

# FINAL FELLOWSHIP EXAMINATION

## (ANAESTHESIA)

### AUGUST/SEPTEMBER 1998

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

The Viva Examination in anaesthesia and medicine was held at Royal North Shore Hospital, Sydney.

Successful candidates were:

|                       |     |                         |       |                        |        |
|-----------------------|-----|-------------------------|-------|------------------------|--------|
| Amjed Aziz            | NSW | Gary P Henderson        | NSW   | Lynne Rainey           | SA     |
| Amanda Baric          | VIC | Malcolm N Hogg          | VIC   | Dayalan Ramasamy       | VIC    |
| Pasquale Belperio     | SA  | Peter W Howe            | VIC   | Frank G P Raymond      | VIC    |
| Christian H Bohringer | NSW | Khoo En Szee            | M'SIA | Alan Rubinstein        | NSW    |
| Michael A Boquest     | VIC | Koo Chi Hung            | HKG   | Richard J Scolaro      | WA     |
| John R Bradshaw       | NSW | Mark Y H Lai            | QLD   | Ann U L See            | NSW    |
| Bernadette T Burke    | QLD | Lam Tung-ching, Doris   | HKG   | Fiona C Sharp          | WA     |
| Darren J Burns        | SA  | Peter J Lane            | TAS   | Craig A Smith          | WA     |
| Adrian G Cain         | VIC | Bassanio C W Law        | HKG   | Jeffrey Suen Cheng Hwa | S'PORE |
| Anne M H Chan         | HKG | Loh Teik-Beng, Benjamin | QLD   | Raymond B K Tam        | VIC    |
| Michael J Davis       | NSW | Michael R Lorimer       | NZ    | Jane M Thomas          | NZ     |
| Guiseppe Di Bartolo   | NZ  | John Z Malczewski       | QLD   | Gerald R Turner        | TAS    |
| Hugh W Douglas        | SA  | Graham P Mapp           | QLD   | Elli Tutungi           | VIC    |
| Nicholas J Eblen      | SA  | Paul P McConkey         | NSW   | Jeremy J Wallace       | TAS    |
| Mark K Egan           | NSW | John E McGann           | NZ    | Timothy G Webb         | VIC    |
| Ginette Falcone       | VIC | Yvette S McKellar       | QLD   | Linda C Wells          | QLD    |
| Stephen A Ford        | NSW | Gary A McKenzie         | VIC   | Monique F Wells        | QLD    |
| Michael J Fredrickson | NZ  | Fiona McWhinnie         | QLD   | John R Whittle         | TAS    |
| Jean-Marie D G Fricot | NSW | Timothy J B O'Brien     | QLD   | Gerard P Willemsen     | NZ     |
| Andrew I Gardner      | WA  | Lena B L Ong            | SA    | Penny Wilton           | QLD    |
| Ramin Gharbi          | WA  | Greta M Palmer          | VIC   | Paul J Wrigley         | QLD    |
| Paul V Goonan         | NSW | Brett A Pearce          | VIC   | Jacqueline C C M Yap   | HKG    |
| Bruce H Graham        | NSW | Karen Pedersen          | NZ    | Patricia Yeo           | HKG    |
| Kim N Gray            | NSW | Angela Playoust         | NSW   | Yeo Khee Sim June      | HKG    |
| Emma L Halliday       | NSW | Laurence B Y C Poon     | VIC   | Sarah R Young          | NSW    |

## FINAL EXAMINATION COURT - SEPTEMBER 1998

*Front Row: Drs Michele Joseph, Michael Jones, Tim Costello, Penny Briscoe, Andy Pybus, Maggie Bailey, Glenda Rudkin, Roman Kluger, Ed Loughman (Chairman), Judy Branch, David Scott.*

*Back Row: Drs Tony Weeks, Peter Hales, Prof. Tony Gin, Drs Chris Johnson, Graham Sharpe, Frank Maccioni, Sandra Taylor, Peter Gibson, Greg Purcell, Peter Moran, David Sage, Patrick Farrell, Doug Rigg, Pam Macintyre.*



# FACULTY OF PAIN MEDICINE

## BACKGROUND

In the August 1998 ANZCA Bulletin, it was announced that the ANZCA Pain Medicine Committee and the Joint Advisory Committee on Pain Medicine (JACPM) of the Specialist Medical Colleges, had recommended to ANZCA Council that a Faculty of Pain Medicine be developed. This followed two and a half years experience of ANZCA's 'Certificate of Pain Management', and numerous meetings of the ANZCA Pain Medicine Committee and the JACPM. The JACPM comprises representatives from: The Royal Australasian College of Physicians, The Royal Australasian College of Surgeons, The Royal Australian and New Zealand College of Psychiatrists and The Australasian Faculty of Rehabilitation Medicine of the RACP. The agreement of these specialty bodies to run a joint training program, examination and specialist qualification represents an unique event in medicine in Australia and New Zealand. This is very much in keeping with the way Pain Medicine is practised and is undoubtedly in the best interests of high standards of patient care.

## UPDATE SINCE AUGUST 1998

The ANZCA Pain Committee and the JACPM held further meetings on the 3rd August and on 1st October, 1998. At the most recent meeting on 1st October, the following were the highlights:

- Draft Regulations for the Faculty of Pain Medicine were recommended for approval by ANZCA Council.
- Required training may include:
  - one year of relevant experience during the course of vocational specialty training. (TY 1-4 for ANZCA, or equivalent for other Colleges)
  - one further year of training in an approved multidisciplinary pain centre during the fifth year of training for FANZCA, or at an equivalent stage of training for other specialist colleges.

It was recommended that during the first years of operation of the training program, due consideration would be given by the Censor to application by trainees for approval of prior experience during TY 1-4 training.

- The Regulations also state candidates for the Diploma will be required to:

- successfully complete the Faculty examination and
- meet other training requirements as specified in the Regulations
- hold or complete the Fellowship of ANZCA or participating Colleges or Faculty.
- The Regulations describe the requirements for **summative assessment** which include a logbook over a period of 18 months and a treatise comprising four case presentations, two of which are expanded to the level of a mini-review as described in ANZCA Policy Document TE15.
- The Regulations describe the examination as:
  - A written examination of 2.5 hours duration, comprising 15 short answer questions. The candidate must answer eight questions.
  - A long case history including an hour for patient examination and history taking, 30 minutes preparation time and a 40 minute oral.
  - A series of case based interviews including patients with acute, chronic and cancer pain ('short cases').
  - A viva voce examination.
- The Regulations specify that holders of the **Certificate in Pain Management** of the Australian and New Zealand College of Anaesthetists may present for the examination provided they have remained in a multidisciplinary pain centre in substantial pain management practice for at least one year. Trainees enrolled in the Certificate in Pain Management during 1998 will be eligible to present for the examination provided they have remained in substantial practice in a multidisciplinary pain centre from completion of the year of training in 1998 up to the time of the examination.
- It was recommended that ANZCA Fellows playing a leadership role in acute pain **management programs** should be strongly involved in the development of the examination and training program for the Fellowship examination. Such individuals should receive appropriate recognition for their contributions to the development of Pain Medicine. There should be strong encouragement for the integration of acute pain programs into multidisciplinary pain centres.

- It was recommended that **paediatric pain medicine** should receive strong support for development within the new Faculty of Pain Medicine. There should be encouragement to link paediatric pain services to nearby adult pain centres with the aim of approving a rotational training program. Individuals playing a prominent role in the treatment of paediatric pain should be involved in the development of the training and examination process for the Fellowship in Pain Medicine.

**The ANZCA Council Meeting of 2nd October, 1998** took the following important steps in the development of the Faculty of Pain Medicine:

- Regulations for the initial Board of Faculty and for the election and operation of subsequent Boards of Faculty were approved.
- These Regulations were forwarded to the Councils of the participating Colleges and Faculty for approval.
- ANZCA Council appointed the six ANZCA Fellows, involved in the practice of Pain Medicine, to the initial Board of the Faculty of Pain Medicine:
  - ◆ Professor M. J. Cousins (Founding President, Australian Pain Society; Past President International Association for the Study of Pain)
  - ◆ Dr Roger Goucke (WA) (Vice President, Australian Pain Society)
  - ◆ Dr David Jones (NZ) (Former President and Councillor, New Zealand Pain Society)
  - ◆ Dr Terence Little (VIC) (Former Victoria Councillor, Australian Pain Society)
  - ◆ Dr Pam Macintyre (SA) (ANZCA Acute Pain SIG)
  - ◆ Dr Suellen Walker (NSW) (Specialist in Paediatric Pain Medicine and holder of ANZCA Certificate in Pain Management)
- Professor John Gibbs (Qld), ANZCA Council Representative to the Faculty Board
- The President of ANZCA Council and the Chairman of the JACPM wrote to the Presidents of the participating Colleges and Faculty requesting the nomination of one member each for appointment by ANZCA Council to the initial Board of Faculty.

It is anticipated that these four remaining Board Members, representing the participating Colleges, will be appointed to the Board by early November, 1998 and that the Board will then be in a position to meet for the first time.

- ANZCA Council approved the revised version of TE16 'Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine'. This document had been forwarded to ANZCA Regional Committees and the Acute Pain SIG for their comments. Following the receipt of comments, modifications were made to the document and these were communicated to Regional Committee Chairmen. In all cases the modifications met with approval. As noted in the accompanying advertisement, TE16 will be used to assess applications for Foundation Diplomates in Pain Medicine.

In summary the immediate points of relevance to those with an interest in Pain Medicine are:

1. There is only one opportunity for application for induction as a Foundation Diplomate in the Faculty of Pain Medicine. Applications must be received no later than 28th February 1999. There will be no further call for induction as Foundation Diplomates.
2. The new Regulations provide for election to Fellowship in the Faculty of Pain Medicine of individuals who have made outstanding contributions to the field of Pain Medicine but may not necessarily meet all of the criteria for induction as a Foundation Diplomate. It is anticipated that individuals in this category will be considered shortly after the induction of Foundation Diplomates.
3. Applications are now invited from individuals with substantial experience in multidisciplinary pain medicine for consideration for appointment to an Examinations Committee and/or appointment as Examiners. The closing date for applications is 28th February 1999.
4. The initial examination for Fellowship of the Faculty of Pain Medicine will be held in November, 1999.

**MICHAEL J. COUSINS**

Chairman, ANZCA Pain Medicine Committee  
Chairman, Joint Advisory Committee on Pain Medicine

# OVERVIEW OF PAIN MANAGEMENT CERTIFICATE

## ASSESSORS' REPORTS

### General

Directors of Centres, and candidates, should ensure that they have current versions of:

- College Policy Document TE15 *Guidelines for Trainees and Departments Seeking College Approval of Posts for the Certificate in Pain Management*
- College Policy Document TE16 (1998) *Requirements For Multidisciplinary Pain Centres Offering Training in Pain Medicine*
- Explanatory notes for the Completion of the Pain Management Logbook (ANZCA 1998)
- Explanatory notes for the Completion of the Pain Management Treatise (ANZCA 1998)

### Specific Comments on Treatise and Case Record Assessments

A number of candidates have submitted outstanding Case Records (Log Books) and Treatises. Examples of these are available to Directors of ANZCA approved Pain Centres. Directors are encouraged to request access to this material if any doubt exists about the format and standard required. Such material must be treated as confidential to the Director and must be returned promptly to ANZCA.

Some of the shortcomings which seem to recur include:

- broad ranging lack of adherence to the requirements clearly outlined in the documents cited above.
- **In Log Books:**
  - failure to demonstrate **continuity of care** in the required **minimum** of 10% of patients in *each* category (acute, chronic, cancer).
  - failure to demonstrate direct involvement with other specialist disciplines and with the referring practitioner.
  - failure to provide clear documentation of diagnoses or problems and treatments provided.
  - in the acute pain category, failure to log a mix of postoperative, post-trauma, acute exacerbations of chronic non-cancer and cancer pain, acute presentations of medical conditions; although obstetric analgesia is a valuable component of this category, it should not constitute more than 10%.

*Note:* It is now necessary for the Director of the Centre to sign off on Log Books at the end of each quarter year of training.

### • In Treatises

- failure to identify which two of the four case reports and discussions are presented as 'mini-reviews'.
- in the 'mini-reviews', failure to accurately analyse the literature, including pertinent up-to-date references.
- failure to demonstrate that the patients received an assessment of the multidimensional aspects of their pain and that the candidate understands the multidisciplinary/interdisciplinary approach to diagnosis and treatment of pain problems.
- in some treatises too much emphasis was placed on presenting only cases involving nerve block procedures and discussing technical aspects of the block and its outcome.
- failure to use pain terms and diagnoses from the IASP Taxonomy.

*Note:* Case reports are now required to include a comprehensive pain history (see 'Guide to Taking a Pain History' – ANZCA 1998).

In **summary**, the majority of candidates have handled the requirements for Log Books and Treatises very well. Those who have experienced problems have usually failed to adequately consult the relevant ANZCA Guidelines material. Also, in some cases, there has not been sufficient periodic discussion with the Director of the Centre. Candidates in Training for Pain Medicine are now also under the overall supervision of the Supervisor of Anaesthetic Training. Directors of Centres receive a detailed document outlining their responsibilities ('Guidelines for Directors of Pain Units').

MICHAEL J. COUSINS  
Chairman  
Pain Medicine Committee

## ACHS CLINICAL SURVEYORS

The Australian Council on Healthcare Standards is seeking nominations of new clinical surveyors for its Australian hospital evaluation and accreditation program.

ACHS Surveyors must be an evaluator and an educator, and supportive of the mission of the ACHS in promotion of quality health care. Acting as ambassadors for the ACHS Council, surveyors offer consultative advice to help identify and overcome existing quality related difficulties. They also offer informal on-site education to help prevent problems developing and assist the organisation to continuously improve its performance.

To ensure their advice and evaluations are pertinent, surveyors must be able to evaluate and offer comment on all functions of ACHS standards, and also act as a sounding board and active work partner to colleague surveyors.

Surveyors are selected in accordance with five key criteria, each of which has sub-criteria:

1. A commitment to, and understanding of, the philosophy of the Australian Council on Healthcare Standards.
2. Has been responsible for preparing a hospital/department/health facility for accreditation within the past five years.
3. Demonstration of a range of human relation skills.
4. Experienced health service manager with recent broad experience in health care of at least five years duration.

5. Medical Clinicians are to be Clinical Specialists of consultant status, however styled. Visiting Medical Specialist Staff or Staff Specialist with Fellowship status who have held their specialist appointment for at least two years.

Each application, submitted on the form available from the ACHS, is considered and interviews conducted periodically in each State. Further to the base criteria, surveyor applicants are expected to demonstrate competency in the following areas:

- Knowledge of the aims and philosophies of the ACHS
- Ability to work as a member of a team
- Communication skills (written and verbal)
- Time management skills
- Computer skills

Candidates successful in gaining appointment are invited to attend a Surveyor Training Workshop and to participate as an observer during a survey following their training.

Further information on the roles, responsibilities and duties of ACHS Surveyors, including application documentation, can be obtained from:

The Australian Council on Healthcare Standards  
Level 5, 70 Phillip Street Sydney NSW 2000  
Telephone: (02) 9251 7400

Facsimile: (02) 9251 7477

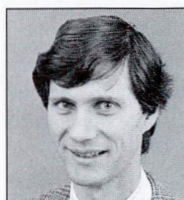
Email: [achs@achs.org.au](mailto:achs@achs.org.au)

Internet: <http://www.achs.org.au>



## 1999 RESEARCH AWARDS

The following Grants, recommended by the Research Committee, were awarded by Council at the October 1998 meeting:



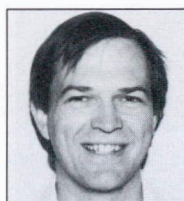
**Dr David Scott** (Vic)  
*Spinal application of  $\omega$ -conotoxin GVIA in modulation of hyperalgesia and neuropathic pain.* \$17,556



**Dr Suellen Walker** (NSW)  
*Role of neuropeptides in nerve injury-induced morphological changes of sensory neurons.* \$34,500



**Dr Mark Fajgman** (Vic)  
*Should pregnant patients have open or laparoscopic surgery? Effect of laparoscopy on fetal well being.* \$27,335



**Dr Charles Minto** (NSW)  
*Brain kinetics and dynamics of intravenous anaesthetic agents – effects of alfentanil.* \$38,000



**Dr Andrew Bersten** (SA)  
*The dynamics of surfactant proteins across the alveolocapillary barrier in ARDS.* \$28,000



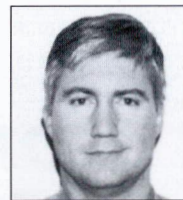
**Dr Robert Turner** (NSW)  
*A study of the effects of anaesthetic drugs on isolated uterine muscle contractility.* \$10,940



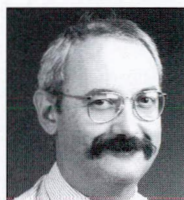
**Dr Michal Kluger** (New Zealand)  
*Stress and job satisfaction in Australian and New Zealand anaesthetic consultants and trainees.* \$ 8,330



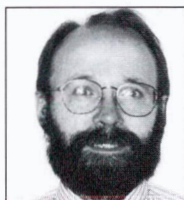
**Dr Haimee Kim** (NSW)  
*Central role of opioids in the haemodynamic response to hypovolaemia.* \$20,385  
**Research Scholar Grant in Aid**



**Dr Mark Priestley** (NSW)  
*Epidural-general anaesthesia versus general anaesthesia alone for coronary artery surgery.* \$30,000



**Assoc. Prof. Harry Owen** (SA)  
*Development of an information package for reducing preoperative anxiety in children.* \$20,000



**Dr Alexander Garden** (New Zealand)  
*Fatigue and anaesthetists' performance: subjective effects and simulation studies.* \$17,000  
**Research Scholar Grant in Aid**

The **Harry Daly Research Fellowship** was awarded to Dr David Scott for his project 'Spinal application of  $\omega$ -conotoxin GVIA in modulation of hyperalgesia and neuropathic pain'.

The **Florence Marjorie Hughes Research Award** was awarded to Dr Mark Fajgman for his project 'Should pregnant patients have open or laparoscopic surgery? Effect of laparoscopy on fetal well being'.

## AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

Report of the

**1998 YOUNGER FELLOWS CONFERENCE****NELSON BAY NSW****30 APRIL - 2 MAY 1998**

The 1998 Younger Fellows Conference was held over three days prior to the ANZCA Annual Scientific Meeting in Newcastle. Its objective was to explore some of the ethical challenges which currently face anaesthetists and intensivists. More specifically, it looked at the role of our specialities as gatekeepers of care for the seriously ill, and perhaps dying patient. Included were issues such as the impact of economic rationalisation on ethically based decisions, and the legal obligations encompassed within our duty of care, notably informed consent.

**DO WE ALL NEED TO BECOME EXPERTS ON ETHICS IN ORDER TO PRACTICE ETHICALLY ?**

Every healthcare worker regularly faces decisions which have an ethical basis. Often, these remain on an implicit level and, ultimately, there may be little difference between a decision which is made by 'instinct', and one which results from an academic ethics-based appraisal, which would consider issues in such terms as beneficence, malifcence autonomy and advocacy.

Most doctors, have attitudes which assists to deliver care which is ethically sound. However, it should not be assumed that we learn 'good judgement' by osmosis, and exercise it with compassion and objectivity at all times. Thus, it is better that we acquire these skills formally. In doing so we will be better able to understand and discuss ethical aspects of any patient's care.

Ethics is a complex discipline. Often, Fellows bemoan the incomprehensible level of its presentation in the literature. Hopefully by accepting it as relevant and important, we can become fluent with the language, and gain a working understanding of ethics.

**'BUYING-IN' TO ETHICS - THE ANAESTHETIC AND INTENSIVE CARE COMMUNITY****Intensivists**

The relevance of ethics is more readily acknowledged by Intensive Care Physicians because they are frequently

involved in situations with an explicit ethical component. Their central role in decision making is recognised within the hospital environment. Faced with this challenge of these responsibilities this group may expect, and be more motivated, to acquire ethical fluency.

**Anaesthetists**

As a group, they may be less likely to recognise the ethical basis of some situations and tend to have limited knowledge of specific ethical principles. They may be uncomfortable with their roles as patient advocates or gatekeepers of care and may be more likely to defer to opinions or decisions made by others. This may result in the initiation of anaesthesia before they are satisfied as to optimisation of risk. Strategies to deal with such issues may be difficult to undertake because of their obligation to be present with the patient continuously.

**IMPLEMENTING CHANGE WITHIN OUR COMMUNITY****The Role of the College and Faculty in Supporting Awareness of Ethics amongst Fellows**

There was strong affirmation for the role of the College and Faculty as commentators, and standard setters. Whilst several other groups have developed their own documents, there was support for the creation of guidelines which would be relevant to the Anaesthesia and Intensive Care, would reflect standards of practice and establish the 'duty of care'.

**Acquiring Expertise in Ethics**

The objectives would be twofold:

1. To assist Fellows to develop a good working understanding of ethics. This would include an ability to:
  - Identify ethical issues relevant to specific patients.
  - Articulate these in a language which is universally understood.
  - Measure the adequacy of patient care in terms of its ethical requirements.
  - Develop processes by which those requirements could be achieved.

2. Acquire skills in communication of ethical matters. This will contribute to ethical care at the ground level. These skills are necessary to deal effectively with patients and their families, and with colleagues.

Techniques might include:

Creation of a an uappropriate and regularly updated reading list which is made available to all Fellows via the College and Faculty.

Acquisition by the College library of documents and other publications relevant to specific ethical issues.

The discussion of specific 'problem-based' case presentations in an 'Ethics Report', similar to the 'Law Report' in the College Bulletin.

'Problem-based' discussions of ethical matters at CME meetings and at the Annual Scientific Meeting.

Encouragement of ethics as an area of special interest. The need for an 'in-house' expert could be considered within the preference criteria of appointments committees.

For trainees the possibilities could include:

Incorporation of ethics into the training curriculum. These might be state-based ethics seminars for trainees.

Communications training can be formally taught and a number of training centres are already available. Training which focuses on the resolution of realistic cases has been shown to be effective. Specifically, trainees need to acquire skills with interview techniques and debriefing after untoward events.

## **BUYING-IN' TO ETHICS IN THE BROADER HEALTHCARE COMMUNITY - INCREASING AWARENESS IN OTHER SPECIALITIES AND HEALTH PROFESSIONALS**

Often, the best established relationship of care of critically ill patients is that between surgeon and patient. Each member of the specialist team has an individual duty of care to the patient.

Patient and family perceptions of the standard of care received is an amalgamation of interactions between the patient or family members and all involved hospital staff. Increasingly, evidence reveals that issues related to communication predominate in these perceptions.

### **Initiatives Should Cross Medical Cultures**

Whilst initiatives on the part of the College and Faculty may contribute in the long term to an overall awareness, it may also cause an escalation of problems in the short term.

An increased awareness by anaesthetists, of their role as patient advocate may be unwelcome from surgeons, who may be perplexed by their 'sudden interest' in factors such as the morality of the procedure, or the need for consideration of surgical options.

Communication between specialities concerning individual and group duty of care should be fostered. This raises issues, such as the need for final arbitration, and the need for processes which are recognized by patients and their families as being reasonable. This should occur as a result of communication between the Colleges, as well as at an institutional and individual level. This process is likely to be accelerated by the harnessing of such communications media such as journalism. It could be taken on by the College Communications Committee.

## **ATTITUDES TO SPECIFIC ISSUES**

### **GATEKEEPING CARE:**

#### **The Anaesthetist as Perioperative Physician and Patient Advocate**

Attitudes of the Younger Fellows

Most have had some experience in which they have felt that a conflict of interest existed with colleagues regarding patient care.

In part, this conflict originates from ambiguity over the role of the Anaesthetist as perioperative physician and patient advocate. Anaesthetists see that their duty of care involves a risk-benefit analysis. Rather than confining this to the intraoperative period, it is generally considered by anaesthetists that this duty extends into the postoperative period, and that their commentary must relate to the risks presented to the patient by their perioperative condition – which is an amalgamation of the post surgery stress response, premonitory medical conditions and contributing factors relating to anaesthesia, like pain relief. This is perhaps not understood by all surgeons and physicians, who may believe that the 'anaesthesia risk' is an intraoperative phenomenon.

Anaesthetists may reserve judgement about the indications for surgery, despite the fact that their own risk-benefit assessment may reveal inconsistencies in care. These include such observations as:

The potential for morbidity resulting from surgery may greatly outweigh the expected benefits.

Surgery may be planned in a patient with a non-viable condition, which serves no purpose. That is, it is not curative, or palliative – and may in fact accelerate death as a result of associated morbidity.

Surgery may be planned where informed consent has not been obtained, despite a completed consent form. That is, the patient does not have an adequate understanding of the risk – benefit equation.

Surgery may be planned where a better option exists.

Surgery may be planned by a practitioner, whom the anaesthetist feels is not qualified to perform the particular procedure.

Conflict can also arise between anaesthetists and other colleagues, who include physicians in consultation, intensivists and nursing staff.

The following viewpoints were upheld:

It is acceptable that discrepancies may exist between the risk-benefit equations generated by the various health professionals who are involved in the care of individual patients. However, reasonable attempts should be made to resolve differences before informed consent is sought from the patient.

The anaesthetist has an individual duty of care to his or her patient. This should not be awarded a lower priority than those of others.

Management plans should be team based.

This duty of care does involve advocacy which may be an indication for contesting the proposed management, if the ethical requirements have not been managed appropriately.

Resolution of these differences should be approached through appropriate communication with the aim of presenting a cohesive management plan to the patient and their family.

In the event that conflict cannot be resolved, then a multidisciplinary case conference should be considered. This should address the indications to proceed, how aggressive the surgery should be, and what level of care is required postoperatively. There are benefits of an independent patient representative.

If final arbitration is sought, then the intensivist may be the most appropriate person to accept this role.

If conflict cannot be resolved then proof of a reasonable process is needed – with documentation of this in the patient's notes.

### **Suggestions for a Process of Implementation**

The College should present statements which indicate its views on the responsibilities of anaesthetists as patient advocates. Ideally, this would contain guidelines which articulate its expectations of these, both from a moral and legal perspective.

The success of such an initiative may be enhanced if the relevance is emphasised. This can be achieved by presenting issues which are linked to case-based problems.

The success of such an initiative may be enhanced if there is a cultural change in specialities with whom anaesthetists interface, so that there is no conflict about the appropriateness of advocacy on the part of the anaesthetist.

### **ACCOUNTABILITY:**

#### **The Impact of Economic rationalisation on Ethically-Based Decisions**

There was consensus that it is not the brief of individuals to make economically-based decisions on a case by case basis. It is appropriate for the cost of various treatment forms to be evaluated and rationalized in the light of available resources. This information can then be used as one aspect of data, along with others, like Evidenced Based Medicine, in order to prepare guidelines.

This process should occur at a department level, so that practitioners are protected from perceptions of economically-based decisions made about individual patients.

The Younger Fellows congratulated the Convenor Dr Peter Saul on the organization and preparation of the Scientific Programme. The level of expertise within the small group of councillors in residence ( Professor John Gibbs and Dr Neil Matthews), and guest facilitators ( Dr Ian Kerridge (medically qualified specialist in ethics) and Mr John McPhee ( specialist in health law)) was evident. The Anaesthesia and Intensive Care Department at John Hunter Hospital has a reputation for carrying ethics as an area of specialist interest, and it was very stimulating to be able to participate in the various discussions the group convened.

LEONIE WATTERSON

The full report of the Conference, which includes Appendices of Notes to Council for the creation of guidelines on Withdrawal of Life Sustaining Treatment (WLST) and Withholding Treatment, are available upon request from the Chief Executive Officer of the College.

# AUSTRALASIAN ANAESTHESIA 1998 LAUNCH



## Abbott Australasia Representatives

*Mr Mark Baker (Business Unit Manager), Mr Chris Chappell (National Sales Manager) with Dr Michael Jones (co-author), Dr Richard Walsh (College President), Mr Peter Lyons (Divisional Director for Hospital and Nutrition Division, Abbott Australasia) and Dr John Keneally (Editor).*



*Dr Siva Ekanayake (Canterbury Hospital) with Ms Jan Taylor (ANZCA Regional Administrative Officer)*



*Mr Chris Chappell with Mrs Vivienne Walsh.*



*Dr Stephen Gatt (Prince of Wales / Prince Henry / Sydney Children's Hospitals) and Dr Graham Searle (Auburn Hospital).*

## REGISTRARS' MEETING

Royal Pines Resort Queensland October 1998



*The Adjudicators and Registrars who presented for the Tess Carmond Prize Winner (centre) Dr Ian Cameron with Prof. Emeritus Tess Cramond.*

*More pictures page 86.*

# **SPECIAL INTEREST GROUPS**

## **ANNUAL REPORTS 1997-1998**

### **WELFARE OF ANAESTHETISTS**

This year has seen growth in the group's activities and our membership continues to increase. We have increasing liaison with other groups concerned with doctors' health, including the regional Doctors' Health Advisory Services (DHAS), the Association of Anaesthetists of Great Britain and Ireland, the American Society of Anesthesiologists and the Royal Australasian College of Surgeons Health Advisory Bureau.

Members of the Welfare Group regional networks are providing contacts and referral avenues for anaesthetists concerned about their own health and that of their colleagues.

#### **ANZCA**

At the October ANZCA Council meeting the Welfare Group's status as a Special Interest Group was ratified. The constitution was accepted, and ANZCA was designated as the parent secretariat provider.

We are indebted to ANZCA for their past support and look forward to continuing liaison as an SIG with College staff, especially Ms Helen Morris, who has been of invaluable help to the Group.

Plans for informative and educational material to be placed on the College website are well under way. The material will include the Action Plans, Substance Abuse Protocols, the Generic Seminar Program and a reading list.

#### **INTERIM EXECUTIVE**

In 1997 an interim Executive was formed. It consisted of Di Khursandi (Qld, Chair), John Gibbs (NZ, secretary), Genevieve Goulding (NSW), Rod Westhorpe (Vic), Lindy Roberts (WA), Phil Odgen (Tas), and Chris Acott (SA). Several teleconferences have been held, kindly provided by ANZCA. In 1998, John Gibbs relinquished the secretary's position and Leona Wilson (NZ) agreed to fill the post. At the next teleconference, the election of the inaugural SIG executive will be initiated.

#### **OTHER MEETINGS**

Sessions on welfare related issues were held at the Dunedin ASA/NZSA Meeting (fatigue and substance abuse). During the last year there have been three other business meetings.

### **WELFARE SEMINARS 1998**

Several regions have conducted seminars, recently titled 'Striving, Thriving and Surviving in Anaesthesia and Intensive Care'. Many registrars, their partners and interested specialists have attended the Seminars. Attendee numbers have ranged from 20 to 50. Information on regional resources is currently being compiled for distribution.

The feedback from the seminars continues to be very positive, resulting in continuing improvement of the program recommended in the generic seminar document. The regional CME Committees have been universally supportive.

We plan to hold a Seminar in each region at least bi-annually. A full day Seminar in Queensland was convened by Di Khursandi at the Holy Spirit Hospital in Brisbane on February 14.

On March 14-15 a weekend Seminar in Tasmania, convened by Phil Ogden, was held at Gowrie Park. Robert Singleton organised a half day Meeting in South Australia on March 21.

Western Australia held a second Seminar, organised by Drs Lindy Roberts and Chris Johnson, together with several registrars, at the Challenge Stadium on June 6.

On October 4, Mark Sandford invited Di Khursandi to speak about the Group to the registrars' meeting at the Sofitel in Melbourne.

Rob Burrell will convene a New Zealand seminar in Auckland in February 1999.

Matthew Swann has spoken on substance abuse at several Seminars. We are grateful to Abbott for sponsoring his attendance. Boots/Portex has also been generous, providing funds for Genevieve' Goulding's fares. We are grateful to Astra for sponsorship; the company has indicated an on-going commitment to sponsor future seminars.

#### **HOSPITAL ACTIVITIES**

Several members have given talks to departments, where welfare issues and information are discussed. Each department is encouraged to designate a senior member to be responsible for welfare issues at his/her hospital.

## MEDIA AND PUBLICATIONS

Several articles by Australian authors on welfare-related topics have appeared this year, in *Anaesthesia and Intensive Care*, the *Medical Journal of Australia*, the *British Medical Journal* and *Australasian Anaesthesia*.

Articles related to doctors' health have also appeared in the press, to which members of the group have had significant input.

## DOCTORS MENTAL HEALTH

A Doctors' Mental Health Implementation Committee has been formed in NSW, with the briefs of literature review, prevention and early detection policies, and advising various training and professional bodies with the development of assistance programs. It also reports to the NSW government.

## FUTURE PLANS

Plans for a Brochure proceed. There are negotiations in train with the American ASA to re-issue their booklet on chemical dependence. The excellent New Zealand DHAS book on doctors' health, 'In Sickness and in Health', edited by John O'Hagan and John Richards, is available to New Zealanders. Plans to distribute it to all Australian doctors have been considered.

A satellite meeting on training issues, in conjunction with the Medical Education SIG, is planned for the Adelaide ASM; a session in the meeting is also proposed. A session on 'Whistleblowing' is being considered for the Cairns NSC. The NSW branch of the ASA is planning a weekend meeting early in 1999 on Lifestyle and Practice management.

DIANA STRANGE KHURSANDI  
Interim Chair

# RURAL

The Rural SIG Executive met at the Newcastle 1998 ASM and has had several teleconferences over the last 12 months. Issues at these meetings revolve around problems central to rural practitioners including registrar rotations, recruitment/retention and CME.

In October Drs Khursandi, Moloney and Catt attended a review of the MOPS program at Ulimaroa. Dr Moloney presented the findings of Rural SIG member feedback. Many of the suggestions have been taken on board in the 'new MOPS'.

At the Newcastle ASM the Rural SIG was involved in two sessions, 'CME - what makes it work and what gets in the way' - a rural perspective by Daryl Catt. There was also workshop 'Paediatric Anaesthesia outside Tertiary Institutions' chaired by Frank Moloney and Rod Westhorpe.

Two current projects which the Rural SIG has sponsored are the Rural Anesthetic Recruitment Service (RARS) and a CME distance learning project. Both projects require Federal Government funding which is being sought.

RARS is aiming to encourage Fellows and trainees to consider a career in rural areas as well as assist rural Fellows with filling rural vacancies (both long and short term). It is a joint project with the Australian Society of Anaesthetists. The Recruitment Committee consists of Richard Walsh, Di Khursandi, Rod Westhorpe and Daryl Catt.

The CME project is a joint venture with the Royal Australian College of General Practitioners to develop 'Virtual Anaesthetic Workshops' with the assistance of the Internet Service Provider Med-E-Serv. Med-E-Serv has significant

experience in facilitating and running such workshops. The ANZCA Project Officers are Mike Martyn and Daryl Catt.

CME contributions from the Rural SIG members are occurring around Australia and New Zealand, particularly in Queensland.

Registrar rotations to rural areas are now occurring in every State which has been helped by a 'Highly Recommended' status from Council. Some areas are still problematic with some rotations having difficulties. The Albury rotation, for instance, is now from Sydney rather than from Melbourne. Overall, however, the rural rotations are successful. A message to Trainees - 'Have a go' - you only regret what you don't do, every experience is a learning experience!

1998 saw the establishment of improved communications to the SIG members with the establishment of an electronic discussion area on the College Homepage. It is planned for the Rural SIG to establish its own web page similar to other SIGs. The first Newsletter has been published. The Executive is hoping for member feedback to continue to make the SIG relevant to its members.

I would like to pay tribute to Ray Cook on his departure as ACT representative and welcome David Kinchington. Thanks to all Executive members for their involvement in 1998 and special thanks to Helen Morris for her splendid assistance and support. The Executive is keen to receive feedback from all Fellows regarding future projects and direction.

DARYL CATT  
Chairman



## CARDIOTHORACIC, VASCULAR AND PERFUSION

The Cardiothoracic, Vascular and Perfusion Special Interest Group is for the development of educational activities and communication amongst Fellows with interests in either cardiac, thoracic or vascular anaesthesia as well as in perfusion. During the past 12 months we have held our biennial conference and contributed to the ASM programme in Newcastle. There has been discussion on training and accreditation for Medical Perfusion and Perioperative Transoesophageal Echocardiography. Three new members have joined the Executive.

### ANZCA Annual Scientific Meeting, May 1998

The ASM was held in Newcastle this year. A session on Management of Heart Failure and Perioperative Anti-coagulation was conducted. Chaired by Dr Greg O'Sullivan, Recent Trends in Heart Failure Management were discussed by Dr Peter Macdonald, Staff Cardiologist, St. Vincent's Hospital, Sydney. This was followed by Dr Mark Hertzberg (Department of Haematology, Westmead Hospital) on 'The Patient on Anticoagulant Therapy for Surgery'. Thanks also to Dr Michele Joseph who helped with the organisation.

### Biennial CVP SIG Meeting, Warrina, October 1997

Last year the meeting was held in two parts. The Friday afternoon session was held in conjunction with the Australian and New Zealand Chapter of the International Society for Cardiovascular Surgery (SCS), at the Stamford Grand Hotel, Adelaide. This session focussed on aspects of vascular anaesthesia and surgery and was co-ordinated by Dr Alan Rainbird.

The rest of the meeting was held at Warrina Cove Resort and focussed on Pulmonary and Cardiac Issues on the Saturday and Perfusion and Echocardiography (including a trial exam) on the Sunday. Overall, there were 17 different presentations, involving 18 speakers and 5 chairpersons who were co-ordinated by Dr David Scott.

The theme of the meeting 'Issues in Cardiac Thoracic and Vascular Anaesthesia' was broad in order to give representation to a range of interest areas within the SIG. The SCS joint session had topics chosen in consultation with both groups, and speakers were nominated by both groups.

A book of abstracts was printed before the meeting, and was considered very worthwhile by the registrants.

Our target number of registrants was 80, and although we fell short of this number with 63, the purchase of eight trade display sites enabled us to come in on budget. One explanation for the registration falling below target was the large number of other meetings, including the ASA NSC

(Hobart) which were occurring in the weeks preceding and following our meeting.

The meeting was a very successful one based on feedback from the participants. The venue worked out well – with a social program organised by Ms Helen Morris and Dr Alan Rainbird. Liaison with the SCS was worthwhile and might again be considered for the future. The issue of scheduling the meeting to avoid conflicts with other conferences is difficult to resolve completely but will be considered when planning for next time.

### Future Meetings – Biennial CVP SIG Meeting, Sheraton Resort Noosa, Queensland, July 9-11, 1999

This meeting is at an advanced stage of organisation with the overall theme on 'Risks and Outcomes'. The focus will include cardiac and vascular anaesthesia, perfusion and echocardiography.

### CVP SIG Executive

The Executive of the CVP SIG has a representative from each state and New Zealand who is nominated by their respective Regional Committee. In the past 12 months, New Zealand representation has passed from Dr Alan Merry to Dr Leona Wilson, Tasmanian representation from Dr Peter Peres to Dr Malcolm Anderson and South Australian representation from Dr Alan Rainbird to Dr Lisa McEwin. The current members of the Executive are:

|                             |                   |
|-----------------------------|-------------------|
| Dr David Scott (Chairman)   | Victoria          |
| Assoc. Prof Peter Klineberg | New South Wales   |
| Dr John Murray              | Queensland        |
| Dr Ken Williams             | Western Australia |
| Dr Lisa McEwin              | South Australia   |
| Dr Malcolm Anderson         | Tasmania          |
| Dr Leona Wilson             | New Zealand       |

The Executive meets four to five times per year to deal with issues arising and meeting organization. A lot of work is performed by members of the Executive to ensure that the main roles of the group are undertaken effectively. The contribution over many years of Alan Rainbird, Alan Merry and Peter Peres to the Executive and the SIG has been greatly appreciated.

### CVP SIG General Meetings

Members can communicate to the SIG at any time through their Executive member or directly to the Chairman. A General Meeting was held during the Warrina Meeting and General Meetings are held during many of the College conferences to enable face-to-face discussion of issues amongst members.

### Transoesophageal Echocardiography

Guidelines for training, accreditation or certification for TOE, are currently being developed in order that discussion based on a proposed College Policy Document be possible at the July 1999 Noosa meeting. The main elements of this will be that training in TOE by anaesthetists should be formalized to the extent that documentation of case experience and supervised training should be recorded and that a process of case review should be continually undertaken. We must be prepared to defend the quality of our practice to both ourselves and outside scrutiny. The establishment of a Certification Examination in Perioperative TOE by the Society of Cardiovascular Anesthesiologists and the American Society of Echocardiography has provided an external form of certification which needs to be considered.

### Medical Perfusion

Due to the wide range of clinical practices in medical perfusion across Australia, progress on an updated Policy Document on Medical Perfusion has been slow. There is general agreement, however, that the role of the Medical Perfusionist should be supported in that it is an integral component of ensuring a high standard of patient care in many centers. In order to establish and maintain standards of practice of medical perfusion, certain minimum standards for training and maintenance of clinical competence are required. Any input or discussion related to such standards should be directed to working group members.

DAVID SCOTT  
Chairman

## DAY CARE ANAESTHESIA

### EXECUTIVE MEMBERSHIP

|                   |                |
|-------------------|----------------|
| David Kinchington | ACT (Chairman) |
| Andrew Bacon      | VIC and NDSC   |
| Brent Donovan     | WA             |
| Ruth Matters      | TAS            |
| Hugh Spencer      | NZ             |
| Robin Limb        | SA             |
| David Gibb        | NSW (retired)  |
| Colleen Kane      | NSW            |
| Michael Fong      | Queensland     |

### MAJOR ITEMS OF BUSINESS

#### 1. Special Interest Group Constitution

There has been much discussion at a SIG and College level. The SIG is in the process of applying this generic constitution to our circumstances.

#### 2. Australian Day Surgery Council

Liaison with the Council continues. The following points were noted in a recent report:

- Discussion on extended stay units as part of day surgery unit
- Public hospital day stay represents 40% of admissions which rises to 49% in private hospitals
- Enormous variations in practice between states and public and private hospitals
- Day surgery nurses will probably join the Council
- Call for the training of willing anaesthetists to act as surveyors for the ACHS

#### 3. Format of input of the SIG at Annual Scientific or Satellite Meetings

Following review of surveys undertaken of membership (Rudkin) and following Day Surgery sessions at the Newcastle ASM (Kinchington), support for issues of everyday importance in a format that allows adequate discussion is consistently supported. This format will be pursued in forthcoming meetings with continued assessment.

#### 4. SIG Internet presence via the College Home Page

The Executive was keen to embrace new communication channels with the membership. The SIG now has an area linked to the College Home Page. This area provides SIG and College members access to the SIG Executive via email or conventional communications, as well as a report of the previous teleconference discussions. The SIG Executive wants College and SIG members to know what is being discussed, to add to this discussion and to be able to suggest new topics for discussion.

#### 5. Survey of Sessions at ANZCA ASM Newcastle Meeting

Surveys of people attending Day Surgery and lower body blocks sessions were taken. Overall respondents were satisfied with the topics, detail and usefulness. Issues of everyday importance and long discussion periods were noted as being important. The full survey reports are available on DCA SIG area at the ANZCA internet site.

### MEETINGS

#### 1. ANZCA ASM Newcastle 1998

The Day Care Anaesthesia programme consisted of three workshop sessions.

- Day surgery workshop (Speakers: Drs Amjed Aziz, David Kinchington, Sharon Tivey and Robin Limb)
- Upper limb blockade with Drs Hugh Spencer, John Currie and John Ebert
- Lower body blockade with Drs Paul Forest, David Kinchington and Vida Viliunas.

All sessions were well attended and well accepted using the style of presentations followed by discussion.

## 2. Day Surgery Conference of Australasia, Sydney November 1998

This conference was organised by the Australian Day Surgery Council and the Australian Day Surgery Nurses Association. The Day Care Anaesthesia SIG is a supporting organisation for this conference. The SIG is involved in two anaesthetic sessions. Both sessions deal with common issues relevant to daily practice. The overall programme is titled 'Looking to the Future'. This conference is eagerly awaited.

## 3. ANZCA ASM, Adelaide 1999

Discussions are well underway with regard to SIG input into this conference. As yet the programme is not finalised.

### GENERAL COMMENTS

This last year has been busy for the Day Care Anaesthesia SIG. Teleconferences have been well attended and

considerable effort has been undertaken by all on the Executive. Changes in Executive personnel have continued with the resignation of Professor David Gibb. David Gibb had been the Chairman of this SIG for five years. His knowledge, enthusiasm and dedication will be missed. The Executive thank him for his work.

The place of the SIG is open to review with the advent of the new constitution. The current SIG functions well providing coordination of day care anaesthesia related education, expertise for the College on SIG matters and a liaison point for external bodies dealing with day surgery. Opportunities arise to extend these functions with more direct relationship between the Executive and the membership. Direct education via the internet and creation of a central information and personnel bank on day surgery anaesthesia are two potential areas of interest. The path of the new SIG will need more input from SIG members.

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

DAVID KINCHINGTON

Chairman

## MEDICAL EDUCATION

There were only two Teleconferences held since September 1997.

### 1) Executive Members

There were two resignations from the Executive.

Professor Geoff Cutfield, who has been active in the SIG as a co-opted member, replaced Professor Barry Baker (NSW).

Dr Chris Acott was replaced by Dr Margaret Wiese (SA).

### 2) SIG Constitution

The committee strongly supported the concept of associate membership. However, during the discussion, there was some concern expressed regarding the term 'allied health professionals' in the draft constitution. Nonetheless, since associate members could only be admitted after nomination by two full members, with endorsement by the Executive and approval by the majority at a meeting, it was felt that this was an adequate safeguard. Furthermore, it was noted that associate members do not have voting rights. On the other

hand, it was also expressed that SIGs might offer associate membership to people in recognition of their contribution, and that this should be regarded as an honour.

### 3) Directory of Training

Approval was obtained from the College Executive regarding the compilation of such a directory. The idea was applauded, however, it was felt that the concept should be referred to the Education Committee for development and implementation. Subsequently, it was suggested that the SIG should compile the Directory and then refer it to the Education Committee. A letter has been circulated to all Supervisors of Training and virtually all have responded. The Directory is now ready for distribution for comments.

### 4) Workshops

Following the successful workshops in Christchurch, three more workshops were undertaken at the Newcastle meeting, and they were oversubscribed, the feedback to Prof Cutfield

had been very positive and it was suggested that these workshops could be offered to Scientific Convenors of future meetings. It is believed that the workshop format allows participants to make a contribution and also to calibrate themselves against experts in the field and their peers.

### 5) In Training Assessment (ITA)

A number of issues pertaining to this topic were raised and discussed.

It is appreciated that there are difficulties encountered by senior anaesthetists to achieve a degree of objectivity when providing confidential reports. It is also felt that written references are inadequate, as hardly anyone writes a 'bad' reference, especially with the Freedom of Information Act, and the fear of litigation. Perhaps a written reference could be supported by a telephone reference.

Prof Cutfield indicated that in Newcastle they are exploring a means of ensuring more objective assessments by establishing a series of Objective Structured Clinical Assessments (OSCA) that can be staged at various points during a trainees progression through the training program. A minimum level of competence could be developed for each OSCA appraisal. Trainees with unsatisfactory assessment could be given the opportunity to remedy and repeat the appraisal.

The Committee also felt that there should be a mechanism put in place to stop unsatisfactory trainees before they reach the final examination, especially those with poor interactional skills and practical dexterity. The Committee appreciates that there are trainees who go from state to state to join the training program, and eventually might achieve a pass in the Final Examination.

As a point of interest, it was pointed out that the Orthopaedic Surgeons set the same examination for all trainees irrespective of the year of training and trainees are then measured against their peers. Also in the U.S., once the trainee is accepted into the training program, trainees can sit all the MCQ Exam every year.

The Committee feels strongly that this ITA is an important issue and perhaps could be explored further at a satellite meeting or workshop with invited speakers.

### 6) Trainees with difficulties

The Committee feels that there could be Australasian wide standards for selecting candidates, which might include interviews. A uniform set of criteria could be established, and there should not be a disparity between different states.

There should also be a mechanism put in place to identify poor performers or unsuitable candidates who are incapable of making decision relating to crisis management or those who lack manual dexterity. Those who are intellectually inept would be rejected by virtue of their failure to pass the Primary Examination. Those who are technically capable but are unable to pass the Primary Examination remain an issue.

It was also felt that it was unfair to allow a trainee to complete the entire program (or even part of the program if the trainee is identified as an unsatisfactory candidate) before rejecting the candidate as unfit. A 'Mentor system' could be explored and expanded.

Unsuitable and unsatisfactory trainees do not only reflect poorly on the professional body as a whole, but we also have an obligation to the general public, as well as to the disadvantaged trainee who should be guided to pursue an alternative career path.

Once again, the Committee feels that a Satellite Meeting might provide an opportunity for the Medical Education SIG to work with the Welfare of Anaesthetists SIG. Dr Guy Ludbrook, the Scientific Convenor for the Adelaide ASM has been contacted in this regard.

### 7) Diving and Hyperbaric Medicine SIG

Since 1994, issues relating to diving and hyperbaric medicine have been discussed by members of the Executive, however, since the resignation of Dr Acott and Dr Griffiths, it was decided that a separate SIG be formed to deal with such issues. This idea was supported by the Australian and New Zealand Anaesthetists who were present at the Undersea and Hyperbaric Medical Society Meeting at Seattle in May 1998. Subsequently, a letter was written to the President, Professor Phillips. The matter was considered by Council who has endorsed the formation of such a Group. The Interim Executive has been formed.

### 8) Simulator Meeting

The Simulator Meeting in Christchurch in 1997 was a success. A surplus of \$6638.05 was recorded.

The Chairman and the Executive Members of the Committee wish to express their sincere gratitude to Ms Helen Morris for her hard work and her assistance with this SIG and applaud her for her continual enthusiasm.

R.M. WONG  
Chairman



## OBITUARIES

### DR GWENIFER CATHERINE MAY WILSON, MD

New South Wales - FFARACS 1956, FANZCA 1992

Dr Gwenifer Catherine May Wilson was born on 12 October 1916, at Broken Hill in New South Wales, the daughter of school teachers. Her schooling followed her parents around the state, and she attended Bowral, Parramatta and Orange High Schools. Awarded a Sydney University Exhibition in 1933, she graduated MB BS from that University in 1939. She spent her Resident Medical Officer years at Balmain Hospital, where she was also Acting Medical Superintendent from 1941 to 1945. She was accepted into the Diploma in Anaesthesia course at the University of Sydney in 1945, and topped the course. Over the next several years, she obtained appointments to the senior staff of Balmain, Rachael Forster, Royal North Shore, St George and Sydney Hospitals.

Gwen became a Foundation Member of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, and a Fellow of the Faculty in 1956. She became a member of the Australian Society of Anaesthetists in 1945, was President of the New South Wales Section of the ASA from 1951-1953, and Federal Secretary from 1954-56. The Faculty of Anaesthetists, RACS, appointed her Honorary Historian in 1966, a post she held until 1992, when she became Honorary Historian of the Australian and New Zealand College of Anaesthetists, and then Historian Emeritus. From 1982 to 1992 she was a member of the Archives Committee of the Royal Australasian College of Surgeons. She was Postgraduate Lecturer in the History of Anaesthesia in the Nuffield Department of Anaesthetics, University of Sydney for 20 years.

Gwen Wilson loved and lived history, the places, the people, the meetings and the publications. She achieved international prominence in her field, and presented and published extensively on the history of anaesthesia. Her three books stood out: *Fifty Years: The Australian Society of Anaesthetists 1934-1984*, published by the Society in 1987; *A Bibliography of References to Anaesthesia and Related Subjects in Australian Medical Publications 1846-1962*, published by the Faculty of Anaesthetists, RACS in 1988; and *One Grand Chain. The History of Anaesthesia in Australia 1846-1962* Volume 1, 1846-1934, published by the College in 1995. Her academic work led to the award of a Doctorate of Medicine by the University of Sydney in May 1995. In October 1995, she received notification that she had become the

inaugural Wood Library Museum Laureate of the History of Anesthesia, American Society of Anesthesiologists. She undertook a whirlwind lecture tour of the USA as the Laureate in 1996. After her return, she hastened to complete the ground work for Volume 2 of *One Grand Chain*. An epilogue, to overview events from 1962-1992, the year in which the Australian and New Zealand College of Anaesthetists was established was also planned.

With progression of the illness which led to her death on 31 October 1998, she arranged for appropriate assistance to ensure that Volume 2 would be published by the College in 2000.

Gwen was recognised by the Faculty of Anaesthetists for her work by award of the Faculty Medal in 1988, and the Robert Orton Medal in 1990.

In describing Gwen Wilson's contributions to anaesthesia, three short quotations are apt: In the introduction to her Bibliography, the then Dean of the Faculty of Anaesthetists, Professor Barry Baker, wrote: *"The work involved has been enormous, with literally years devoted to the complete classification of all journals and to every article on anaesthesia between 1846 and 1962. Gwen Wilson has pursued this bibliography with a quiet dedication that is truly academic"*.

In his forward to *One Grand Chain*, historian Geoffrey Blainey said, *"This book is a detective story. Historians who, like me, know little about medical research, will take pleasure not only in the clarity with which technical events are described but in the stamina and integrity which Dr Wilson shows in presenting evidence"*.

Professor Nicholas Greene, Professor Emeritus of Anesthesiology of Yale University, included the following in his announcement of the award of the Laureate: *"Dr Wilson's career reflects the thoroughness, the scholarship, the meticulousness, and the dedication of time and effort needed to produce definitive studies of the history of anaesthesia. She provides us with an example to which we, everywhere, can aspire"*.

Gwen Wilson is survived by her son Richard, daughter Janet, her grandchildren and great grandchildren.

## DR KEVIN LORNE MERRETT

Victoria - FFARACS 1991, FANZCA 1992

Admitted to Fellowship of the Faculty of Anaesthetists, RACS in June 1991, Dr Kevin Merrett was a keen sportsman and dedicated anaesthetist with an active interest in teaching prior to his death earlier this year.

A graduate of the University of Melbourne, taking his MBBS in 1981, Kevin Merrett's anaesthesia training consisted of a mixture of appointments in Great Britain and Australia. His professional appointments following the award of his FFARACS were in a number of British hospitals, including St Mary's Hospital and Kings College Hospital, London. He held

the post of Staff Anaesthetist at the Norfolk and Norwich Health Care Trust at the time of his diagnosis with chondrosarcoma in December 1996.

During his short career in anaesthetics, Dr Merrett was an active teacher and publisher of his work, including the production of a textbook chapter.

Remembered by many as a friendly and pleasant man, Dr Merrett married in 1990 and was father to two children.

## DR BEDE PATRICK FRANCIS MOONEY

New South Wales - FFARACS 1968, FANZCA 1992

Dr Bede Mooney was elected to the Faculty of Anaesthetists, RACS in 1968 following his graduation with the Diploma of Anaesthesia from his alma mater Sydney University in 1960.

Prior to his entering anaesthesia, Dr Mooney graduated MBBS in 1941, completing his resident years at the Mater Hospital North Sydney before serving with the Australian Army during World War II.

Returning to civilian life and St Vincent's Hospital, Sydney in 1947, Dr Mooney spent a short time in general practice prior to commencing practice as a specialist anaesthetist. He held

appointments at Sydney Hospital in 1951 and at the Mater and Lewisham Hospitals in 1952.

Dr Mooney was a member of the AMA and ASA, and practiced with the Macquarie Anaesthetic Group until his retirement at age 65 in 1982, although he subsequently continued his work with his role as consultant anaesthetist at Sydney Hospital and by remaining active at the Sydney Eye Hospital.

His life was entirely devoted to both his large family and profession. Survived by his wife Jill, and three sons and three daughters, Dr Mooney died on 6 November 1992.

## DOUGLAS GEOFFREY TABRETT

New South Wales - FFARACS 1973, FFARACS 1981, FANZCA 1992, FICANZCA 1993

Dr Douglas Tabrett was admitted to FFARACS following his graduation from Sydney University in 1967 and his residency at Sutherland Hospital. He commenced his anaesthetic training at the Launceston General Hospital and then worked at Guys Hospital, London where he completed his FFARACS in 1973. Upon his return to Australia he completed his

FFARACS and worked as Director of Intensive Care at the Sydney Hospital. Intensive Care Units, at this time, were just developing and very much one-man bands where they worked day and night. Upon the downgrading of Sydney Hospital, Doug moved to Manly Hospital and practised in several private hospitals on Sydney's peninsula.

## PROFESSOR GUSTAV JULIUS FRAENKEL

South Australia - Honorary Fellow, 1986

The development of the specialty of anaesthesia has been significantly influenced by support from a number of surgeons. One of the most prominent in Australia and New Zealand was Gus Fraenkel.

Born in Berlin, Gus Fraenkel was raised in an academic family where his father was a Latin scholar and university lecturer, and his mother was a PhD graduate of the University of Berlin in classical philosophy. The family moved to England in 1934 where Fraenkel's father held academic posts initially in Cambridge and then later in Oxford. Gus Fraenkel studied Medicine at Oxford and subsequently qualified as a surgeon. His mentors at Oxford included Howard Florey and Hugh Cairns, both graduates of the University of Adelaide.

He had a distinguished academic career at Oxford before accepting an invitation to apply for the Chair of Surgery at the University of Otago, New Zealand. As a result of his exposure to the development of academic anaesthesia at Oxford, Fraenkel was a significant force in the development of the first Academic Chair of Anaesthesia in New Zealand at the University of Otago. Barry Baker was the first incumbent.

In 1970, Fraenkel became the founding Dean of the Medical School at Flinders University, South Australia. It was Fraenkel's dream to have the Medical School within the Medical Centre where patient care, teaching and research were integrated both at basic science and clinical levels. This successful model has subsequently been endorsed by other universities. It was at Flinders University that Fraenkel made his other major contribution to anaesthesia with his unwavering insistence on the development of a full Chair of Anaesthesia and Intensive Care. Fraenkel had a memorable ability to recruit new promising, young staff to the newly formed Chairs. The academic output from the Flinders University Medical School is testimony to his success. An outstanding example was the appointment of Michael Cousins to the Chair of Anaesthesia and Intensive Care.

In 1986, the then Faculty of Anaesthetists recognised Gus Fraenkel's contribution to our specialty by granting him Honorary Fellowship.

In retirement, Gus Fraenkel remained a strong supporter of academic medicine, both in Adelaide and interstate. His wife, Ruth, died in 1990. He is survived by his three children, Margaret, David and Graham, all of whom are medical specialists.

## DR JAMES GORDON OPIE

New South Wales - FFARACS 1959, FANZCA 1992

James Opie was born in Coraki in 1918. James' father, Dr A J Opie, was the general practitioner in that Northern Rivers town. The family moved to Lismore shortly after and James continued to live in that town, except for schooling, medical education and military service, until his death on 3 September 1997.

He graduated from Sydney University in 1942 and served as a Flight Lieutenant in the RAAF after internship at Balmain District Hospital in Sydney. After the war he returned to Lismore and joined the Lismore Clinic, set up by his father, as a general practitioner. However, in the 1950's he proceeded to pursue further specialist training in the United Kingdom and obtained the DA RCP&S in 1957 and in 1958 the MRCP. In 1959 he became a member of the Faculty of Anaesthetists

of the Royal Australasian College of Surgeons and a member of the Royal Australasian College of Physicians in the same year.

He returned to Lismore and practised as a physician and anaesthetist throughout the Northern Rivers District of New South Wales until 1988. During this time he practised with the principle of taking medicine to the patient and would attend the many small surrounding hospitals to provide both anaesthetic and physician services usually on the same day.

He was elected FRACP in 1973 and FRCP Ed in 1982. In 1992, with the formation of the Australian and New Zealand College of Anaesthetists, he was, with the other remaining four MFARACS, elected to Fellowship of the College.



## EMERITUS PROFESSOR COLIN ARTHUR SHANKS

United States of America - MD FRCA, FANZCA

Emeritus Professor Colin Shanks died in Chicago on 14 August 1998 aged 62 years, after a long illness which had produced little physical incapacity until recent times.

Colin graduated MB ChB from the University of Otago in 1959 and completed his residency at Timaru Hospital, New Zealand. He was appointed Anaesthetic Registrar to the Christchurch group of hospitals and achieved the diploma of FFARACS (1969) and FFARCS (1965). He was appointed Staff Specialist in the Department of Anaesthetics at the Royal Prince Alfred Hospital, Sydney from 1964 to 1981, when he resigned to take up a professional research position in anaesthesia at Northwestern University in Chicago, USA.

Colin's talents as a teacher and researcher were apparent to the trainees who passed through the RPAH Department and many registrars had cause to be grateful for his expert tutorials on a wide range of subjects, but particularly applied anatomy. His commitment to teaching led to his joining the

Panel of Examiners of the Faculty of Anaesthetists, RACS in 1973 and the Final Examination Committee in 1977, of which he became Deputy Chairman in 1978.

His second love was anaesthesia research. His wide interests included studies, conducted with Dr Charles Sara, on heat conservation and airway humidity and, subsequently, his interest in neuromuscular relaxants and their dynamics led to a number of publications. This work culminated in his being awarded the degree of Doctor of Medicine (University of Otago) in 1979 for his thesis on humidification in anaesthesia. The last seventeen years of Colin's life were spent in Chicago where his research commitment could be pursued on a virtually full time basis.

Colin is survived by his wife Ann and four children, all of whom have excelled in their chosen fields. His daughter Megan completed her training as a neurologist at The Cleveland Clinic, and now practises in Chicago.

## DR SANKARAKURUP GOPINATHAN NAIR

New Zealand - FFARACS 1984, FANZCA 1992

Following his MB BS at Trivandrum Medical College in 1958 "Gopi", as he was known to his friends, decided on a career in anaesthesia. He obtained his DA at Christian Medical College in Vellore in Madras State, followed by a Masters Degree in Anaesthesia at Victoria Jubilee Hospital in 1965. Subsequently he worked in various capacities as tutor, Assistant Professor, Associate Professor and, subsequently, Professor of Anaesthesia in the various Medical College Hospitals in Calicut in Kerala State, India. He completed his FFARCS in Belfast, Northern Ireland in 1974 and his PhD at Queens University of Belfast in 1977. He chose the topic of

benzodiazepines and their clinical effects as the subject for his thesis. He immigrated to New Zealand in 1978, having worked in Holland and Sweden. He was a senior lecturer in anaesthesia and intensive care at the University of Otago and consultant at Dunedin Hospital until the end of 1985, when he was appointed Director of Anaesthesia at Taranaki Base Hospital until his untimely death. Gopi will be remembered for his vast knowledge on most subjects. He was a very good friend and entertainer, a prolific reader, excellent communicator, speaking at least six languages. He was a well known film critic in his home state of Kerala.

## DR DAVID GOVETT ROMAINE WRIGHT

New Zealand - FFARACS 1956, FANZCA 1992

Dr David Wright was born in Taranaki but spent his childhood in Hawkes Bay. He attended Wanganui Collegiate School and Otago Medical School, graduating in 1950. His House Officer years were at Wellington Hospital and in 1952 he married Jennifer, the daughter of Dr James Church of New Plymouth, himself an anaesthetic pioneer.

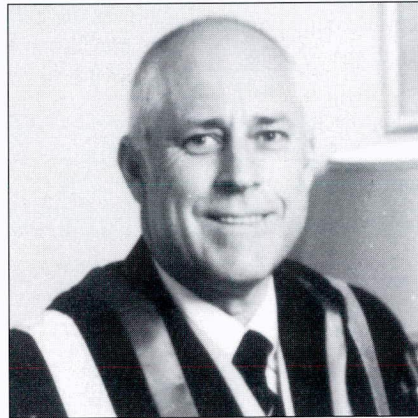
He went to England for post-graduate training in anaesthesia in 1954 and returned in 1956 to work as a specialist at the Wellington Hospital. After 1958 he also worked at Bowen, Calvary and other hospitals in Wellington. He remained on

the consultant staff of Wellington and Hutt Hospitals until he retired from anaesthetic practice in 1986.

David spent 21 consecutive years contributing to the Regional Committee of Faculty and the New Zealand Society of Anaesthetists, holding senior office in both organisations. He served as a Territorial Officer in the Royal New Zealand Airforce, visiting South East Asia and Western Samoa as the anaesthetist in the Red Cross orthopaedic team. Following retirement David was a part time consultant in occupational medicine to the New Zealand Rail and Aviation Authority.

## FACULTY OF INTENSIVE CARE

# DEAN'S MESSAGE



At its October meeting, the Board completed changes to the process by which intensive care units are recognized for training. Under the new system, units will continue to undergo rigorous inspection every seven years. All are agreed that inspections not only foster an appropriate training environment but also provide strong support to Directors in dealing with hospital administration about staffing and other resource requirements.

From 1999, units accredited for training will no longer have a restriction on the number of training posts. This represents a major philosophical shift. An increased responsibility will rest with Directors to ensure that trainees receive adequate clinical exposure. The Censor will also have an important role in monitoring the experience trainees receive. Units that meet criteria will be accredited for varying periods of core training - unlimited (C24), 12 months (C12), six months (C6) or three months (S3). When a unit is given a C24 classification, the Board is in effect saying that it would be acceptable for a trainee to spend the whole of their core training in that unit. Related observations can be made for units receiving the other classifications. The S3 classification has been developed specifically to facilitate a secondment from a larger tertiary unit. This classification may also be used for other services such as retrieval services and hyperbaric units.

Details of these changes can be found in the revised Policy Document IC-3 (1998) 'Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care'.

Intensive care units already approved for training have been reclassified according to the new system based on information from the most recent inspection and the knowledge of Board members. All units have either maintained their previous accreditation or have had their status upgraded. Units will be advised of their classification in the near future.

It is the hope of the Board that this new system will be easier and fairer to administer and that it will facilitate rotational training programs. The challenge will be to ensure that the experience of trainees is not diluted and that the graduates from our program remain of the same high standard.

The results of the survey of Fellows seeking their views on 'A Single Body for Training and Certification in Intensive Care' are published in this issue of the Bulletin. The response to the survey and the views expressed were invaluable. Fellows overwhelmingly recognise the problems that arise from having two pathways to certification in intensive care and from not having a single body that speaks on matters pertaining to training, certification and standards. Ninety per cent of Fellows who responded favour the ultimate formation of a separate College of Intensive Care Medicine, the largest group favouring a 2 - 5 year time frame. Our Fellows strongly (85%) believe that a College should evolve from the Faculty and 60% indicated that election to Fellowship of other bona fide specialists in intensive care should occur at the time the new College is formed. Discussion on these matters is being pursued by the Board.

At the recent Annual General Meeting of ANZICS, those present voted strongly in favour of further exploring the formation of a College. This matter is on the agenda for future meetings of the Joint Specialist Advisory Committee in Intensive Care.

Finally the Board has been deliberating on the circumstances in which exemption from the ANZCA Primary Examination should be granted. It has long been held that the ANZCA Primary is not 'ideal' for trainees in Intensive Care. In general the Board has agreed to follow the College's approach based on demonstration of 'equivalence'. One significant change from a Faculty perspective, however, has been the decision to exempt from the Primary Examination Fellows of the Royal Australasian College of Surgeons and the Australasian

College for Emergency Medicine. Although both bodies have basic sciences examinations that are relevant to intensive care training, it is stressed that the exemption only applies to those who have completed specialist training and only for the purposes of intensive care training. Such Fellows must complete all other aspects of the Faculty training program and pass the Fellowship examination. This important change now provides another pathway to supra-specialty training in intensive care.



A.W. DUNCAN, DEAN

## OBITUARY

### DR CATHERINE (KATE) GERALDINE MARY FLYNN,

FFARACS (IC) 1990, FANZCA 1992, FFICANZCA 1993

Kate passed away suddenly and peacefully at her family home in County Kerry, Ireland on Christmas Eve 1997.

Kate graduated from University College, Cork in 1981. During her undergraduate Medical studies she had a kidney transplant. She undertook Postgraduate training in Anaesthesia in Ireland and obtained her Fellowship in Anaesthesia at the Royal College of Surgeons, Ireland in 1985.

Her interest in Intensive Care led her to Australia where she enrolled in formal Intensive Care training. She initially came to Perth but undertook the main part of her training in Adelaide where she obtained Fellowship of the Faculty of Anaesthetists, RACS endorsed in Intensive Care, in 1990.

During her time in Australia, Kate took great pride in becoming an Australian Intensivist, the ideals of which she fostered and promoted.

Kate had a deep interest in renal resuscitation and renal replacement therapy and spent time at the University of Galveston, Texas as an Associate Professor, undertaking

research in renal replacement, mediators of inflammation and cytokine clearance.

She was appointed as a Consultant in Anaesthesia and Intensive Care at the Beaumont Hospital, Dublin. This is the major Teaching Hospital of the Royal College of Surgeons in Ireland.

She promoted excellence in Intensive Care both as a clinician and as a teacher. She cared deeply for her patients and had a strong grasp of the importance of the team approach.

She was a Founding Member of the Intensive Care Society of Ireland and worked with others to develop Intensive Care as a specialty in Ireland spurred on by the Australian model.

Kate was a warm and natural person with no airs and graces. She had a forthright and moral character. She made people laugh and raised their spirits.

Her untimely death caused a sense of great loss and sadness to her beloved family, her multitude of friends and colleagues on all sides of the globe. Intensive Care has lost a true and loyal friend.

## FACULTY OF INTENSIVE CARE, ANZCA RESULTS OF THE SURVEY OF FELLOWS REGARDING A SINGLE BODY FOR INTENSIVE CARE TRAINING AND CERTIFICATION

This Questionnaire was circulated to all Fellows (215 as at 1st July 1998), accompanied by a discussion document.

The total number of responses received: 140 or 65% of Fellows

### 1. How importantly do you consider the problems outlined in the discussion document?

|                              | Very<br>imp. | %    | Imp. | %    | Unsure | %   | Of little<br>imp. | %   | Of no<br>imp. | %   |
|------------------------------|--------------|------|------|------|--------|-----|-------------------|-----|---------------|-----|
| Lack of common certification | 55           | 39.3 | 66   | 47.1 | 9      | 6.4 | 6                 | 4.3 | 4             | 2.9 |
| Lack of a single body        | 84           | 60   | 46   | 32.9 | 5      | 3.6 | 4                 | 2.8 | 1             | 0.7 |

### 2. Do you support formation of a separate College of Intensive Care?

|                           |     |       |
|---------------------------|-----|-------|
| Yes                       | 125 | 89.3% |
| No                        | 14  | 10.0% |
| 1 abstained and commented |     | 0.7%  |

### 3. If you answered yes to Question 2, what time frame would you consider ideal?

(Note: some respondents who ticked No at Question 2 still answered Question 3)

|                   |                 |       |
|-------------------|-----------------|-------|
| 0 - 2 years       | 30              | 21.4% |
| 2 - 5 years       | 65              | 46.4% |
| 5 - 10 years      | 32 <sup>1</sup> | 22.9% |
| 13 did not answer |                 | 9.3%  |

### 4. If you favour or acknowledge ultimate formation of a College of Intensive Care, what would be your preferred pathway?

|                               |     |       |
|-------------------------------|-----|-------|
| a) formation de novo          | 13  | 9.3%  |
| b) evolution from the Faculty | 119 | 85.0% |
| 8 did not answer              |     | 5.7%  |

### 5. If b) is your preferred pathway, would you favour

|    |  |    |       |
|----|--|----|-------|
| B1 | election of other specialists<br>followed by formation of a separate College | 31 | 22.1% |
| B2 | continued development of JSAC<br>followed by formation of a separate College | 84 | 60.0% |
|    | 25 did not answer  |    | 17.9% |

<sup>1</sup> Three of these preferred longer than 10 years.

# 1998 NATIONAL INTENSIVE CARE DAY

## REPORT ON QUESTIONNAIRES

MANDY WILLIAMS  
10 September 1998

176 Questionnaires sent out (to all that participated)  
114 returned (65%) as well as 3 letters and 3 emails.

### TYPE OF ACTIVITY

|                                   |    |     |
|-----------------------------------|----|-----|
| • Display in hospital foyer       | 89 | 78% |
| • Display in shopping centre/mall | 24 | 21% |
| • Patient reunion                 | 42 | 37% |
| • Open Day                        | 32 | 28% |
| • Other                           | 33 | 29% |

### PROPS EMPLOYED

|  |     |     |
|--|-----|-----|
| • Old/new equipment display                | 68  | 60% |
| • Posters supplied by the Faculty          | 105 | 92% |
| • Leaflets supplied by the Faculty         | 98  | 86% |
| • History of Intensive Care in Australasia | 39  | 34% |
| • Stickers supplied by ANZICS              | 100 | 88% |
| • Static Displays                          | 61  | 53% |
| • Other                                    | 26  | 23% |

### MEDIA ADVICE KIT

|        |    |     |
|--------|----|-----|
| • Used | 62 | 54% |
|--------|----|-----|

### PUBLICITY

|             | <i>Sought</i> | <i>Achieved</i> |
|-------------|---------------|-----------------|
| • Newspaper | 81            | 70              |
| • Radio     | 51            | 50              |
| • TV        | 44            | 27              |

### DID YOU USE HOSPITAL PUBLIC RELATIONS DEPARTMENT OR EQUIVALENT?

|       |    |     |
|-------|----|-----|
| • Yes | 80 | 70% |
|-------|----|-----|

### COMMENTS ON 1998

"hard work but well worth the effort to raise the profile of the specialty and services provided", "promoted a lot of interest within the hospital and was well supported", "thanks for the faculty support", "effective public relations and health education activity", "excellent", "great success", "thanks for the information - the day was a huge success", "excellent feedback", "huge amount of hard work by charge nurse/staff/medical bods", "an excellent idea to create community awareness", "the day was enjoyed by staff and boosted morale", "people were very receptive", "the patient reunion was very emotional and appreciated by all", "very positive feedback from community organisations", "very worthwhile for boosting the profile of intensive care".

### SUGGESTIONS

"could we look at an annual event?", "hopefully this will become an annual event", "the text on poster must in future be larger and bolder", "held busiest time of the year - can it be held earlier in year?", "if this is to become a regular event, I would appreciate more warning. This will allow me to better plan activities for the day", "people have requested an annual event".

## ADMISSION TO FELLOWSHIP BY ELECTION

The following were admitted to Fellowship of the Faculty of Intensive Care,  
Australian and New Zealand College of Anaesthetists by election under Regulation 5.3.

David Hugh Stephens, Qld  
Dr Jeffrey Lipman, Qld

## FACULTY BOARD

### October 1998



*At rear: Administrative Assistant (Ms S. Monnet), Executive Officer (Ms C. J. Cunningham-Browne), Drs R.J. Barnett, D.J. Cooper, R.P. Lee, P.D. Thomas, G.F. Bishop, Registrar (Mrs J. Sheales).*

*Foreground: Drs R.V. Trubuhovich, F.H. Hawker, A.W. Duncan, Prof. T.E. Oh, Dr N.T. Matthews.*

## AMENDMENT TO ADMINISTRATIVE INSTRUCTIONS

Following the decision of the Board of Faculty that the EMST Course is no longer a compulsory requirement of intensive care training, please note that the following Administrative Instructions have been revised as follows:

- 1.4.4 Holders of a higher qualification in anaesthesia for which there is a basic science examination equivalent to the College's Primary Examination must produce evidence of training acceptable to the Board before presenting for the Fellowship Examination.
- 1.4.5 For trainees commencing approved vocational training from the beginning of the 1996 Hospital Year, no further Vocational Training will be recognised after the completion of the second year of training, until the trainee has passed or has been exempted from the ANZCA Primary Examination.
- 1.4.6 That trainees commencing approved vocational training on or after the beginning of the 1997 Hospital Year must complete a Formal Project as a prerequisite for awarding the Diploma FFICANZCA, in accordance with the guidelines outlined in the JSAC-IC document 'Formal Project Requirements'.

C.J. CUNNINGHAM-BROWNE  
Executive Officer

## ITEMS OF INTEREST FROM THE OCTOBER BOARD MEETING

### HONOURS AND APPOINTMENTS

The President, Dr R.G. Walsh has been awarded Fellowship of the Academy of Medicine in Singapore.

### DEATH

The Board noted with regret the death of Dr Douglas Geoffrey Tabrett, NSW, FFARACS (IC) 1981, FANZCA 1992, FFICANZCA 1993. An obituary is provided elsewhere in the Bulletin.

### SUPERVISORS OF INTENSIVE CARE TRAINING

The Board ratified the appointment of Dr Chris Joyce as Supervisor of Training in Intensive Care at the Princess Alexandra Hospital, Queensland.

### EDUCATION

#### *Review of Accreditation*

Following the in principle decision made earlier in the year to revise the system of accrediting Intensive Care Units for training, the Board has revised Policy Document IC 3 'Guidelines for Intensive Care Units Seeking Faculty Accreditation for Training in Intensive Care'. The new system removes the previous limit on the number of training posts accredited within a Unit. It also removes the classification of units as suitable for elective training only. Units will now be accredited for periods of 24, 12 or 6 months of the core component of intensive care training. In some cases, smaller or peripheral units may be classified as S3, or suitable for a secondment of 3 months on rotation from a larger tertiary hospital. The new classifications will take effect from the commencement of the 1999 Hospital Year.

The Administrative Instructions are currently under review to incorporate the new system of accreditation.

The revised document is printed elsewhere in the Bulletin.

#### *Trainee Selection in Medical Colleges*

Following consideration of the Brennan Report, the Board ratified a policy for selection and registration of its trainees, in closer association with hospitals. The following general principles were adopted:

1. The Faculty of Intensive Care, ANZCA accredits intensive care units and some other facilities for training.
2. Hospitals and other institutions select and appoint trainees to their units and departments.
3. The Faculty of Intensive Care registers trainees for its vocational training program.

Eligibility and selection criteria were defined and a process of selection recommended. This will form the basis of a 'package' which will be distributed to Hospitals. It will be recommended that a Faculty representative should be included in selection panels for trainees.

***Early Management of Severe Trauma (EMST) Course and Advanced Paediatric Life Support (APLS) Course***

The Board resolved that completion of the EMST Course will no longer be a mandatory requirement of intensive care training. Both the EMST and/or APLS Courses are endorsed by the Faculty for trainees. Prospective trainees may wish to consider undertaking the EMST Course within the first two years of postgraduate education. The Board believes that trainees will receive greater benefit from this course early in vocational training.

***Survey of Trainees***

The Board considered the results of a survey of intensive care trainees undertaken by the RACP and has agreed to undertake a similar survey of Faculty trainees to assess quality of training and supervision.

***Weighting of Marks***

The Board has resolved that the weighting of the marks for each section in the Fellowship Examination be amended as follows:

|                   |                   |     |
|-------------------|-------------------|-----|
| Written           | (20% SAQ/10% LAQ) | 30% |
| Clinical          |                   | 30% |
| Investigations    |                   | 20% |
| Cross Table Vivas |                   | 20% |

***The G.A. (Don) Harrison Medal***

The Board resolved that there will be no award of the G.A. (Don) Harrison Medal for 1998.

***Appointment of Examiners***

The Board approved guidelines for the Appointment, Training and Duties of Examiners.

***Exemption from the Primary Examination***

The Board resolved that Fellows of the Australasian College for Emergency Medicine and the Royal Australasian College of Surgeons will be exempt from the requirement to sit the ANZCA Primary Examination for the purposes of gaining certification in intensive care only. It was agreed that the Censor will continue to refer applications for consideration of recognition of other Primary Examinations to the Board on an individual basis.

The Board approved terms of reference for a New Zealand JSAC-IC. This Committee will be established to consider applications for specialist recognition from the Medical Council of New Zealand on behalf of the Faculty and the Royal Australasian College of Physicians.

**EXAMINATIONS**

**JOINT SPECIALIST  
ADVISORY  
COMMITTEE IN  
INTENSIVE CARE  
FOR NEW ZEALAND**



# FACULTY FELLOWSHIP EXAMINATION

AUGUST/SEPTEMBER 1998  
AT ST GEORGE HOSPITAL, SYDNEY



*The Court of Examiners: from left, Drs Ron Trubuhovich, Jim Tibballs, Jamie Cooper, Steve Edlin, Prof. Ken Hillman, Drs Richard Lee (Chairman), Andrew Bersten, Felicity Hawker, Peter Morley and John Myburgh*



*Successful candidates: Foreground: Drs Myrene Kilminster, Michael Corkeron, Cheng Ai Yu, Mani Gopalakrishnan  
At rear: Drs Peter Sharley, Steve Fletcher, Vince Pellegrino, John Torrance, Michael O'Leary and PW Cheung*

# FACULTY OF INTENSIVE CARE

## ANZCA

# GENERAL INTENSIVE CARE EXAM

# CHANGES FOR THE APRIL/MAY 1999 EXAM

### FORMAT

The next exam of the Faculty will see the introduction of the changes to the exam format communicated over the last two years. The content and coverage will be unchanged from previous years. Candidates and tutors should refer to past Exam Reports to understand the expectations of the examiners. Only the oral sections will be changed.

The changes are aimed at improving the feasibility of the exam and maintaining fairness in the face of increasing numbers of candidates, so that each candidate as far as possible gets the same exam.

The changes will not apply to the Paediatric Intensive Care Fellowship Exam, which will retain its previous format.

This article provides an opportunity to explain the changes in more detail. The changes to each section are:

#### 1. The Clinical Section

The Clinical of the past will be split into two 30-minute segments with two pairs of examiners.

- a) One segment will cover examination of and discussion about 2 to 3 'cold' cases. These patients will be from the general wards or brought in as outpatients. They will have signs and problems relevant to intensive care practice. The candidate will be expected to perform an orderly and purposeful assessment of a system, a part of the body or those parts of the body involved in a local or general disease process. There will be stress on correct assessment of each potential clinical sign and then synthesis of the signs to derive an acceptable diagnosis and differential diagnoses. The candidate may be asked to briefly discuss management including priority setting and ethical dilemmas.
- b) The other segment will involve exposure to ICU patients and will follow the same principles as the 'cold' cases within the limitations of the ICU environment.

These cases are neither Short nor Long Cases. In the time available they are problem-solving exercises.

For example:

- i) The candidate may be asked to examine the cardiovascular system of a patient 'who was admitted with acute severe breathlessness'. The candidate finds signs of severe aortic stenosis in this patient brought into hospital for the exam. A discussion would follow on the best future management, rationale and risks.
- ii) An ICU case might include for instance a patient with general weakness following a prolonged ICU course. An examination of the peripheral motor system would be followed by a discussion of likely causes and basic management.
- iii) Alternatively a candidate may be asked to assess the level of consciousness and hence prognosis of an unconscious patient after out-of-hospital cardiac arrest.

#### 2. The Cross-Table Vivas

The Vivas will be structured and six tables will be encountered. The candidate will be given two minutes outside the viva room to read an introduction to the viva and will then spend ten minutes with the examiner answering questions related to that introduction, a clinical scenario or problem. There will be one examiner per room.

For example the introduction may be:

'An Intra-aortic Balloon Pump has been inserted in a patient just admitted to ICU after coronary artery grafting. He is a 65 year old diabetic.'

The structured questions in the vivas may then be:

What is the rationale for the use of the IABP ?  
 What other indications are there?  
 What are the risks?  
 How is it timed?  
 How is removal planned?

Each candidate receives the same introduction and lead-in question at that table and each candidate must go to all the tables.

The examiner has the flexibility to explore the candidates' responses further and if time is available add supplementary topics.

The range of questions will be the same as in previous years (for guidance on the coverage of this section see previous Exam Reports).

### 3. The Investigation Section will be incorporated into an OSCE

The OSCE (Objective Structured Clinical Exam) will be the most foreign section and will consist of twelve stations at which the candidate will spend ten minutes. The candidates will rotate through the stations in turn (refer diagram).

The stations will contain not only investigations but also two stations on procedures and equipment and one station at which an ethical or management problem will be explored with an 'actor'.

The variety of stations encountered may be:

- |         |   |
|---------|---|
| Station | 1: Arterial blood gases/acid-base       |
|         | 2: Chest X-RAYS                         |
|         | 3: CT scans                             |
|         | 4: Procedure assessment                 |
|         | 5: Biochemical profiles                 |
|         | 6: Miscellaneous – lumbar puncture, RFT |
|         | 7: Equipment                            |
|         | 8: Ethics/management                    |
|         | 9: Other X-RAYS                         |
|         | 10: ECG                                 |
|         | 11: Chest X-RAYS                        |
|         | 12: ECG                                 |

At the investigation stations there will be several examples of varying difficulty. The candidate will be given a question sheet to answer specific questions relating to the displayed investigations (abnormalities, cause and alternative investigations).

The procedure station may include for example assessment of central line insertion on a dummy with discussion about indications/risks etc.

The ethics station may include for example discussion with an upset relative who is asking about organ donation, complaining about mistreatment or inquiring about prognosis.

Outside the ethics and procedure stations there will be introductory explanations to be read before entering.

For example:

Procedure station: 'You are visiting a patient in the ward when the next patient suddenly collapses while eating lunch. What will you do? Demonstrate on the manikin.'

Ethics station: 'Your patient Mr Brown, aged 80 years, was admitted 24hrs ago after an asystolic out-of-hospital arrest. His son wants to talk to you about withdrawing treatment. Mr Brown has extension posturing to pain, breathes and coughs spontaneously although he is presently intubated and ventilated.'

### 4. General Organisation

The aim will be to hold the oral sections over 2 days depending on the number of candidates presenting.

In several sections it will be important to quarantine groups of candidates from each other so that each candidate gets the same exam. This will involve candidates staying in a tearoom in a group for perhaps 30-40 minutes until the next group has entered the exam area.

Candidates who are planning to sit in 1999 are advised to contact the Executive Officer to receive a copy of the Notes for Candidates.

**R.P. LEE**

Chairman

Fellowship Examinations

## FACULTY OF INTENSIVE CARE

### ADMISSION TO FELLOWSHIP BY EXAMINATION

|                   |             |     |                 |          |     |
|-------------------|-------------|-----|-----------------|----------|-----|
| David Thomas      | GREEN       | NSW | Helen Ingrid    | OPDAM    | VIC |
| Stuart Russell    | GREEN       | QLD | Mary            | PINDER   | WA  |
| Charles D.        | GOMERSALL   | HK  | Yuen-heng Peggy | TAN      | HK  |
| Catherine Rosarie | MOTHERWAY   | SA  | Anthony Brendan | WILLIAMS | NZ  |
| Patrick Gerard    | O'CALLAGHAN | SA  |                 |          |     |



# FACULTY OF INTENSIVE CARE POLICY DOCUMENT

*Review IC-3 (1998)*

## GUIDELINES FOR INTENSIVE CARE UNITS SEEKING FACULTY ACCREDITATION FOR TRAINING IN INTENSIVE CARE

### 1. GENERAL

- 1.1 The Faculty of Intensive Care classifies intensive care units into a number of categories for the purpose of its Administrative Instructions related to training in intensive care.
- 1.2 Intensive care units accredited for training by the Faculty must meet the following criteria:
  - 1.2.1 The unit must be fully established and operational and have a director who fulfils the Joint Specialist Advisory Committee – Intensive Care (JSAC-IC) criteria for recognition as a specialist in intensive care.
  - 1.2.2 The unit must offer trainees a wide spectrum of experience with an acceptable case load.
  - 1.2.3 The hospital should provide a comprehensive range of medical and surgical specialties.
  - 1.2.4 There must be access to a wide spectrum of investigations and therapeutic procedures.
  - 1.2.5 The unit must have an adequate number of specialised medical, nursing and ancillary staff.
  - 1.2.6 Clinical supervision by appropriately qualified specialist medical staff must be available at all times.
  - 1.2.7 There must be suitable facilities for the role of the unit and for the staff who work in it.
  - 1.2.8 A program of education, quality assurance and research must be offered which includes a formal teaching program readily available to trainees.
  - 1.2.9 Adequate on-site intensive care textbooks, journals, management guidelines, protocols or clinical care pathways must be available, and the unit should have Internet or Medline access.
  - 1.2.10 Defined admission, management, discharge and referral policies must be in place.
  - 1.2.11 Trainees must work adequate hours within the intensive care unit as distinct from high dependency units or other activities. If inadequate hours are worked in intensive care, the Censor may rule that the trainee or trainees must extend the duration of their core training.
  - 1.2.12 The unit must ensure that adequate clinical management experience (including performance of procedures) is available to trainees. If excessive numbers of trainees are considered to limit the adequacy of training then the Censor may rule that the trainee or trainees must extend the duration of their core training.
  - 1.2.13 Safe working hours for trainees must be maintained and welfare issues addressed.
- 1.3 The hospital must have a comprehensive continuing education program for its staff and should provide adequate library facilities.
- 1.4 The hospital must be prepared for the Faculty, at intervals determined by the Board, to carry out visits to the unit to assess its suitability for training. Information about case load, staffing patterns and the rosters will be required.
- 1.5 The training appointment must be entirely in intensive care, and should include provision for the trainee to take part in out-of-hours rosters for intensive care.
- 1.6 When appointments to the specialist staff are made, the advice of a properly constituted committee capable of evaluating the qualifications of the applicants must be sought. Faculty nominees are available to committees for this purpose.
- 1.7 The Faculty expects that the job specifications of the specialist medical staff will comply broadly with Faculty Policy Document IC-2 "The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts".

- 1.8 Supervisors of Training are nominated by the Unit and appointed by the Board of Faculty. The Supervisor is expected to carry out the duties listed in Faculty Policy Document IC-6 "Supervisors of Training in Intensive Care".
- 1.9 The Faculty expects that supervision of vocational trainees will conform to the principles of the Faculty Policy Document IC-4 "The Supervision of Vocational Trainees in Intensive Care".
- 1.10 Positions for training in intensive care units accredited by the Faculty must be advertised and the unit classification (see 2 below) must be indicated in the advertisement. The selection process must conform to Faculty guidelines. Selection panels for the appointment of trainees in intensive care should include a representative of the Faculty of Intensive Care, ANZCA.
- 1.11 The hospital must agree to notify the Board, through its Supervisor of Training, of any changes that might affect training. Changes such as a reduction in the workload or a reduction in the number of specialist staff working in the unit are regarded as important.
- 1.12 Applications for a change in classification will be received by the Board, and may necessitate re-inspection of the unit.

**2. CLASSIFICATION OF UNITS**

- 2.1 Subject to criteria being met, the number of training posts in a unit accredited for training is unrestricted unless otherwise specified. All accredited units are suitable for core training, elective training and, unless otherwise specified, the intensive care component of anaesthetic training.
- 2.2 The duration of core training is restricted according to the classification of the unit as outlined below.

**2.2.1 C24: Unrestricted core training**

This classification is granted to units where it would be appropriate for a trainee to spend the whole of their core training in intensive care. This applies to major/tertiary hospitals and implies a high case load, diverse case mix and adequate severity of illness. Trainees are required to spend at least one year of core intensive care training in a unit with a C24 classification.

**2.2.2 C12: Twelve months core training**

This classification is granted to units where

the case load and case mix are adequate but where it would be considered inadequate for a trainee to spend the whole of their core intensive care training in such a unit or where it is necessary for the trainee to spend a period of training in another unit to gain some specific clinical experience.

**2.2.3 C6: Six months core training**

This classification is granted to units where the case load, case mix, supervision or facilities are limited such that the period of core training in that unit should be restricted to six months. It is not a reflection on the quality of care in that unit. The C6 classification is also designed to encourage rotations to such units. Normally not more than one period of C6 training in a given unit is allowed during core intensive care training. A second period of C6 training in another unit requires prior approval of the Censor and will only be granted if specific benefit in training will be achieved.

**2.2.4 S3: Three months core training in specific circumstances**

A unit is granted an S3 classification to allow a trainee to gain some specific clinical exposure. Only one period of S3 is allowed during core intensive care training. One period of C6 and one period of S3 training require prior approval of the Censor and will only be granted if specific benefit in training will be achieved. For administrative purposes, other services such as retrieval or hyperbaric units etc. may be considered under this classification.

**2.3 Criteria for determining classification of units**

The determination of a unit's classification will be made with regard to points listed in 1 above, the unit's case load, case mix, severity of illness of patients, range and frequency of procedures, supervision of trainees and facilities of the unit.

More specifically:

- 2.3.1 The Director of the unit must fulfil the JSAC-IC criteria for recognition as a specialist in intensive care.
- 2.3.2 An appropriately qualified specialist must be rostered to supervise the unit at all times.

When providing supervision the specialist must be rostered only for intensive care duties.

- 2.3.3 For units classified as C24 or C12, trainees must be exposed to more than one specialist who fulfils the JSAC-IC criteria for recognition as a specialist in intensive care. More than one such specialist should have a minimum of 50% involvement in the unit.
- 2.3.4 The minimum unit case load for units seeking C24 or C12 approval should be 500 admissions per annum. The minimum case load for C6 or S3 units should be 350 admissions per annum.
- 2.3.5 Units classified as C24 or C12 should offer trainees a broad general experience of intensive care.
- 2.3.6 At least one medical officer must be exclusively rostered and when on duty predominantly present in the unit. 'On duty' signifies that this medical officer must be present in the hospital at all times.
- 2.3.7 The unit must have a quality assurance program and carry out evaluations in accordance with Faculty Policy Document IC-8 'Ensuring Quality Care – Guidelines for Departments of Intensive Care'.
- 2.3.8 There shall be an active teaching program for medical staff, to which daily review of patients in the unit will make a significant contribution.
- 2.3.9 The Faculty expects there will be adequate office space for both the senior and the junior staff. Neither can be expected to carry out their roles properly without it.
- 2.3.10 Adequate secretarial help must be provided in accordance with Faculty Policy Document IC-7 'Secretarial Services to Intensive Care Units'.

- 2.4 Elective intensive care training in non-accredited Units. This will only be permitted where prior approval has been obtained from the Censor.

### 3. PHYSICAL FACILITIES AND EQUIPMENT

#### 3.1 The Patient Care Area

- 3.1.1 The number of intensive care beds available

(a minimum of six) should be appropriate to the size and function of the hospital.

- 3.1.2 The area for each bed should be sufficient to allow easy access to the patient and to allow the deployment of equipment needed to manage the patient appropriately.
- 3.1.3 Services to the bed must be conveniently placed and in sufficient number to cope with the peak demand.
- 3.1.4 The design should take into account the serious risk of cross infection. There should be easy access to hand washing from each bed station and it should be possible to isolate individual patients.

#### 3.2 Equipment

- 3.2.1 Equipment available in the unit must be appropriate to the work done in the unit and to the workload, judged by contemporary standards.
- 3.2.2 There must be a regular equipment safety checking system in force.
- 3.2.3 The beds must be of suitable design.

#### 3.3 Support Areas

- 3.3.1 Adequate storage space is essential.
- 3.3.2 There should be a clear separation of clean and dirty working areas.
- 3.3.3 A ward administration area is required that must readily accommodate the staff who work there.
- 3.3.4 Offices must be provided for each of the full time specialist medical staff working in the unit.
- 3.3.5 There must be a suitably quiet area for the trainees to study when they have the opportunity.
- 3.3.6 The unit should have ready access to a teaching area with the appropriate facilities.
- 3.3.7 A relatives' waiting area must be available, with a separate private area for distressed relatives.

### 4. TEACHING AND RESEARCH

- 4.1 There must be a formal program of teaching provided for trainees. This teaching will include:
  - 4.1.1 Tutorials

# POLICY DOCUMENTS

*Review PS14 (1998)*

## GUIDELINES FOR THE CONDUCT OF MAJOR REGIONAL ANALGESIA IN OBSTETRICS

Major regional analgesia is a safe and effective method of pain relief during labour. Safety is enhanced by adherence to the following guidelines:

1. Cannulation of the epidural and/or subarachnoid spaces should only be carried out by a medical practitioner with appropriate training and experience in all relevant techniques. Major regional analgesia has the potential to change many of the normal physiological attributes of labour and delivery. From the time that major regional analgesia is instituted, it is essential that the mother is under the care of a medical practitioner with obstetric training who can assess the mother as necessary and rapidly effect delivery of the fetus by whatever technique is appropriate.
2. The practitioner establishing regional analgesia must:
  - 2.1 establish that the mother has consented to the procedure and has been appropriately informed about risks associated with the procedure. This should normally be a part of ante-natal education.
  - 2.2 be readily available to supervise the management of epidural and/or spinal analgesia.
  - 2.3 be competent to deal with any complication arising from the injection of drugs into the epidural or subarachnoid spaces.
  - 2.4 ensure that full instructions are provided to allow for the proper management and maintenance of major regional blockade.
3. An appropriately trained person must be present to assist the medical practitioner who is establishing major regional blockade.
4. When major regional analgesia has been established and the response of the mother to the administered drugs has been established by the medical practitioner, further doses to maintain epidural analgesia may be administered by other suitably trained medical or nursing staff provided that:
  - 4.1 all drugs have been prescribed by the medical practitioner.
  - 4.2 the person who will carry out the delegated tasks has received appropriate written and verbal instructions and understands those instructions.
  - 4.3 the person is competent to carry out the delegated tasks and to monitor the mother and the fetus.
  - 4.4 appropriate equipment and skilled staff are readily available to care for mother and fetus and to treat any complications arising from the regional analgesia or the labour.
5. All patients receiving major regional analgesia in labour must be nursed in an area appropriately staffed and equipped to:
  - 5.1 monitor both patient and fetus.
  - 5.2 assess the extent of neural blockade and detect any adverse effects of epidural or spinal analgesia.
  - 5.3 determine the need for further medication, treatment or interventions according to the circumstances of the labour.
6. When patient controlled or continuous infusion devices are in use, the practitioner establishing regional analgesia must be satisfied that both attending staff and the mother understand the use of the technique including its advantages, limitations and potential risks.
7. A permanent record of instructions given and observations made during the conduct of major regional analgesia must form a part of the mother's management notes.
8. All mothers receiving major regional analgesia must have an intravenous cannula inserted before establishment of neural blockade. Intravenous access must be maintained for the entire duration of neural blockade.



9. Removal of a regional analgesia catheter must be documented in the mother's management notes and should include comment on the time, the state of the catheter and of the puncture site.
10. At all times the responsibility for major regional analgesia remains that of the practitioner who performs the procedure or that of a delegated practitioner. The requirements of College Policy Document P10 – The Handover of Responsibility During an Anaesthetic apply.

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Promulgated: 1987

Revised: 1993

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*Review TE16 (1998)*

**REQUIREMENTS FOR MULTIDISCIPLINARY PAIN CENTRES OFFERING TRAINING IN PAIN MEDICINE**

**1. INTRODUCTION**

- 1.1 These guidelines establish the minimum standards for Multidisciplinary Pain Centres offering training for the **Diploma of Fellowship in Pain Medicine** of the Australian and New Zealand College of Anaesthetists.
- 1.2 A Multidisciplinary Pain Centre is a healthcare delivery facility staffed by medical practitioners of various specialties and other allied health professionals. These individuals specialise in the diagnosis and management of patients with chronic pain and/or patients with acute pain and/or patients with cancer pain, referred to generically as patients with pain.
- 1.3 The staff of a Multidisciplinary Pain Centre must be able to assess and treat the physical, psychosocial, medical, vocational and social aspects of patients with pain.
- 1.4 A number of allied health care disciplines must be represented on the staff of a Multidisciplinary Pain Centre. Such disciplines include nursing, occupational therapy, physiotherapy, clinical psychology, social work, vocational counselling and others appropriate to the population being served.
- 1.5 A session is a notional period of 4.5 hours devoted exclusively to the specified duty.

**2. ADMINISTRATIVE STRUCTURE AND STAFFING**

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

2.4.3 **Rheumatology, oncology, neurology, neurosurgery, orthopaedic surgery and other appropriate medical specialties:** regular clinical input is highly desirable from medical specialists.

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

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

**2.4.6 Allied Health Staff:**

2.4.6.1 **Clinical Psychologist:** there must be a minimum clinical input of five sessions weekly.

2.4.6.2 **Physiotherapist/Physical Therapist:** there must be a minimum clinical input of five sessions weekly.

2.4.6.3 **Occupational Therapy:** regular clinical sessions are highly desirable.

2.4.6.4 **Social Work:** regular clinical sessions are highly desirable.

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

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

- 1. Review of prior medical records
- 2. History taking and physical examination relevant to Pain Medicine
- 3. Psychological assessment and treatment
- 4. Referral for external medical consultation
- 5. Medical management
- 6. Physical therapy
- 7. Pain relief procedures
- 8. Vocational assessment and counselling
- 9. Other appropriate services, eg:
  - Cognitive behavioural programs

- Relaxation techniques
  - Biofeedback
  - Work hardening/exercise physiology
- 2.6 Regularly scheduled staff education sessions are essential.
- 2.7 Involvement in undergraduate and graduate medical, nursing and allied health education is highly desirable.
- 2.8 Regularly scheduled Quality Improvement/Peer Review activities are essential.
- 2.9 An active research program related to Pain Medicine is highly desirable.
- 2.10 A comprehensive patient record system is essential. A computerised data review system for diagnosis/treatment is highly desirable.
- 2.11 Documentation of treatment protocols and procedures for patients together with a statement of their rights and responsibilities is essential.
- 2.12 At least one full-time equivalent of secretarial assistance to the Centre is essential.
- 2.13 Allocation of RMOs is highly desirable.

### 3. PHYSICAL FACILITIES

- 3.1 Appropriate consulting and examination rooms are essential.
- 3.2 Access to procedure rooms with adequate equipment and staffing is essential. Staffing will include nurses, technicians and radiographers as required.
- 3.2.1 Anaesthesia and resuscitation equipment must comply with ANZCA College Policy Document T1 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites*.
- 3.2.2 Recovery facilities and procedures must comply with ANZCA College Policy Document P4 *Guidelines for the Care of Patients Recovering from Anaesthesia*.
- 3.3 Suitable office space for permanent staff and trainees is essential. See ANZCA College Policy Document E1 *Guidelines for Hospitals seeking College Approval of Training Posts in Anaesthesia*.
- 3.4 Access to in-patient beds.
- 3.4.1 Access to in-patient beds is mandatory.
- 3.4.2 In-patient beds designated to the Multidisciplinary Pain Centre are highly desirable.
- 3.5 Access to an adequate library with major pain medicine books and access to bibliographic database(s) for journal publications are mandatory.

### 4. CLINICAL WORKLOAD AND STANDARDS

- 4.1 Numbers of new patients per annum:
- 4.1.1 **Acute perioperative/Trauma:** a minimum of 200 new patients per annum per trainee.

4.1.2 **Chronic non-cancer pain and cancer pain:** a minimum of 300 new patients per annum per trainee.

- 4.2 **Out-patient medical specialist sessions:** There should be a minimum of five per week.
- 4.3 **Formal interdisciplinary case conferences:** must be held at least once weekly (to draw up a treatment plan in discussion among a number of health professionals who have seen the patient in consultation). Preferably three to five per week will be held.
- 4.4 **Procedural sessions:** A minimum of one pain relief session (eg: diagnostic and therapeutic nerve blocks, etc.) per procedural specialist per week.
- 4.5 **In-patient rounds:** There must be a minimum of six day rounds per week to cover all patients under the care of the Pain Centre. There must be medical specialist input to the rounds.
- 4.6 There must be a medical specialist designated to the Pain Centre available 24 hours per day throughout the year. This cover must include scheduled out-of-hours rounds.
- 4.7 **Therapeutic interventions:** Nerve blocks and similar interventions should total a minimum of 300 procedures per trainee per annum.
- 4.8 **Audit and clinical review sessions:** These must be held at least monthly and include documentation of results.

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*Promulgated: 1992*

*Reviewed: 1995*

*Date of Current Document: Oct 1998*

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*This document supersedes ANZCA Policy Document P25 Minimum Standards for Pain Management Units (1996).*

*Review PS3 (1998)***MAJOR REGIONAL ANAESTHESIA AND ANALGESIA****1. GENERAL PRINCIPLES**

- 1.1. Major regional anaesthesia and analgesia must be undertaken only by medical practitioners with adequate tuition and experience in the technique, or by others under appropriate supervision. All persons who undertake such procedures must understand the relevant anatomy, physiology, pharmacology and complications of the particular procedure and the contraindications to it being performed. They must be able to recognise and promptly treat any complications.
  - 1.2 Major regional anaesthesia and analgesia techniques (eg epidural, spinal, plexus or intravenous regional blockade) can have serious side effects and complications due to marked physiological changes, local anaesthetic drug toxicity and problems arising from insertion of the needle.
  - 1.3 One person must not assume the dual responsibility of both the operator and the anaesthetist for patients having any form of major regional anaesthesia or analgesia.
  - 1.4 Informed consent must be obtained from the patient for all regional anaesthesia and analgesia.
  - 1.5 Infection control and aseptic procedures appropriate to the particular regional anaesthesia technique must be used.
  - 1.6 Management of major regional anaesthesia must include secure intravenous access and patient monitoring in accordance with Policy Document P18 "Monitoring during Anaesthesia".
  - 1.7 The anaesthetist must be in attendance throughout the procedure or until the blockade has been demonstrated to be satisfactory, its extent determined, the condition of the patient is satisfactory and stable and the potential for acute complications has passed.
- 2. SPECIFIC PRINCIPLES FOR POSTOPERATIVE ANALGESIA MANAGEMENT USING AN EPIDURAL OR OTHER INDWELLING CATHETER**
    - 2.1 Safe and effective analgesia via an epidural or other catheter in situ depends on the following:
      - 2.1.1 Secure intravenous access must be present throughout the administration of analgesia.
      - 2.1.2 The catheter must be clearly labelled to avoid the accidental administration of other substances.
      - 2.1.3 All drugs and management instructions must be prescribed by the anaesthetist who performed the procedure, or by an appropriately trained delegate.
      - 2.1.4 Written protocols for the management of overdose, acute problems such as hypotension, respiratory depression, over-sedation and central nervous system toxicity must be readily available for reference at all times.
      - 2.1.5 Protocols must be available describing the identification and management of suspected complications at the catheter insertion site, particularly with regard to epidural abscess and spinal cord compression.
      - 2.1.6 Information regarding the prevention, identification and management of other potential complications must be available.
      - 2.1.7 The required observations specific for the particular technique must be charted.
      - 2.1.8 Removal of the catheter must be documented in the management notes, including the date, time, state of the catheter and of the puncture site. Follow-up assessment is desirable.
    - 2.2 The anaesthetist may delegate the further intermittent administration of drugs or the supervision of an infusion to another medical practitioner or registered nurse or to a pain service provided that:
      - 2.2.1 The personnel managing major regional anaesthesia and analgesia have received specific training concerning epidural or other catheter analgesia management and complications, and have carried out a sufficient number of administrations satisfactorily under supervision.

2.2.2 It is the responsibility of the anaesthetist to satisfy himself/herself of the competence of the person or service to manage the analgesia and its potential complications.

### 3. EQUIPMENT AND STAFFING

Equipment and staffing of the area in which the patient is being managed should satisfy the requirements of the following Australian and New Zealand College of Anaesthetists Policy Documents:

- T1 Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites.
- T6 Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites.
- P2 Privileges in Anaesthesia.
- P4 Guidelines for the Care of Patients Recovering from Anaesthesia.
- PS8 The Assistant for the Anaesthetist.
- P9 Sedation for Diagnostic and Surgical Procedures.
- P10 Handover of Responsibility during an Anaesthetic.
- P14 Guidelines for the Conduct of Epidural Analgesia in Obstetrics.

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*Promulgated: 1982*

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*Drs Des O'Brien, Gavan Carroll and Phelim Reilly with Prof. Emeritus Tess Cramond at the 1998 Registrars' Meeting, Royal Pines Resort, Queensland.*



*Staff members, Helen Morris and Carolyn Handley celebrate Conferment of Australian Citizenship.*

**FACULTY OF INTENSIVE CARE  
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS**

ACN 055 042 852

**POLICY DOCUMENTS**

E = Educational    P = Professional    T = Technical    EX = Examinations  
PS = Professional Standards    TE = Training and Examinations

- 130
- IC-1 (1997) Minimum Standards for Intensive Care Units *Bulletin Aug 94, pg 44*
  - IC-2 (1994) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin Aug 94, pg 49*
  - IC-3 (1998) Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care *Bulletin Nov 98, pg 70*
  - IC-4 (1994) The Supervision of Vocational Trainees in Intensive Care *Bulletin Aug 94, pg 54*
  - IC-5 (1995) Duties of Regional Education Officers in Intensive Care *Bulletin Nov 95, pg 50*
  - IC-6 (1995) Supervisors of Training in Intensive Care *Bulletin Nov 95, pg 46*
  - IC-7 (1994) Secretarial Services to Intensive Care Units *Bulletin Aug 94, pg 57*
  - IC-8 (1995) Ensuring Quality Care - Guidelines for Departments of Intensive Care *Bulletin Mar 95, pg 32*
  - IC-9 (1997) Statement on Ethics and Patients' Rights and Responsibilities *Bulletin Nov 97, pg68*
  - IC-10 (1996) Minimum Standards for Transport of the Critically Ill *Bulletin Mar 96, pg42*
  - IC-11 (1996) In-Training Assessment of Trainees in Intensive Care *Bulletin Mar 96, pg 46*
  - IC-12 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin May 96*

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- E1 (1996) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
- 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, pg 88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
- E6 (1995) The Duties of an Anaesthetist *Bulletin Nov 95, pg 70*
- E7 (1994) Secretarial Services to Departments of Anaesthesia *Bulletin Nov 94, pg 43*
- E9 (1993) Quality Assurance *Bulletin Mar 93, pg 38*
- TE11 (1997) Guidelines for the Completion of a Formal Project *Bulletin Nov 97, pg 91*
- E13 (1996) Guidelines for the Provisional Fellowship Year *Bulletin Nov 96, pg 66*
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, pg 62*
- TE15 (1998) Guidelines for Trainees and Departments seeking College Approval of Posts for the Certificate in Pain Management *Bulletin Mar 98, pg 70*
- TE16 (1998) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin Nov 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 (1998) Major Regional Anaesthesia and Analgesia *Bulletin Nov 98, pg 85*
- P4 (1995) Guidelines for the Care of Patients Recovering from Anaesthesia *Bulletin Aug 95, pg 64*
- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
- PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
- PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 98, pg 76*
- 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 66*
- P28 (1995) Policy on Infection Control in Anaesthesia *Bulletin Mar 95, pg 38*
- PS29 (1997) Anaesthesia Care of Children in Healthcare Facilities Without Dedicated Paediatric Facilities *Bulletin Nov 97, pg 82*
- PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg 84*
- PS36 (1997) Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg 93*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 98, pg 79*