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Australian and New Zealand College of Anaesthetists
Faculty of Pain Medicine
Joint Faculty of Intensive Care Medicine

Perioperative Medicine
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THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
As part of our commitment to the general health and wellbeing of all Australians, ANZCA President, Dr Walter Thompson, has called on the Federal and State Governments to introduce wide-ranging measures the College believes could have a significant impact on the obesity epidemic currently threatening the nation.

In a letter to Prime Minister John Howard, and all state health ministers (see page 5) Dr Thompson urges a ban on all marketing of food that targets children, and suggests fiscal policies to make healthy food cheaper than junk foods.

There is an epidemic of obesity in the Australian community. We have become complacent regarding obesity in the adult population, but we are now seeing a growing problem in our children, with dire consequences for their future health and wellbeing. The potential impact on the cost and outcomes of healthcare, is enormous.

Australians have known that having an anaesthetic carries a risk of death or serious injury, but they have rightly come to believe that the risk is small and diminishing. The risk of death due to anaesthesia has fallen from 1 in 1000 in 1950, to 1 in 80,000 today, despite more complex surgery on patients at the extremes of age. The three million Australians who undergo surgery each year expect to have a good outcome, and to return to their normal life, barring deterioration of their underlying medical condition.

Despite what is arguably the safest anaesthesia in the world, can we continue to guarantee that good outcome? Are obese adults and children compromising the ability of our highly trained specialists to deliver the world’s best healthcare? Is it time for patients to take some responsibility for their healthcare outcomes?

So how does obesity compromise the safety of an anaesthetic?

It has been said that ‘inside every fat man, is a small man trying desperately to get out!’, and therein lies one of the basic problems for an anaesthetist – just how big is the small man inside? Every anaesthetic involves the administration of a myriad of drugs, often ten or more over the course of the procedure, while the patient remains blissfully unaware of the constant care and attention being administered. All drugs need to be tailored to the size and condition of the patient, but in obese patients, we don’t know what their real size is – we have to make a calculated guess. We can get it roughly right most of the time, but sometimes there will be underdosing, and sometimes there will be overdosing.

With obesity comes the increased likelihood that a patient may suffer from a range of other diseases, including heart disease, hypertension, diabetes, and respiratory disease, and it has been shown that extremely obese individuals have a life expectancy of 20 years less than the average. We now know that many of these diseases begin in childhood. In one study in Cincinnati, in the USA, 25% of children aged 4 to ten years were glucose intolerant – a precursor to diabetes, and a recognized risk factor for the development of coronary artery disease. There is already a well established increase in the incidence of obesity in children, indeed the rate of increase in childhood obesity in Australia is greater than in any other country in the world. 70 to 80% of obese adolescents will become obese adults.

Heart disease, hypertension and diabetes, all significantly increase the risk associated with having an anaesthetic. Despite all the knowledge and skill of today’s highly trained anaesthetist, with the benefit of a vast array of continual monitoring information during an anaesthetic, a patient with major cardiovascular disease exists on a ‘knife-edge’ during an anaesthetic.

Respiratory disease is a common accompaniment to obesity, with frequent infections, asthma and sleep apnoea. We all know that snoring is more common in obese people. Snoring is often a sign of sleep apnoea, or interrupted breathing while asleep. Obese patients, or those with sleep apnoea are at significantly increased risk of having breathing complications during and after an anaesthetic. They are more likely to have difficulty sustaining adequate oxygen levels in the blood at the beginning of the anaesthetic, and it is more difficult for the anaesthetist to place a breathing tube in the patient’s trachea for control of their breathing. After the procedure, obese patients are less able to breathe deeply, to cough, and to get moving out of bed – thus they are more likely to suffer from postoperative lung infections or pneumonia.

Obese patients are more likely to regurgitate or vomit both at the beginning of an anaesthetic, and as they recover.
Regurgitation at the beginning of an anaesthetic is particularly dangerous, as stomach contents can find their way into the lungs, resulting in life-threatening pneumonia. Many of the drugs used during an anaesthetic are given intravenously. There is often great difficulty in securing suitable intravenous access in obese patients, so that multiple attempts are not uncommon. Although not a direct result of the anaesthesia, obese patients are at much greater risk of other complications after surgery, including venous thrombosis and breakdown of the surgical wound. The thrombosis, usually in the legs, may give rise to clots which can travel to and lodge in the lungs, sometimes resulting in sudden death. Surgical wounds in obese patients are more likely to become infected, and to fall apart.

How do we measure obesity? We use the Body Mass Index, or BMI, calculated by dividing the body weight in kilograms, by the height in metres squared. For instance, for an adult of 70kg with a height of 180cm, the BMI is 22. In adults, a BMI over 25 is considered overweight, and a BMI of 30 or more is a sign of obesity. A BMI of over 40 signifies extreme obesity.

The health of the Australian community is at a crisis point. Every year, an additional 1.1% of Australian adults become overweight, but an additional 1.7% of Australian children become overweight. An estimated 20 to 25% of Australian children aged 5 to 17 are now overweight or obese.

Many patients, and even many health professionals, have come to believe that anaesthesia is very safe – and indeed it is – for the average healthy person. With so many ‘average’ members of the population becoming unhealthy as a result of obesity, it may no longer be so certain that an anaesthetic can be provided without significant risk.

Do anaesthetists have a responsibility to warn obese patients (or their parents) of the increased risks associated with having an anaesthetic? Should anaesthetists advise patients to lose weight, to embark on a weight loss diet, or to exercise, or change their lifestyle before surgery?

Do we continue to treat the obese patient with severe sleep apnoea, by giving them an anaesthetic and taking out their tonsils, rather than addressing the underlying problem?

Is it reasonable for the anaesthetist to refuse to anaesthetize an obese patient for an elective procedure, unless that patient makes some determined effort to lose weight?

Should the obese patient be obliged to accept part of the medicolegal risk associated with the administration of an anaesthetic?

These are all questions that need to be addressed, but, it is time for the Governments, State and Federal to address the issue seriously. Unless the Federal Government, and the States follow the lead of Victoria and New South Wales, and more, the obesity crisis will grow.

The removal of high sugar containing foods and drinks from school canteens is an important first step, but a ban on advertising of snack foods and drinks, especially to children, is an urgent national health measure. A national advertising campaign must be undertaken to advise parents on the dangers of an unhealthy diet, and the means to improve it. The Prime Minister’s well publicized morning walks are also an ideal basis on which to launch new initiatives in increasing the amounts of exercise undertaken by adults and children.

The Australian and New Zealand College of Anaesthetists calls on the Prime Minister, and the Federal and State Health ministers to urgently address the obesity epidemic.

Dr Rod Westhorpe - The Editor

‘Are obese adults and children compromising the ability of our highly trained specialists to deliver the world’s best healthcare?’
Surgery deaths feared because of obesity

Adam Cresswell
Health editor

LIFE-THREATENING complications on the operating table are becoming more common in a sinister but little-known consequence of the nation’s growing obesity epidemic.

As more than 2500 experts gather in Sydney today for the International Congress on Obesity, doctors say they are increasingly having to struggle to ensure correct anaesthesia and blood-oxygen levels in obese patients undergoing surgery.

Refusing surgery to obese patients may become more common in an effort to limit the added risks, the doctors warn.

Being overweight makes it harder to gauge the correct dose for the mix of up to 10 anaesthetic drugs given to patients during major operations.

And obese patients are at higher risk of other things that can go wrong — such as vomiting during the operation, which can result in stomach contents being inhaled into the lungs and cause life-threatening pneumonia.

Analysis of height and weight data from the 1999-2000 Australian Diabetes, Obesity and Lifestyle (AusDiab) Study estimated 21 per cent of Australians aged 25 and older were obese. Among those older than 55, the rate was just over 20 per cent.

Already some obese patients are being refused surgery because the added risks they face are not worth the benefits.

In one recent case in Melbourne, a 12-year-old boy who weighed 100kg had surgery to remove his tonsils cancelled after the anaesthetist raised concerns with the surgeon.

The patient, who had breathing difficulties related to his weight, was referred to a dietitian.

The Australian and New Zealand College of Anaesthetists is so concerned by the situation it has written to John Howard to warn that rising obesity rates mean the “continuation of safe anaesthesia in Australia is in jeopardy”.

The letter, signed by college president Walter Thompson, says the death rate under anaesthesia has improved from one death per 1000 in 1950 to one in 80,000 now — but that this improvement might be turned around “due to the epidemic of obesity in the Australian community”.

“Childhood obesity is acknowledged to be increasing at a faster rate in Australia than in any other country, and almost invariably childhood obesity leads to adult obesity,” Dr Thompson wrote.

His letter urges the Prime Minister to ban all marketing of food targeting children, establish strong physical activity targets in schools, ban junk food and drinks from public buildings and adapt tax and other policies to make healthy foods cheaper than high-fat, high-sugar foods.

ANZCA council member Rod Westhorpe, a pediatric anaesthetist at Royal Melbourne Hospital, said there was “no question among my colleagues and I that there’s a significant increase in the numbers of obese children coming in for surgery”, and that those patients were experiencing more complications.

Dr Westhorpe — who raised the concerns over the 12-year-old patient — said that as in that case, many young obese people were scheduled for surgery to remove tonsils and adenoids to make breathing easier.

“Things are going wrong more often,” he said.

“I talk to my colleagues every day, and they will all have stories to tell about obese patients. If a patient has major breathing problems during an anaesthetic, or if a patient has diabetes and hypertension (high blood pressure), or heart disease related to their diabetes and obesity, they may be more likely to have a heart attack under the anaesthetic.”
PM08060000906

1st September 2006

The Hon. John Howard MP
Prime Minister
Parliament House
CANBERRA ACT 2600

Dear Prime Minister,

The Australian and New Zealand College of Anaesthetists takes pride in its achievements with respect to the improved safety for patients undergoing anaesthesia in Australia. The rate of death related to anaesthesia is now less than 1 in 80,000 anaesthetics, compared with 1 in 1,000 in 1950, when specialist anaesthesia training began. The safety of anaesthesia in Australia is a direct consequence of the depth and standard of specialist training overseen by the College.

The continuation of safe anaesthesia in Australia is in jeopardy due to the epidemic of obesity in the Australian community. Obesity poses a serious hazard to patients having anaesthesia and surgery, for the reasons outlined in the attached document.

Childhood obesity is acknowledged to be increasing at a faster rate in Australian than in any other country in the world, and almost invariably, childhood obesity leads to adult obesity.

The future costs to healthcare as a result of the obesity epidemic are enormous, through increases in both morbidity and mortality.

I urge you to take the initiative and implement the following strategies in order to secure the future health of our nation.

- Ban all marketing of food directed at children.
- Establish strict food and physical activity requirements in primary and secondary schools.
- Remove “junk” foods and drinks from all publicly funded premises.
- Institute clear “traffic light” labelling of all foods, identifying the nutritional profile.
- Implement fiscal policies that progressively change the relative prices of foods and drinks that are high in fat or sugar, in favour of more nutritionally beneficial foods.
- Implement a national campaign on healthy eating and food preparation.

Prime Minister, I sincerely hope you consider these strategies as they will be of great benefit to the future health and wellbeing of Australians.

Yours sincerely,

[Signature]

Dr W J Thompson
President
‘That is, we know roughly where we want to go but not precisely’

That is a short quote from Hon. Pete Hodgson, the New Zealand Health Minister, at the opening of a ‘Health Workforce Sustainability Conference’ in New Zealand. He was explaining why he was establishing a Workforce Taskforce to take over from the HWAC Medical Reference Group and the Doctor’s in Training Roundtable in considering changes to undergraduate and postgraduate medical education.

A similar comment might well apply to the changes and initiatives that came out of the July Council of Australian Governments (COAG) meeting. The two initiatives that are of particular interest to medical practitioners in Australia are:

National Professional Registration. This is to be established by July 2008 and it is proposed that it would apply to the nine occupational groups that are currently subject to statutory registration in all jurisdictions. COAG’s preferred model is stated to be a single cross-profession national registration board that would assume ongoing administration for a consolidated health practitioner registration scheme. The Commonwealth, State and Territory Governments would determine implementation, governance and policy setting via a ministerial council of Health Ministers. It is likely that professional input will be restricted to certain profession-specific panels.

The proposed scheme goes far beyond the notion of ‘portability’ which has gained acceptance amongst the medical profession. It will place state-based medical registration within a large and complex organisation which is at the behest of various levels of government. Medicine will have to share representation with the other nine occupational groups and the professional medical input will be reduced to that provided by the professional panels. The role of the current Medical Boards is not clear and there is no indication at this stage how matters relating to competency, impairment, ill health, discipline and remediation would be dealt with.

National Accreditation. COAG agreed that ‘in order to simplify and improve the consistency of accreditation arrangements for education and training of the health professions, a national scheme for the accreditation of health professions’ education and training be established by 1 July 2008’. The scheme would apply to the nine occupational health groups, alluded to above but would include other health occupations as determined by the ministerial council.

The proposals in relation to national accreditation beg the question as to what would happen to the Australian Medical Council. The suggestions have ranged from abolition, to maintaining the status quo, to placing it under a new ‘over-arching body’. The AMC has proven to be a useful body for accrediting medical schools, medical colleges and specialties, and it has credibility plus a good track record. There would be grave concerns if there was to be an entirely new approach to accreditation.

National Registration already exists in New Zealand with all health professionals under a single Act of Parliament but there is a separate statutory authority for medical practitioners, which deals with both medical registration and accreditation.

In discussions this week with senior officials from the Department of Health and Ageing in Canberra, it was clear that the Department is of the view that there should be one registration body for all health professions. We expressed our concerns regarding the complexity of the proposed scheme and the risk that the standards applied to medical registration would be reduced to facilitate the registration of the other health professions. They saw it rather as an attempt to bring the registration of other health professionals to the standard of medical practitioners and to ensure that there was a uniform standard across the country. In relation to the AMC they suggested that it might retain its current role but noted that it is currently not a statutory body and the lines of accountability were not defined.

In general discussion, it was pleasing to note that they had a good understanding on the changes to the ANZCA training program and the accreditation of departments and were also aware of the work being done to meet the requirements of the jurisdictions. The officials were also interested to hear of the exploration of peri-operative medicine and the developments proposed in relation to the Quality and Safety Committee. It was interesting to note that in the context of registration and accreditation they inquired as to the College’s processes for continuing professional development (CPD). We pointed out that as a result of the Taskforces there is currently a review of MOPS program, which is in line with the concepts of CPD and aimed at ‘life long learning’.

The College was seen as being proactive in these initiatives and it is important that we continually review our directions and continue to lead developments in education, training, quality and safety in order to the practice and status of anaesthesia.

In closing, I would like to welcome Dr Annabel Orr to Council. Annabel was recently elected as the New Fellow Representative on Council. Dr Orr has previously served on College Committees as the Representative from the New Fellows Conference and as the Chair of the Trainee’s Committee. We look forward to her contributions to the work and deliberations of Council.
Distance Education: A Proposed Initiative to Supplement Preparation for the Final Examination

Trainees preparing for their Final Examination all face similar educational challenges regardless of the region or country in which they are located.

The last issue of the Bulletin published an article entitled ‘Distance Education within ANZCA’. This article drew attention to several challenges faced by ANZCA as an educational organisation. First, our teaching and learning must be able to reach all Trainees who wish to optimise their knowledge, skills and abilities within anaesthesia. Second, our Traineeship is geographically dispersed primarily throughout five countries; Australia, New Zealand, Hong Kong, Singapore and Malaysia. Third, travel to educational events for busy anaesthetists is not always practical and, where possible, education should be available at convenient locations. Finally although many of ANZCA’s more than 170 training sites are well equipped with educational resources and supported by educationally dedicated Fellows, Trainees at other sites are less fortunate. Hence, it would seem educationally advantageous to facilitate distance education programs that can benefit all Trainees with the intent of supplementing the many valuable educational programs already available in some regions and countries. The intent would not be to replace any of these programs but rather to complement them and to expand their reach.

Videoconferencing offers the opportunity to bring geographically dispersed content area experts together into a single educational presentation no matter where they are located. For example, if a course was designed to be videoconferenced for two or three hours each fortnight focusing on specific topics relevant to the Final Examination, then it would be possible to bring together via videoconference several content area experts from any region or country for any given topic presented at any given time.

1) A greater impact factor
Those of us who have created courses, coordinated instructors for an educational program, and developed educational materials for specific topics know how much time and effort this requires. Whereas it is gratifying for this effort to benefit any Trainee, it is much more advantageous, and satisfying, if a course can reach a wider audience.

2) Ready access to content experts
Videoconferencing offers the opportunity to bring geographically dispersed content area experts together into a single educational presentation no matter where they are located. For example, if a course was designed to be videoconferenced for two or three hours each fortnight focusing on specific topics relevant to the Final Examination, then it would be possible to bring together via videoconference several content area experts from any region or country for any given topic presented at any given time.

3) Management of instructor fatigue
After several years, instructors may no longer wish to present on a particular topic. Videoconferencing allows course developers access to a larger pool of instructors thereby reducing workload on individual instructors. This also has the advantage of there being additional instructors available in case a scheduled instructor cannot make a particular event at short notice due to an illness or unexpected clinical event.

4) Provision of resources for Trainees on rural rotations
The tyranny of distance means Trainees in rural locations often find attendance at examination courses particularly challenging. Videoconferencing a course would enable all Trainees, regardless of their location, greater access to a valuable examination preparation resource.

It is possible to place copies of slides used in a videoconference together with an audio recording of the accompanying dialogue into an electronic file. Thus, any trainee who was unable to attend a videoconference site would be able to view the slides as well as listen to a recording of the event at a later time (accessed from the College website). Trainees may also choose to use this technique as a pre-examination refresher. This additional availability of the course would also allow distance disadvantaged rural anaesthetists the option to access the material for continuing medical education. Access to this online material would be pass word protected and data could be kept regarding usage ‘hits’ and, if by Fellows, then used to accumulate credit towards continuing professional development activities.

NEXT STEPS
ANZCA is fortunate that there are already a number of very successful Final Examination preparation courses that are provided weekly or fortnightly within specific regions. It would seem advantageous to offer those involved in the organisation, running and instruction of these courses the opportunity to combine their considerable expertise in the development of a
course for dissemination via videoconference to Trainees in all regions and countries. It is important to emphasise that the purpose of such a course would not be to replace any of the excellent courses that are already in existence. Rather the purpose of the course would be to broaden support for all Trainees and those involved in the preparation of trainees for the Final Examination. Those regions and countries that are already involved in the provision and preparation of courses and materials for the Final Examination are encouraged to continue to do so. In particular, it is important to acknowledge that the videoconferencing of a fortnightly course could not (and should not) replace the value of intensive one or two week exam preparation courses or practice vivas. I would like to invite those regions who already run weekly or fortnightly courses to consider whether they would like to expand their course throughout all regions and countries where ANZCA Trainees prepare for final examinations.

CONCLUSION
In closing, it is important to consider that if the model described above requiring cooperation between all ANZCA regions and countries is successful as an aid in preparing Trainees for the Final Examination, then such a model can be duplicated for other educational initiatives for the benefit of both Fellows and Trainees.

ACKNOWLEDGEMENTS
I would like to thank Dr Tracey Tay and Dr Taff Hughes for valuable suggestions on an earlier draft of this article.

Professor Russell Jones
Director of Education, ANZCA
Systematic reviews

**RESEARCH REPORT**

This installment of the Research Report attempts to provide a brief overview of systematic review methodology and provide those with a keen interest with some useful resources. To start it is important to understand that a systematic review is different from a standard narrative review. Put simply, systematic reviews apply (and report) a scientific approach to the identification, selection, appraisal and synthesis of evidence on a focused clinical question – narrative reviews do not. Also in terms of linking the evidence to clinical decisions narrative reviews can be unreliable.1,2,3,4

Summarising the evidence has proved to be a science in itself and just like conventional research the first step is to develop a protocol outlining the methods of your review. In developing your protocol you will need to define your clinical question, develop your search strategy; select the databases you intend to search; establish your inclusion and exclusion criteria for selecting the studies, and outline how you intend to analyse the results. It’s important to establish these methods a priori in order to limit the potential for the data of individual studies to influence the review (for example excluding studies with unexpected or undesirable results).5 The following are some examples of review protocols published on the Cochrane library.6,7

**Development of a defined clinical question:** For a systematic review to work well you need a research question that is clear and focused.8 From the outset the research questions provides the framework for how you develop your search strategy and how you choose which articles to include or exclude from your review. In developing your research question you’ll need to consider the patient population your interested in, the intervention you wish to investigate, the treatment alternative you want to compare it to and suitable outcomes with regards to clinical effectiveness and safety. A good way to think about it is in terms of PICO (patient, intervention, comparator and outcome). The following is an example of a well formulated clinical question ‘Does propofol lead to fewer unexpected overnight admissions than thiopental after adult day case laparoscopic sterilization?’

**Searching and locating the evidence:** When searching and locating the evidence for systematic reviews the ultimate goal is to identify ALL high quality studies on your topic. Some of the ways in which this can be maximised is to search multiple electronic databases such as Medline, Embase, Pubmed and the Cochrane Central Register of Controlled trials (One of the main reasons for searching more than one database is that there are differences in the journals and articles that each of them index). It is also important to consider unpublished or ‘Grey literature’ such as theses, internal reports, non peer reviewed journals and industry reports as these may also uncover relevant studies. All of the databases listed above can be accessed through the College website http://www.anzca.edu.au/libonlinejournals/index.htm. For those that haven’t accessed the library website before you’ll need to register for a user name and password on the following link http://www.anzca.edu.au/reg/anzca_reg.cfm.

You will also need to document how you searched these databases. If you are unfamiliar with developing a search strategy or are unsure about the syntax you should use (which can vary between databases), Trisha Greenhalgh (1997) has published a guide for searching Medline which is a good introduction.9 I also strongly suggest that you contact the College librarian Shanti Nadaraja who has a wealth of expertise in search strategy development and database searching.

**Selection of relevant studies:** Decisions regarding which studies to include in your review will depend on your research question. For example you may wish to limit your review based on:

- study design e.g. only include randomised controlled trials;
- types of participants e.g. you may only want to include studies of adult patients and exclude children;
- types of interventions
- outcome measures and
- Language

Reviews investigating the effect of health care will generally only include randomised controlled trials as they are widely accepted as the gold standard for assessing the effectiveness and safety of a particular treatment. However a cohort study may be more appropriate for reviews investigating the accuracy of diagnostic tests. You will also need to consider whether it’s worth placing specific language restrictions on the articles you include. A study by Egger 1997 showed that there was a language bias in randomised controlled trials published in English and German, whereby RCT’s of negative findings were more likely to be published in German language journals.10

**Quality assessment:** The interpretation of results is dependent on how bias was limited in the study. An essential part of the systematic review process is to critically appraise the studies that you have selected. The critical appraisal process is essential in determining whether the results are clinically important in terms of answering our review question and whether the results are valid. For
question and whether the results are valid. For randomised controlled trials the accepted criteria for assessing methodological quality includes:11

- Quality of concealment of random allocation
- Clarity of inclusion exclusion criteria
- Adequacy of information about study withdrawals
- Adequacy of description of treatment and control groups at study entry

Data analysis: As part of the protocol you’ll need to plan the statistical analyses that you will use as part of your review. One of the most common techniques used in systematic reviews is Meta-analysis whereby the results of individual studies are statistically pooled to give an overall estimate of effect. The value of using this technique is that it can improve the overall precision of the effect and increase power (i.e. the probability of detecting a statistically significant effect if one exists). However meta-analysis is not always appropriate particularly if the results of the study differ greatly. One of the approaches used to ascertain whether pooling is appropriate is to test for heterogeneity across studies.12 Generally if the results do differ you should explore why this variability exists for example it may be that the studies investigate different patient populations, interventions may differ in terms of dosage or route administration or there may be differences in how outcomes measures were defined. It also important to note that one of the limitations of meta-analysis is that it cannot control for sources of bias from individual studies. In the end a good meta-analysis of badly designed studies will result in poor validity.

A useful adjunct to the meta-analysis is the funnel plot, which is primarily used to detect publication bias. A funnel plot is essentially a scatter plot of the treatment effect against the sample size. In the absence of bias the plot should resemble a symmetrical inverted funnel. An asymmetric funnel indicates the presence of publication bias or systemic differences between smaller and larger studies.5

ADDITIONAL READING
For those with a keen interest in conducting a systematic review one of the most comprehensive resources is the Cochrane Handbook for Systematic Reviews of Interventions.23 The Cochrane Anaesthesia Review Group also has a Guide for authors wishing to develop a systematic review for the Cochrane library.24

The Trials Group is currently undertaking three systematic reviews: Target controlled infusion versus manual infusion of propofol; Transoesophageal echocardiography; and Agreement in cardiac output thermodilution versus non-invasive techniques. For anyone who would like some additional information or assistance regarding systematic reviews the Trials Group are happy to help: ph (03) 8517 5326 or email: oclavisi@anzca.edu.au

REFERENCES:
8. Richardson et al. The well-built clinical Question: A key to evidence based decisions. ACP J Club 1995; A12-3.
THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

EDUCATIONAL GRANTS FOR TRIALS OF WORKPLACE ASSESSMENT TOOLS

The Education and Training Committee of ANZCA has resolved to investigate appropriate instruments for assessing vocational trainees in the workplace. The ultimate aim of this investigation is to provide tools for the summative in-training assessment of trainees. Applications are therefore invited from ANZCA Fellows for grants to investigate the possible application of three educational assessment tools (the mini-CEX, DOPS and ANTS). The budget available to support these projects is up to AUD$100,000 in total.

These grants are offered subject to the following conditions:

1. ANZCA will support the development of one site each to investigate the Mini-CEX, DOPS and ANTS. Sites must be ANZCA-Approved Hospital Departments of Anaesthesia in Australia or New Zealand. The first-named investigator must be a financial ANZCA Fellow.

2. Investigators must submit a detailed research plan, the curriculum vitae of each of the named investigators and a letter of support from the Director of the Department. Each proposal must include a budget. Each proposal must also include a statement that ethics committee approval will be sought or that the local ethics committee has stated that ethics committee approval is not necessary. Applications will be processed but monies will not be disbursed until such approval or statement is received by the College.

3. Applications must be received as a hard copy or pdf file including all signatures, by 5pm EST at ANZCA House on the closing date. Late or incomplete applications WILL NOT BE ACCEPTED.

4. Proposals must address the following issues of interest to the College: validity, reliability, feasibility, acceptability, resource utilisation. Not all proposals need address all issues.

5. Proposals must address the assessment of core knowledge, skills, attitudes and behaviours as outlined in the ANZCA Curriculum Modules.

6. Sites must be prepared to commence investigation by the start of the 2007 Training Year and have final results available for the ANZCA Education and Training Committee in April 2008.

7. Sites may present their results or offer them for publication in the peer-reviewed literature, with the prior permission of the Chair of the Education and Training Committee.

CLOSING DATE: 5 PM EST Friday 27 October, 2006

Please submit enquiries and applications to:

Ms Jill Humphreys
Executive Officer (Professional Areas)
Australian and New Zealand College of Anaesthetists
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Email: jhumphreys@anzca.edu.au
On Friday 16th June, 2006 a significant event in the history of ANZCA and of anaesthesia as a research based discipline took place. In the Great Hall of the University of Sydney, Professor Michael Cousins was awarded the degree of Doctor of Science (DSc) for his thesis ‘Pain, Analgesia and Anaesthesia: Management of Acute, Chronic and Cancer Pain’

FIRST DOCTOR OF SCIENCE DEGREE FOR ANZCA

The research in this thesis spans the 36 years 1969-2005, and was carried out at McGill University, Montreal Canada; Stanford University, California USA; Flinders University Adelaide SA; and the University of Sydney. The DSc is the highest research degree of Universities and is the first to an ANZCA Fellow in the history of our specialty. A significant number of ANZCA Fellows have received MD and PhD degrees; Professor Cousins was awarded MD in 1976 by Sydney University.

The research comprises 130 of Professor Cousins 148 original publications, a selection of relevant material from his 101 reviews / book chapters and from his 10 editorials and 10 case reports. This two volume 2226 page thesis includes the large majority of these 269 publications resulting from his research with various research teams that he developed and led. The research resulted in many invitations to present keynote lectures at International meetings with over 200 invited lectures between 1975 and 2005 alone.

Professor Cousins’ first research degree (MD) resulted from 18 publications in collaboration with Richard I Mazze at Stanford University on the topic of Metabolism and Renal Toxicity of Inhalation Anaesthetics. This research partnership over the years 1970-74 produced the 52nd most frequently cited paper in the Anesthesiology literature over the past 60 years, (248 citations) and overall the 5th most cited in the Anesthesiology literature over the past 60 years (738 citations) and the 5th most cited in the Pain literature.

The final 3 chapters comprise studies aimed at improving the efficacy and safety of intravenous sedatives, analgesics and anaesthetic agents, as well as inhalation anaesthetics, used in the relief of nociception and pain during and after surgery.

At Professor Cousins’ Farewell College Dinner he presented a copy of the thesis to President Wally Thompson to be placed in the ANZCA Library. Some of the key publications in the pain oriented section of the thesis are:

- The first John J Bonica Lecture in 1989, which proposed the concept of ‘acute rehabilitation’ linked to acute pain management (Reg Anesth Pain Med 1989;14:162-78)
- The first critical analysis of basic and clinical science underpinning the concept of persistent pain as a disease entity. (Anesth Analg 2004;99:510-20) This concept had first been presented in Professor Cousins’ EA Rovenstine Lecture of the American Society of Anesthesiologists in 1997.

The anaesthesia oriented section of the thesis contains over 50 references published in Anesthesiology, Anaesthesia & Analgesia, British Journal of Anaesthesia, Anaesthesia & Intensive Care. There are also key references in the Pharmacology literature in leading journals.

The citation at the ceremony in the Great Hall of Sydney University read in part:

‘What is most impressive is that the thesis includes several concentrated areas of work, which are directed at different questions. Even to this day Professor Cousins continues to gather an impressive group of basic and clinical scientists to address fundamental questions relevant to the treatment of pain and general surgical anaesthesia issues. The body of work on spinal opioids is not only distinguished, but without question has given rise to significant changes in the direction of research and of practice. The research was critical to the rapid adoption of spinal opioid treatment in patients’.

• The first Australian study, and one of two worldwide, to document total lost workdays (36.5 millions per annum) and associated costs ($5.1 bn per annum) (Europ J Pain 2006;10:161-66)
• An ‘Invited Editorial’ on the main theme of the first WHO-IASP “Global Day Against Pain” entitled “Pain Relief: a Universal Human Right” (Pain 2004;112:1-4)
• The studies were pivotal in the development of spinal opioid treatment of acute, chronic and cancer pain and resulted in an invitation to write a comprehensive review of the basic and clinical science of spinal opioids (Cousins MJ Mather LE Anesthesiology 1984;61:276-309) This paper was the most cited in the Anesthesiology literature over the past 60 years (738 citations) and the 5th most cited in the Pain literature.

The body of work on spinal opioids is not only distinguished, but without question has given rise to significant changes in the direction of research and of practice. The research was critical to the rapid adoption of spinal opioid treatment in patients’.
The participation rate in MOPS among the Fellows over the past 12 months has increased to 54% (cf 50% in 2004). Once again, New Zealand stands out at 88%. South Australia’s participation has again increased; from 38% in 2004 to 44%. In addition, there have been significant increases in participation rates from other states: ACT from 50% in 2004 to 60% and NSW from 56% in 2004 to 69%. The remaining states have participation rates as follows: QLD 47%, VIC 53%, WA 31%, TAS 65% and NT 53%.

Of those returns submitted 92% met all criteria.

The number of non-fellows continues to increase with 157 participants in 2005. 63% of these are from New Zealand.

1. 40 participants were randomly selected for auditing. All participants bar one have sent in the documentation to support their 2005 Annual Returns.

The participants audited came from NZ (8), NSW (9), VIC (6), SA (3), TAS (2), WA (1), NT (1), CANADA (1), SINGAPORE (1) and UK (1).

Of those selected the average number of CME/TTR points was 210 and the average number of QA points was 50.

2. The audit was performed by members of the CE & QA committee who are also Councillors.

3. The returns were audited according to the criteria set out in the programme manual, which are the accuracy of returns and the relevance of activities to the participants practice.

4. Results: (thus far, with documentation for one participant not yet received)
   - 38 were satisfactory
   - 1 was given Provisional Approval. This participant has been asked to provide further documentary evidence
   - 0 returns had significant errors in documentation.

5. The auditors were pleased to see the range of activities that participants had taken part in. It was noted that several participants had under claimed, particularly in the area of Local CME and QA Meetings.

6. Errors noted:
   - Evidence of attendance at CME (Code 1.2) or QA (Code 2.1) hospital/practice meetings is variable in quality. Annual attendance certificates seem to be provided only occasionally by practices.
   - Some participants claimed CME and QA activities that they could not provide supporting documentation for.
   - It is sometimes unclear which documentation referred to which activity claimed.

7. The auditors considered that the activities recorded by the participants were relevant to their practice.

8. Recommendations:
   - To use the findings from this and previous audits for the revision of the program
   - For the MOPS Program Manual to indicate clearly what evidence needs to be retained – particularly for rural practitioners
   - The same format and timetable should be used for next year. Selected Councillor members of CE & QA will be asked to perform the audit of 40 randomly selected returns

9. The auditors made a note of any outstanding issues with each participant’s returns, and these were notified to the participant when the material was returned to them.

10. The MOPS program is currently undergoing revision, using the information from the audits of this and previous years.

Dr Frank Moloney – Quality Activities / Maintenance of Professional Standards Officer, ANZCA
31 July 2006
The Maintenance of Standards (MOS) Program was developed from 1991 and introduced in 1995. It was revised in 1998 as Maintenance of Professional Standards (MOPS) with updates in 2001. The Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ) require the program to be accredited, and expect all Fellows to participate.

NEED FOR REVISION
The current MOPS program was drafted before ANZCA accreditation by AMC and program recognition by MCNZ. Both bodies then indicated that an inadequate MOPS program, or one that sanctioned token participation, would not be acceptable.

The landscape on continuing education has changed considerably. Much more is now known about professional and personal learning with evidence of effective learning activities. These newer concepts should be incorporated into MOPS.

The term Continuing Professional Development (CPD) is now universally used, replacing ‘Continuing Medical Education’ (CME). CME refers to education after vocational training. CPD embodies both professional learning and personal growth and may be defined as:

‘Any activity to maintain and improve knowledge, skills, and attitudes, and to develop professional and personal attributes required throughout a career as a Specialist Anaesthetist.’

CPD differs from vocational training in that it involves mainly self-directed and practice-based learning activities rather than supervised training. It incorporates much of the theory and practice of adult learning, self-directed learning, and reflective practice. The scope of CPD extends past maintenance of knowledge and skills, to include improving personal and professional qualities throughout a Fellow’s working life, such as in ethics, management, and communication skills. MOPS should embody this concept.

DOES CPD WORK?
Doctors represent themselves as competent to practise, as having mastered a body of knowledge and skills to deliver quality health care. CPD is a life-long development of professional and personal qualities that benefits the doctor, and as a flow-on, the patient and the profession. The literature reports many publications on the benefits of CPD on doctor performance and patient outcome. Effectiveness varies with CPD activities or interventions, but there is good RCT Level 1 evidence that overall CPD improves doctor performance and the process of care.

PROGRAMS OF AUSTRALIAN AND NEW ZEALAND MEDICAL COLLEGES
The MOPS/CPD programs of our Medical Colleges have been reviewed. Most Colleges’ programs are called ‘CPD’ except for ‘MOPS’ by ANZCA, RACS, and RACP. ANZCA, RACS, and RANZCP have 1-year cycles; five Colleges have 3 year cycles, and three have 5-year cycles. The program is voluntary for ANZCA and RACP and mandatory for the other Colleges.

Recognized CPD activities are fairly similar across the Colleges, although categorized differently. Most programs conduct a random audit of 3-5% of participants or of the Fellowship. RANZCOG withdraws Fellowship from those who fail to participate or meet requirements. RACGP Fellows who do not meet their College requirements have their names removed from the HCIC register. RCPA and RANZCO disallow such Fellows to hold office. The rest of the Colleges have no penalties for non-compliance. Support, in terms of guidance or toolkits for planning, reflection, and evaluation vary.

LEAP
LEAP (Learning, Education and Professionalism) was developed by RANZCOG in 2002-03 on behalf of the Committee of Presidents of Medical Colleges, funded by the Commonwealth Department of Health and Ageing. LEAP was intended as a Framework for CPD for Fellows of Australasian specialist Colleges. The Framework has three main ‘Strands’ or areas of practice: Clinical Expertise; Risk Management and Professional Values and Responsibilities. Each Strand has a number of ‘Components of professionalism’, and for each Component, there are three Levels of CPD activities. A project to test the validity of LEAP in practice, using a sample of Fellows from the Colleges, was conducted in 2004 05. The response of the Colleges to LEAP and the project has been less than enthusiastic. It is unnecessarily complex and is not appropriate for every College.

INTERNATIONAL COMPARISONS
There has been a move internationally from CME to CPD. Although countries have varied CPD systems, there are some common features. Nearly all are based on a time related credit system. Learning activities need to be accredited, and are external activities (e.g. conferences, meetings, and courses), internal activities (e.g. hospital or practice based activities), and ‘enduring’ materials (e.g. print, CD, or web based materials). Where there is mandatory Recertification or Revalidation, CPD is a major component of the process.

CPD IN USA
The majority of the 24 American Boards of Medical Specialties, including the American Board of Anesthesiology (ABA), have CPD linked to Recertification. The ABS offered a voluntary Recertification examination that was replaced in 2004 by the mandatory Maintenance of Certification in Anesthesiology (MOCA) Program. MOCA is a 10-year cycle program and requirements are an unrestricted licence to practice (‘Professional Standing’), performance evaluations from workplace heads (‘self-directed Program of Practice Assessment and Performance Improvement, PPAI’), CPD (‘Lifelong Learning and Self-Assessment, LLSA’), a Cognitive Expertise Assessment,
and the MOCA examination ‘designed to assess current knowledge of the breadth of anesthesia practice’. Those who fail to complete MOCA in their cycle will lose certification by the ABA.

CPD in Canada
The Royal College of Physicians and Surgeons of Canada (RCPSC), working with national specialist societies and Faculties of Medicine, conducts the Maintenance of Certification (MOC) Program, introduced in 2000 to ‘support, enhance and promote CPD’. RCPSC clearly states that it is not a program to confirm competence or fitness to practise. MOC has a 5-year cycle and requires Fellows to complete at least 40 CPD time-based credits each year, with a minimum of 400 credits each cycle. Credits are gained for Accredited Group Learning Activities, Non-accredited Learning Activities, Accredited Self-assessment Programs, Structured Learning Programs, Personal Practice Review and Personal Education Development. Activities that are recognized as being more effective at changing practice earn more credits. Fellows may use an electronic diary to plan learning, record activities, and reflect on clinical experiences. A searchable database allows Fellows to compare their learning needs and practices with those of their peers. Each year 3% of Fellows are randomly audited for ‘Credit Validation’. Fellows who fail to comply each year are so noted in the Directory of Fellows. Those who do not meet requirements at the end of their cycle have their Fellowship (FRCP or FRCS) terminated.

CPD in Europe and UK
European countries have a diversity of CPD systems, but none with a US style examination. The European Union of Medical Specialties established an European Accreditation Council for CME in 2000 to facilitate access to CME and recognition of credits in Europe and with the US.

The Royal College of Anaesthetists provides guidance on CPD activities and the relative value of specific activities, and approves activities. However, the Trust hospital and not the College, decides whether a doctor has satisfactorily completed CPD at the annual appraisal, taking into account the duties of the doctor, GMC principles, and College recommendations.

Template for Revision
Name of Program
The term ‘CPD’ is now universally used and recognized by all professions. ‘MOPS’ infers an element of competence assessment, is incomprehensible to the lay public, and does not include aspects of ongoing self-development. A program name of ‘ANZCA CPD Program’ is recommended.

Objectives
The planning and organization of CPD must rest with practising doctors and their professional organizations (ANZCA and Colleges) and not with health authorities. Objectives must be clear and consistent, and suitable to Fellows’ professional practice, and should (with the whole program) be evaluated.

The renewal of registration to practise, for which the term Recertification has been used, remains the responsibility of registration bodies. Rather than conduct their own, Recertification assessments, they may wish to use the ANZCA CPD Program as a sole or supplementary credential to grant registration. This is appropriate, as CPD has been shown to improve doctor performance. However, it must be clear that the program does not assess fitness to practice.

The recommended Objectives of the ANZCA CPD Program are:
- To promote and facilitate the participation of Fellows and anaesthetists in effective CPD;
- To encourage a culture of self-directed learning, review, and reflection on professional practice;
- To consider and embrace acknowledged international standards in CPD and to contribute to knowledge in this field;
- To demonstrate the accountability of anaesthetists to the community by monitoring participation and evaluating the effectiveness of the program.

Principles
The ANZCA CPD Program should be anchored on the following principles:
- Open Participation
  The Program is open to Fellows and all anaesthetists to participate.
- Individual Focus and Needs-Based
  Each Fellow’s participation hinges on planning and completing the Program on an individual basis and involves:
- Needs Assessment
to decide on areas of improvement and activities to engage, as participation must be needs based;
- Planning
  an individual program and personal objectives to achieve;
- Self-directed Learning
  Personal Learning Style that best suits participation, and includes choice of activities.
- Reflection
to critically self-review current practice, identify areas for future learning, evaluate effectiveness and progress of learning, and address barriers to learning.
- Application to Professional Practice
  CPD activities should be relevant to the participant’s specialty, roles, and responsibilities, and to the ANZCA Attributes of a Specialist Anaesthetist (see below).
- Emphasis on Effective Interventions
  Attention should be given to activities and interventions that have been proven to be effective.
- Life-Long Learning
  CPD is an ongoing commitment of participation to promote excellence in the participant’s professional work.

Framework of ANZCA CPD Program
CPD should embrace practical, theoretical, clinical and organizational activities. A Framework of CPD activities grouped under four easily recognizable Categories is recommended for simplicity. Some activities may overlap and can be claimed once in either category. The categories are:
1. Group Learning Activities, where there are a number of participants, large or small, involved in an activity, e.g. conferences, hospital meetings, workshops, and seminars.
2. Self-Learning Activities, as planned and developed individually. They include learning with journals, books, audio and videotapes, and computer or web based programs and databases. This Category also includes relevant self-initiated activities such as learning projects, Hospital Attachment, and approved courses.
3. Practice Assessment Activities are QA activities relevant to the participant’s practice. They include Practice Peer Review and activities under QA Activities in the current MOPS Program, all activities in simulation and skills centres (including EMAC courses), self-assessment programs (eg HELP), and reports to mortality committees.
4. Education Development Activities are those that stimulate learning by engagement in pedagogical and academic endeavours. They include presentations, teaching, research, publications, reviews of manuscripts or grants, and work in professional committees.

Attributes of a Specialist Anaesthetist
The ANZCA Attributes of a Specialist Anaesthetist, as specified in the FANZCA Program, are those of the AMC and the RCPSC CanMEDS Framework. The Attributes or roles are:
- Medical Expert
- Communicator
- Collaborator
- Manager
- Health Advocate
- Scholar
- Professional

CPD activities must have relevance to an Attribute to be recognized and credited in the ANZCA CPD Program. This will also facilitate the continuum from FANZCA training.

Credits
As the standard measure of engagement in activities by Colleges and international bodies is time expended, a system of time-based credits is recommended. Validation by hours of activity accumulated offers no advantage, and may be seen as a less valid measure of such activity. Obviously behaviour and outcome measures are more valid, but objective measurement is difficult and there are no established standards.

Different educational activities and interventions have varying effectiveness to effect change in practice and health outcomes. This process of learning new knowledge and transferring it to practice is referred to as Knowledge Translation.

Educational materials are less effective, and formal CME lectures or activities, without enabling or practice-reinforcing strategies, have a variable or relatively small impact. Hence, the Program should give weighting to activities that are more effective. The Program should be aware of barriers to completing activities by Fellows.

Documentation and Reporting
A CPD Portfolio is recommended to document the learning process (including planning CPD and writing Reflection notes) and any outcomes and improvements. This will enable the participant to review and reflect on the effectiveness of his/her learning. Compiling good documentation and records of activities in the Portfolio also validates the participant's CPD for any audits and compliance with health authorities. The Portfolio and the CPD Plan should be eligible to earn credits. The Portfolio may be compiled on line (similar to the present dairy but with modifications), as a paper folder, or as both.

Support
Support to Fellows and other participants is important. ANZCA should provide support by:
- Providing general and specific guidance;
- Recognizing external courses or activities;
- Providing confirmation of completion of CPD to participants for the requirements of health oversight bodies;
- Providing toolkits to participants on Planning CPD, Needs Assessment, Self-Evaluation of individual CPD, Reflection, and Keeping a Portfolio. These have to be developed.

Evaluation
Each participant needs to self-evaluate his/her CPD each year to decide effectiveness of learning and changes to the CPD Plan. Guidance could be provided by means of a toolkit for participants. ANZCA needs to evaluate the whole CPD Program every 1-3 years to determine if the Objectives are being achieved and to consider new developments in CPD. This evaluation process needs to be developed.
In response to recommendations from its taskforces on Data and on an Integrated Approach to Quality and Safety, Council has established a new Quality and Safety Committee (see Table 1).

**PURPOSE OR MISSION STATEMENT**

It is interesting to note that ANZCA’s mission statement (‘To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain medicine’) would suggest that the entire organisation is about quality and safety, which begs the question “why a quality and safety committee?” However, there is clearly a perceived need for more focus and greater feedback on certain aspects of quality and safety in ANZCA, and this was articulated by the two taskforces. A draft purpose statement for the Committee is as follows:

‘To assist Council in actively advancing the mission of ANZCA to serve the community by fostering safety and quality in patient care in anaesthesia, intensive care and pain medicine.’

Comments from Fellows would be appreciated.

**TRIPARTITE DATA COMMITTEE**

One of the first actions taken by the Committee has been to facilitate the formalisation of a long anticipated agreement between the Australian and New Zealand college of Anaesthetists, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists by the establishment of The Australia And New Zealand Tripartite Anaesthesia Data Committee (ANZTADC).

The principle objectives of this committee will be:

- a. to contribute to the improvement of safety and quality of anaesthesia in Australia and New Zealand.
- b. to capture, analyse and disseminate information (made anonymous) relative to the safety and quality of anaesthesia.
- c. To provide advice to parent organisations, health authorities and patients on safety and quality of anaesthesia.

The first goal of this Committee will be to reestablish an effective incident monitoring service for anaesthetists in Australia and New Zealand, which will include regular reporting and feedback to contributors. At this stage the precise vehicle for incident reporting has not been determined – a process of tendering and evaluation will be required. It is anticipated that this will be a slow process.

**REGULAR REPORTS IN THE BULLETIN**

The new Committee has identified communication as a priority. A regular section in the Bulletin will be devoted to reports from the Committee, dealing with different aspects of quality and safety. We envisage publishing a brief case report in each bulletin as well, highlighting possible topical points of concern in relation to anaesthesia and pain management. In addition anaesthetic alerts will be published and it is anticipated that readers will be referred to relevant publications. The first of these accompanies this article.

The success of this initiative depends on involvement of all Fellows and contributions will be actively sought. Anyone who would like to contribute cases to this column should contact Pat Mackay.

(patmack@bigpond.net.au)

It is hoped that, with the redevelopment of the ANZCA website, a much more extensive information hub on safety and quality will be established.

Please do feel free to contact any member of the Committee with suggestions or comments about how we can promote safer and better perioperative care for our patients.

Alan Merry (Chair)
Dr Pat Mackay (Communications Facilitator)

Table 1. Members of the Quality and Safety Committee

| 1. Alan Merry (Chair) |
| 2. Christine Jorm |
| 3. Neville Gibbs |
| 4. Pat Mackay |
| 5. Greg Deacon |
| 6. Graham Sharpe |
| 7. Michelle Joseph |
| 8. Frank Moloney |
| 9. Garry Phillips |
| 10. Bruce Corkill |
| 11. Diana Khursandi |

Prof Alan Merry (Chair)
Dr Pat Mackay (Communications Facilitator)
EMERGENCY MANAGEMENT OF SEVERE ANAPHYLAXIS

1. Remove or cease administration of causative agent
2. Administer oxygen
3. Inject adrenaline
   **ADULTS** use 1:1000 intramuscularly
   - <50kg: 0.25ml = 0.25mg
   - 50-100kg: 0.5ml = 0.5mg
   - >100kg: 0.75ml = 0.75mg
   **CHILDREN** use 1:10,000 intramuscularly
   - <25kg: 10 microgram/kg (0.1ml/kg) to a maximum of 250 microgram (2.5ml)
   - 25 – 50 kg: as for adults
4. Establish intravenous access and administer 0.9% saline solution
5. Institute airway/ventilation support as required
6. If response is inadequate, repeat IM injection or commence intravenous adrenaline infusion at 0.25 microgram/kg/minute

Although it is recognized that anaesthetists would normally administer adrenaline intravenously, the following protocol is published in response to the recent publication of an erroneous dosage in the ‘Medical Journal of Australia’. The protocol is adapted from the Wall Chart published by ‘Australian Prescriber’.

CURRENT ISSUES IN SAFETY AND QUALITY IN ANAESTHESIA IN VICTORIA


It is recognised that providing timely feedback to the anaesthesia community is an important component of the work of agencies responsible for receiving adverse event reports. VCCAMM is the only such committee that reviews morbidity as well as mortality data and is currently preparing the triennial report for cases that occurred in 2000–2002. In addition a VCCAMM Annual Report for 2005 has been produced in order to identify major ‘current’ issues.

During 2005, VCCAMM reviewed 228 cases. Of the 110 mortality cases, there were only 20 (18%) classified as anaesthesia related. Therefore, under the current system of case review, Council is involved in a considerable workload reviewing perioperative deaths in which no contribution from anaesthesia can be identified. It is acknowledged that this is inevitable and important to continue in order to analyse all factors contributing to perioperative mortality. It is noteworthy that of the 110 mortality cases, 77 were obtained from the Coroner’s office, 9 were direct reports from individual anaesthetists, and there were 24 reports from quality assurance committees.

In comparison, of the 118 morbidity reports, 83 (70%) were classified as anaesthesia related, reinforcing the value of morbidity reporting to identify potentially preventable events. 76 morbidity reports were from QA committees. 42 were direct reports from individual anaesthetists which reflects the ‘culture of trust’ in the Victorian anaesthesia community in providing these confidential reports voluntarily.

The major clinical issues to emerge from anaesthesia related mortality and morbidity reports were:

**Preoperative assessment**
Council considered that inappropriate or inadequate preoperative assessment was a significant factor in the outcome in 3 of the 20 anaesthesia related mortality cases (15%) and 10 of the 83 anaesthesia related morbidity cases (12%). These included failure to identify patient information details, poor evaluation of medical status, inadequate airway assessment, and, of paramount importance, failure to adequately assess the cardiovascular system.

**Medical Co-Morbidities**
Council identified that medical co-morbidities were considered to have made a significant contribution to the outcome in 16 of the 20 anaesthesia related mortality cases (80%) and 11 of the 83 anaesthesia related morbidity cases (13%). This clearly is an indication of the higher risk profile of patients presenting for anaesthesia and surgery. Cardiac disease, diabetes, cerebrovascular disease and chronic renal impairment were most implicated. The potential exists for improving anaesthesia outcome (particularly mortality) by increased emphasis on assessment and planning for perioperative care for patients with significant co-existing disease.

**Monitoring, Crisis Management and Resuscitation**
Council considered that anaesthesia management had been a significant factor in the adverse outcome in 4 of the 20 anaesthesia related mortality cases (20%) and 10 of the 83 anaesthesia related morbidity cases (12%). There was potential for improvement in monitoring, crisis management and resuscitation, particularly in the setting of pre-existing cardiac disease. Lack of appropriate monitoring, failure to seek extra help and inadequate supervision in complex cases were identified as issues in several cases.

**Postoperative and Organisational Problems**
Council identified either postoperative and/or organisational problems in 9 of the 20 anaesthesia related mortality cases (45%) and 19 of the 83 anaesthesia related morbidity cases (23%). In this total of 28 cases, 6 were postoperative problems, 14 were organisational problems, and 8 were both.

The implication is clearly that improvement in perioperative care planning and resource allocation is most likely to be of benefit. There were several cases in which the decision to send patients to the general ward rather than an extended stay in recovery or HDU/ICU was seen as important. Provision must be made for ensuring appropriate postoperative care and postoperative triage should be evaluated in this regard, particularly in terms of discharge criteria for the PACU.

Assoc Prof Larry McNicol, Chairman VCCAMM

THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
NEW ADDITIONS TO THE COLLEGE LIBRARY


Brian Eric Dwyer, AM, born 9th February 1925, died 7th June 2006
MBBS, FRCA, FANZCA, FFPM ANZCA (Hon)
Dean, Faculty of Anaesthetists 1974-1976.

Educated by the Marist Brothers at Mosman and at St Joseph’s College Hunter’s Hill, he captained the first XI and represented the school in the first XV, a further achievement in that nursery of international and national rugby players.

His sporting prowess was further recognised at Sydney University where he was awarded Blues in both cricket and baseball.

Later he captained N.S.W. Colts and always reminded me that when the team played against Queensland the weather was hot and humid or there was heavy rain! The Colts included Richie Benaud, and Brian recounted the story of when playing at the M.C.G. Benaud was hit on the head. Brian ran to his aid, reaching him at the same time as a Victorian team member who happened to be Ian McDonald, later also a registrar at Oxford and a great contributor to anaesthetics as a specialty.

After graduation in 1948, Brian did his resident posts at Lewisham Hospital and at Concord. Early in 1951, with his wife Jacqui, he went as ship’s surgeon on SS Esperance Bay to begin his career in the Nuffield Department of Anaesthetics in Oxford. There his clinical ability, innate dexterity and technical skills were enhanced under the guidance of Sir Robert Macintosh. He was ever appreciative of his other teachers - Roger Bryce Smith, Alex Crampton Smith and James Mitchell.

Sir Robert was the doyen of local anaesthetic techniques and was already applying those skills to the treatment of cancer pain by effective use of neurolytic blocks.

During his sojourn in Oxford he obtained the two part Diploma in Anaesthesics and made time to play county cricket for Oxford and for the hospital.

On his return to Australia he was appointed the first full-time Director of the Department of Anaesthesia at St Vincent’s Hospital – the Department that rightly is named in his honour. Some of his older and less charitable colleagues felt threatened, but displaying leadership and personal skills, and supported by those with foresight, he soon had the loyalty of the whole department.

From the outset his determination to look beyond the narrow confines of the operating theatre was apparent. He made available to medical and surgical patients the special expertise of the trained anaesthetist - the term peri-operative medicine was unknown then.

A pioneer in his craft, his innovations at St Vincent’s are now regarded as basic care - the postoperative recovery ward in the 1950’s, the cardiac perfusion service in the 1960’s, the latter making possible the developments that facilitated Australia’s first heart transplant.

He appreciated the need for an organised unit of well trained medical, nursing and allied health staff to care for the victims of poliomyelitis and tetanus, as well as those who had attempted self-destruction with barbiturates in the 1950’s and 1960’s. However it was the successful treatment in 1958 by the cardiac surgeon Harry Windsor and Brian of a patient with a flail chest by paralysing him with curare and applying long term positive pressure respiration, which made the advent of an intensive care ward inevitable.

It is no exaggeration to say that Brian Dwyer was the father of Pain Medicine in Australia and also that he was recognised internationally as a world leader.
It is no exaggeration to say that Brian Dwyer was the father of Pain Medicine in Australia and also that he was recognised internationally as a world leader.

In 1962, to remedy the appalling deficiency in the relief of cancer pain, he established Australia’s first Multidisciplinary Pain Clinic, modelled on the clinic established by John Bonica at Seattle just two years earlier. He had the support of Kevin Bleasel and Tom Connelly neurosurgeons, Dudley O’Sullivan neurologist and psychiatrist John Woodforde.

Not surprisingly, his compassion for terminally ill patients with cancer pain lead to the establishment of a consultant palliative care service at St Vincent’s in 1982 - and subsequently to the adjoining Sacred Heart Hospice.

Prior to the establishment of the Pain Clinic at Royal Brisbane Hospital in 1967, he welcomed me to his clinic on many occasions and it was through this experience that I appreciated the essential involvement of the psychiatrist in the care of patients with persistent pain - a philosophy that I still espouse. Brian even made the effort to visit Brisbane to assist my colleagues and me in the development of management plans for problem patients.

This generosity of spirit and his understanding of the need to decentralise specialist services was highlighted by his readiness, like that of the late Kevin McCaul, to accept in his department, interstate and overseas registrars.

When Vic Callanan was awarded the Renton Prize it was felt that he should broaden his personal and professional horizons. Brian welcomed him to St Vincent’s where he was able to develop expertise in cardiac anaesthesia, intensive care and pain medicine - to the benefit of thousands of patients in North Queensland and the doctors and nurses Vic has trained.

It was Brian who acted as intermediary with Sister Mary Felix so that Queensland nurses were assured of places on the Intensive Care courses at St Vincent’s in Melbourne, participation in which was afforded to few nurses from other states.

But it was as a member of the Board of the Faculty of Anaesthetists and as an Examiner for the Faculty that I was able to appreciate his wise counsel and his meticulous attention to detail that permeated his every contribution to the development of the specialty he loved.

I had the privilege of his support as Vice Dean while I was Dean, and I served on the Board as Past Dean while he was Dean.

His command of English - written and spoken - and his ability to crystallise discussion were the envy of many Board members.

With the late Trevor (Peter) Currie and Brian Pollard we were co-examiners for the first M.Med Singapore and for the first final examination for Fellowship of the Faculty in South East Asia - a wonderful experience with lasting international friendships.

Brian had already been to Papua New Guinea with a thoracic team as part of the WHO anti-tuberculosis campaign. I was the anaesthetist with the next team and his practical advice assisted in making this experience the most enjoyable challenge of my professional life.

It was Brian who brought to fruition important Board projects that had been initiated by the late Kevin McCaul and continued by me - the opening of the Faculty Education Centre and Certification in Intensive Care.

The opening of the Faculty Education Centre provided a much needed venue for seminars, courses and other educational activities as well as facilities for meetings including those of the Australian Resuscitation Council which was launched in his Deanship.

Protracted discussions with the Royal Australasian College of Physicians to develop a conjoint qualification in Intensive Care had been unsuccessful but the endorsement of the FFRACs in Intensive Care lead to the advancement of the specialty and ultimately to the establishment of the Faculty of Intensive Care. Brian’s efforts were rewarded some thirty years later when joint certification by both ANZCA and RACP was achieved - and the award of FJIFICM.

Prior to 1972, the Dean of the Faculty attended meetings of the Council of the RACS only to present the Board report and to answer questions relating to that report. From June 1972 the Dean attended the full Council meeting, but could speak only when invited. The support of many surgeons especially Evan Raine, Alistair McEachern, Noel Newton, Ken Jamieson, Doug Tracy, John Ludbrook and John Clareborough, ensured that the views of the anaesthetists were sought. The great morale boost came for me when Council invited the Faculty to send two representatives. Brian’s negotiating skills added impetus to progress within the College.

Brian’s outstanding service to anaesthesia was acknowledged by the award of the Orton Medal in 1984 - the highest honour the College (Faculty) bestows.

He was admitted as a member in the Order of Australia in 1997. The Faculty of Pain Medicine bestowed on him its Honorary Fellowship in 2000.

His service to St Vincent’s was acknowledged by a significant papal honour - Knight Commander in the Order of St Gregory the Great.

Brian Dwyer’s deep religious faith was matched by his respect for and tolerance of the beliefs of others. In retirement he obtained a Graduate Certificate in Theology and taught religious instruction at North Sydney Girls High School.

Above all, Brian Dwyer was a family man - devoted husband to Jacqueline his wife of 55 years and loving and proud father of Nicholas, Julia, Dominic, Sophie, James and Vincent. They will take their comfort from the goodness that was his life and his selfless contribution to the care of his fellow man.

Brian Dwyer commanded by leadership and respect. Medicine is blessed with men of his calibre once in a life time. His memorial meeting will be the standards he set and the countless registrars he influenced. As we express our sadness at his passing and offer to Jacqueline and their children our sincere sympathy, we salute a distinguished colleague and loyal generous friend.

Professor Teresa Cramond
Ronald ‘Rollo’ Rollison was a husband, father, sailor, doctor and musician. He was also a humanitarian, a combat serviceman and a great friend and mentor to many.

His early medical training was interrupted by World War 2 where he served in the Navy on the Australian Destroyer ‘Norman’. More than fifty years ago Rollo graduated in Medicine from the University of Sydney and began his practice in earnest, developing a recognised skill in anaesthesia, which he realised, was his major strength. As training in anaesthesia in Australia was essentially non-existent Rollo set sail for Great Britain where he trained in Anaesthesia and became exposed to Intensive Care, to the marvellous advances being made in thoracic surgery, and to the life saving care of the thousands of young people affected by the polio epidemic. Rollo revelled in his new specialty and passed his exams easily. Before returning to Australia, he spent several years in Africa where he put his new skills to work in treating the less fortunate.

On his return to Australia his skills and knowledge were put to use in both the Public and Private Sectors. He had an acute sense of what was important for the development of Medicine. His major contributions were in three areas. He challenged the physicians about their negative attitude towards the treatment of Cardiac Arrest and had an important foundation and educational role in the training of ambulance officers, doctors and paramedics in CPR. He and Victor Hercus at the Prince Henry Hospital in Sydney established the First Respiratory Unit, a forerunner of modern Intensive Care. This was, of course, done against the wishes of the senior consultants of the day. Together they wrote the first paper on Intensive Care to be published in the prestigious Lancet Medical Journal. At Prince Henry Hospital he took part in the pioneering experiments on bypass surgery of the heart and spent many hours in the laboratory developing the techniques that would allow surgeons to operate on the heart.

These were heady times – and by now he had a family and added responsibilities. Yet he had the energy not only to contribute to the Public Sector as an unpaid Honorary, but also to set up one of the most successful private groups of Anaesthetists in Sydney. He did not choose the wealthy eastern suburbs but built his rooms and provided anaesthesia to the poorer and needy patients in the western suburban hospitals of Sydney. It was an enormous success.

It is pretty hard for us to imagine the advances he saw and took part in. The introduction of all the new relaxants, gases and narcotics happened in Rollo’s lifetime, taking anaesthesia from mask, ether and chloroform to the safe specialty it is today for routine operations; for women having children; for advanced cardiac and neurosurgery for patients of all ages. Rollo’s passion for sailing and new adventures saw him move to Townsville with his young family in the middle 80’s. In North Queensland Rollo contributed to both the Public and Private Sectors. He taught all who came near him and, except for Wednesday evening sailing, was always available. He was as successful here as he was in Sydney. He was a silent but persistent enthusiast for the improvement of Medicine and the development of our specialty. He was most encouraging of innovation and excellence. It goes without saying that he did not suffer fools, but he was always civil in their presence.

In spite of the need for bypass surgery, he recovered to again take up clinical practise. Failing eyesight and the passage of time led to his retirement. Unfortunately his health deteriorated over the last few years, but his passion for involvement in all things remained. He revelled in lengthy conversations with respected colleagues on any area of medicine, remaining abreast of the important developments, not only in anaesthesia but in medicine generally. One of his last acts was to organise for the restoration of an old iron lung ventilator he had stored under his house.

At his last public medical occasion when he was the guest of honour at a function to mark ten years of Intensive Care at the Mater Misericordiae Hospital in Townsville he amazed all of us with his wit, his compassion and his love of Medicine. On that occasion he had rehearsed his speech several times, only to misplace it on the way to the lectern at the very last minute, and amused and impressed us all by speaking off the cuff in the most eloquent way.

Despite his remarkable career, Rollo was at his happiest on the ocean. Perhaps it was because of the unshakeable bonds born of war, or perhaps it was a time for reflection. I never did ask him. The words of John Masefield however form a most apt eulogy:

‘I must go down to the seas again, to the lonely sea and the sky,
And all I ask is a tall ship and a star to steer her by….’

Rollo mate, you have started your next adventure. We wish you calm seas and a trailing breeze and thank you for the privilege of knowing and of working with you.

To Jeannie, Penny and Andrew we offer our sympathy, but at the same time celebrate a life well lived.

Geoff Gordon
John Stokes
Victor Brand, MC
16 July 1914 – 9 June 2006
(Victoria) FFARACS 1952, FANZCA 1992

Victor Brand died a month short of his 92nd Birthday. On Anzac Day this year he proudly led the 8th Division AIF again as one of the last surviving decorated officers. He received the Military Cross after the Battle of Muar in Malaya in January 1942 and was a prisoner for three and a half years.

Victor was the second of five children of Isaac and Toba Brand who migrated from Poland to Melbourne via Palestine in 1913. His family experienced relative hardship and poverty; he was able, however, to attend Caulfield Grammar. On leaving school in 1931 he enrolled in medicine at Melbourne University, graduating in 1937.

Victor became a resident at The Alfred hospital for 12 months and then worked as a locum around Victoria and the Riverina for a hospital for 12 months and then worked as a locum around Victoria and the Riverina for a year. He was then forced to leave behind those who could not walk, escorting the walking wounded through jungle to the battalion.

The 2/29th and the 2/19th Battalions had held up the advancing Japanese Imperial Guards for six days to enable the main British force to pull back to avoid being entrapped. Nearly 60% of the 2/29th was killed and the 150 seriously wounded men left in the trucks were later massacred by the Japanese at Parit Sulong. Victor never got over the slaughter of these men.

Later, on the Thai-Burma Railway, Victor spent nearly a year operating a primitive hospital for up to 200 men in a rainforest clearing 240km up the line from Bampong in Thailand. His only supplies at first were a wok, machete, bamboo and quinine tablets. Most of the men suffered from malaria, dysentery and cholera. Regarding the treatment of cholera, Victor wrote: ‘I cut down on a vein in the ankle and inserted a length of bamboo – with half the bore of a drinking straw – attached to lengths of stethoscope tubing fixed to the bottom of a pint-sized container. The idea was to pour about six pints of boiled and strained river water with added rock salts into the patient’s blood stream for 24 hours.’

With the liberation of Singapore in 1945, Victor went down to the docks every day. After a meal on board a British battleship, he got back to Changi ‘waving a slice of white bread, the first seen for over three years’, he wrote. ‘As a result of being a naval hospital ship was moored at the wharf with large openings in the side. There were rows of beds and nurses in uniform, all brilliantly illuminated. Outside in the dusk was a long line of emaciated men dressed in a few rags. I could see them enter into the light and be divested of their rags andmess tins and taken away to be washed.They returned dressed in pyjamas and were put to bed between the white sheets so tenderly’. Recalling his time in Changi and in Thailand, Victor was always at pains to point out that his own experience was nothing compared to the suffering endured by the men building the railway – in fact, Changi Prison was relatively comfortable except for the shortage of food. Years later he visited the memorial at Changi and, on seeing hundreds of white crosses, wept uncontrollably.

Back in Melbourne, Victor initially practised as a GP and later as an anaesthetist. He served as an honorary at The Alfred from 1951 to 1971. Although very much against Australia’s involvement in Vietnam, in 1966 he joined a voluntary group of medical specialists and nurses, sponsored by The Alfred hospital, to serve in a civilian hospital near Saigon.

Victor was always a passionate supporter of Israel and, following the Six Day War in 1967, volunteered to work in a military hospital for a short time.

He loved scuba diving with an underwater camera or spear fishing around Aireys Inlet. As founding member of SPUMS (South Pacific Underwater Medicine Society) he dived in many exotic locations, including Fiji, Vanuatu, Tahiti and the Solomon Islands.

Victor loved meeting people from other cultures and was a lively and at times confronting conversationalist. He had a wonderful memory, a powerful intellect and a sharp sense of humour. He rapidly devoured books of all kinds and in his last year re-read classics by Anatole France and the complete volumes of Voltaire in French.

He is survived by his children, Melanie and Andrew (Michele having died in June 2005) and grandchildren Josephine, Isabelle and Emma.

Andrew Brand, Andrew Kennon
Melanie Brand

These further notes are prepared by Dr Ian Rechtmann, taken from The Alfred hospital ‘Faces and Places’

Victor Brand graduated MB BS in 1937 and was a resident at The Alfred hospital, working for Hugh Trumble, a neurosurgeon and James Officer Brown who became a famous thoracic surgeon. During this year the first pneumonectomy was performed by James Officer Brown which caused a considerable stir and a lot of stress for Victor. On return from the war he practised as a GP and passed the DA (University of Melbourne) 1950. He became a Foundation Fellow of the Faculty of Anaesthetists, RACS in 1952 and FANZCA upon incorporation of the College in 1992. He was an Honorary anaesthetist at The Alfred hospital from 1951 to 1971 and continued in private anaesthetic practice until his retirement. In addition, he served with The Alfred hospital Civilian Surgical Team in Vietnam from October to December 1966 and was loved by the local children as he always carried a bag of lollies.
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Victor became a resident at The Alfred hospital for 12 months and then worked as a locum around Victoria and the Riverina for 10 guineas a week plus keep. In his first locum he had to perform a tonsillectomy on the patient’s kitchen table!

Captain Brand became the regimental Medical Officer of the 2/29th Infantry Battalion, training at Bonegilla and Bathurst. Before sailing for Singapore he married Emilie Rechtman, taken from The Alfred hospital

From January 1942 Fifi had no definite news of Victor (who was listed as missing in mid 1942) until she was advised in January 1943 that he was a Prisoner of War ‘interned in a Malayan Camp’. Over the next two years there were unreliable reports of ‘Dr Bran’ and ‘Captain Grand’ being mentioned in Japanese broadcasts.

In September 1943 it was confirmed that the Military Cross had been awarded to Captain Brand, cited for his heroic deeds during the ferocious Battle of Muar. Under continuous bombardment and with complete disregard for his personal safety, he remained in the open, tending to the wounded Australian and Indian troops. When the battalion withdrew he refused to leave the wounded, loading them into trucks which were subsequently stopped at a road block. He was then forced to leave behind those who could not walk, escorting the walking wounded through jungle to the battalion.

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RESHAPING HEALTH CARE
Where is the Productivity Commission leading us?

The Australian Productivity Commission (PC) published its research report ‘Australia’s Health Workforce’ in December 2005, and the Council of Australian Governments (COAG) released its responses relating to the PC’s recommendations in July 2006. The impact of these events is likely to be of great significance for the entire health workforce, its education and training, its evolution and redesign, and its distribution, over the next several years. Changes will affect all health sectors, including the medical colleges.

For just over five years, ANZCA has reported to the Australian Medical Council (AMC), which was established by the Australian Health Ministers (AHMC) in 1984 as an independent national standards body for medical education and training. In 1998, the AMC took on the functions of the former National Specialist Qualifications Advisory Committee, which had advised medical boards and the Specialist Recognition Advisory Committees of the Health Insurance Commission on recognition of Australian and Overseas Trained Specialist qualifications.

Will all this now change, as the PC clearly wanted, or will the COAG responses result in significant modifications of the PC’s recommendations? Looking at these:

WORKFORCE INNOVATION
The PC wanted AHMC to establish an advisory health workforce improvement agency to replace AMWAC (and AHWAC – the Australian Health Workforce Advisory Committee). This body would ‘facilitate major health workforce innovation possibilities on a national, systematic and timetabled basis.’ COAG has agreed that a Taskforce on the National Health Workforce be established, to advise Health Ministers.

EDUCATION AND TRAINING
The PC wanted to establish an advisory health workforce education and training Council, which would report to health ministers on ‘opportunities to improve health workforce education and training approaches.’ The Commission also wanted to establish a high level taskforce to review all health training. COAG referred this to the National Health Workforce Taskforce, and to the Health Ministers. The Universities, not the Colleges, were prominent in the PC’s report, and there were specific PC recommendations relating to university-based health education and training, and its funding, which were agreed by COAG.

ACCREDITATION
The PC wanted a single National Accreditation Board for health professional education and training. It would function across all health sectors, including overseas trained health workers. COAG resolved that the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) should be involved in this, and that there should be consultation with stakeholders. This may give a reprieve to the AMC and the Colleges.

REGISTRATION
The PC and COAG supported national registration, as has the medical profession generally. The PC recommended that the new board should ‘subsume the operations of all existing registration boards and entities’ (including the State and Territory Medical Boards), and would ‘determine which professions to register and specialties to recognize’. COAG again wanted stakeholder consultation.

WORKFORCE PLANNING
The PC wanted abolition of AMWAC and AHWAC, to be replaced by a single secretariat responsible to AHMAC. COAG agreed to rationalize its committee structure with
creation of the new Taskforce on the National Health Workforce. While all of the above is in the process of consideration, discussion and implementation, a number of other congruent processes have been underway. The most relevant of these are:

- AHMAC Medical Specialist Training Steering Committee, chaired by Professor John Horvath, has had three Reference Groups looking at new training models, particularly involving the private sector. One reference group is looking at the costs and benefits of the new model; a second, the implications for public sector service delivery; and the third is reviewing College training programs. All of these deliberations will be crucial to managing the massive increase in medical school graduates in Australia from 2010.

- ACCC/AHWOC implementation plan following review of the medical colleges, based on the ACCC authorization of RACS. ANZCA is involved in five projects. The first relates to selection and appointment of trainees, and their distribution, with implications for workforce. The second is clarifying the interfaces between the College and jurisdictions. The third is examining accreditation processes. The fourth aims to obtain uniform data reporting to various Government bodies. The fifth takes the form of a Rapid Assessment Unit, whose objectives are to streamline processes for assessment of Area of Need and Overseas Trained Specialists.

**LIKELY DEVELOPMENTS BY EARLY 2007**

Assuming that the above are pursued as actively as at present, it is envisaged that the flow on from the PC, COAG and AHMAC deliberations is that there will be established, probably within 1-2 years, at least two new bodies which will either subsume, or overview bodies such as AMWAC (and AHWAC) for workforce; AMC for accreditation; and State and Territory Medical Boards for registration.

The playing field for health workers, and therefore patients will change, with a new approach to who will train whom and for what, where and how. There will of course be much consultation, liaison etc., and spending of money, but will it actually improve the quality and safety of patient care?

Dr Wally Thompson & Prof Garry Phillips
This occasion was also to farewell Dr Liz Feeney following her term as Chair, NSW Section, Australian Society of Anaesthetists and ASA representative to NSW Regional Committee.

Yet another farewell was to Dr David Duke, following his year as the Trainee representative and we also welcomed Dr Philip Black to this role.

Professor Michael Cousins and Dr John Keneally were invited guests in recognition of their long association with ANZCA - Professor Cousins (amongst other things) as recently retired President and Dr Keneally as recently retired long-standing Editor of Australasian Anaesthesia.

A wonderful evening was had by all, despite the fact it was raining cats & dogs, and the logfire in our section of the restaurant certainly kept everyone warm and cozy. The speeches were succinct, with much laughter, and the food superb.

All members of the Committee thank Jan Taylor for organizing a splendid night.
In 1954 when young New Zealander, Dr Bernie Dunn, decided he wanted to be an anaesthetist there were only ten training positions available in a country where ‘people in medicine were, frankly, a bit stuck up’.

That’s when he decided to move to Melbourne where he says the medical fraternity was ‘incredibly generous, launching me on my lifetime of adventure’.

After a stint at the Royal Childrens Hospital Bernie went to Singapore under the Colombo Plan for what was to become a ‘life-changing experience’ of working round the clock on up to 100 births a day.

From 1959 until 1986 he was part-time Director of Anaesthesia at Box Hill Hospital, but after his Singapore experience ‘travel and adventure were in my blood’.

Over the next 27 years he made several trips to Papua New Guinea and served on three missions to Vietnam. In the 1970’s he spent so much time in Indonesia he spent 11 years studying the nation, and its culture at night classes.

‘The more I saw and learned the less I knew’ he said.

Last month Dr Dunn was back at ANZCA House to fill in another piece of the College’s history by presenting a specially commissioned painting of the merchant ship Ulimaroa, named after Ulimaroa House by its first and most famous tenant, John Traill, co-owner of the Huddart-Parker shipping company.

One of the most popular ships in the region the Ulimaroa was in regular service between Australia and New Zealand from 1908 to 1934, a service only interrupted by the First World War when it was commissioned by the NZ Government to carry troops.

During the Depression the Ulimaroa was de-comissioned and lay in Sydney Harbour until 1934 when it sailed under its own steam to Japan to become scrap metal.

A few years ago Dr Dunn was visiting Melbourne’s Pollywoodside Museum when he spotted a model of the Ulimaroa and decided to commission Danish ship artist Ib Odfeldt to depict the vessel at sea.

Neither Dr Dunn nor the artist liked the first version ...’I tend to be a bit obsessive’ but the second version was deemed good enough to donate to the College.

‘I owe a lot of gratitude to this College and to a lot of Australian doctors, so I hope this helps repay some of that in some way.’

David Broadbent
A Strategic Blood Forum was held in Sydney on 30 August, attended by representatives from Colleges and Societies, Government Health Departments, the Australian Red Cross Blood Service (ARCBS), the National Blood Authority and the Therapeutic Goods Administration.


One cannot but be impressed by the complex arrangements which now ensure efficient supply of safe blood products in amounts adequate to meet often unpredictable demand even in “normal” times, and the planning going into managing as well as possible in the event of surgical or medical disasters.

The interim National Emergency Blood Management Plan makes provision for such things as establishment, management and review of Emergency Donor Panels in rural areas, aimed at ready access to O Rh-negative blood; review of current ARCBS standard inventory management practices; categorization of patients who may require red blood cell transfusion into three groups:

• Priority 1 – resuscitation of life-threatening/on-going blood loss, including trauma.
• Priority 2 – cancer surgery; symptomatic anaemias
• Priority 3 – elective surgery likely to require donor red cells; elective medical transfusion.

Blood supplies are currently facilitated by a transfer system between distribution centres based on a ‘traffic light’ system of green, amber or red, determined by the number of days supply held. Proposed revisions under the interim Emergency Blood Management Plan will recommend three stages (normal, alert, activate), triggered by inventory levels that include the ARCBS and Approved Health Providers’ stock details – again, depending on the ‘days of cover’ available.

In addition to within country responses, import and export of labile blood components is possible under specific circumstances, under appropriate legislation.

The Australian Government Health Management Plan for Pandemic Influenza will impact on blood supply, if a pandemic occurs. The ‘containment strategy’ could effectively close down blood collection centres. Quarantine of a region would stop blood product movement in and out of the quarantine area.

During the SARS epidemic in Hong Kong, there was an initial 50% drop in normal blood donor attendance. Overall, there was a 20% drop in collection, and a 14% drop in demand for blood transfusion.

During the SARS epidemic in Toronto, there was a 25% drop in blood usage in hospitals treating SARS patients, and a 10% drop in demand overall.

The key strategies of the ARCBS response to a pandemic would include screening of both staff and donors for pandemic flu symptoms; enhanced infection control measures; use of personal protective equipment; education of staff and donors; relaxing of donor acceptance criteria (such as haemoglobin level and donation interval) as a last resort; deployment of the Emergency Blood Management Plan; and an all out effort to maintain blood supply.

An ‘aside’ at the Forum was presentation of the current risks of blood transfusion, with two tables reproduced below:

### Infection

<table>
<thead>
<tr>
<th>Infection</th>
<th>Residual risk with tested blood per unit transfused</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>1 in 7,299,000</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>1 in 3,636,000</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>1 in 1,339,000</td>
</tr>
<tr>
<td>HTLV</td>
<td>Considerably less than 1 in 1,000,000</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Considerably less than 1 in 1,000,000</td>
</tr>
<tr>
<td>Variant CJD</td>
<td>Possible and cannot be excluded</td>
</tr>
</tbody>
</table>

### Per unit transfused unless specified

<table>
<thead>
<tr>
<th>Morbidity</th>
<th>Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial sepsis: Red Cells</td>
<td>1: 40,000 to 500,000</td>
</tr>
<tr>
<td>Haemolytic reactions: Platelets</td>
<td>1: 10,000 to 100,000</td>
</tr>
<tr>
<td>Acute</td>
<td>1: 12,000 to 38,000</td>
</tr>
<tr>
<td>Delayed</td>
<td>1: 1,000 to 12,000</td>
</tr>
<tr>
<td>Anaphylaxis – IgA deficiency</td>
<td>1: 20,000 to 50,000</td>
</tr>
<tr>
<td>Fluid overload / cardiac failure</td>
<td>1: 100 to 700 per patient</td>
</tr>
<tr>
<td>TRALI</td>
<td>1: 5,000 to 100,000</td>
</tr>
<tr>
<td>TA-GVHD*</td>
<td>Rare</td>
</tr>
</tbody>
</table>

Prof Garry Phillips
Director of Professional Affairs
The Queensland Trainee Committee is delighted to report on its experiences in putting together an Introduction to Anaesthesia course for our BTY1’s. This was designed to complement in-hospital teaching and to bring together trainees, who tend to be scattered out with the major teaching hospitals of Brisbane. Often BTY1’s may number only one or two in a department.

We wanted to cover basic areas so that trainees could talk about queries that would help each other in the transition time to progress beyond level 1 supervision and take part in after hours rosters.

SATURDAY MORNING PROGRAM
Dr Kathy Cooke started the morning with an introduction to course aims and to the trainee committee. Hopefully it will encourage trainees to become active in the future.

Dr Jeneen Thatcher, Supervisor of Training at Gold Coast Hospital gave the first session which provided a guide to surviving the training program. She covered the module system, ITA assessments, reflective learning, exams and suggestions about how to study. It answered many questions about the FANZCA before they had even been asked.

Drs Kath Cooke and Diana Webster jointly ran the next session designed to cover surviving on call. Looking at issues such as knowing who is (or is not) around to help in times of crisis, and ideas on how to prepare for moving beyond level one supervision.

They also covered what to do in the aftermath of a major crisis.

A number of resources were provided to the participants for some background reading. Documents from the Welfare of Anaesthetists Special Interest group we found particularly helpful.

AIRWAY SKILLS SESSION
The final session on Sunday morning was held in the airway skills lab at the simulator centre at Royal Brisbane and Womens Hospital.

The session was arranged by Dr Kersi Taraporewalla. There were three stations:

1. Difficult airway station to run through difficult airway algorithm, use of bougies, cricoid pressure, different laryngoscope blades and elective and emergent scenarios.
2. LMA station, which covered pro-seal insertion techniques, fast-track LMA and the new glide scope.
3. Cricothyroidotomy station covering emergency surgical airway, for the can’t intubate or ventilate situation.

This session was particularly well received and participants enjoyed the hands on nature of the session. It was a good session to end the course on.

GENERAL ANAESTHESIA SESSION AND MACHINE CHECK
Dr Alex Donaldson started this with a practical demonstration of the how and why in relation to checking an anaesthetic machine.

Dr Kate Hames ran the session relating to problem solving during general anaesthesia. She provided a simple framework for airway choice (LMA or ETT) and spontaneous vs IPPV. She then proceeded to discuss potential issues that occur during each scenario and how to manage them successfully.

This session was pitched at just the right level and answered many questions that arise when running cases and allowed participants to think about them ahead of time.

REGIONAL ANAESTHESIA SESSION
Dr Steve Cook from Redcliffe Hospital led the session and talked about issues relating to regional anaesthesia, mainly neuraxial blockade.

Given that many trainees are in hospitals which all have considerable obstetric workloads, there was a reasonable amount of time given over to problem solving issues related to clocks in labour ward.

Communication issues relating to block problems were emphasised to allow participants a chance to think of how they might approach patients who have problems with their block.

We were able to access an epidural simulator, however equipment failure meant that hopefully this will run better next year.

FUTURE COURSES
Program
We had initially planned to hold the regional anaesthesia session on Saturday morning which would have allowed 2 hours. This would be our preferred option for next year. The on
call/critical incident session would have been better placed on the Sunday morning and 1 1/2 hours is adequate time to cover the issues raised.

**Funding**

We hope to approach the College next year to see if we can obtain funding to pay for use of the skills centre. Use this year was very kindly arranged by Kersi but in future years we should really be paying for the fabulous services of the centre.

We had no difficulty in securing sponsorship for meals from our drug/equipment company reps. and our thanks go to Baxter, Pacific Medical, Cook and Astra Zeneca.

**Committee Members**

It was very helpful to have a number of members at each session to provide examples and help to get discussion going.

**Timing**

Ideally we think that the course is best held a few months into the year so that participants have done enough anaesthetics but before they may have to start on call rosters. We will try to hold the course March/April next year. Thanks to Steve Cook for volunteering to run the course.

**Queensland Trainee**

**Committee Chairman:**
Dr Kath Cooke (Royal Brisbane)

**Secretary:**
Dr Diana Webster
(Princess Alexandra Hospital)

**Northside Rep:**
Dr Alex Donaldson
(Royal Brisbane Hospital)

**Southside Rep:**
Dr Rod Grant (Mater Hospitals)

**Social Secretary:**
Dr Masha Golikov (Mater Hospitals)

**GASACT rep:**
Dr Ben Lloyd (Royal Brisbane)

We also have regular attendees from Ipswich, Logan, Gold Coast, Redcliffe and Nambour.
COUNCIL HIGHLIGHTS
AUGUST 2006

Highlights from Council Meeting held on 19th August 2006

WELCOME NEW FELLOW REPRESENTATIVE – DR ANNABEL ORR
Dr Orr was congratulated on her recent election as New Fellow Representative.

DEATH OF FELLOW
The death of Dr Victor Brand (Vic) – FFARACS 1952, FANZCA 1992 was noted with regret.

Death of Dr John Zorab (UK), FRCA Although not a Fellow of ANZCA, the death of Dr John Zorab was noted by Council.

EDUCATION AND TRAINING
Supervisor of Training Workshops
The SOT and Module Supervisor workshops for the 2007 ASM will focus upon development of supervisor skills for the delivery of feedback for coaching and improving Trainee performance.

Trainee Committee
The College is committed to supporting and promoting Trainee Committees in the regions and New Zealand. The Education and Training Committee considered that recruitment to these Committees may be addressed by providing more detailed direction on the purpose and function of the Committees.

Anaesthesia Training in the Private Sector
The Hospital Accreditation Committee is addressing this issue. The Education and Training Committee considered it unnecessary for there to be separate policies for Supervisors of Training in private institutions. The same standards are to apply to all training institutions.

FINANCE
Utilisation of CME Funds Request
Council supported the development of a policy on the utilisation of surplus funds from CME Meetings.

CONTINUING EDUCATION AND QUALITY ASSURANCE
Annual Scientific Meetings
ANZCA Registered Trainee and New Fellow Registration fee for ASM
Council resolved that the registration entitlements for Trainees, Fellows with low incomes or new Fellows be altered in line with those offered in the full registration package.

2008 ASM - Sydney
Professor Steven Shafer (USA) has been invited to attend the 2008 ASM as Foundation Visitor. Prof Shafer is Professor of Anaesthesiology at Stanford University, and Editor in Chief of ‘Anesthesia and Analgesia’.

2007 New Fellows’ Conference
The theme for next year’s New Fellows’ Conference is: Interacting Constructively with Trainees. The intention is to focus on how new Fellows might improve various aspects of their working relationship with trainees, as well as their role as teachers and mentors.

Continuing Education for Fellows/ Individual CME
New Development in Distance Education – ‘Seeds’
Council supported a proposal for a program of six ‘Seeds’ to be made available to Fellows. This is an interactive web-based program which will be run over 18 months, with a new ‘Seed’ every three months. This support was granted as an interim measure until the College strategies are completed.

Maintenance of Professional Standards Program
Draft Continuing Professional Development (CPD) Program
As part of the review of MOPS, consideration is being given to introducing a new CPD Program. Feedback will be sought from the Regional/NZ Committees and Fellows in due course following consideration by Council of a revised draft in December. It is anticipated that the new program, if accepted, will be introduced for the commencement of the 2008 calendar year.

REGULATIONS
Regulation 15.6.3 – Interrupted Training – an additional paragraph has been added to clarify that this Regulation applies to all trainees, regardless of the date Approved Training commenced. The implementation date is 1st October 2006.

Regulation 15.10.3 – Documentation for Approval of Training Time – documentation verifying completion of the various Modules and years of training must be forwarded to the College within three months of completion of the year of training. This applies to all trainees from the 2007 Hospital Employment Year, regardless of the date they commenced their Approved Training.

Regulation 23 – OTS – there was a general review of this Regulation to reduce duplication and inconsistency with the information in the OTS Process documentation.

Regulation 32 – New Fellow on Council – a new clause was added to clarify that the New Fellow will be appointed to his/her Regional/National Committee as an ex-officio member.
INTERNAL AFFAIRS

Appointments
- Dr Russell Jones has been appointed to an Honorary Professorship in the Faculty of Medicine, Nursing and Health Sciences at Monash University, Melbourne, as from 28th July 2006. Within the College his appointment will be styled the ‘ANZCA Professor of Education’.
- Mr Ian Lardner has been appointed Director, Finance and Business Administration, as from 26th July 2006.
- Ms Pam Edwards has been appointed Executive Officer, Education and Training, as from 3rd August 2006.

Strategic Planning
Council agreed on a framework for progressing strategic planning, and four priorities were agreed:
- Education
- Government and External Relations
- Model of Anaesthesia Care
- Support for Fellows and Trainees and Support to Council and Committees (these items came equal 4th)

Joan Sheales Memorial
Following discussion with the Sheales family, Council resolved to commission a portrait in memory of the inaugural CEO, Mrs Joan Sheales.

Review of OTS Assessment Process Document
In line with the revisions to Regulation 23, the OTS Assessment Process documentation was also amended.

PROFESSIONAL

Professional Documents
Following the normal review process, two Professional Documents were approved by Council:
- PS4 – Recommendations for the Post-Anaesthesia Recovery Room
- PS15 – Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery

ANAESTHESIA CONTINUING EDUCATION CO-ORDINATING COMMITTEE (ACECC)

Obstetric Anaesthesia Special Interest Group
Development of Evidence-Based Guidelines for Obstetric Anaesthesia
Council supported in principle the production of evidence-based clinical practice guidelines for Obstetric Anaesthesia. More detailed information on projected costs were to be received before a firm decision could be made.
2006 JFICM ANZICS ASM
SEPSIS: SURVIVING THE GUIDELINES

MEMBERS OF THE BOARD RECEIVED GRADUANDS AT THE CEREMONY

DON HARRISON AWARD WINNER DR TIMOTHY STANLEY WITH DR JACK HAYILL AND PROFESSOR DON HARRISON

STANDING OVATION FOR DR LINDSAY ‘TUPE’ WORTHLEY

DR PETER VERNON VAN HEERDEN ANNOUNCED THE DON HARRISON MEDAL WINNER

NEW FELLOWS PRESENTING WERE, FROM LEFT: DR MAX SEET, DR STEPHEN WARRILLOW, DR HIMANGSU GANGOPADHYAY, DR MATTHEW MAIDEN, DR LEO NUNNINK, DR NIKKI BLACKWELL, DR ALAN DAVY QUINN, DR ANTHONY HOLLEY
The second Annual Scientific Meeting of the Joint Faculty of Intensive Care Medicine in association with the Australian and New Zealand Intensive Care Society was held at the Sofitel Melbourne on 9-11 June 2006. The event was an enormous success with over 300 delegates.

The meeting featured a series of pro con debates that generated much discussion. Once again the presentation of new Fellows and awards were presented at the conference dinner.

I would like to thank all speakers for their contribution and also Ms Juliette Mullumby, the conference secretary, and Carol Cunningham Brown for their efforts in ensuring the meeting’s success. On behalf of Ian Seppelt and the Organising Committee of the 2007 ASM I encourage all Fellows and Trainees to attend the “Heart of the Matter” in Sydney next year.

Craig French Convenor ASM 2006
2006 NEW FELLOW ON COUNCIL ELECTION

BALLOT RESULTS 31 JULY 2006

In April 2006, Council supported the inclusion of a New Fellow within three years of admission to ANZCA Fellowship by Examination, on Council.

A call for nominations was made to eligible Fellows in May, and five nominations were received. The Election was held on Monday 31 July and we welcome Dr Annabel Orr as the New Fellow Representative on Council.

Ballot Results for the Election are as follows:

<table>
<thead>
<tr>
<th>POSITION ON BALLOT</th>
<th>VOTES COUNTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ORR, Annabel</td>
<td>32</td>
</tr>
<tr>
<td>2 MILLARD, Alan George</td>
<td>31</td>
</tr>
<tr>
<td>3 McIntosh, Catherine Ann</td>
<td>30</td>
</tr>
<tr>
<td>4 ALKHAZRAJY, Waleed Khalid</td>
<td>18</td>
</tr>
<tr>
<td>5 ACHESON, Matthew William Keith</td>
<td>11</td>
</tr>
</tbody>
</table>

TOTAL VOTES COUNTED 122

TOTAL BALLOTS COUNTED 122

Envelopes Received 131
Less Invalid Envelopes 9
Ballots Received 122
Less Invalid Ballots 0

TOTAL BALLOTS COUNTED 122

REGIONAL BREAKDOWN OF BALLOTS

<table>
<thead>
<tr>
<th>REGION</th>
<th>Ballots Received</th>
<th>No. of Fellows Eligible to Vote</th>
<th>% Voted</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>4</td>
<td>6</td>
<td>66.7</td>
</tr>
<tr>
<td>New South Wales</td>
<td>27</td>
<td>123</td>
<td>22</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>2</td>
<td>2</td>
<td>100</td>
</tr>
<tr>
<td>Queensland</td>
<td>17</td>
<td>82</td>
<td>20.7</td>
</tr>
<tr>
<td>South Australia</td>
<td>9</td>
<td>28</td>
<td>32.1</td>
</tr>
<tr>
<td>Tasmania</td>
<td>7</td>
<td>15</td>
<td>46.7</td>
</tr>
<tr>
<td>Victoria</td>
<td>37</td>
<td>108</td>
<td>34.3</td>
</tr>
<tr>
<td>Western Australia</td>
<td>17</td>
<td>37</td>
<td>45.9</td>
</tr>
<tr>
<td>New Zealand</td>
<td>7</td>
<td>54</td>
<td>13</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>1</td>
<td>25</td>
<td>4</td>
</tr>
<tr>
<td>Malaysia/Singapore</td>
<td>1</td>
<td>12</td>
<td>8.3</td>
</tr>
<tr>
<td>USA/Canada</td>
<td>0</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1</td>
<td>16</td>
<td>6.3</td>
</tr>
<tr>
<td>Rest of World</td>
<td>1</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Others (No Address)</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Ballots Received</td>
<td>131</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Invalid Ballots</td>
<td>9</td>
<td>----</td>
<td>----</td>
</tr>
</tbody>
</table>

TOTAL BALLOTS COUNTED 122 519 23.5
Visits to the Museum are welcome and can be made by arranging an appointment with the Museum Manager. All bookings and enquiries regarding the Museum should be directed to, Ms Elizabeth Triarico, on: (61 3) 9510 6299 or museum@anzca.edu.au

To accept or not to accept? – this is the question that all museums face almost on a daily basis. The answer to this important question needs to be considered carefully as it will have major implications on resources such as storage space and the significance of a collection.

The Museum Collection Management Policy has been developed so that this question can be answered with confidence. It provides a clear collecting focus and an agreed framework for the successful management of the collection.

The Policy takes into account a number of important factors such as: Dr Kaye’s original collecting focus; the existing collection strengths (e.g. prototypes); available resources and the collecting focus of similar collections.

To ensure that the Collection is of high significance the collection focus needs to be unique. Therefore, any overlaps with the collecting aims of similar institutions will be avoided where possible.

Donations have been the core component of the Museum Collection since its inception in 1935 when Dr Kaye sourced items from hospitals and instrument houses throughout Australia, including a significant amount of 19th Century material. The Collection continued to grow steadily through donations from trade houses and as a result some duplicate material was sent to the United States, New Zealand and the United Kingdom.

The Museum Collection continues to grow with approximately 10 offers of donations being received per year. These vary in size from small items such as airways and masks to larger items such as Boyles Machines. Recent donations include:

- Selection of Airways, Donated by Dr R Haridas, Victoria.
- East-Freeman Automatic Vent and Trade Pamphlets. Donated by Dr John Foley, S.A.
- Coles Vaporiser and Bird Ventilator, Trade Manual and early copy of Anaesthesia & You. Donated by Dr Ray Cook, ACT.
- Various anaesthetic material. Donated by Dr Ian Rechtman, Victoria.
- Photograph of a group of Anaesthetists (includes Dr Lunt and Dr Kester Brown) taken in 1969 and Penlon Trade Literature. Donated by Dr Robert Lunt, Victoria.

Recent donations also include highly significant prototypes of anaesthetic machines that were developed in Australia these include:

- Waveform Generator. Made and Donated by Professor Barry Baker, N.S.W.
- The Monash Computer-Controlled Electromyograph, built on a model developed at the Department of Electrical Engineering, Monash University. Donated by Dr. Kester Brown, Victoria.

Donations to the Museum Collection are always welcome and should be directed to the Museum Manager, on: (61 3) 9510 6299 or museum@anzca.edu.au. Copies of the Museum Collection Management Policy can also be obtained by contacting the Museum Manager.
In June I took over from Jack Havill as Dean. My hope is to play as useful a part in the future of JFICM as have Jack and all the past Deans.

The Dean is usually the benign personage wearing a flowing robe and bit of Jewellery, smiling out of the back pages of the Bulletin. The reality is that we are not a back-page group. We represent a group which has achieved excellence in research, education and training, leading the world. So I would like to take the opportunity of the Dean’s Report to provide a little lectern-thumping rhetoric, which I hope does not go unnoticed by the intensive care community.

My first priority is to thank Jack Havill for his unstinting work as Dean from 2004–06. Jack has been one of the pioneers of ICM in New Zealand and has established a vibrant department in Hamilton, which has produced many intensivists. He brought typical New Zealander skills to his role as Dean. He was steadfast in the scrum of policy, tenacious in the ruck and maul of college and faculty politics and with excellent vision never lost sight of the try-line. The ceremonial haka at the beginning of each Board meeting put fear into the heart of all the novices, but Board meetings usually followed smoothly from that point with little rebellion. Jack’s leadership was very productive and he continues to contribute to the Board as Past-Dean.

The end of an era has occurred with the departure from the Board of Neil Matthews who is leaving after 12 years of service. He will be greatly missed as worker, raconteur and visionary. His contribution has been enormous as Dean, Censor, Education Officer and examiner. Further details are contained in the following pages.

Also in this issue of the Bulletin there is a citation for Lindsay (Tub) Worthley. At the recent very successful JFICM ASM we celebrated the contribution of Tub with the award of the JFICM Medal. Tub has been a leader and tireless worker for intensive care medicine over 30 years. He pioneered the South Australian Course and the journal and inspired, dare I say, hundreds of intensivists. As toasted/roasted in the December 2005 issue of our journal, Critical Care and Resuscitation, he has been an amazing character.

**VOLUNTEERISM**

Reflecting on the contributions of these three great doctors leads one to realise how much the intensive care community has achieved and how much it is dependent on the principle of volunteerism. The effort represented by Tub editing the journal on his kitchen table is duplicated around Australia and New Zealand in relation to courses, conferences, committees and mentoring of trainees by numerous dedicated doctors.

Although Tub’s contribution to ICU may represent a level of dedication that may be difficult to match, there are hundreds of intensivists around the country giving large slabs of their time. It is not only ‘enlightened self-interest’ that drives these volunteers. I am sure they do this work not only because they wish to foster their own specialty, attract good trainees or train their next Senior Registrar or Specialist colleague, but because the principles of altruism and volunteerism run deep within our specialty. This is also reflected in the desire to help others, patients and families for instance, and the desire to help the ICU team.

With that in mind, JFICM is keen that the SOT is provided with adequate non-clinical time to perform the role. Our policy document on Intensive Care Practice (IC-2) states that the amount of time will vary depending on the number of trainees but should be 1 to 2 sessions per week. The Hospital Accreditation Committee will insist on compliance with this regulation and at present a survey is gaining feedback from our accredited Units.

Commensurate with the value that we place on SOT work, we feel that the SOT has the responsibility to attain and maintain certain skills. This should be aided by attending a SOT workshop within a year of being appointed and each 2 years thereafter. A full day workshop is planned for December 6th 2006 and airfares and accommodation, if necessary, will be provided by JFICM. Registration is limited to 25.

The Board has been concerned that the role of SOT has too often been left to the most junior intensivist in the department. From the extent of the role and the range of skills required, it can be seen that the SOT should be a mature member of the ICU team. The SOT should be appointed by the ICU team. The SOT should be able to provide feedback from our accredited Units.

**SUPPORTING THE ROLE OF THE SUPERVISOR OF TRAINING (SOT)**

The SOT represents a great example of the principle of volunteerism and it is timely that the SOT is given recognition for work done and support for future work. The SOT has many roles in mentoring, teaching, advising and assessing the trainees and liaising with JFICM, as set out in our Policy Document relating to the Role of the Supervisor (IC-6). With proposed changes to the ITA process and proposed provision of longitudinal mentoring of trainees between hospitals, the role of the SOT will become even more important.
CONSTITUTION OF BOARD 2006 – 2007

One of the ten elected positions on the Board became vacant this year with the retirement of Dr Neil Matthews. There being only one nomination for the position, Dr Bruce Lister, of Queensland was automatically elected to the Board. South Australia and Tasmania were no longer represented so the Board has agreed to co-opt representatives from those states.

Elected Members:
- R.P. Lee, Dean
- P.V. van Heerden, Vice-Dean and Censor
- J.A. Myburgh, Treasurer and Research Officer
- D. Ernest, Education Officer, Co-ordinator of Advanced Training
- R. Freebairn, Chairman, Hospital Accreditation Committee and International Liaison Officer
- J.H. Havill, Immediate Past Dean
- B. Lister, Communications Officer, Journal CC&R Representative
- P.T. Morley, Chairman, Examinations Committee
- M.S. Robertson, Assistant Censor, MOPS Officer and ASM Officer
- B. Venkatesh, Chair, Fellowship Examination Committee

Appointed Members:
- G.D. Phillips, Director of Professional Affairs, ANZCA
- N. Thomson, President, RACP

Co-opted representative:
- A. Beswick, Co-opted Representative, Tasmania

ELECTION OF A NEW FELLOW REPRESENTATIVE TO THE BOARD

In June 2006, the Board of the Joint Faculty of Intensive Care Medicine, ANZCA and RACP established an additional position on the Board to represent the interests of Trainees and New Fellows, to be known as the New Fellow Representative.

RETIREMENT FROM THE BOARD OF FACULTY

Dr Neil Matthews

At its recent meeting, the Board held a dinner in honour of Dr Neil Matthews who retired from the Board after 12 years dedicated service to the Faculty of Intensive Care, ANZCA and the Joint Faculty of Intensive Care Medicine. It is of note that Neil is the first Board member to make the distance!

Neil was first elected to the Board of Faculty of Intensive Care, ANZCA in 1994. He undertook portfolios in nearly every facet of the Board’s work, initially as Treasurer, as well as Communications Officer, Maintenance of Standards Officer, Education Officer, Censor and Vice-Dean. During this time he contributed with skill and tact to the Joint Specialist Advisory Committee for Intensive Care, which was the basis for the evolution of the joint training program and ultimately the Joint Faculty. He also participated in the Intensive Care Medical Liaison Committee with ANZICS. Some major contributions were made in his role as Chair of the Hospital Accreditation Committee where there was considerable policy development and the processes relating to the quality of training environments for our Trainees were enhanced.

Neil was also an active participant in the South Australian Regional Committee and held the offices of Secretary and Chairman from 1996 to 1999 and as early as 1989 contributing to the Faculty of Anaesthetists, RACS as the South Australian Regional Education Officer for Intensive Care. Like many supporters of our education and training program, Neil acted as Supervisor of Training at the Women’s and Children’s Hospital where he has been Director of the Department of Paediatric Critical Care Medicine since 1983.

His duties on the Board also involved representation on many ANZCA Committees. On top of all of these duties since 1992 Neil was an active Examiner for both the General Fellowship Exam and the Paediatric Exam when it was established in 1997.

Shortly after the establishment of the Joint Faculty, Neil was elected Dean and served from 2002 to 2004. During his term as Dean, a number of very significant developments were achieved. The review of the training program took considerable work and many iterations of the Regulations, a significant challenge in itself! His crowning achievement surely must be the role he has played in establishing links with the Australasian Academy of Critical Care Medicine which has resulted in the Journal of Critical Care and Resuscitation becoming the official Journal of the JFICM. Neil’s excellent liaison skills also came to the fore in helping establish the Inaugural JFICM ASM in 2005 and during his time on the Council of the RACP. All of these achievements have had a crucial role in creating the standing that the Joint Faculty enjoys today.

Most of all, we would like to honour Neil for his easy going good humour, and genuine concern and care for Trainees and Fellows alike.

JOINT FACULTY OF INTENSIVE CARE MEDICINE
PROSPECTIVE APPROVAL OF ADVANCED TRAINING

The Censor of the Joint Faculty would like to draw attention to the following Regulation regarding prospective approval of Advanced Training:

7.4.7.5 All ATYs must be prospectively approved.

Any Advanced Training period which has not been prospectively approved by the Joint Faculty will not be accredited.

For positions commencing in December/January approval must be sought before 30th April 2007. For positions commencing in July/August approval must be sought before 31st October 2007. For all other positions approval must be sought within 3 months of commencement of the position for periods 12 months or longer. If the position is for less than 12 months it is recommended that approval is sought 2 months prior to appointment.

If you have any questions regarding this process, or any other training enquiry, please do not hesitate to contact our Administrative Officer of Training and Examinations, Narelle Hardware at nhardware@anzca.edu.au

THE JFICM MEDAL

The Board is delighted to announce the award of the JFICM Medal (established in 2005) to Dr Ronald V. Trubuhovich, ONZM, FANZCA, FFJFICM. This Honour recognises Dr Trubuhovich’s contributions to Intensive Care in Australia and New Zealand, which date from his early involvement from 1966 when he was appointed Deputy Medical Officer in charge of the ICU in Auckland, his involvement as a Foundation member of ANZICS, Vice-President and President of ANZICS and Vice-Dean of the Faculty of Intensive Care, ANZCA.

The Award will be presented at the JFICM ASM in 2007 in Sydney.

Other honours to Fellows:
Prof Teik E Oh (WA) – Emeritus Professor, University of Western Australia, and Honorary Fellowship, Hong Kong College of Anaesthesiologists

Prof Barry Baker (NSW) – Emeritus Professor, University of Sydney

Dr Paul J. Torzillo, AM (NSW) – The RACP John Sands Medal

Dr Elizabeth Segedin FFJFICM, MNZM (NZ) – MNZM Member of the New Zealand Order of Merit.

Associate Professor David Ernest FFJFICM (Vic) – Associate Professor, Department of Medicine, Monash University

JOINT FACULTY OF INTENSIVE CARE MEDICINE PRIMARY EXAM

The Joint Faculty plans to hold the first Intensive Care Primary Examination in July 2007.

This Examination is not a mandatory requirement for trainees but rather an option for trainees not undertaking dual certification (who may still sit the ANZCA Primary or RACP Written or Clinical Examination) or another training and examination program deemed appropriate by the Censor. There are a growing number of trainees who wish to train in intensive care only.

The syllabus is now published and available from the JFICM office and at http://www.jficm.anzca.edu.au/training/index.htm

The subject areas for the Examination will be:
- Physiology including Clinical Measurement
- Pharmacology including Statistics

While it closely follows that of the ANZCA Primary Exam, there are some differences:
- Topics are listed under major systems with relevant anatomy, physiology, pharmacology and measurement.
- Topics not relevant to Intensive Care e.g. inhalation agents have been replaced with other topics such as microbiological principles

The format of the Exam will be a Written component, comprising two papers of short answer questions and short facts questions. The Oral component will consist of a mixture of OSCEs and orals.

The Exam will not be split into physiology and pharmacology as is the current ANZCA Primary Exam. Both Written papers and Orals will examine the whole syllabus so this Exam cannot be sat in two independent sections.
Lindsay Ian Grant Worthley, affectionately known amongst his colleagues as ‘Tub’, was born in Adelaide in 1944 and graduated from the University of Adelaide in 1968. He then trained in Internal Medicine and Anaesthesia and obtained the FFARACS in 1973, FRACP in 1974, FANZCA in 1992, FFICANZCA in 1994, FCCP in 1995, and the FJFICM in 2002. He was appointed as a Staff Specialist in Intensive Care at the Royal Adelaide Hospital in 1975 which was the beginning of an illustrious career in Intensive Care Medicine. He moved to the Flinders Medical Centre in 1991 where he remained a Senior Staff Specialist until his retirement in 2005.

Thanks to Tub’s efforts at teaching and training, Adelaide became the hub of Intensive Care training and activity. He commenced and for 22 years ran, the famous Adelaide Short Course in 1983 which was highly popular and well attended. He ran it for 22 years. It is fair to say that almost every Intensivist in Australia has gone through Tub’s tutelage.

Tub has made several outstanding contributions to the development of Intensive Care in Australia. These include:

- Commencement of the famous Adelaide Short Course in 1983
- Original work on acid-base and electrolytes, the use of intravenous hydrochloric acid for alkalosis, and the use of intravenous sterile water for hyperosmolar syndromes
- Development of TPN service in Adelaide
- Instrumental in the development of the Fellowship Examination in Intensive Care and Examiner for the Fellowship 1979-1990
- ANZICS President 1982-1983
- Founded and developed the Norva Dahlia Foundation
- Founded and developed the Australasian Academy of Critical Care Medicine (AACCJM)
- Convener of several national and regional ANZICS Meetings
- Served on several ANZCA and ANZICS committees both at national and regional levels
- Was part of the group that pioneered the Percutaneous Tracheostomy Forceps Dilator Technique

He has published more than 150 articles and abstracts, 3 major textbooks, several book chapters and numerous course year books.

In 1999, he launched the journal ‘Critical Care And Resuscitation’ of which he remained the Editor in Chief until 2005. In a short span of 6 years, the Journal has now become indexed on Medline.

One of Tub’s hallmarks is his boundless energy. An article submitted to Critical Care and Resuscitation would be reviewed, and if accepted, galley proofed in a space of 48 hours, all by that one man.

In the course of his academic career, Tub has received scores of honours.

- ANZCA Council Citation - 2001
- ANZICS Honour Roll - 2003
- ANZICS Oration - 2003

Following a 30 year career, Tub is truly considered a giant amongst his peers. He exercised unique influence as a bedside clinician, as an educator, a productive investigator, and a decisive leader for Intensive Care Medicine.

Tub also has a very full private life, ably supported by his wonderful wife Janice. He is a proud father and a doting grandfather.

As Fellows of the Joint Faculty of Intensive Care Medicine we are indeed fortunate to belong to the first training and accreditation body for Intensive Care Medicine in the world. The Joint Faculty and Fellows owe much to the giants who laid the foundations and continue to build this organisation – names such as Spence, Trubuhovich, Fisher, Wright, Duncan, Hawker, Matthews, and Clarke among others. Tub walks tall among them!
EXAMINATIONS
Intensive Care Primary Examination
The Board approved the Syllabus for this proposed Examination which has now been circulated and posted on the website. It was agreed the first Exam will be conducted in the second half of 2007.

Generic Notes for Candidates
The Board approved a revised set of guidelines for Exam candidates to encompass the General, Paediatric and OTS Assessment Examinations. It includes changes to the format of the Paediatric Exam to bring it into line with the General Fellowship Exam format.

Restructuring of the Exam Committee
With the growing workload associated with the introduction of an Intensive Care Primary Exam, and bringing the Paediatric Exam into line with the format of the General Fellowship Exam, the Board resolved:
• That the Fellowship Examination Committee be renamed the Examinations Committee.
• That a General Fellowship Examination Committee, a Paediatric Fellowship Examination Committee and a Primary Examination Committee be established, elected from the Panel of Examiners.
• That the membership of the Fellowship Admissions Committee be changed to include the Chairman of the respective Examination Committee.

Dr Gill Bishop was appointed Chair of the Primary Examination Committee.
Dr Bruce Lister will Chair the Paediatric Exam Committee and Dr Bala Venkatesh was appointed Chair of the General Fellowship Exam.

EDUCATION AND TRAINING
Compulsory intensive care component of anaesthesia training
ANZCA Council recently confirmed that the three month intensive care component for anaesthesia trainees can only be undertaken in Units accredited by the Joint Faculty for Core (Advanced) Training.

Senior Registrar Requirement
Following further review of this requirement and feedback from Regional and National Committees, the Board reaffirmed its requirement for trainees to undertake a minimum of six months in a senior registrar role during their core intensive care training.

HOSPITAL ACCREDITATION
Accreditation of Units for Basic Training
The following Units were approved for Basic Training:
• Ipswich Hospital, Qld
• Hawke’s Bay Hospital, NZ
• Allamanda Private Hospital, Qld
• Port Macquarie Base Hospital, NSW

Accreditation for Advanced Training
• Wakefield Hospital, SA
• Alice Springs Hospital, NT

Joint Committee on Consensus Recommendations for Utilization of Echocardiography in Anaesthesia and Intensive Care
Following requests for nominations for JFICM representation on this proposed committee, the Board believe that such guidelines should be developed as an initiative of ANZICS and the JFICM rather than at an ad hoc level. ANZCA will be developing guidelines specifically for anaesthesia. The role of where echocardiography in with the training program will be considered in the review of the curriculum.

FELLOWSHIP AFFAIRS
Admission to Fellowship
The Board admitted to Fellowship the following by examination:
Christopher Thomas Allen, WA
Todd Adam Fraser, Qld
Hui Ling Tan, Singapore
Timothy James Wigmore, UK
Alexander Paul Sinclair Wurm, SA
Via the OTS pathway:
Bart de Keulenaer, WA
Via Regulation 5.1.8:
Christopher Mark Johansson Qld
New Fellows Conference, 2006
Dr Nikki Blackwell presented a report on this Conference held in May. Some of the key issues raised by the intensive care delegates were:

1. The shortage of anaesthetic posts for intensive care trainees.
2. Rural incentives. These should be developed, given that the delegates attending had received rural training and found it very valuable.
3. Formal Projects. Either trainees were research oriented and enjoyed this component, or hated it. It was suggested that consideration should be given to a choice for trainees of either completion of a Formal Project or a three month rural rotation.
4. Meeting the needs of International Medical Doctors and facilitating training.

INTERNAL AFFAIRS
JFICM Staff
Andrew Coghill resigned in May and we have welcomed Ms Narelle Hardware as Admin Officer Training and Examinations to the staff.

Regional Representation on the Board
With the departure of Neil Matthews, the Board is seeking to co-opt a new representative from South Australia. Since the departure of Dr John Gowdman to Queensland, Dr Allan Beswick as agreed to act as Chair of the Tasmanian Regional Committee and be co-opted to the Board.

Election for a New Fellow Representative on the Board
Further discussions were held on the appointment of a New Fellow representative to the Board. Two new Regulations were approved as follows, and an election will be conducted.

1.1(d) One Fellow, within five years of admission to Fellowship, elected to represent Trainees and New Fellows (in these Regulations referred to as ‘New Fellows Representative’). This election and appointment will take place in accordance with Regulation 1.1.8.

1.1.8 New Fellow Representative
This Representative is elected for a maximum tenure of three years and will not be eligible for re-election as a New Fellow Representative. A Fellow standing as an ordinary member of the Board will be unable to stand for the New Fellow Representative position. The time spent in this position shall be counted towards the 12 years that an ordinary elected member may spend on the Board. The Fellow shall have full voting rights. The Fellow will be able to hold portfolios, but will not be eligible to be an Officer of the Board.

Amendment to the Regulations
Other Regulations were amended:
• To highlight that ANZCA and RACP Council appointees to the Board are Appointed members and not co-opted (Regulation 1.1.7).
• To incorporate the changes to the Exam Committee restructure.
<table>
<thead>
<tr>
<th>Document Code</th>
<th>Title</th>
<th>Year</th>
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<tr>
<td>IC-1</td>
<td>Minimum Standards for Intensive Care Units</td>
<td>2003</td>
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<tr>
<td>IC-2</td>
<td>Intensive Care Specialist Practice in Hospitals Accredited for Training in Intensive Care Medicine</td>
<td>2005</td>
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<tr>
<td>IC-3</td>
<td>Guidelines for Intensive Care Units seeking Accreditation for Training in Intensive Care Medicine</td>
<td>2003</td>
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<tr>
<td>IC-4</td>
<td>The Supervision of Vocational Trainees in Intensive Care</td>
<td>2000</td>
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<tr>
<td>IC-6</td>
<td>The Role of Supervisors of Training in Intensive Care Medicine</td>
<td>2002</td>
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<tr>
<td>IC-7</td>
<td>Secretarial Services to Intensive Care Units</td>
<td>2006</td>
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<td>IC-8</td>
<td>Quality Assurance</td>
<td>2003</td>
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<tr>
<td>IC-9</td>
<td>Statement on the Ethical Practice of Intensive Care Medicine</td>
<td>2002</td>
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<tr>
<td>IC-10</td>
<td>Minimum Standards for Transport of the Critically Ill</td>
<td>2003</td>
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<tr>
<td>IC-11</td>
<td>Guidelines for the In-Training Assessment of Trainees in Intensive Care Medicine</td>
<td>2003</td>
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<tr>
<td>IC-12</td>
<td>Examination Candidates Suffering from Illness, Accident or Disability</td>
<td>2001</td>
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<tr>
<td>IC-13</td>
<td>Recommendations on Standards for High Dependency Units Seeking Accreditation for Training in Intensive Care Medicine</td>
<td>2002</td>
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<tr>
<td>IC-14</td>
<td>Statement on Withholding and Withdrawing Treatment</td>
<td>2004</td>
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<tr>
<td>IC-15</td>
<td>Recommendations of Practice Re-entry for an Intensive Care Specialist</td>
<td>2004</td>
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<tr>
<td>PS38</td>
<td>Statement Relating to the Relief of Pain and Suffering and End of Life Decisions</td>
<td>2004</td>
</tr>
<tr>
<td>PS39</td>
<td>Minimum Standards for Intrahospital Transport of Critically Ill Patients</td>
<td>2003</td>
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<tr>
<td>PS40</td>
<td>Guidelines for the Relationship Between Fellows, Trainees, and the Healthcare Industry</td>
<td>2005</td>
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<tr>
<td>PS45</td>
<td>Statement of Patient’s Rights to Pain Management</td>
<td>2001</td>
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<tr>
<td>PS48</td>
<td>Statement on Clinical Principles for Procedural Sedation</td>
<td>2003</td>
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<tr>
<td>PS49</td>
<td>Guidelines on the Health of Specialists and Trainees</td>
<td>2003</td>
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The Board of Faculty held a planning meeting in July where a wide range of topics were identified and discussed. Priority for implementation of the tasks was identified from highest to lowest. Those issues ranking highly included the promotion of Pain Medicine to the undergraduate and early postgraduate years and to this end I will be making contact with Deans of Medical Schools to offer Pain Medicine modules at an undergraduate level and we will continue discussions with the Confederation of Post-Graduate Medical Education Councils to ensure that Pain Medicine features in the education of post-graduate years 1 and 2. Those Fellows interested can visit the CPGMEC website http://www.cpmec.org.au/curriculum/ to view the proposed new curriculum and offer feedback and comment on this initiative.

The Board has also supported the Education and Training Committee developing patient education pamphlets along the lines offered by the Royal Australian College of Surgeons and the Australasian Society of Anaesthetists. Any Fellows who are interested in having input into this process should contact the Executive Officer.

The Board reaffirmed its strong support for Supervisors of Training and hopes that as many Supervisors of Training as possible can attend the clinical teaching course workshop being held in November 2006.

The Faculty’s agreement with the American Academy of Pain Medicine with respect to our combined journal Pain Medicine has developed well with the Faculty’s name now on the masthead of Pain Medicine. Our Senior Australian Editor has announced that selected free papers presented at the Annual Scientific Meeting in Melbourne will be published in Pain Medicine. The Board encourages all Fellows to consider Pain Medicine as an avenue for their research. As announced previously in Synapse, the Board has endorsed the Research Committee’s proposal for a Pain Medicine prize to be awarded for the best free paper presented at the Annual Scientific Meeting. Fellows and trainees eligible for this prize should look out for the call for free papers coming in October of this year. The Board and the Research Committee are committed to promoting research amongst trainees and Fellows and hope that the Faculty prize will be both an encouragement and some reward for research into any area of pain medicine.

While the Faculty has focused heavily on education, training and examination for trainees, educational services such as CPD opportunities for Fellows were also seen as high priority and it is planned to develop a number of new initiatives appropriate to Pain Medicine. There was support also, particularly in the larger states, for the development of regional committees where Fellows could be encouraged to interact with the Faculty.

Strengthening relationships with the Australian and New Zealand Pain Societies was given high priority in order to foster educational activities and coordinate opportunities for joint projects.

The Faculty is pleased to be meeting with Professor Nip Thompson President of RACP at the October Board meeting.

At the July Board Meeting, further discussion on the eligibility of overseas trained specialists and doctors as faculty trainees ensued. It was confirmed that rigorous assessment of their specialist qualification, experience and training will be maintained.
| PM1 | (2006) | Policy for Trainees Seeking Faculty Approval of Programs for Training in Multidisciplinary Pain Medicine |
| PM2 | (2005) | Guidelines for Units Offering Training in Multidisciplinary Pain Medicine |
| PM3 | (2002) | Lumbar Epidural Administration of Corticosteroids |
| PM4 | (2005) | Guidelines for Patient Assessment and Implantation of Intrathecal Catheters, Ports and Pumps for Intrathecal Therapy |
| PS3 | (2003) | Guidelines for the Management of Major Regional Analgesia |
| PS45 | (2001) | Statement on Patients’ Rights to Pain Management |

ANZCA Professional Documents adopted by the Faculty:

- PS15 (2000) | Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery with amendment to the title to read Recommendations for the Perioperative Care of Patients Selected for Day Care Procedures (Adopted February 2001)
POLICY FOR TRAINEES SEEKING FACULTY APPROVAL
OF PROGRAMS FOR TRAINING IN MULTIDISCIPLINARY
PAIN MEDICINE

1 DEFINITION OF A TRAINEE

1.1 A trainee for the Fellowship of the Faculty of Pain Medicine will be:

1.1.1 A Fellow or a Trainee towards Fellowship of one of the following bodies
Australian and New Zealand College of Anaesthetists
Royal Australasian College of Surgeons
Royal Australasian College of Physicians
Royal Australian and New Zealand College of Psychiatrists
Australasian Faculty of Rehabilitation Medicine (RACP); or
1.1.2 A Fellow of the Royal Australian College of General Practitioners or of the Royal New Zealand College of General Practitioners; or
1.1.3 A Fellow of a Faculty or Chapter of a participating College (other than AFRM); or
1.1.4 A holder of a specialist qualification, experience and training acceptable to the Board

2 TRAINING

2.1 For trainees as defined in 1.1.1,

2.1.1 Training is for a minimum of two years and may commence
during, and may be concurrent with, the training program of the specialties of anaesthesia, surgery, medicine, psychiatry or rehabilitation medicine; and
2.1.2 Trainees must undertake a prospectively approved structured
one year training period in a Faculty accredited Pain Medicine Program as outlined in Faculty Professional Document PM2 Guidelines for Units Offering Training in Multidisciplinary Pain Medicine; and
2.1.3 Up to one year of additional experience of direct relevance to
Pain Medicine is required. Prior training may be accredited; approval thereof is not automatic.

2.2 For trainees as defined in 1.1.2 and 1.1.3,

2.2.1 Training is a minimum of three years; and
2.2.2 Trainees must undertake a prospectively approved two year
training period in a Faculty accredited Pain Medicine Program as outlined in Faculty Professional Document PM2 Guidelines for Units Offering Training in Multidisciplinary Pain Medicine; and
2.2.3 Up to one year of additional experience of direct relevance to
pain medicine is required. Prior training may be accredited; approval thereof is not automatic.

2.3 For trainees as defined in 1.1.4, the training requirements will be
determined by the Censor.

2.4 Registration with the Faculty must be completed before the
period of structured training commences.

2.5 A trainee must work in posts approved for training in
Pain Medicine.

2.5.1 When Pain Medicine training is concurrent with training
towards a Fellowship specified in 1.1.1, the program must meet the requirements of the Faculty of Pain Medicine and the other College or Faculty. Prospective discussions are mandatory.

2.6 Trainees are expected to spend at least 0.9 FTE (90%) in
Pain Medicine. Not all this time need be clinical. The trainee may
work in their primary specialty outside normal hours.

2.7 Training program(s) run by approved Units should be tailored
to the trainees’ requirements and should allow for exposure to the topics as outlined in the Objectives of Training.

2.8 Part-time or interrupted training may be approved
on prospective application.

3 ASSESSMENT COMPONENTS

The following requirements must be satisfied as set out in the
Administrative Instructions (Sections 5 & 6):

3.1 Log Book
3.2 Quarterly In-Training assessments by the Supervisor of Training.
3.3 Final assessment report by the Supervisor of Training.
3.4 Case Report.
3.5 Examination.

FACULTY OF PAIN MEDICINE

POLPROFESSIONAL DOCUMENTS

POLICY – defined as ‘a course of action adopted and pursued
by the Faculty. These are matters coming within the authority
and control of the Faculty.

RECOMMENDATIONS – defined as ‘advisable courses of
action’.

GUIDELINES – defined as ‘a document offering advice’.

These may be clinical (in which case they will eventually
be evidence-based), or non-clinical.

STATEMENTS – defined as ‘a communication setting
out information’.

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

Professional documents are reviewed from time to time and it is the
responsibility of the practitioner to ensure that the practitioner has obtained
the current version. Professional documents have been prepared having
regard to the information available at the time of their preparation, and the
practitioner should therefore have regard to any information, research or
material which may have been published or become available subsequently.

Whilst the College and Faculty endeavour to ensure that documents are as
current as possible at the time of their preparation, they take no responsibility
for matters arising from changed circumstances or information or material
which may have become available subsequently.

Promulgated: February 2002
Date of Current Document: July 2006
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in whole or in part without prior permission.

FPM Website: http://www.fpm.anzca.edu.au
Supervisors of Training are the Faculty’s representatives with respect to training in units accredited by the Faculty. They have an important role and should have a broad understanding of and experience in Faculty activities. They provide liaison between registered trainees, hospital or institution authorities and the Faculty regarding matters related to training.

1. APPOINTMENT AND TENURE

1.1 The Supervisor of Training in Pain Medicine shall be nominated by the Director of an approved Multidisciplinary Pain Medicine Unit.

1.2 The Supervisor shall not be the Director of the Multidisciplinary Pain Medicine Unit or administratively responsible for its functioning unless the circumstances are exceptional.

1.3 The appointee shall hold the Fellowship of the Faculty of Pain Medicine.

1.4 The Board of the Faculty of Pain Medicine shall normally ratify the appointment upon the recommendation of the Education and Training Committee but, at its discretion and after consultation, may not approve that appointment.

1.5 The appointment of a Supervisor of Training shall be for an initial term of three years. Supervisors will be eligible for reappointment by the Board of the Faculty of Pain Medicine.

2. DUTIES OF SUPERVISORS

2.1 Within the Unit

2.1.1 To be familiar with the Faculty’s Administrative Instructions on registration of trainees, training, assessment and examination.

2.1.2 To notify the Executive Officer of the Faculty of any senior staffing or workload changes likely to impact on training programs.

2.1.3 To advise the Executive Officer of the Faculty if there are significant changes in their unit such that it may no longer be suitable for training.

2.1.4 To advise potential and current Registered Trainees on their registration requirements, fee payments, training and examination preparation.

2.1.5 To be aware of the materials that are available from the Faculty to assist Supervisors of Training in their duties.

2.1.6 To monitor supervision, experience and fair allocation of duties for trainees and to facilitate such changes as may be necessary.

2.1.7 To liaise with the Director of the Multidisciplinary Pain Medicine Unit regarding trainee duties, supervision, rest and study time and release for approved courses.

2.1.8 To ensure compliance of the Multidisciplinary Pain Medicine Unit with the Faculty’s requirements for In-Training Assessment.

2.2 Outside the Unit

2.2.1 To establish and maintain liaison with the Fellows in the region and with other Supervisors of Training.

2.2.2 To attend training courses for Supervisors of Training.

2.2.3 To refer any difficulties regarding training programs or trainees to the Executive Officer of the Faculty.

2.2.4 To be aware of appropriate training courses and examination requirements and to see that trainees receive this information.

3. RESOURCES

The Supervisor of Training shall be provided by the approved Multidisciplinary Pain Medicine Unit with the resources needed to fulfil his or her responsibilities, as outlined in Faculty Professional Document PM2 - Guidelines for Units Offering Training in Multidisciplinary Pain Medicine. In larger Multidisciplinary Pain Medicine Units this will require a time allocation of approximately one session per week.

The Faculty will provide training resources to aid Supervisors of Training in their work. Supervisors of Training should be aware of the Faculty provided resources and training.

This Professional Document should be interpreted with regard to the following Documents:

- PM1 Policy for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine
- PM2 Guidelines for Units Offering Training in Multidisciplinary Pain Medicine
- PS49 Guidelines on the Health of Specialists and Trainees

FACULTY OF PAIN MEDICINE PROFESSIONAL DOCUMENTS

POLICY – defined as ‘a course of action adopted and pursued by the Faculty. These are matters coming within the authority and control of the Faculty.

RECOMMENDATIONS – defined as ‘advisable courses of action’.

GUIDELINES – defined as ‘a document offering advice’. These may be clinical (in which case they will eventually be evidence-based), or non-clinical.

STATEMENTS – defined as ‘a communication setting out information’.
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ABN 82 055 042 852
PROFESSIONAL DOCUMENTS

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

TE1  (2005)  Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia
TE2  (2006)  Policy on Vocational Training Modules and Module Supervision (interim review)
TE4  (2003)  Policy on Duties of Regional Education Officers in Anaesthesia
TE5  (2003)  Policy for Supervisors of Training in Anaesthesia
TE7  (2005)  Guidelines for Secretarial and Support Services to Departments of Anaesthesia
TE8  (2003)  Guidelines for the Learning Portfolio for Trainees in Anaesthesia
TE10 (2003)  Recommendations for Vocational Training Programs
TE13 (2003)  Guidelines for the Provisional Fellowship Program
TE14 (2001)  Policy for the In-Training Assessment of Trainees in Anaesthesia
TE17 (2003)  Policy on Advisors of Candidates for Anaesthesia Training
TE18 (2005)  Guidelines for Assisting Trainees with Difficulties
EX1  (2001)  Policy on Examination Candidates Suffering from Illness, Accident or Disability
T3   (2006)  Minimum Safety Requirements for Anaesthetic Machines for Clinical Practice
PS1  (2002)  Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia
PS2  (2001)  Statement on Credentialling in Anaesthesia
PS3  (2003)  Guidelines for the Management of Major Regional Analgesia
PS6  (2001)  Recommendations on the Recording of an Episode of Anaesthesia Care (the Anaesthesia Record)
PS7  (2003)  Recommendations on the Pre-Anaesthesia Consultation
PS8  (2003)  Guidelines on the Assistant for the Anaesthetist
PS9  (2005)  Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures
PS10 (2004)  Handover of Responsibility During an Anaesthetic
PS12 (2001)  Statement on Smoking as Related to the Perioperative Period
PS14 (1998)  Guidelines for the Conduct of Major Regional Analgesia in Obstetrics
PS15 (2006)  Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery
PS16 (2001)  Statement on the Standards of Practice of a Specialist Anaesthetist
PS18 (2006)  Recommendations on Monitoring During Anaesthesia
PS19 (2001)  Recommendations on Monitored Care by an Anaesthetist
PS26 (2005)  Guidelines on Consent for Anaesthesia or Sedation
PS29 (2002)  Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities
PS31 (2003)  Recommendations on Checking Anaesthesia Delivery Systems
PS37 (2004)  Regional Anaesthesia and Allied Health Practitioners
PS42 (2006)  Recommendations for Staffing of Departments of Anaesthesia
PS43 (2001)  Statement on Fatigue and the Anaesthetist
PS44 (2001)  Guidelines to Fellows Acting on Appointments
PS45 (2001)  Recommendations for Responsibilities of Posts for Vocational Training in Diving and Hyperbaric Medicine
PS46 (2004)  Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults
PS47 (2002)  Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine
PS50 (2004)  Recommendations on Practice Re-entry for a Specialist Anaesthetist
1. INTRODUCTION
Approved Vocational Training consists of Basic Vocational Training of a minimum two years duration (BTY1 and BTY2), and Advanced Vocational Training of a minimum three years duration (ATY1, ATY2 and ATY3).
In each year, trainees will complete a number of learning experiences organised into Modules.
All Modules must be completed to satisfy ANZCA training requirements.

2. MODULE TITLES
2.1 Module 1 – Introduction to Anaesthesia and Pain Management
2.2 Module 2 – Professional Attributes
2.3 Module 3 – Anaesthesia for Major and Emergency Surgery
2.4 Module 4 – Obstetric Anaesthesia and Analgesia
2.5 Module 5 – Anaesthesia for Cardiac, Thoracic and Vascular Surgery
2.6 Module 6 – Neuroanaesthesia
2.7 Module 7 – Anaesthesia for ENT, Eye, Dental and Maxillofacial Surgery
2.8 Module 8 – Paediatric Anaesthesia
2.9 Module 9 – Intensive Care
2.10 Module 10 – Pain Medicine – Advanced Module
2.11 Module 11 – Education and Scientific Enquiry
2.12 Module 12 – Professional Practice

3. MODULES
Each Module provides the aims for the acquisition of knowledge, skills and attitudes in the relevant area, and includes basic sciences, clinical and technical skills, educational skills and clinical management skills. Modules are arranged with consideration of the stage of training, and with a few exceptions, the Modules need not be completed sequentially or as dedicated rotations, so as to allow for flexibility in training.

3.1 Modules 1 to 3 must be completed to satisfy the requirements of Basic Training. Modules 2 and 3 cannot be commenced until six months of training have been completed.
3.2 Modules 4 to 10 may be completed during Basic or Advanced Training, as described in Regulations 14 and 15.
3.3 Modules 11 and 12 must be completed during Advanced Training.
3.4 The sequence of undertaking the Modules is flexible, and will depend on the trainee’s learning plan, in consultation with the Supervisors of Training and the Directors of Departments forming a recognised training program.

4. MODULE COMPLETION
Module 1 and Modules 3 – 10 require validation of completion by the Module Supervisor. The following steps are involved in Module completion.
4.1 The Trainee will record their clinical experience in the Learning Portfolio.
4.2 The Module Supervisor will review the Trainee’s clinical experience, as recorded in the Learning Portfolio.
4.3 The Trainee will complete the Module specific assessments, which will be validated by the Module Supervisor.
4.4 The Trainee will self assess whether they have met the Core Trainee Aims of the Module.
4.5 The Module Supervisor will discuss the Trainee’s self assessment with the Trainee, and will validate that the Trainee considers that they have met the Core Trainee Aims of the Module.
4.6 When the above have been completed, the Module Supervisor will sign Form K validating module completion. Form K will be countersigned by the Supervisor of Training. Modules 2 and 12 are completed using web based assessments. Module 11 is completed by completing the Formal Project (see College Professional Document TE11 – Formal Project Guidelines).

5. MODULE SUPERVISORS
Supervisors of Vocational Training Modules are key people in training in anaesthesia in its approved hospitals. They have an important role and must have a broad understanding of, and experience in the contents of the modules they supervise. They work directly with both the Trainee and the Supervisor of Training.

6. APPOINTMENT AND TENURE
6.1 The Supervisor of FANZCA Training Module(s) in Anaesthesia shall be nominated by the Director and Supervisor of the relevant Department of Anaesthesia. The appointment shall be ratified by the relevant Regional/National Committee.
6.2 The appointee shall hold the Diploma of FANZCA or a comparable qualification acceptable to the College Council, should not be a candidate for any College examination, and should have relevant clinical knowledge and experience.
6.3 The Department shall be responsible for notifying the Regional/National Committee of the recommendation for appointment.
6.4 The appointment of a Supervisor of FANZCA Training Module(s) shall be for an initial term of five years with an annual review by the relevant Department of Anaesthesia. Supervisors will be eligible for reappointment by the Regional/National Committee after advice from the relevant Department of Anaesthesia.
7. DUTIES OF MODULE SUPERVISORS

7.1 To oversee training in the specific module for which they are responsible.

7.2 To be familiar with the Module’s learning objectives, required clinical experience and assessment(s).

7.3 To guide the Trainee in setting their goals for the Module.

7.4 To guide the Trainee in obtaining appropriate clinical experience for the Module.

7.5 To validate Module completion by the Trainee.

7.6 To participate in the regular In Training Assessment(s) for the Trainee(s) undertaking the specific Module.

7.7 To liaise with the Supervisor of Training on all matters related to the Module and the Trainees undertaking it.

7.8 To attend Courses for Module Supervisors.

8. RESOURCES

The Module Supervisor shall be provided by the Department with the resources needed to fulfill his or her responsibilities.

Each Module Supervisor should have:

8.1 Adequate time set aside to fulfill the duties of a Module Supervisor.

8.2 Access to private space for meeting with Trainees.

8.3 Access to appropriate secretarial and administrative assistance.

8.4 Access to appropriate information technology.

8.5 Appropriate office equipment.

The College will provide training resources to aid Module Supervisors in their work. Module Supervisors should be aware of these College provided resources and training.

9. TRAINING AFTER COMPLETION OF MODULES 1 TO 10

An Advanced Vocational Trainee who has completed the first two years of Advanced Vocational Training, passed the Final Examination, completed all requirements of Modules 1 to 10, and who has gained prospective approval from the Assessor for an optional individualised program of training during all or part of Advanced Vocational Training Year 3 within a Hospital Department (or other organisation) approved by the College for Provisional Fellow appointments, may complete Modules 11 and 12 during that year, if not already completed.
POLICY ON SUPERVISION OF CLINICAL EXPERIENCE FOR VOCATIONAL TRAINEES IN ANAESTHESIA

1. INTRODUCTION

Supervision of clinical experience allows vocational trainees in anaesthesia to learn in safety as they progress towards independent practice as a specialist anaesthetist.

2. SUPERVISORS

2.1 Supervisors must be appropriately qualified by holding FANZCA or other qualifications acceptable to Council.

2.2 Other supervisors acceptable to Council include:

2.2.1 Anaesthetists employed as specialists in ANZCA-approved Hospital Departments or other organisations who hold a specialist qualification in Anaesthesia.

2.2.2 Provisional Fellows as defined in Professional Document TE13 – Guidelines for the Provisional Fellowship Program.

2.2.3 Trainees in ATY3 who have completed modules 1-10 and passed the Final Examination.

2.3 Anaesthetists who hold specialist qualifications other than FANZCA, but who are not appointed as a specialist are not acceptable as supervisors of ANZCA trainees.

3. LEVELS OF SUPERVISION

There are four such levels, viz.:-

3.1. Level 1 Supervisor rostered to supervise one trainee and available solely to that trainee.

3.2. Level 2 Supervisor rostered to supervise two trainees who are in anaesthetising locations in close proximity. The supervisor must be fully conversant with the nature of the patients in both locations and able to provide one-to-one supervision of each as appropriate.

3.3. Level 3 The supervisor is available in the institution but is not exclusively available for a specific trainee.

3.4. Level 4 The supervisor is not in the institution but is on call within reasonable travelling time and is exclusively rostered for the period in question. This level of supervision applies mainly to out-of-hours cases. Consultation must be available at all times.

4. MINIMUM SUPERVISION LEVELS

4.1 General

4.1.1 Supervision must be provided by a supervisor with appropriate experience of the particular area of anaesthesia or relevant discipline.

4.1.2 Supervision at level 1 or 2 must be provided for all cases during an initial period varying in length according to the trainee’s previous experience and their development of skills and judgement. For trainees without previous anaesthesia experience, this will need to be for at least six months. Before being permitted to practise anaesthesia beyond level 1 supervision, all trainees must achieve a satisfactory standard in a structured assessment of competence by at least two appropriate, designated consultant anaesthetists. It is the responsibility of the Supervisor of Training, Head of Department and Trainee to ensure this occurs.

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

4.1.4 Assessment of competence before moving beyond level 1 supervision also applies to more experienced trainees who are working in unfamiliar sub-specialty areas. That assessment is the responsibility of the Module Supervisor or Supervisor of Training, and the Trainee and Head of Department.

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

4.1.6 As trainees become experienced, more independent practice should be encouraged. Guidelines are presented in items 4.2 to 4.4. The Supervisor of Training must advise the Head of Department on appropriate levels of graduated supervision for individual trainees.

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

4.1.8 The same standards of supervision must apply both in-hours and out-of-hours.

4.1.9 Trainees must be encouraged to seek advice and/or assistance as early as possible whenever they are concerned. This applies both in and out of hours. At all stages of training, a supervisor must attend an anaesthetic whenever a trainee requests assistance. Conversely, a supervisor should attend an anaesthetic whenever this is deemed appropriate. It is the responsibility of the supervisor to make this decision.

4.1.10 Trainees should be encouraged to discuss their progress on an informal basis with their Supervisor of Training, or Module Supervisors at frequent intervals throughout their training. This is in addition to the structured In-Training Assessments (College Policy Document TE14 - Policy for the In-Training Assessment of Trainees in Anaesthesia).

4.1.11 Workload should be measured in time units, normally sessions of 4 hours.

4.2 Supervision levels that aim to ensure learning in the Basic Training Years

4.2.1 In the first two years of Basic Training, supervision should be provided at levels 1 and 2 for 50% of the workload.

4.2.2 In the first two years of Basic Training, supervision at level 4 should not average more than 10% of the workload.

4.2.3 In Basic Training, out of hours work should comprise between 25% and 50% of the workload.
4.3 Supervision levels that aim to ensure learning in the Advanced Training Years

4.3.1 In the first two years of advanced training, supervision should be provided at level 1 or 2 for at least 50% of the workload.

4.3.2 In the first two years of advanced training, supervision at level 2 or 3 should be an integral part of the training program. Supervision at level 2 or 3 should be provided for at least 5% of the workload.

4.3.3 In the first two years of advanced training, supervision at level 4 should not average more than 25% of the workload.

4.3.4 In Advanced Training, out of hours work should comprise between 25% and 50% of the workload.

4.4 Supervision levels that aim to ensure safety for both trainees and their patients

4.4.1 In the first year of supervised experience in clinical anaesthesia, after the initial period of level 1 supervision, the supervisor should be notified of all out-of-hours cases. The supervisor should attend for all patients with conditions such as the following:-

4.4.1.1 Patients requiring major resuscitation.
4.4.1.2 Patients with serious medical illness.
4.4.1.3 Debilitated patients.
4.4.1.4 Children under the age of ten years.
4.4.1.5 Operative procedures on pregnant patients.
4.4.1.6 Surgery which poses special anaesthesia problems.
4.4.1.7 Any other high risk patients.
4.4.1.8 Any patient who the trainee does not feel competent to anaesthetise.
4.4.1.9 Any patient who has a potential or known difficult airway.

4.4.2 In the second year of supervised experience in clinical anaesthesia the supervisor must be advised of all children under three years of age, all seriously ill patients and any patients posing special problems for anaesthesia.

4.4.3 In the third year of supervised experience in clinical anaesthesia, supervision at level 3 may be appropriate for many of the in-hours cases except where new areas of practice are encountered. In subspecialty areas, such as cardiothoracic anaesthesia, level 1 supervision is normally appropriate.

4.4.4 In the third year of supervised experience in clinical anaesthesia, for out-of-hours work, the supervisor must be advised of all children under one year of age, all seriously ill patients or those posing special problems for the anaesthetist, or unfamiliar clinical situations.

4.4.5 In the fourth year of supervised experience in clinical anaesthesia, for out-of-hours work, consultation can be at the discretion of the trainee although consultation (and where necessary supervision) remains essential for unfamiliar clinical situations.

4.4.6 In the fifth year of supervised experience in clinical anaesthesia, or during the Provisional Fellowship Program, consultation and appropriate supervision must be available at all times.

This Professional Document should be interpreted with regard to the following Documents:

TE1 Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia
TE4 Policy on Duties of Regional Education Officers in Anaesthesia
TE5 Policy for Supervisors of Training in Anaesthesia
TE13 Guidelines for the Provisional Fellowship Program
TE14 Policy for the In-Training Assessment of Trainees in Anaesthesia
TE17 Policy on Advisors of Candidates for Anaesthesia Training
RECOMMENDATIONS ON MINIMUM FACILITIES FOR SAFE ADMINISTRATION OF ANAESTHESIA IN OPERATING SUITES AND OTHER ANAESTHETISING LOCATIONS

1 PRINCIPLES OF ANAESTHESIA CARE
1.1 The provision of safe anaesthesia in hospitals requires appropriate staff, facilities and equipment. These are specified in this Document.

1.2 Anaesthesia should be administered only by medical practitioners with appropriate training in anaesthesia or by trainees supervised according to College Professional Documents

• TE3 Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia,
• PS1 Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia and
• PS2 Statement on Credentialling in Anaesthesia.

1.3 Every patient presenting for anaesthesia should have a pre-anaesthetic consultation by a medical practitioner who has appropriate training in anaesthesia. See College Professional Document PS7 Recommendations on The Pre-Anaesthesia Consultation.

1.4 Appropriate monitoring of physiological and other variables must occur during anaesthesia. See College Professional Document PS18 Recommendations on Monitoring During Anaesthesia.

2 STAFFING
2.1 In addition to the nursing or other professional staff required by those carrying out the operative procedure, there must be:

2.1.1 An assistant for the anaesthetist. See College Professional Document PS8 Guidelines on The Assistant for the Anaesthetist.

2.1.2 Adequate assistance for positioning the patient.

2.1.3 Adequate technical assistance to ensure proper functioning and servicing of all equipment used.

3 AREAS IN WHICH ANAESTHESIA IS ADMINISTERED

3.1 Anaesthesia Equipment

3.1.1 Essential requirements are listed below. Where a range of equipment is recommended, the facility is expected to provide the type most suitable for its needs.

3.1.2 Each facility must designate:

3.1.2.1 One or more specialist anaesthetists to advise on the choice and maintenance of anaesthesia equipment.

3.1.2.2 One or more of its nursing or technical staff to be responsible for the organisation of cleaning, maintenance and servicing of anaesthesia equipment.

3.1.3 In each anaesthetising location where inhalational general anaesthesia is to be performed, there must be an anaesthesia delivery system which is capable of delivering an accurately measured flow of oxygen (and medical air where this is clinically indicated). Essential equipment includes:

3.1.3.1 Calibrated vaporisers or other systems designed for the accurate delivery of inhalational anaesthetic agents when required.

3.1.3.2 Infusion devices designed for controlled delivery of intravenous anaesthetic agents when required.

3.1.3.3 A range of suitable breathing systems with appropriate measures to ensure the sterility of breathing gases supplied to each patient. See College Professional Document PS28 Guidelines on Infection Control in Anaesthesia.

3.1.3.4 Breathing systems suitable for paediatric use when necessary.

3.1.4 Each anaesthesia machine must comply with minimum safety requirements as specified in College Professional Document T3 Minimum Safety Requirements for Anaesthesia Machines for Clinical Practice.

3.1.5 A separate means of inflating the lungs with oxygen must be provided in each anaesthetising location. This apparatus should comply with the current relevant national Standards. The size of the device and its attachments must be appropriate for patients being anaesthetised at that location. Its oxygen supply must be independent of the anaesthesia delivery system.

3.1.6 Suction apparatus must be available for the exclusive use of the anaesthetist at all times together with appropriate hand pieces and endotracheal suction catheters. This apparatus should comply with the current relevant national Standards. Provision must be made for an alternative suction system in the event of primary suction failure.

3.1.7 In every anaesthetising location there must be:

3.1.7.1 Appropriate protection for the anaesthesia team against biological contaminants. This must include gowns, disposable gloves, masks and eye shields.

3.1.7.2 A stethoscope

3.1.7.3 A sphygmomanometer

3.1.7.4 Monitoring equipment complying with College Professional Document PS18 Recommendations on Monitoring During Anaesthesia. Where volatile agents are not available, agent monitoring is not required.

The particular requirements of magnetic resonance imaging facilities can be met with appropriate equipment designed for the environment.

3.1.7.5 An appropriate range of face masks.

3.1.7.6 An appropriate range of oropharyngeal, nasopharyngeal, laryngeal mask and other artificial airways.

3.1.7.7 Two laryngoscopes with a range of suitable blades.

3.1.7.8 An appropriate range of endotracheal tubes and connectors.

3.1.7.9 A range of endotracheal tube introducers and bougies.

3.1.7.10 Endotracheal cuff inflating syringe.

3.1.7.11 Magill’s forceps and throat packs.

3.1.7.12 A suitable range of adhesive and other tapes.

3.1.7.13 Scissors.

3.1.7.14 Sterile lubricant suitable for use with airway devices.
3.2 Drugs
3.2.1 In addition to the drugs and agents commonly used in anaesthesia, drugs necessary for the management of the following conditions (which may complicate or co-exist with anaesthesia) must also be available. Such conditions include:

- Adrenal dysfunction
- Anaphylaxis
- Bronchospasm
- Cardiac arrest
- Cardiac arrhythmias
- Coagulopathies
- Hypoglycaemia
- Hypotension
- Hyperglycaemia
- Hypertension
- Pulmonary oedema
- Raised intracranial pressure
- Respiratory depression
- Uterine atony (where relevant)

3.2.2 In making an appropriate selection of drugs and administration equipment for the management of these conditions, advice should be sought as in 3.2.1.

3.2.3 Appropriate mechanisms must exist for the regular replacement of all drugs and drug administration equipment after use or when their expiry date has been reached.

3.2.4 An initial supply of dantrolene sufficient for commencing the treatment of a suspected case of malignant hyperpyrexia should be readily accessible to all anaesthetising locations. The minimum supply is nine 20mg ampoules of dantrolene. Additional doses must be readily available on request. Large hospitals and isolated hospitals should have thirty-six 20mg ampoules of dantrolene readily available; this is sufficient to treat an adult to the maximum recommended dose.

3.3 Routines for Checking, Cleaning and Servicing Equipment
3.3.1 Regular sterilising, cleaning and housekeeping routines for the care of equipment should be established.

3.3.2 Documented servicing of the anaesthesia delivery system and medical gas equipment by an appropriate organisation must be carried out at intervals recommended by the manufacturer. In the absence of a manufacturer’s recommendation on servicing, servicing must be carried out twice a year. After any maintenance or modification to the gas distribution system, tests of gas flow, pressure and identification must be carried out and documented according to current national standards prior to use.

3.3.3 A copy of the College Professional Document PS31 Recommendations on Protocol for Checking the Anaesthesia Delivery Systems or a similar document should be available on each anaesthesia delivery system.

3.4 Recovery Area
3.4.1 Recovery from anaesthesia should take place under appropriate supervision in a designated area which conforms with College Professional Document PS4 Recommendations for the Post-Anaesthesia Recovery Room.

3.4.2 Contingency plans should exist for the safe emergency evacuation of patients from the operating suite and/or recovery areas under adequate medical supervision.
4. SPECIFIC ISSUES WITH PARTICULAR ANAESTHETISING LOCATIONS

This is a general document which is intended to be interpreted in the context of the particular service for which anaesthesia is administered. Additional specific issues occur with some particular anaesthetising locations:

4.1 Delivery suites and Operating Rooms used for Obstetrics

4.1.1 Staffing: For the establishment and management of epidural blockade in labour, the presence of a midwife trained and competent in obstetric epidural management is required. See College Professional Document PS14 – Guidelines for the Conduct of Major Regional Analgesia in Obstetrics.

4.1.2 Analgesia equipment: Any apparatus used for administration of inhalation analgesia must deliver at least 30% oxygen.

4.1.3 There must be suction apparatus for the exclusive use of the anaesthetist which is separate from that required for resuscitation of the neonate.

4.1.4 There must be separate oxygen outlets and suitable attachments for administering oxygen to the mother and to the neonate.

4.1.5 Neonatal resuscitation equipment must include a suitable range of items for:

4.1.5.1 Administration of oxygen to the neonate.

4.1.5.2 Clearing of the airway.

4.1.5.3 Intubation and ventilation of the lungs.

4.1.5.4 Administration of intravenous fluids and drugs.

4.1.5.5 Maintenance of the neonate’s temperature.

4.1.6 An appropriate range of drugs must be available.

4.2 ECT Locations

Where provision of an anaesthesia delivery system is not essential, as in an ECT area, there must be:

4.2.1 A breathing system capable of delivering 100% oxygen for both spontaneous and controlled ventilation. An alternative breathing system should be immediately available. Where more than one patient is to be treated, this equipment must be duplicated or there must be an inline viral filter. See College Professional Document PS28 Guidelines on Infection Control in Anaesthesia.

4.2.2 Adequate reserves of oxygen must be available. If a reticulated or indexed gas connection system is in use, an oxygen failure warning device is necessary. An emergency cylinder supply of oxygen is necessary in the event of a central supply failure.

4.3 Dental surgeries

4.3.1 There must be a dental operating chair which will allow the patient to be placed rapidly in the horizontal or head-down position.

4.4 Organ Imaging Locations

4.4.1 Monitoring equipment complying with College Professional Document PS18 Recommendations on Monitoring During Anaesthesia. Although special problems are encountered in MRI facilities, appropriate equipment to meet the recommendations is available.

4.4.2 The specific problems associated with the location of the anaesthesia delivery system, monitoring equipment and other necessary equipment (eg drug trolley and suction apparatus) in an environment where space is often limited due to the presence of imaging equipment must be prospectively considered.

RELEVANT PROFESSIONAL DOCUMENTS

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College Website: http://www.anzca.edu.au/
# MINIMUM SAFETY REQUIREMENTS FOR ANAESTHETIC MACHINES FOR CLINICAL PRACTICE

## 1. PURPOSE AND SCOPE

1.1 Safe anaesthetic machines are essential to the provision of safe patient care.

1.2 This document specifies minimum safety requirements for anaesthetic machines in clinical practice in Australia and New Zealand.

1.3 The general intent of this document is that all anaesthetic machines in clinical use should comply with Australian/New Zealand Standard AS/NZS 3200.2.13:2005 "Medical electrical equipment - Particular requirements for safety - Anaesthetic systems" and other relevant national standards by 1st January 2011.

1.4 It also provides guidance to anaesthetists when considering whether an anaesthetic machine is suitable for clinical use or should be replaced.

1.5 This document does not cover:

1.5.1 Anaesthetic ventilators, suction systems or anaesthetic gas scavenging systems.

1.5.2 Alternative equipment used for the delivery of anaesthesia (e.g. anaesthesia drug infusion devices).

1.5.3 Monitoring equipment, whether integral to or separate from the machine, except as required by AS/NZS 3200.2.13:2005. Monitoring recommendations are in College Professional Document PS18 - Recommendations on Monitoring During Anaesthesia.

## 2. ANAESTHETIC MACHINE SAFETY ASSESSMENT

2.1 Anaesthetic machines must be assessed for safety, reliability and functionality by a specialist anaesthetist or other person with appropriate technical knowledge at least once a year.

2.2 This assessment will result in a classification of each machine into one or more of the following categories, each of which defines a specific course of action for that machine:

2.2.1 Anaesthetic machines that fail to comply with one or more of the essential safety requirements specified in section 3.  
*Action:* Anaesthetic machines in this category should be removed from clinical use. If they can be upgraded to meet the requirements of section 3, they may be returned to clinical practice only after re-assessment confirms full compliance with all essential safety requirements.

2.2.2 Anaesthetic machines that meet all of the essential safety requirements of section 3 but fail to comply with one or more of the relative safety requirements of section 4.  
*Action:* Anaesthetic machines in this category should enter an update or replacement process for which planning should start immediately. By 1 January 2011, all anaesthetic machines in this category must either have been upgraded to comply with all the safety requirements of this document or have been removed from clinical use.

2.2.3 Anaesthetic machines that do not comply with one or more of the safety requirements of section 5 (whether or not they comply with the requirements of sections 3 and 4).  
*Action:* Anaesthetic machines in this category must be withdrawn from clinical use no later than 6 months from the date on which their lack of compliance with section 5 was documented.

2.2.4 Anaesthetic machines that comply with all the safety requirements of this document.  
*Action:* Anaesthetic machines in this category are not excluded from clinical use. These machines require assessment of other safety areas not covered in this document (e.g. see section 2.3) and future reassessment as per section 2.1.

2.3 An anaesthetic machine may be unsafe for clinical use for reasons other than those assessed in this document (e.g. failure to meet electrical safety requirements, lack of appropriate monitoring equipment). Unsafe anaesthetic machines, regardless of the reason, should not be used.

## 3. ESSENTIAL SAFETY REQUIREMENTS

3.1 Connections for medical gas cylinders (e.g. yokes or regulators) must be pin indexed.

3.2 An automatically-activated reserve supply of oxygen (e.g. from an attached oxygen cylinder) must be functionally attached to the anaesthetic machine.

3.3 Non-interchangeable gas hose connectors, e.g. Diameter Index Safety System or Sleeve Index System connectors, must be present on any gas inlet socket to prevent incorrect gas hose connections.

3.4 Means to display gas supply line and cylinder pressures shall be provided. This display (or a suitable indication of the gas supply status) must be visible from the front of the machine.

3.5 An oxygen supply failure warning device must be present. This must:

3.5.1 Activate automatically when the oxygen supply pressure falls below a predetermined critical level.

3.5.2 Generate an auditory alarm to warn the operator.

3.5.3 Prevent the delivery of hypoxic gas from the fresh gas outlet (e.g. by promptly interrupting the nitrous oxide supply).

3.6 If the anaesthetic machine incorporates a gas flowmeter bank, oxygen must be the last gas to enter the common gas manifold at the top of the flowmeter tubes.

3.7 If mechanical means are provided to mix the anaesthetic gases on the anaesthetic machine, there must be only one gas flow control knob for each gas.

3.8 If a mechanical oxygen flow knob is provided, it must be fluted and larger than the other flow control knobs so that tactile identification of the oxygen control knob is possible.
3.9 If the anaesthetic machine is capable of delivering nitrous oxide, means must be provided to prevent unintentional selection of a hypoxic gas mixture, e.g. an O₂/N₂O proportioning system.

3.10 If two or more vaporisers can be simultaneously mounted on the anaesthetic machine, only one vaporiser may be “ON” at a time (i.e. a vaporiser interlock system must be present, functional and unable to be bypassed).

3.11 Vaporisers with mechanical rotary dials must increase the delivered anaesthetic vapour concentration when the dial is rotated in an anti-clockwise direction.

3.12 A fresh gas outlet, if provided, must be 22mm outer diameter and 15 mm inner diameter, visible to the operator, and capable of being connected to the breathing system in such a way as to prevent accidental disconnection.

3.13 A breathing system high pressure relief valve or other means of automatically preventing dangerously high and/or prolonged pressures in the breathing system must be provided.

3.14 Anaesthetic gas scavenging system connections must be of a diameter that is different (e.g. 19mm or 30mm) from the other connections used in the breathing system.

3.15 When each functional sub-system of the anaesthetic machine is enabled, its associated monitors and alarms must be automatically activated.

3.16 Adequate maintenance of the anaesthetic machine must be possible. Replacement parts of suitable quality and appropriately qualified certified service personnel must be available, so that the anaesthetic machine can continue to operate to its original performance specification.

4. RELATIVE SAFETY REQUIREMENTS

4.1 An airway pressure alarm that responds to sustained positive pressure in the breathing system must be present.

4.2 The emergency oxygen flush control must be protected from accidental activation.

4.3 An “on/off” switch, if present, must be protected from unintended activation.

4.4 If an immediate return to normal operation is not possible, turning “off” an anaesthetic machine should either require a confirmatory step or the machine should display a warning (for a period of at least 10 seconds) that it is going to turn off and provide an option to cancel this action.

4.5 If the anaesthetic machine requires electrical power for normal operation, a backup power supply must be a part of the machine and permit normal operation for at least 30 minutes after a mains power supply failure. An alarm must be activated at the time of the mains failure, and the state of the reserve power supply must be indicated while it is in use.

4.6 An airway pressure alarm should be provided in response to high peak pressure and negative pressure in the breathing system because these conditions can result in patient harm.

5. OTHER SAFETY REQUIREMENTS

5.1 A maintenance record and problem log should be kept for all anaesthetic machines in clinical use. A machine should be considered for replacement if its maintenance history indicates that problems with the machine are adversely impacting clinical service to an extent that is unacceptable to the institution or which threatens patient safety.

5.2 An anaesthetic machine should be considered for replacement if it cannot meet the reasonable needs of current anaesthetic practice in the facility.

REFERENCES

- Australian/New Zealand Standard AS/NZS 3200.2.13:2005 “Medical electrical equipment - Particular requirements for safety - Anaesthetic systems”.

RELEVANT PROFESSIONAL DOCUMENTS

T1 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and Other Anaesthetising Locations
PS18 Recommendations on Monitoring During Anaesthesia
PS31 Recommendations on Checking Anaesthesia Delivery Systems

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1. INTRODUCTION
A well-planned, well-equipped, well-staffed and well-managed post-anaesthesia recovery area is essential for the safe early management of patients who have recently undergone a surgical or other procedure, irrespective of the type of anaesthesia or sedation used.

2. GENERAL PRINCIPLES
2.1 Recovery from anaesthesia should take place under supervision in an area designated for the purpose.
2.2 This area should be close to where the anaesthesia or sedation was administered.
2.3 The staff working in this area must be trained for their role and able to contact supervising medical staff promptly when the need arises.
2.4 In some situations (for example, paediatric hospitals) minor variations in these recommendations may be appropriate.

3. DESIGN FEATURES FOR THE RECOVERY AREA
3.1 The area should be part of the operating or procedural suite with easy access for management of emergencies by both theatre medical staff and staff in street clothes from outside the theatre suite. Provision should be made for rapid evacuation of patients from the area in an emergency.
3.2 Ventilation of the area should be of operating theatre standard.
3.3 Space allocated per bed/trolley should be at least 9 square metres. There must be easy access to the patient’s head.
3.4 The number of bed/trolley spaces must be sufficient for expected peak loads and there should be at least 1.5 spaces available per operating room.
3.5 The layout of bed spaces should allow staff to have an uninterrupted view of several patients at once.
3.6 Each bed space must be provided with:
3.6.1 an oxygen outlet
3.6.2 medical suction complying with relevant national standards
3.6.3 two general power outlets
3.6.4 appropriate lighting and wall colour to allow accurate assessment of skin colour
3.6.5 emergency lighting
3.6.6 appropriate facilities for mounting and operating any necessary equipment and for the patient’s chart
3.7 Space must be provided for a nursing station, utility room and storage for drugs, equipment and linen.
3.8 There must be appropriate facilities for scrubbing up for procedures.
3.9 There should be a wall clock with a sweep second hand or analogue display clearly visible from each bed space.

3.10 Communication facilities should include:
3.10.1 an emergency call system to areas where specialist staff are available
3.10.2 a telephone with access to the hospital paging system
3.11 There must be access for portable X-Ray equipment. Appropriate power outlets and viewing box must be available.
3.12 An emergency power supply must be available in the area.

4. EQUIPMENT AND DRUGS
4.1 Each bed space should be provided with:
4.1.1 oxygen flowmeter and patient oxygen delivery systems
4.1.2 suction equipment including a receiver, appropriate hand pieces and a range of suction catheters
4.1.3 pulse oximeter
4.1.4 facilities for blood pressure measurement including cuffs suitable for all patients
4.1.5 stethoscope
4.1.6 means of measuring body temperature
4.2.1 means for manual ventilation with oxygen in a ratio of one unit per two bed spaces, but with a minimum of two such devices
4.2.2 equipment and drugs for airway management and endotracheal intubation
4.2.3 emergency and other drugs
4.2.4 a range of intravenous equipment and fluids and a means of warming those fluids
4.2.5 drugs for acute pain management
4.2.6 a range of syringes and needles
4.2.7 patient warming devices
4.2.8 devices for measuring expired carbon dioxide
4.3 There should be easy access to:
4.3.1 12 lead electrocardiograph
4.3.2 defibrillator
4.3.3 neuromuscular function monitor
4.3.4 chest drains
4.3.5 warming cupboards
4.3.6 refrigerator for drugs and blood
4.3.7 procedure light
4.3.8 basic surgical tray
4.3.9 blood gas and electrolyte measurement
4.3.10 diagnostic imaging services
4.3.11 apparatus for mechanical ventilation of the lungs
4.3.12 monitors for direct arterial and venous pressure monitoring
4.4 The recovery trolley/bed must:
4.4.1 have a firm base and mattress
4.4.2 tilt from one or both ends both head up and head down at least 15 degrees
4.4.3 be easy to manoeuvre
4.4.4 have efficient and accessible brakes
4.4.5 provide for sitting the patient up
4.4.6 have secure side rails which must be able to be dropped below the base or be easily removed
4.4.7 have an I.V. pole
4.4.8 have provision for mounting monitoring equipment, apparatus for delivering oxygen, patient ventilation equipment, underwater seal drains and suction apparatus during transport of patients

5. STAFFING
5.1 Staff trained in the care of patients recovering from anaesthesia must be present at all times.
5.2 A registered nurse trained in recovery area care should be in charge.
5.3 Trainee nurses and registered nurses who are not experienced in the care of patients recovering from anaesthesia must be supervised.
5.4 The ratio of registered nurses to patients needs to be flexible so as to provide no less than one nurse to three patients, and one nurse to each patient who has not recovered protective reflexes or consciousness.

6. MANAGEMENT AND SUPERVISION
6.1 Written protocols for management should be established. The Director of Anaesthesia should be responsible for the medical aspects of these policies.
6.2 A written routine for checking the equipment and drugs must be established.
6.3 When an anaesthetised patient is being transferred from one trolley/bed to another, a minimum of three people must assist with lifting. An anaesthetist must be present to have prime responsibility for the patient’s head, neck and airway.
6.4 A designated anaesthetist should be contactable in the event that the responsible anaesthetist is unavailable. In larger hospitals, recovery duties should be the designated anaesthetist’s primary duty
6.5 Observations should be recorded at appropriate intervals and should include state of consciousness, oxygen saturation, respiratory rate, pulse rate, blood pressure and temperature.
6.6 All patients should remain until they are considered safe to be discharged from the recovery area according to established criteria.
6.7 The anaesthetist responsible for the patient should:
6.7.1 accompany the patient until transfer to recovery area staff is completed
6.7.2 provide written and verbal instructions to the recovery area staff
6.7.3 specify the type of apparatus and the flow rate to be used for oxygen therapy
6.7.4 remain in the vicinity until the patient is safe to be left in the care of recovery area staff
6.7.5 supervise the recovery period and authorise the patient’s discharge from the recovery area. It is recognised that in some circumstances it may be necessary for the anaesthetist previously responsible for the patient to delegate these duties to a trained recovery area nurse or to another anaesthetist who should be fully informed of the clinical state of the patient
6.8 The practitioner responsible for the patient’s overall care should be available to consult with the anaesthetist in the recovery period if necessary and, in appropriate circumstances, authorise the discharge of the patient.

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Day Care Surgery means that the patient will ordinarily be discharged from the hospital or unit later on the day of the procedure. Anaesthesia for the procedure may require general, regional or local anaesthesia, sedation or a combination of techniques. Almost all ANZCA Professional Standards documents are relevant to day care anaesthesia. The facility should meet the standards set out in the Day Surgery Handbook published by the Australian Day Surgery Council.

**SELECTION GUIDELINES**

In all cases, the ultimate decision as to the suitability of a patient for day care surgery is that of the procedural anaesthetist. The decision as to the type of anaesthesia must remain in the province of the anaesthetist and will be based on surgical requirements, patient considerations, the experience of the anaesthetist and the facilities and personnel of the day care unit.

**1 PROCEDURES SUITABLE FOR DAY CARE SURGERY MUST ENTAIL:**

1.1 A minimal risk of post operative haemorrhage.
1.2 A minimal risk of post operative airway compromise.
1.3 Post operative pain controllable by outpatient management techniques.
1.4 Post operative care managed by the patient and/or a responsible adult and any special post operative nursing requirements met by day surgery, home or district nursing facilities.
1.5 A rapid return to normal fluid and food intake.
1.6 Operative list organisation to achieve early commencement of procedures for which a long recovery period is likely

**2 PATIENT REQUIREMENTS FOR DAY CARE SURGERY INCLUDE:**

2.1 A willingness to have the procedure performed, together with an understanding of the process and an ability to follow discharge instructions.
2.2 The patient’s place of residence for post-surgery care being within one hour’s travelling time from appropriate postoperative medical attention
2.3 Physical status of ASA I or II or medically stable ASA III or IV patients. Physical status alone does not dictate acceptability. Early consultation with the involved anaesthetist is essential.

**3 SOCIAL REQUIREMENTS FOR DAY CARE SURGERY INCLUDE:**

3.1 A responsible person able to transport the patient home in a suitable vehicle. A train or bus is usually not suitable.
3.2 A responsible person staying at least overnight following discharge from the unit. This person must be physically and mentally able to make decisions for the patient’s welfare when necessary.
3.3 Ensuring that the patient and/or responsible person understands the requirements for postanaesthetic care and intends to comply with these requirements particularly with regard to public safety.
3.4 The patient remaining within one hour of appropriate medical attention until the morning following discharge.
3.5 The patient having ready access to a telephone in the postoperative dwelling.
3.6 The patient having advice as to when to resume activities such as driving and decision making.

**4 PATIENT PREPARATION:**

4.1 ANZCA Professional Document PS7 Recommendations on The Pre-Anaesthesia Consultation describes the essential nature of this consultation for all patients who are to receive anaesthesia.
4.2 ANZCA Professional Document PS26 Guidelines on Consent for Anaesthesia or Sedation is relevant to preparation for day stay surgery.
4.3 Appropriate time for adequate preoperative anaesthetic assessment by the involved anaesthetist must be scheduled for all day case patients.

4.4 Patient assessment can be assisted by:

4.4.1 A standardised patient health/anaesthesia questionnaire.

4.4.2 Prior referral of the patient by the surgeon to the anaesthetist in cases of doubt as to the suitability for day case surgery.

4.4.3 Preliminary nurse assessment according to guidelines approved by an anaesthetist.

4.4.4 Anaesthesia consultation and preparation prior to the day of surgery preferably by the involved anaesthetist

4.4.5 Instructions for fasting according to the following guidelines

4.5 The patient should be provided with information in an understandable written format which must include:

4.5.1 General information about the procedures to be followed in the day care unit.

4.5.2 Instructions for fasting according to the following guidelines unless otherwise specifically prescribed by the anaesthetist or where other institution guidelines apply:

4.5.2.1 For healthy adults having an elective procedure, limited solid food may be taken up to six hours prior to anaesthesia and clear fluids totalling not more than 200 mls per hour may be taken up to two hours prior to anaesthesia.

4.5.2.2 For healthy children over 6 weeks of age having an elective procedure, limited solid food and formula milk may be given up to six hours, breast milk may be given up to four hours and clear fluids up to two hours prior to anaesthesia.

4.5.2.3 For healthy infants under 6 weeks of age having an elective procedure, formula or breast milk may be given up to four hours and clear fluids up to two hours prior to anaesthesia.

4.5.2.4 Only medications with a little water if required as ordered by the anaesthetist should be taken less than two hours prior to anaesthesia.

4.5.2.5 A proton pump inhibitor or other appropriate agent should be considered for patients with an increased risk of gastric regurgitation.

5 SEDATION AND ANAESTHESIA FOR DAY CARE PROCEDURES

5.1 General, regional or local anaesthesia, sedation or a combination of techniques may be used.

5.2 ANZCA Professional Standards documents should be satisfied where appropriate. (PS3, PS6, PS 9, PS18, PS 21, PS24, PS 28, PS 31, PS48)

6 RECOVERY FROM ANAESTHESIA

6.1 ANZCA Professional Document PS4 Recommendations for the Post-Anaesthesia Recovery Room establishes requirements for the facilities and staffing of recovery areas. This document is fully applicable to day care units.

6.2 An area must be provided with comfortable reclining seating for patients during the second stage of recovery prior to discharge home. This area must be adequately supervised by nursing staff and should also have ready access to resuscitation equipment, including oxygen and suction. Patients must not leave this area unaccompanied.

7 DISCHARGE OF THE PATIENT FROM THE DAY CARE UNIT

7.1 The discharge area should have ready access to wheel chairs, a parking area and ambulance facilities so as to minimise walking for the post-operative patient and to aid transfer of the patient to inpatient hospital care when this is necessary.

7.2 The following criteria apply to patients being discharged home:

7.2.1 Stable vital signs for at least one hour.

7.2.2 Correct orientation as to time, place and relevant people.

7.2.3 Adequate pain control. ANZCA Professional documents PS41 Guidelines for Acute Pain Management and PS45 Statement of a Patients Rights to Pain Management are applicable to day care anaesthesia.

7.2.4 Minimal nausea, vomiting or dizziness.

7.2.5 Adequate hydration and likelihood of maintenance of hydration with oral fluids.

7.2.6 Minimal bleeding or wound drainage.

7.2.7 Patients at significant risk of urinary retention (central neural blockade, pelvic and other surgery) must have passed urine.

7.2.8 A responsible adult to take the patient home. For some patients it may be important to have an adult escort as well as the vehicle driver.

7.2.9 Discharge should be authorised by an appropriate staff member after discharge criteria have been satisfied.

7.2.10 Written and verbal instructions for all relevant aspects of post-anaesthetic and surgical care must be given to the patient and the accompanying adult. A contact place and telephone number for emergency medical care must be included.

7.2.11 Suitable analgesia should be provided for at least the first day after discharge with clear written instructions on how and when it should be used. Advice on any other regular medication is also necessary.

7.2.12 A telephone enquiry as to the patient’s wellbeing on the following day should be made whenever possible.

7.3 If the patient is to be transferred to an inpatient facility, the anaesthetist and/or the surgeon will be responsible for the patient until care has been transferred to another appropriate medical officer.

8 QUALITY ASSURANCE

8.1 Each day care unit must have an established system for audit of the outcomes related to anaesthesia care, and include these outcomes in quality assurance and peer review processes.
9 RELATED DOCUMENTS

PS2 Statement on Credentialling in Anaesthesia
PS3 Guidelines for the Management of Major Regional Analgesia
PS4 Recommendations for the Post-Anaesthesia Recovery Room
PS6 Recommendations on the Recording of an Episode of Anaesthesia Care (The Anaesthetic Record)
PS7 Recommendations on The Pre-Anaesthesia Consultation
PS9 Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures
PS16 Statement on the Standards of Practice of a Specialist Anaesthetist
PS18 Recommendations on Monitoring during Anaesthesia
PS20 Recommendations for the Responsibilities of an Anaesthetist in the Postoperative period
PS21 Guidelines on Conscious Sedation for Dental Procedures in Australia
PS24 Guidelines on Sedation for Gastrointestinal Endoscopic Procedures
PS26 Guidelines on Consent for Anaesthesia or Sedation
PS28 Guidelines on Infection Control in Anaesthesia
PS29 Statement on Anaesthesia Care of Children in Healthcare Facilities Without Dedicated Paediatric Facilities
PS41 Guidelines on Acute Pain Management
PS45 Statement on Patients’ Rights to Pain Management
PS48 Statement on Clinical Principles for Procedural Sedation


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RECOMMENDATIONS ON MONITORING DURING ANAESTHESIA

1. INTRODUCTION
1.1 Monitoring of fundamental physiological variables during anaesthesia is essential. Clinical judgement will determine how long this monitoring should be continued following completion of anaesthesia.

1.2 The Health Care Facility in which the procedure is being performed is responsible for provision of equipment for anaesthesia and monitoring on the advice of one or more designated specialist anaesthetists, and for effective maintenance of this equipment (see College Professional Document T1 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and other Anaesthetising Locations.)

1.3 Some or all of the recommendations in this document may need to be exceeded depending on the physical status of the patient, the type and complexity of the surgery to be performed as well as the requirements of anaesthesia.

1.4 Monitoring must always be used in conjunction with careful clinical observation by the anaesthetist as there are circumstances in which equipment may not detect unfavourable clinical developments.

1.5 The following recommendations refer to patients undergoing general anaesthesia or major regional anaesthesia for diagnostic or therapeutic procedures and should be interpreted in conjunction with other Professional Documents published by the Australian and New Zealand College of Anaesthetists.

2. CLINICAL MONITORING BY AN ANAESTHETIST
2.1 Clinical monitoring by a vigilant anaesthetist is essential for safe patient care during anaesthesia. This should be supplemented by appropriate devices to assist the anaesthetist.

2.2 A medical practitioner whose sole responsibility is the provision of anaesthetic care for that patient must be constantly present from induction of anaesthesia until safe transfer to Recovery Room staff or Intensive Care Unit has been accomplished. This medical practitioner must be appropriately trained in Anaesthesia, or be a Trainee Anaesthetist supervised in accordance with College Professional Document TE3 Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia.

2.3 In exceptional circumstances brief absences of the person primarily responsible for the anaesthetic may be unavoidable. In such circumstances that person may temporarily delegate observation of the patient to an appropriately qualified person who is judged to be competent for the task.

2.4 Permanent handover of responsibility must be to an anaesthetist who is able to accept continued responsibility for the care of the patient (see College Professional Document PS10 Guidelines on the Handover of Responsibility during an Anaesthetic).

2.5 The individual anaesthetist is responsible for monitoring the patient and should ensure that appropriate monitoring equipment is available. Some procedures necessitate special monitoring (e.g. MRI scanning) or remote monitoring to reduce the hazard to staff (e.g. radiological procedures). (See College Professional Document T1 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and other Anaesthetising Locations).

2.6 Patient Monitoring
2.6.1 Circulation
   The circulation must be monitored at frequent and clinically appropriate intervals by detection of the arterial pulse and measurement of arterial blood pressure.

2.6.2 Ventilation
   Ventilation must be monitored continuously by both direct and indirect means.

2.6.3 Oxygenation
   Oximetric values must be interpreted in conjunction with clinical observation of the patient. Adequate lighting must be available to aid with assessment of patient colour.

3. MONITORING EQUIPMENT
3.1 Oxygen Analyser
   A device incorporating an audible signal to warn of low oxygen concentrations, correctly fitted in the breathing system, must be in continuous operation for every patient when an anaesthesia delivery system is in use.

3.2 Pulse Oximeter
   Pulse oximetry provides evidence of the level of oxygen saturation of the haemoglobin of arterial blood and identifies arterial pulsation at the site of application. A pulse oximeter must be in use for every anaesthetised patient.

3.3 Breathing System Disconnection or Ventilator Failure Alarm
   When an automatic ventilator is in use, a monitor capable of warning promptly of a breathing system disconnection or ventilator failure must be in continuous operation. This must be automatically activated.

3.4 Electrocardiograph
   Equipment to monitor and continually display the electrocardiograph must be available for every anaesthetised patient.

3.5 Temperature Monitor
   Equipment to monitor temperature continuously must be available for every anaesthetised patient.

3.6 Carbon Dioxide Monitor
   A monitor of carbon dioxide level in inhaled and exhaled gases must be in use for every patient under general anaesthesia.
3.7 **Neuromuscular Function Monitor**
Equipment to monitor neuromuscular function must be available for every patient in whom neuromuscular blockade has been induced.

3.8 **Volatile Anaesthetic Agent Concentration Monitor**
Equipment to monitor the concentration of inhalational anaesthetics must be in use for every patient undergoing general anaesthesia from an anaesthesia delivery system where volatile anaesthetic agents are available. Automatic agent identification should be available on new monitors.

3.9 **Continuous Blood pressure Monitor**
Equipment to provide continuous blood pressure monitoring should be available. In most cases, this refers to a monitor connected via a transducer to an intra-arterial line.

3.10 **Monitor of Anaesthetic Effect on the Brain**
When clinically indicated equipment to monitor the anaesthetic effect on the brain should be available for use on patients at high risk of awareness during general anaesthesia.

3.11 **Other Equipment**
When clinically indicated, equipment to monitor other physiological variables (e.g. the electroencephalogram, cardiac output monitor or spirometry) should be available.

**RELATED DOCUMENTS**

- T1 Recommendations on Minimum Facilities for Safe Administration of Anaesthesia in Operating Suites and other Anaesthetising Locations
- TE3 Policy on Supervision of Clinical Experience for Vocational Trainees in Anaesthesia
- PS10 The Handover of Responsibility During an Anaesthetic

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1. AIM

These recommendations on staffing of Departments of Anaesthesia are made to ensure that vocational trainees in Anaesthesia are trained with appropriate supervision, and in Departments with appropriate Educational and Quality Assurance Programs.

2. INTRODUCTION

2.1 ‘Staffing’ refers to the numbers of senior and junior medical staff, nursing staff and technical staff in the various areas of clinical activity, and also the numbers of departmental management and clerical staff.

2.2 Participation in personal education, teaching, quality assurance, research and other activities is fundamental to the provision of high quality and safe clinical anaesthesia, and requires appropriate staffing levels.

2.3 In training institutions, appropriate staffing is necessary to provide a satisfactory environment in which trainees can acquire the knowledge, experience and support necessary to fulfill the requirements for the award of Fellowship of the College.

3. PRACTICE OF SENIOR MEDICAL STAFF IN TRAINING HOSPITALS

3.1 Different industrial awards and enterprise agreements have given rise to widely varying weekly work patterns, often resulting in staff spending less time in the training hospital.

3.2 Differentiation of staff into either full-time or visiting medical specialists is not relevant in the context of their input to trainee education and welfare. The contribution of specialist anaesthesia staff to trainee education should be considered in terms of the number of hours or sessions per week that the specialist spends in the training institution.

3.3 A core of staff who spend all or most of their professional time in the institution is important in order to ensure continuity of training programs, cohesion and corporate memory.

4. DUTIES OF SPECIFIC STAFF

4.1 Medical Staff

The duties of specialist anaesthetists are outlined in College Professional Document TE6 Guidelines on the Duties of an Anaesthetist. In institutions accredited by ANZCA for training, the duties are the same but with a greater focus on all aspects of training.

Time free from clinical duties must be set aside for the other professional duties of the Department and its members. Such activities include organisation and participation in teaching programs for anaesthesia trainees and other professional groups, administration, research, continuing medical education, quality assurance and audit, participation in maintenance of professional standards programs, and in programs directed at maintaining the health and welfare of professional colleagues. (College Professional Documents TE9 Guidelines on Quality Assurance in Anaesthesia and PS16 Statement on the Standards of Practice of a Specialist Anaesthetist.)

In order to provide time for other professional duties, clinical work should not exceed an average of 0.7 of specialists’ workload. This discretionary time should be allocated to staff by the Department Director in such a way as to ensure that all the Department’s goals are achieved and individuals’ expertise is best utilised, while still guaranteeing that all staff have adequate allocated time for professional development.

Medical staff duties are as follows:

4.1.1 Director of Anaesthesia

The Director has a primary responsibility to ensure that the Department functions safely and efficiently. Administration and personnel management comprise a significant part of the workload. Approximately 40% of the Director’s workload should be allocated to clinical activities. If the Director is a part-time appointee, appropriate time must still be available for managerial duties as well as other professional activities. This may result in a clinical commitment of less than 40%.

4.1.2 Deputy Director of Anaesthesia

In large Departments, a Deputy Director should be appointed to assist the Director with administrative tasks. Approximately 40% of the combined workload of both the Director and Deputy Director should be allocated to clinical duties.

4.1.3 Supervisor of Training

Supervisors of Training are the College's representatives for training in anaesthesia in its approved hospitals. They provide liaison between Registered Vocational Trainees and Hospital Authorities regarding matters related to training as well as with Regional Education Officers and the central administration of the College. (College Professional Document TE5 Policy for Supervisors of Training in Anaesthesia). The Supervisor is responsible for ensuring adherence to the College’s Policy on In-Training Assessment for trainees in anaesthesia. College Professional Document TE14 Policy for the In-Training Assessment of Trainees in Anaesthesia. At least one half day per week should be allocated to accomplish the necessary tasks. A greater period of time may be required in larger Departments.

4.1.4 Assistant Supervisor of Training

In larger institutions, an Assistant may provide useful support for the Supervisor of Training in his/her demanding and time-consuming role. An allocation of one half day is appropriate.
4.1.5 Module Supervisors

Module Supervisors have a broad understanding of, and experience in, the contents of the modules they supervise, and work directly with both trainees and the Supervisor of Training. There will be a variable number of Module Supervisors in any Department, depending upon the range of clinical experience available to the trainees. The Module Supervisors should have time allocated to fulfil their duties. (College Professional Document TE2 Policy on Vocational Training Modules and Module Supervision).

4.1.6 Specialist Anaesthetist

In addition to clinical activities, all specialist anaesthesia staff have obligations to teaching, some administrative duties, maintenance of professional standards and other non-clinical activities. The time made available for these activities must be assessed in the context of the other professional activities of all the Department members.

4.1.7 Trainee

The trainee is a specialist-in-training who requires clinical supervision as an essential component of the training process. A trainee can contribute to the clinical service of the Department to a limited degree after an initial period of Level 1 supervision. The extent of such service will be dictated by the educational needs of the trainee, the experience of the trainee, the mix of surgical specialties, subspecialty training requirements and the roster pattern, and may therefore vary significantly between institutions. The supervision of trainees must comply with the minimum requirements outlined in College Professional Document TE3 Policy on the Supervision of Clinical Experience for Trainees in Anaesthesia.

Trainees should be assigned educational, quality assurance and administrative responsibilities appropriate to their level of training. Time must be allocated for these duties.

4.2 Non-Medical Staff

4.2.1 Assistant for the Anaesthetist

The presence of a trained assistant for the anaesthetist during the conduct of anaesthesia is a major contributory factor to safe patient management. The assistant may be a nurse or a technician. Staff numbers must be sufficient to provide a dedicated assistant available both in-hours and after-hours for every patient who is being anaesthetised. (College Professional Document PS8 Guidelines on the Assistant for the Anaesthetist).

4.2.2 Nurses

Nurses may fill the role of the assistant for the anaesthetist and/or provide staffing for the Recovery Room. For staffing of the Recovery Room, the ratio of nurses to patients needs to be flexible so as to provide no less than one nurse to three patients, and one nurse to each patient who has not recovered protective respiratory reflexes or consciousness. (College Professional Document PS4 Recommendations for the Post-Anaesthesia Recovery Room).

4.2.3 Technical Staff

Technicians may fill the role of the assistant for the anaesthetist and/or provide technical support for equipment maintenance and repair.

The required number will vary with each particular hospital and be dependent on the relative involvement of other groups (e.g., Biomedical Engineering Department) and external service contracts.

4.2.4 Secretarial Staff

Secretarial staff duties include support for individual anaesthetists, support for departmental administration and support for educational and quality assurance activities. The number of staff required will depend on the size and activity of the Department. Refer to College Professional Document TE7 Guidelines for Secretarial and Support Services to Departments of Anaesthesia.

5. STAFFING NUMBERS

5.1 The Department of Anaesthesia must have (College Professional Document TE1 Recommendations for Hospitals Seeking College Approval for Vocational Training in Anaesthesia):

5.1.1 A minimum of one specialist anaesthetist who holds the Diploma of FANZCA

5.1.2 A minimum of two full time equivalent (FTE) specialist anaesthesia staff with qualifications acceptable to Council

5.1.3 At least one full-time equivalent (FTE) specialist anaesthetist for each trainee

5.1.4 No more than two non-specialist anaesthetists (including trainees) for each FTE specialist anaesthetist employed.

5.2 The calculation of the number of specialist anaesthesia staff required to provide all the required anaesthesia-related services is complex. The following matters must be fully understood in order to make a meaningful calculation:

5.2.1 Number of hours of clinical work provided per week by each staff member

5.2.2 Full extent of the weekly clinical services to be staffed

5.2.3 Full extent of out-of-hours clinical cover to be staffed

5.2.4 Leave of all types taken by clinical staff in weeks per year

5.2.5 Changing work practices and enterprise agreements

5.2.6 Need to ensure that staff are not expected to work when fatigued

5.2.7 Other factors specific to the individual hospital.

5.3 Assumptions underlying staffing workload calculations:

5.3.1 The calculations aim to ensure that there are adequate staff numbers to allow appropriate supervision of trainees.

5.3.2 The Director of the Department should have 40% of available time counted as contributing to the Department’s staffing of in-hours clinical work.

5.3.3 All specialists should have 70% of available time counted as contributing to the Department’s staffing of in-hours clinical work.
5.3.4 Supervisors of Training should have at least one session per week available for their duties.

5.3.5 Module Supervisors should have up to one session per week available for their duties.

5.3.6 Trainees in basic training should not have any time counted as contributing to the Department’s staffing of in-hours clinical work.

5.3.7 Trainees in advanced training should have 20% of available time counted as contributing to the Department’s staffing of in-hours clinical work.

5.3.8 Provisional Fellows should have 30% of available time counted as contributing to the Department’s staffing of in-hours clinical work.

5.3.9 The number of weeks per year that staff are available should be calculated. This should account for the duration of all types of leave (annual, sick, bereavement, study, educational, and other). The number of weeks available for work may be different for specialists and trainees.

5.3.10 There should be appropriate staffing to ensure that staff can be rostered off after overnight duties.

5.3.11 The number of weeks per year that the Department is working at full capacity should be calculated; this is often 50 weeks per year.

RELEVANT PROFESSIONAL DOCUMENTS

TE2 Policy on Vocational Training Modules and Module Supervision.
TE3 Policy on Supervision of Clinical Experience for Trainees in Anaesthesia
TE5 Policy for Supervisors of Training in Anaesthesia
TE6 Guidelines on The Duties of an Anaesthetist
TE7 Guidelines for Secretarial and Support Services to Departments of Anaesthesia
TE9 Guidelines on Quality Assurance in Anaesthesia
TE13 Guidelines for the Provisional Fellowship Program
TE14 Policy for the In-Training Assessment of Trainees in Anaesthesia
TE15 Guidelines for the Provisional Fellowship Program
PS4 Recommendations for the Post-Anaesthesia Recovery Room
PS8 Guidelines on the Assistant for the Anaesthetist
PS16 Statement on the Standards of Practice of a Specialist Anaesthetist

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