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Editorial

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The Australian and New Zealand College of Anaesthetists' Bulletin is published four times per year by the Australian and New Zealand College of Anaesthetists, ABN 82 055 042 852, 630 St Kilda Road, Melbourne, 3004, Victoria.

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Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the author’s personal observations and do not imply endorsement by, nor official policy of, the Australian and New Zealand College of Anaesthetists.
Mention of the word 'Accreditation' normally elicits a yawn from most of us. We have grown used to the visits to our hospitals of teams from the Australian Council on Healthcare Standards (ACHS) and from the various learned Colleges including our own. Usually these visits imply an increased workload as we review the necessary documents, organize staff to be interviewed and prepare for the worst. Some see the visits as a waste of their time but most acknowledge that the subsequent report is useful and that the changes that are required are ultimately of benefit to the institution and to the welfare of our patients.

With this introduction, I would like to discuss the new process of accreditation of ANZCA by the Australian Medical Council (AMC). For those who have not had the opportunity to read the Bulletin articles that have described the development of this process, I will repeat some of the information already circulated. The AMC is the national body that has responsibility for several tasks including the accreditation of overseas trained doctors and specialists, recognition of new medical specialties, development of national medical registration and accreditation of medical schools in both Australia and New Zealand. More recently the accreditation of the specialist medical colleges for education, training and professional development programs of ANZCA, the Joint Faculty of Intensive Care Medicine and the Faculty of Pain Medicine. Professor Garry Phillips had the unenviable task of collating this submission and did a superb job. Questionnaires were sent to a variety of stakeholders including all trainees, Supervisors of Training, Deans of medical schools, other specialist medical Colleges and Health Departments in Australia and New Zealand. All trainees and supervisors of training in Queensland, New South Wales, Victoria, Wellington and Auckland in New Zealand were invited to an 'off site' venue to meet with members of the team. This provided an opportunity for all attendees to provide their personal views on the training scheme in a non-threatening environment. Finally, the College Councillors and staff were interviewed at the College headquarters in Melbourne.

The report of over 45 pages (excluding appendices) represents an accurate and fair assessment of the College and Faculties. Four possible levels of accreditation are described. It is very pleasing to be able to report that we have achieved the highest level. The recommendation is for accreditation of ANZCA and JFICM for six years subject to satisfactory annual reports from the College. A satisfactory report in the fifth year of accreditation may result in a further four years of accreditation. The training program of the Faculty of Pain Medicine meets appropriate standards but accreditation will depend on the outcome of a decision on the recognition of Pain Medicine as a medical specialty or subspecialty. This excellent result is tempered by a list of matters that the AMC wants us to address in our annual reports. These matters include such predictable issues as assessment policy and procedure, overcoming bottlenecks in training, increased participation and flexibility in the MOPS program, and selection of trainees.
These issues will be discussed in appropriate forums and should not present major problems. The full text of the AMC report will be available on the College website when it becomes a public document, probably within a month.

I would like to emphasise the importance to the College of this accreditation. It is no great revelation that these are difficult and uncertain times for the practice of medicine. Challenges to the way we practise, and indeed what qualifications we need to practise, are occurring increasingly often. To have undergone an independent review of our activities and to have what we believe is an excellent report will be of inestimable value when we have to justify the standards of care that some would seek to diminish.

As the year draws to a close, I would like to acknowledge all the hours of voluntary work that so many Fellows give to the College. Without this help the College simply would not function in the efficient and cost-effective way that it does. I trust that all Fellows, trainees and the hard-working College staff have a happy, relaxing and re-invigorating Christmas and New Year.

Richard Willis
President, ANZCA

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**Inquiries to the college**

The College receives a steady stream of enquiries seeking information on a wide variety of issues. Most enquiries are handled by the relevant College staff member. Those relating to professional issues, including matters covered by the Professional Documents, are passed on to a Fellow with particular expertise in the area, or are handled by the Director of Professional Affairs.

Topics raised tend to recur, and relate particularly to a few of the documents, especially PS8, (The Assistant for the Anaesthetist), PS3, (Guidelines on the Conduct of Major Regional Anaesthesia and Analgesia), PS9, (Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures), PS10, (The Handover of Responsibility during an Anaesthetic), and PS18, (Recommendations on Monitoring during Anaesthesia.)

One of the issues referred to in the last four of these documents for which enquirers seek clarification is that of the responsibility of the anaesthetist to the patient during a procedure performed under regional anaesthesia, general anaesthesia, or sedation.

Some of the issues sound minor, but can become major. For example, does the College have any views on an anaesthetist who “takes phone calls”, “reads”, “is in the tea room”, “is out seeing the next patient”, while responsible for a patient?

The relevant Professional Documents are quite clear:

**PS3**: The anaesthetist must be in attendance throughout the procedure or until the blockade has been demonstrated to be satisfactory, its extent determined, the condition of the patient is satisfactory and stable and the potential for acute complications has passed (1.7).

**PS9**: If general anaesthesia or loss of consciousness is sought for the procedure, then an anaesthetist must be present to care exclusively for the patient (3.4).

**PS10**: During an anaesthetic, the major responsibility of the anaesthetist is to provide care for the patient. This requires the continuous presence of an anaesthetist (1). The primary anaesthetist will only leave while the patient is in a stable state and no potential adverse events are likely to occur (3.1).

**PS18**: Clinical monitoring by a vigilant anaesthetist is the basis of safe patient care during anaesthesia. 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 (1)

G.D.Phillips
Director of Professional Affairs
MOPS Annual Returns for 2002 are due by the end of February 2003. If you have any questions or concerns with regard to your Return, please contact Juliette Mullumby at the MOPS Office at cme@anzca.edu.au or phone 61 3 9510 6299.

Please note that, commencing MOPS Year 2002, the electronic disk diaries have been replaced by the new MOPS Online Diary (http://www.anzca.edu.au/mops_fellows/index.cfm). We are no longer able to process returns generated by the disk program, however, if you have used the old system to enter your 2002 year’s activities, your Annual Return data can still be submitted electronically using the Online Annual Return Form outlined below for Paper Diary Users.

**Paper Diary Users**

Paper Diary users now have two options for submission of their Annual Return.

- Completion of the Annual Return Form in the back of the Paper Diary
- Completion of the Online Annual Return Form available on the College Website (www.anzca.edu.au). The website form is accessed through the CE&QA section

Participants submitting a paper Return should ensure that they complete the details section at the head of the form, for identification purposes, and sign the declaration on the reverse. Instructions on completing the Annual Return can be found on pages 4 and 5 of the Paper Diary.

A number of Paper Diary users are not correctly completing the Outcome on Practice section. This section records the impact of activities on a participant’s practice and is an important factor in the feedback process. To ensure that accurate feedback is provided in the Individual Comparison Report, circulated annually to each participant, please ensure that you enter the appropriate response against each diary entry and total each of the columns for transfer to the Annual Return. As a guide, the total of the “Outcome on Practice” columns (Change/Wait/None) should balance with the “Count Entries” column on your Annual Return. For full instructions, see page 5 of the Paper Diary.

**Online Diary Users**

Participants using the Online Diary will find the “Submit Annual Return” function in the User Administration section of their Online Diary.

Please check the information shown in your Annual Return, and when satisfied that your Return is accurate, scroll down to the bottom of the page and click Continue. You are then required to complete the statement with regard to certification of medical registration, health and freedom from chemical dependence before submitting your Final Annual Return.

Please ensure that all activities for the year have been entered before pressing “Submit Final Annual Return”, as the information cannot be edited or resubmitted after selecting this option.

**Leona Wilson**

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**Honours and Appointments**

Congratulations were extended to:

- Dr Kate Leslie (Vic) – Honorary Associate Professor, Department of Pharmacology, University of Melbourne
- Dr Edmund Loong (NSW) – Medal of the Order of Australia (OAM)
- Associate Professor José Carvalho (Canada) – Associate Professor of Anaesthesia, University of Toronto and Director of Obstetrics Anaesthesia, Mount Sinai Hospital
- Professor Harry Owen (SA) – Professor of Anaesthesia, Department of Anaesthesia and Intensive Care, Flinders University and Flinders Medical Centre
- Dr Michael Paech (WA) – Associate Professor of Obstetric Anaesthesia, School of Medicine and Pharmacology, Faculty of Pain Medicine and Dentistry, University of Western Australia
Each anaesthetist will perform many thousands of consultations during their professional lifetime. Therefore it is worthwhile to maximise the effectiveness of these interactions. Communication is a core clinical skill essential to high quality anaesthesia. Effective communication improves health outcomes for patients, increases patient satisfaction, and leads to greater accuracy, efficiency and supportiveness. Furthermore, although it is recognised that problems can occur between patients and Specialists, what is less well known is that most litigation has at least some foundation in poor communication. However, few people are naturally perfect communicators — communication skills need to be taught and learned. To this end the College is considering developing instruction to maximise communication effectiveness.

Types of Communication Skill

There are three types of interconnected communication skill. All should be addressed in any communication skills instructional curricula:

**Content** — What the Specialist communicates; the substance of their questions and responses; the information they gather and give; and the treatments they discuss.

**Process** — How the Specialist communicates; how they discover history and provide information; the verbal and non-verbal skills they use; how they develop relationships with patients; and the way they structure and organise communication.

**Perceptual** — What the Specialist thinks and feels; their internal decision making, clinical reasoning and problem solving; their awareness of people’s feelings and thoughts about the patient, the illness and other issues; and awareness of their own self-concept, biases, attitudes, intentions and distractions.

Principles of Communication

Communication is complex and multifaceted. A technique that is successful with one person may not be successful with another. Similarly, strategies that work best in one situation will not necessarily work well in another. However studies of communication reveal several aspects common to effective communication. These may be used to define five principles.

**Ensure interaction (not merely transmission)**

- Merely providing information or instruction on what to do adversely affects communication accuracy, efficiency and relationship building.
- It is essential to also provide appropriate feedback together with opportunities for questions and responses, clarification, etc.

**Clarify areas of uncertainty**

- Uncertainty distracts attention and interferes with accuracy, efficiency and effective relationships.
- For example, a Specialist should clarify uncertainty about their role in a patient’s care, clinical concerns, anticipated outcomes, expectations of the patient and carers, the functioning of the medical team, and relationships between key players.

**Plan and think in terms of outcomes**

- Clearly focusing on the specific desired communicative outcomes is essential.
- For example, if a patient (or Specialist) is angry and wishes to vent that anger then this will affect communication.
- Conversely, if the patient (or Specialist) wants to overcome a misunderstanding that caused the anger then a different communicative approach is required.
Demonstrate dynamism

- Being able to be flexible in their approach.
- This includes developing and appropriately using a repertoire of different approaches in order to communicate with a variety of people who may be in a variety of different moods and situations.

Follow a helical rather than a linear model

- Repetition, reiteration and feedback are essential elements of effective communication.
- Accurate understanding is not possible with the “said once and therefore done” approach.
- Instead it is necessary to repeat information multiple times in a helical fashion, each time improving the extent of the understanding and seeking confirmation of understanding (or the identification and eradication of inaccuracies).

References


Celebration of Civil Rights

Partner, Michael Gorton, as Co-chair of Reconciliation Victoria Inc., hosted a major function for Martin Luther King III as part of an Australia wide tour.

Mr King, the son of the American civil rights campaigner, toured Australia discussing the issues of civil rights, indigenous reconciliation and other issues. A social fund-raising function to mark the occasion was held at Crown Casino, with over 500 guests attending.

Russell Kennedy is a pro bono supporter of Reconciliation Victoria Inc.

Mr Gorton is an Honorary Fellow of the College and Honorary Solicitor.

Reproduced with permission, Russell Kennedy Solicitors, Melbourne.
WELCOME
The President welcomed Dr Margaret Cowling, Chairman of the South Australian and Northern Territory Regional Committee and Dr Frank Lah, Chairman of the Australian Capital Territory Regional Committee to the meeting as Observers. Both Chairmen have just taken office.

CERTIFICATES COMMITTEE
Diving and Hyperbaric Medicine
The Objectives of Training have been developed for an 18 month course, the first six months of which involve working towards the SPLIMS Diploma. A further twelve months training will then be undertaken in a diving facility. Assessment will consist of attainment of a number of objectives, a short written paper and an oral examination. It is anticipated that the course will be available from January 2003 and that examinations will probably take place around the time of the Annual Scientific Meeting, in order to limit expenses.

Currently advertisements have been placed in the College Bulletin seeking expressions of interest for Foundation Certification.

CONTINUING EDUCATION AND QUALITY ASSURANCE
2003 Annual Scientific Meeting - Hobart
Professor Richard Smallwood AO, Commonwealth Chief Medical Officer, has accepted the President's invitation to deliver the Oration at the College Ceremony in Hobart.

2005 Combined Scientific Meeting - Malaysia
Following discussions with the Malaysian and Singapore Academies, it has now been agreed that the Annual Scientific Meeting in 2005 will be a combined meeting with the Malaysian and Singapore Academies, to be held in Kuala Lumpur.

2006 Annual Scientific Meeting – Auckland
The 2006 ASM will be held in Auckland, New Zealand.

2003 New Fellows’ Conference
Dr Steuart Henderson has been appointed the Councillor in Residence to the 2003 New Fellows’ Conference.

EDUCATION
Educational Resources
A Working Party comprising Dr Kerry Brandis (Chair), Dr Richard Willis, Dr Julia Fleming and Dr Russell Jones has been established to consider the issue of educational resources within the College.

Trainees’ Support Kit
Council has approved the Trainees’ Support Kit for publication on the College website. However, new trainees will receive a hard copy at the time of registration with the College.

Provisional Fellowship Year – Prospective Approval
Despite a reminder to trainees at the time of a successful Final examination that prospective approval is required for a Provisional Fellowship post, the College is consistently being requested to consider such training retrospectively. Council has again reiterated to trainees that unless specific prospective approval is obtained for a job description, irrespective of whether the post has previous approval, such training will not be recognised. It has been necessary to enforce this prospective approval as many trainees believe they are not obtaining the experience anticipated following their commencement of such a post.

FANZCA Program
Following receipt of input from interested parties, the draft proposed FANZCA Program has now been revisited and is available on the College website for input and comment from Fellows, trainees and other stakeholders.

Supervisors of Training Workshops
Council proposes to hold numerous workshops around Australia and areas of New Zealand to provide up-skilling for Supervisors of Training.

EXAMINATIONS
Primary Examination – Hong Kong
In the past the Hong Kong Hospital Authority has made a large contribution towards defraying the costs of mounting the Primary Examination in Hong Kong. Recently, because of financial restraints, the Hong Kong Hospital Authority has had to withdraw such financial assistance. In an effort to support the College trainees in Hong Kong and neighbouring areas, the College has agreed that the Primary Examinations will still be held in Hong Kong provided there is a minimum of 10 candidates.

FINANCE
Fees
Council has agreed to retain the following fees (this means that fees have not been increased for five years):

Annual Subscription for ANZCA Fellows for 2004
(due and payable on 1st January 2003)
Non Fellows Participation in MOPS Fee
Examination Entry Fee
Register of Training Fee
Annual Training Fee
Australia
New Zealand
Hong Kong
Malaysia (local currency converted into AUD)
Singapore (to be capped at an amount in AUD equivalent to that paid by Australian Trainees)
Occupational Training Visa Assessment Fee
Area of Need Assessment Fee
Overseas Trained Specialist Assessment Fee
Overseas Trained Specialist Reviewer's Fee
(Invoiced to the Institution and paid to the College)

A$990 plus GST where applicable
A$500 plus GST where applicable
A$1,900
A$950
A$925
NZ$925 plus GST
A$925
$925

A$100
A$250 plus GST
A$1,300 plus GST
A$1,500 plus GST
plus reasonable travel and accommodation costs

B-Pay Payment Facility
The College has approved to offer B-Pay to Fellows and trainees in addition to credit card facilities. Unfortunately this process is only available to bank accounts in Australia.

INTERNAL AFFAIRS
South Australian and Northern Territory Regional Committee
A representative from the Northern Territory has recently been co-opted to the South Australian Regional Committee. This involvement has been very beneficial to the Fellows and trainees located in the Northern Territory. Council has now approved the expansion of the South Australian Regional Committee to include the Northern Territory. In future, the Northern Territory representative will participate in the meetings of the South Australian and Northern Territory Regional Committee by teleconference and will be funded to attend two meetings per year in Adelaide. In addition, the Supervisor of Training at the Royal Darwin Hospital will be funded to attend at least one of the Education Sub Committee meetings in Adelaide.

College Information Technology Committee
As a number of Regions now have IT Officers, Council has approved the co-option of these Regional IT Officers to the College IT Committee. It is anticipated that such co-option will not only provide support but an avenue for exchange of ideas.

Virtual Congress
Following a three year trial period of the Virtual Congress associated with Annual Scientific Meetings, Council has agreed that a formal evaluation, including feedback from Fellows on past Virtual Congresses and future expectations, be conducted. In the meantime, focus will be placed on publishing as many presentations online as possible in a simple format, utilising audio streaming and PowerPoint slide presentations provided by the presenters.

Honorary Historian
Dr Michael Cooper and Dr Tony Newson have been reappointed Honorary Historian and Honorary Assistant Historian respectively.

Fellows' Room
An area within "Ulimaroa" adjacent to the Library has been identified as a Fellows' Room for the use of all Fellows. Interstate and overseas Fellows are particularly welcome to use these facilities which will provide a meeting place or somewhere just to relax whilst visiting the College.

College Website – Employment Section
The College plans to establish an Employment Section for both consultants and trainees on the College website. While this facility will be provided at no cost to the parties, the exposure of the advertisements will be time limited.

Regulation 13 – Gilbert Brown Prize
Regulation 13 has been amended to remove the restriction of location where applicants for the Gilbert Brown Prize may complete their research.

Regulation 14 – Primary Examination for FJFICM
Regulation 14 has been amended to require Fellows of the Joint Faculty of Intensive Care Medicine who have not successfully completed the ANZCA Primary Examination (or other examination satisfying the requirements of 14.1.2) to successfully complete this examination as a requirement for the award of FANZCA.

AMC Draft Accreditation Report
Council has now viewed the draft Report and corrected any errors of facts. It is anticipated that the Reviewers' recommendations will be available mid October.

Geoffrey Kaye Museum of Anaesthetic History
Council approved the appointment of a fulltime curator to review and catalogue the collection. The College aims to publish the catalogue on the College website when completed which will enable interested parties to borrow particular pieces for local display. An area on Level 6 of ANZCA House will be available temporarily to allow assessment and cataloguing of the collection.
PROFESSIONAL

Professional Documents

Council revised the following Professional Documents which are published in this Bulletin:

TE4  Policy on Duties of Regional Education Officers in Anaesthesia
TE5  Policy for Supervisors of Training in Anaesthesia
PS1  Recommendations on Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia
PS29 Statement on Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities

Council promulgated the following Professional Documents which are published in this Bulletin:

PS46 Recommendations for Training and Practice of Diagnostic Perioperative Transoesophageal Echocardiography in Adults
PS47 Guidelines for Hospitals Seeking College Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine

The following Professional Document was withdrawn:

PS17 Guidelines on Endoscopy of the Airways

Australian Day Surgery Council

Dr Colleen Kane (NSW), replacing Dr Andrew Bacon, will now join Dr Glenda Rudkin (SA) as ANZCA representatives on the ADSC.

National Health and Medical Research Council (NHMRC)

The following Working Party was approved by Council to revise the NHMRC Guidelines on Acute Pain Management:

Dr Pam Macintyre (Chair)
Dr Penny Briscoe
Dr Suellen Walker
Associate Professor Dr Stephan Schug
Professor Ian Power
Dr Michael Cooper
Dr David Scott
Dr Eric Visser

RESEARCH

2003 Research Grants

Total funding requested by the twenty-four applications was $1,167,082 with $363,945 available funding for 2003. Due to the large response, some excellent applications were unable to be granted support. Details of these grants are published in this Bulletin.

Deaths

The death of the following Fellows is noted with regret:

Dr Loraine Clare Hibbard (NSW) - FFARACS 1961, FANZCA 1992
Dr Peter John Forgan (SA) - FFARACS 1967, FANZCA 1992
Dr Graeme Alexander Ronaldson (QLD) - FFARACS 1977, FRANZCA 1992
Your best defence – Communicate!

Recent studies, both in Australia and overseas, have confirmed that one of the prime reasons for patients seeking to make claims against their doctor after an adverse outcome is the manner in which the doctor dealt with them and communicated with them.

In other words, the way doctors communicate with their patients after an adverse event will substantially influence whether the patient considers making a formal claim or even suing their doctor for negligence.

The doctor who is attentive, responsive and sympathetic after an adverse outcome is less likely to be sued than the doctor who is dismissive, distant or less empathetic.

It is common knowledge that there are doctors who achieve less than optimal outcomes, but whose patients would never think of taking action against them. That is because their patients “love them” as a result of the attention, empathy and friendly treatment they receive.

There are certainly occasions when doctors, despite their best efforts, and with no suggestion of legal negligence, nonetheless face claims from patients because of the perception of less than optimal outcomes or the perception of poor care.

Open Disclosure

As part of the response by governments, both Federal and State, to the medical indemnity crises, legislation has been introduced into most states to permit “Open Disclosure”. That is, the legislation now permits doctors to have a frank discussion with their patients, without there being any adverse legal implications.

The legislation fosters the concept of openness and a frank discussion with patients after an adverse outcome (whether or not there has been negligence). There can be an open acknowledgment of an adverse outcome, and even an apology (to express regret for the fact that the patient has not had an optimal outcome).

It may not be “trendy” in Australia to give an apology. However, in the case of adverse events, an apology may well be a critical factor as to whether a patient sues a doctor or not.

Legislation in most states now allows doctors to deal with adverse outcomes, without there being any admission of liability, by:-

• expressing regret or apologising for an adverse outcome;
• expressing sorrow or sympathy;
• reducing fees; or
• waiving fees entirely.

Such events will also not constitute an admission of professional misconduct, or otherwise expose the doctors to civil liability for carelessness, incompetence, or unsatisfactory performance.

Open Disclosure Standards

In addition to these legislative changes, the Australian Council for Safety and Quality Health Care has undertaken a major project to draft standards or guidelines to assist doctors and hospitals in discussing these issues frankly with patients.

The draft standards, developed by the Council address the following issues:-

• openness and timeliness of communication;
acknowledgment of the adverse event;
apology or expression of regret;
recognition of the reasonable expectations of patients;
support for staff throughout the process;
processes for risk management and systems improvement;
governance frameworks to ensure appropriate clinical risk management;
confidentiality.

The Council is developing a draft standard or guideline to assist doctors, nursing staff and administrators in dealing with the issues raised by “Open Disclosure”.

Once an adverse event has occurred, it is important that the patient is kept informed, as appropriate. The clinical team should ensure that:-

- they establish the basic clinical and other facts relevant;
- assess the event and the level of response required;
- identify who will take responsibility for advising the patient;
- consider whether additional patients report is required;
- identify other support and needs;
- ensure that all appropriate staff are sufficiently informed and ensure a consistent response to the patient.

Clearly, as matters develop, patients should be provided with sufficient and up to date information, so that they feel appropriately informed. Recommendations for further remedial care should be made as soon as possible. Follow up is an essential part of the process.

Nonetheless, the process should ensure:-

- confidentiality, privacy and professional privilege;
- responses to any negligent or criminal or unsafe acts (if any) including coronial investigations;
- any disclosure consideration of whether it might further harm the patient;
- consideration of any other insurance or contractual arrangements.

These statutory reforms are helpful. They should give confidence to doctors and medical administrators to deal with adverse outcomes (whether negligence or not) in a caring and humane way. It is, after all, human nature to be able to express regret and sympathy where a patient has had an adverse outcome to treatment or procedure, without such concern being considered an admission of legal liability.

The medical indemnity crisis requires much more to be done before the medical profession can be satisfied that all of the issues have been adequately considered. However, moves to greater “Open Disclosure” by legislative reform are most welcome.
Day Care Anaesthesia

Executive

Postal elections for positions on the SIG Executive were held in April 2002 and the results declared at the AGM in May. The Executive is comprised as follows:

- Dr Steve Watts WA (Chair)
- Dr Michael Fong QLD
- Dr Colleen Kane NSW
- Dr Elliot Rubinstein VIC
- Dr Rowan Thomas VIC
- Dr Carolyn Fowler NZ
- Dr Robin Limb SA
- Dr David Kinchington ACT
- Dr Ruth Matters TAS
- Ms Helen Morris ANZCA (secretariat)

In addition, Dr David Kinchington is the ASA representative to the Australian Day Surgery Council (ADSC). Dr Colleen Kane is the newly appointed ANZCA representative to the ADSC. Dr Andrew Bacon (Vie) served the College and SIG for many years in this role, and is to be thanked for his dedicated service. His wisdom and experience on the Day Care SIG Executive has been much appreciated.

Continuing Medical Education

ASA NSC Canberra, October 2001

The Day Care session centered on issues relating to perioperative care. Presentations on preoperative investigations, management of medications and pain control in the elderly contributed to a successful meeting. Our thanks to Professor Frances Chung (Toronto) who made a number of well researched and powerful presentations covering many aspects of Day Surgery. Controversies surrounding the expansion of anaesthesia services and "sedation" into the office-environment were also explored in a lively discussion.

Satellite Meeting / ANZCA ASM, Brisbane May 2002

"Setting the Standard"

The biennial Day Care SIG single-theme meeting was held immediately prior to the ANZCA Golden Jubilee ASM and the primary focus was on best practice in ambulatory anaesthesia. Invited speakers were Professor Kari Korttila (Finland) and Dr Greg Wotherspoon (NSW). Morning sessions covered evidence-based assessments of how to approach common day surgery problems including the use and interpretation of clinical audit. Innovative approaches to the management of borderline day cases were presented by a number of Auckland speakers in the afternoon. The SIG Executive thanks all those who contributed to making this meeting a success.

Forthcoming Events

ASA NSC Adelaide, October 2002 “Day Care outside the OR”

This session will cover aspects of anaesthesia provision outside the traditional theatre or day surgery setting. Topics include Anaesthesia for ECT, Interventional Radiology and Anaesthesia Support to the Cath Lab. Special requirements for these settings and issues relating to maintenance of standards will be discussed.

ANZCA ASM Hobart, May 2003

The SIG will contribute a session to this meeting. Potential topics and speakers are currently under discussion.

Future Involvement

The SIG has a philosophy of support for the major scientific meetings of the College and ASA. The organization of the Day Care sessions at these meetings relies on the goodwill of many members of the profession. Members of the SIG with a project or area of interest suitable for inclusion / discussion at one of these meetings are encouraged to become involved and make themselves known to their local Executive member.

Policy Development

The SIG has had input into College Policy Document PS9 “Guidelines on Conscious Sedation for Diagnostic, Interventional Medical and Surgical Procedures” promulgated late last year. This document outlines clearly the minimum standards for the safe administration of sedation in all environments, the major portions of which have been incorporated into the WA Health Department’s Standards for Office-Based Practice. Members are advised to familiarize themselves with the details of this document which is available on the ANZCA web site.

Day Care Fellowship

The SIG has received a number of queries in recent time from Registrars seeking information about placements that will further their experience in Day Care Anaesthesia. This information is not readily available. Dr Carolyn Fowler is conducting a project to improve the quality of information we hold on Day Care facilities in Australasia. She will be circulating a letter to SIG members seeking initial feedback on likely suitable placements. This will be followed-up by a more detailed survey in due course. Your cooperation and assistance in this matter will be appreciated.
Hornabrook Prize

The Hornabrook Prize is administered by the Day Care SIG and is designed to encourage and reward research in the field of ambulatory surgery. The most recent prize was awarded to Dr Bernard Lee (Sydney) for a project completed at King Edward Hospital, Perth and published recently in Anaesthesia and Intensive Care. The promotion of the Hornabrook Prize is considered a key responsibility of all members of the SIG.

In summary it has been another busy year for the Day Care SIG Executive. We aim to promote and encourage quality initiatives in the provision of Day Care Anaesthesia, to assist in the setting and maintenance of standards and to provide regular forums for presentation and discussion of current issues. The SIG is however more than just its Executive, and we would encourage all Fellows and Trainees to consider their own involvement in fostering these aims and to provide feedback through their local Representative.

Steve Watts
Chair

Medical Education

Executive

At the SIG AGM in Brisbane in May, the elected Executive Committee was ratified. As there were seven nominations for nine vacancies, no ballot was required. Drs Leonie Watterson and Simon Maclaurin have since been appointed to the Committee by the SIG Executive, which now comprises:

- Dr Guy Buchanan ACT
- Dr Ed Loughman NSW
- Dr Simon Maclaurin WA
- Dr Kym Osborne SA
- Dr Karen Smith NZ
- Dr Kersi Taraporewalla QLD (Chair)
- Dr Rod Tayler VIC (Chair)
- Dr Leonie Watterson NSW
- Dr Jenny Weller NZ

The new SIG Executive elected Dr Rod Tayler as Chair. A vote of thanks is extended to the retiring Chair, Dr Barrie McCann, for his outstanding contribution to the development of the SIG.

Continuing Medical Education

The Medical Education SIG held its 2nd Annual CME Meeting at the Sheraton Mirage in Port Douglas, North Queensland, from 26-28 July. There were 49 registrants from almost all regions of Australia and New Zealand. The program incorporated a variety of formats, including lectures, small group workshops and a debate. Topics included The Place of Lecturing, Teaching and Learning Strategies, Teaching in the OT, Applying Learning Styles, Managing Conflict, and Giving Feedback.

There was considerable discussion on a wide range of educational issues affecting trainees and consultants. The meeting was judged by the participants to be stimulating and productive, as evidenced by the highly positive feedback sheets at the conclusion of the meeting. It was widely agreed that the SIG should hold an annual meeting of this type.

At a teleconference of the SIG Executive held on 1st October, provisional plans were made to have the 2003 annual meeting at Noosa Heads in early September.

The SIG will be involved with sessions at the NSC in Adelaide and the ASM in Hobart.

Rod Tayler
Chair

Rural

Executive

The Annual General Meeting of the Rural SIG was held during the Brisbane ASM on Tuesday 14 May 2002. At that meeting the current SIG Executive was confirmed as:

- Dr Kevin Johnson SA
- Dr David Kinchington ACT
- Dr Di Khursandi QLD
- Dr Mike Miller NZ
- Dr Frank Moloney NSW
- Dr Mark Tuck VIC (Chair)

No formal ballot was necessary as fewer nominations were received than positions available. The absence of members from WA and Tasmania is unfortunate, however the new SIG Administrative Guidelines allow vacancies during the term of the SIG Executive to be filled at its discretion and this will be addressed prior to the next AGM.

Rural Issues

This year the main issues considered by the Rural SIG related to the ongoing issues of recruitment and retention of staff in regional Australia as well as CME and MOPS difficulties experienced in rural practice.

Meetings

A successful workshop was held during the ANZCA ASM in Brisbane looking at the current crises in rural practice. Dr Frank Moloney addressed the confirmed maldistribution of anaesthetists within NSW and Dr Mike Miller looked at similar aspects of the New Zealand experience.

Of note was the particular concern developing in New Zealand regarding the advocacy for Nurse Anaesthetists from various non-medical stakeholders within the New Zealand healthcare system. Discussion from the floor highlighted the potential problems in maintaining the standards of care, if groups with a more limited skill base dilute the current anaesthetic workforce. Dr Wal Grimmett described an innovative and helpful use of video conferencing technology to solve a problem with the delivery of intensive care in rural Queensland and Dr Michael Catchpole provided Queensland Health's view on the perceived problem and solutions.

General discussion from the floor focussed on the Australian and New Zealand College of Anaesthetists
significant industrial relations issues facing the rural practitioners in NSW at the time. Dr Michael Hodgson was present and affirmed the ASA’s intention to make all possible efforts to aid resolution of these issues.

During the next twelve months the Rural SIG will be contributing to the ASA NSC in Adelaide in October and the 2003 ANZCA ASM. The SIG Executive intends to achieve representation from all areas of Australia and New Zealand and to focus on the positive aspects and achievements of anaesthetic practice in non-metropolitan Australia.

Mark Tuck  
Chair

Simulation and Skills Training

Executive

The Executive of the Simulation and Skills Training SIG comprises:

Dr Stephen Bignell  
QLD
Dr Brent Donovan  
WA
Dr Brendan Flanagan  
VIC (Chair)
Dr Richard Morris  
NSW
A/Prof Kwok Fu Jacobus Ng  
HK
Prof Harry Owen  
SA
Dr Richard Riley  
WA
Dr Richard Waldron  
TAS
Dr Jennifer Weller  
NZ

The role of this SIG is to discuss academic issues including assistance in the formulation of training syllabuses of Simulation and Skills Training courses; maintenance of standards, quality assurance, and research and teaching. Copies of the Special Interest Group’s Constitution are available through the College.

Continuing Medical Education

During the past twelve months the SIG Meeting contributed to the ASA NSC 2001 in Canberra and the May 2002 ASM program in Brisbane.

Canberra ASA NSC

Dr Leonie Watterson from the Sydney Medical Simulation Centre conducted one large group workshop and a series of small group workshops at the 2001 NSC. The large group session was interactive involving observation and discussion of a video on the matter of patient safety. The small group workshops were on latex allergy and communication issues in the Operating Room. As always, the sessions were overbooked and extremely well received. Many thanks to Leonie for once again providing extremely thought-provoking sessions.

Brisbane 2002 ASM

Dr Stephen Bignell chaired a successful session on the theme of “Simulation as a means of assessment”. Assoc Professor Harry Owen spoke on “Anaesthesia assessment - from pen and paper to virtual reality”. Captain Peter Telling gave a brief discussion on the history of flight simulation and other factors associated with safe flight. And Dr Patrick Cregan, a surgeon from Nepean Hospital gave an overview of virtual reality and simulation in surgical training. Many thanks to Stephen for presiding over such an interesting and varied series of presentations.

Future Meetings

Planning is underway to ensure a presence at the major upcoming meetings, namely the ASA NSC in Adelaide in October 2002 and the ANZCA ASM in Hobart May 2003.

EMAC Course

The past twelve months has seen the initial rollout of the Effective Management of Anaesthetic Crises (EMAC) course. Although the development of this course does not fall directly under the responsibility of the SIG, it is the first evidence of the College’s interest in formalising the prospect of simulation and skills based training. It has been developed with input from existing Simulation Centres. The Course is developing under the guidance of the College Courses Subcommittee, chaired by Dr Wally Thompson, and is available to trainees as an alternative to the EMST course.

Membership

Enquiries regarding membership to the SIG can be made through Helen Morris at the College. Membership of this SIG is open to Fellows, Members of the ASA and NZSA. Fellows of other Colleges, practitioners and allied health professionals will also be encouraged to participate as Associate Members.

I would like to thank Helen Morris at ANZCA for her assistance in preparation of this report.

Brendan Flanagan  
Chair

Diving and Hyperbaric Medicine

Executive

The SIG Executive presently comprises:

Dr Mike Bennett  
NSW
Dr Alistair Gibson  
NZ
Dr David Griffiths  
QLD
Dr John Knight  
VIC
Dr Brian Spain  
NT
Dr Margaret Walker  
TAS
Dr David Wilkinson  
SA
Dr Robert Wong  
WA (Chair)

Coopted Members

Dr Simon Mitchell (South Pacific Underwater Medicine Society)
Dr David Smart (ANZ Hyperbaric Medicine Group)

Formal Qualification in Diving and Hyperbaric Medicine

ANZCA Council has granted the Award of a Certificate in Diving and Hyperbaric Medicine. Over the past 12 months, the SIG Executive has been active in bringing the Certificate to its final stages for consideration by the
Certificates Committee. The "Objectives of Training" and "Training Program" have been accepted by Council and the Certificate Program in Diving and Hyperbaric Medicine will commence in January 2003.

It is envisaged that accreditation of facilities seeking approval for Vocational Training in Diving and Hyperbaric Medicine will commence in January 2003. A number of documents have been generated, discussed and referred to the College for ratification. These include:

1) Register of Training
2) Application to sit the Examination
3) Guidelines for Facilities seeking Approval of Posts for Vocational Training in Diving and Hyperbaric Medicine
4) Facility Data Sheet
5) Selection Criteria for Appointments of Examiners
6) Application for Appointments as Examiners
7) Fee Structure

Foundation Certificate in Diving and Hyperbaric Medicine

The College has approved the issue of Certificates to those experienced practitioners who are active in the specialty. Two documents relating to this have been generated.

1) Criteria for Foundation Certificate for the Certificate in Diving and Hyperbaric Medicine
2) Call for Applications as Foundation Certificate Holders in Diving and Hyperbaric Medicine

Those members seeking the Foundation Certificate will need to apply to the College. Applications close on 30 June 2003.

Diving and Hyperbaric Medicine Course

The two-week full-time course continues into its third year in 2002. The venue changed in 2002, and was conducted in April at the Alfred Hospital in Melbourne. This course again was well attended. This is one of the two requisite courses for training in the ANZCA Certificate in Diving and Hyperbaric Medicine.

Standards Australia

Members of the SIG Executive Committee continued to contribute to the SF/046 document. In 2002, the SF/046 was published as AS4774 WORK IN COMPRESSED AIR AND HYPERBARIC FACILITIES. (Part 2:AS 4774.2 HYPERBARIC OXYGEN FACILITIES is now available. Part 1 on tunnelling work, having received public comments, will be published later in 2002).

Scientific Meetings

The SIG contributed to the scientific program of the ANZCA ASM in Brisbane in May. Members also contributed to other national and international scientific meetings during the year, including meetings of the Undersea and Hyperbaric Medical Society (UHMS); South Pacific Underwater Medicine Society (SPUMS); European Underwater and Baromedical Society (EUBS) and the Australasian Hyperbaric Meeting hosted by the Hyperbaric Technicians and Nurses Association (HTNA). The Australian and New Zealand Hyperbaric Medicine Group (ANZHMG), a subcommittee of SPUMS, also holds its AGM during this meeting.

SIG Constitution

The generic SIG Constitution states that full Membership is open to Fellows of ANZCA, or Ordinary members of the ASA/NZSA. At the May meeting of the Anaesthesia Continuing Education Coordinating Committee (ACECC) held in Brisbane, Dr Wong moved that item 3 of the Diving and Hyperbaric Medicine SIG Constitution be amended to allow Associate Members holding the ANZCA Certificate of Diving and Hyperbaric Medicine to become full Members. The recommendation was supported by ACECC and is awaiting ratification by the three parent bodies.

Man-Power Survey

Whilst the exact number of candidates wishing to receive training for the Certificate is unknown, it has been suggested that the following might be a realistic estimate.

TAS 1 - 2
SA 1 every 2 - 3 years
NSW 1 every 1 to 2 years
VIC 1 every 2 years
NT Training requirement could not be met currently
WA 1 per year for the next 2 years
QLD No funding in Townsville
NZ

Retirement

Under the stewardship of Dr John Knight, Editor of the South Pacific Underwater Medicine Society (SPUMS) Journal since 1990, the quality of the journal has continued to improve. And, largely through his hard work, the Journal was accepted for indexing by Embase, Excerpta Medica database (published by Elsevier Science), in January 2001. Before taking up the post as Editor, John had been setting up the journal for publication since 1979. The journal is internationally well received as is illustrated by the fact that, at the 2002 UHMS Meeting, Dick Clarke spoke on "A Hyperbaric Medicine Literature Update" and stated that "perhaps the single most consistently valuable resource for clinicians practising diving medicine has been the Journal of the South Pacific Underwater Medicine Society (SPUMS Journal). This journal (published quarterly) literally teems with information essential to the evaluation and treatment of decompression accidents". After nearly 23 years, John finally decided to retire as Editor. We wish him a happy, healthy and fulfilling retirement. However, he is still active as the Victorian representative on the SIG and the Chairman of Standards Australia in Diving and Hyperbaric Medicine.

Appointments

The Chairman and the Executive Members of the SIG extend their congratulations to those members who have been appointed to the various diving and hyperbaric organisations.
The new Editor of SPUMS Journal is Dr Mike Davis of Christchurch.

Dr David Smart has been elected as Chairman of the Australian and New Zealand Hyperbaric Medicine Group (ANZHMG) and Dr David Wilkinson as the Honorary Secretary.

Dr Simon Mitchell has been appointed to the Editorial Board of the Journal of Undersea and Hyperbaric Medicine, the premiere journal in the field. He is also the Member at Large of the Executive Committee of the Undersea and Hyperbaric Medical Society Inc USA and continues to be a member of the Adjunctive Therapy Committee of the same organisation.

Dr Mike Bennett is serving as Vice President of the Undersea and Hyperbaric Medical Society and continues to serve on the Hyperbaric Oxygen Therapy and Education Committees of that organisation.

Dr Robert Wong continues to serve on the Editorial Board of the Journal of Undersea and Hyperbaric Medicine.

Robert M Wong
Chair

Welfare of Anaesthetists

Executive

The SIG Executive currently comprises:

- Dr Rob Burrell  NZ
- Dr Mary Cardosa  Malaysia
- Dr Margie Cowling  SA
- Dr Genevieve Goulding (Chair)  Qld
- Dr Di Khursandi  Qld
- Dr Greg Purcell  NSW
- Dr Lindy Roberts  WA
- Dr Maurice Vialle  Tas
- Dr Jack Warhaft  Vic

Co-opted members:

- Dr Gretel Davidson  GASACT
- Prof George Mendelson  RANZCP

This has been another busy and successful year for the Welfare of Anaesthetists SIG.

Welfare issues continue to have a profile in both the College's and the ASA's Scientific Meetings and the ANZCA Part II Examinations.

At an Executive Teleconference in July, Dr Diana Khursandi stepped down from her position as inaugural Chair. Dr Genevieve Goulding has now succeeded her. The SIG would like to formally acknowledge Dr Khursandi for her drive and enthusiasm, which led to its formation and for leading it to its current position.

Continuing Medical Education

The group has availed itself of every opportunity to contribute to scientific sessions or conduct workshops at major anaesthetic meetings.

- In May 2002, at the ANZCA ASM, Brisbane, two workshops were conducted, one on Impairment and the other on Career Choices and Lifestyle. Both workshops were very well attended and there has been excellent feedback.
- Victorian State CME Meeting, Melbourne, themed 'Welfare and the Anaesthetist': Both Dr Warhaft and Dr Goulding were invited speakers at this meeting.
- A session on Retirement issues was held at the ASA NSC in Adelaide, October 2002.
- Sessions have been booked for the College and ASA major meetings in 2003, topics to be decided.

Action Plans

The Action Plans have been reviewed by the three parent bodies and minor changes suggested, which may be incorporated when the documents are reviewed by the SIG.

Following a request in 2001, a disclaimer was drafted with advice from the College solicitor, Mr Michael Gorton, and this has been added to the text of the Action Plans.

Parent Secretariat

The Welfare of Anaesthetists Group nominated ANZCA to be its parent secretariat provider in 1998 for a period of six years. Helen Morris has provided efficient, professional and thorough service in this role since the SIG's inception. At its Executive meeting in July, the SIG acknowledged Helen's contribution and voted to continue with the current arrangement.

Professional Diversity Survey

AMWAC figures show that the proportion of female anaesthetists has increased over the last few years. WOAG research and feedback from some of the workshops also suggests that lifestyle issues feature prominently in choice of anaesthesia as a career, both in males as well as females. This could have major implications for future workforce planning.

Accordingly, it has been decided to repeat Dr Khursandi's gender-based survey from approximately ten years ago.

The ASA has very kindly agreed to assist with the distribution and analysis of this survey and it is anticipated it will be mailed along with the Society's annual subscription notices in December 2002. The membership renewal already contains a demographic and workforce questionnaire. It is hoped that a few questions on health and lifestyle issues may also be included.

Abbott Australasia has provided some funding to assist with the costs of the statistical analysis, which hopefully will utilise scanning technology.

Outstanding Projects and Future Directions

i) Development of a Statement on Impairment
ii) Review and updating of the SIGs Action Plans and Reading List

Bulletin Vol 11 No 4 November 2002
iii) Clarification of QA indemnity status

iv) Selection of themes/topics for sessions at major meetings 2003

v) Executive member representing Hong Kong yet to be found

vi) Development of CME Modules for ANZCA Syllabus

vii) Development of research topics suitable for Trainees' Special Projects

viii) Development of generic lectures eg in a Powerpoint format, suitable for distribution to Departments to assist with tutorials on welfare topics

Genevieve Goulding
Chair
Fitness to drive after Anaesthesia

The National Road Transport Commission is updating its publication "Assessing Fitness to Drive for Commercial Private Vehicle Drivers", to be released in 2003. It is an extensive document which contains specific reference to Anaesthesia, Alcohol and Drugs (I illicit, Prescription and Over the Counter), as well as to issues relating to Cardiovascular Disease, Diabetes, Epilepsy, Psychiatric Disorders, Sleep Disorders, Vision and Eye Disorders and many other disorders.

Of particular relevance to Anaesthetists are the following statements:

"Post anaesthesia, both physical and mental capacity may be impaired for some time, thus affecting an individual’s ability to drive. This is applicable to both general and local anaesthesia. The effects of general anaesthesia will depend on factors such as the duration of anaesthesia, the drugs administered and the surgery performed. The degree of effect of local anaesthesia on driving ability is dependent on dosage and region of administration. A further factor to consider is the effects of analgesics and sedatives".

"In cases of post-operative recovery following surgery or procedures under general or local anaesthesia, it is the responsibility of the surgeon and anaesthetist to advise patients not to drive until physical and mental recovery is compatible with safe driving. Following minor procedures under local anaesthesia without sedation (eg. dental block), driving may be acceptable immediately following the procedure. Following brief surgery or procedures with short acting anaesthetic drugs, the patient may be fit to drive after a normal night’s sleep. After longer surgery or procedures requiring anaesthesia, it may not be safe to drive for 24 hours or more".

Reference:
Lichtor I, Alessi R, Lane B, "Sleep tendency as a measure of recovery after drugs used for ambulatory surgery". Anesthesiol. 2002; 96 : 878 - 883

GARRY D PHILLIPS
Director of Professional Affairs

Admission to Fellowship by Election

The following were admitted to Fellowship:

Under Regulation 6.3.1(b)
Alison Margaret Berry, Queensland
Pieter Wilhelm Hattingh, Queensland
Marian Michelle Hussey, New Zealand
Mark Alan Kaplan, New South Wales

Under Regulation 6.3.1(c)
Alexander Laird Gillies, Victoria
Stephanie Phillips, New South Wales

Honours

The ANZCA Medal was awarded to:
Dr Margaret Smith, OBE, New Zealand

ANZCA Council Citations were awarded to:
Dr Alan John Board, Queensland
Dr Alison Mary Holloway, Queensland
Dr Michael Bennett, New South Wales
The written section of the examination was held in all capital cities in Australia, Newcastle, Townsville, Auckland, Christchurch, Dunedin, Hong Kong, Kuala Lumpur, Singapore and Wellington.

The viva examination was held at The Prince of Wales and Sydney Children’s Hospitals, Sydney.

**SUCCESSFUL CANDIDATES**

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Overseas Trained Specialists Performance Assessment

The following candidates were successful at the recent Overseas Trained Specialist Performance Assessment and are yet to complete the requirements of the OTS Assessment Process:

<table>
<thead>
<tr>
<th>Name</th>
<th>State</th>
<th>Name</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen Lesley Ashworth</td>
<td>NSW</td>
<td>Helen Margaret Jeffrey</td>
<td>NSW</td>
</tr>
<tr>
<td>Chimene Bhar</td>
<td>NSW</td>
<td>Brian Francis McAweaney</td>
<td>NSW</td>
</tr>
<tr>
<td>Sarah Louise Green</td>
<td>NSW</td>
<td>Mohan Nerlekar</td>
<td>TAS</td>
</tr>
<tr>
<td>Catherine Anne Caldwell</td>
<td>NZ</td>
<td>Robert Daren Rix</td>
<td>NSW</td>
</tr>
<tr>
<td>Bernd Froessler</td>
<td>SA</td>
<td>Daniel Andries Roux</td>
<td>QLD</td>
</tr>
</tbody>
</table>

Overseas Trained Specialists Performance Assessment – 2003

<table>
<thead>
<tr>
<th>APRIL/MAY</th>
<th>LOCATION</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>WRITTEN SECTION</td>
<td>All Major Centres</td>
<td>7 April 2003</td>
</tr>
<tr>
<td>ORAL SECTION</td>
<td>Melbourne</td>
<td>23-25 May 2003</td>
</tr>
<tr>
<td>CLOSING DATE</td>
<td></td>
<td>10 February 2003</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>AUGUST/SEPTEMBER</th>
<th>LOCATION</th>
<th>DATE</th>
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<tbody>
<tr>
<td>WRITTEN SECTION</td>
<td>All Major Centres</td>
<td>4 August 2003</td>
</tr>
<tr>
<td>ORAL SECTION</td>
<td>Sydney</td>
<td>19-21 September 2003</td>
</tr>
<tr>
<td>CLOSING DATE</td>
<td></td>
<td>10 June 2003</td>
</tr>
</tbody>
</table>

The examination fee of A$1,900.00 is to be remitted in Australian dollars by bank draft, personal cheque (in Australia) or credit card directly to College Headquarters by the examination closing date, together with completed OTS Performance Assessment Application Form.

Closing Date For Applications

Please note that the College will not accept any applications to present for the OTS Performance Assessment after the closing date. This ruling must also apply to documentation in support of the application.

Undergraduate Prize in Anaesthesia

The recipient of the 2001 ANZCA Prize for the University of Auckland was Dr Angela Fraser. Dr Fraser was presented with her Prize during the Auckland Single Theme Meeting held in March.
Errata - ANZCA Bulletin Vol.11 No3 September, 2002

Inaugural Renton prize winner, 1958, Dr Vera Gallagher

In the publication "50 Years of the Faculty and College of Anaesthetists" Dr Vera Gallagher, the Inaugural Renton Prize Winner, was identified from Queensland. This is incorrect; Dr Gallagher presented for her Primary Examination from New South Wales and has practiced in that State most of her professional life.

The September 1958 Primary Examination had a candidature of 25, with six successful, Dr Gallagher being the only successful female.

Dr Gallagher recalls the late Professor Douglas Joseph was delighted that this Inaugural distinction went to a New South Wales candidate.

Cecil Gray prize winners

October 1982 – Allan Douglas Forbes Mackillop, QLD
May 1983 – Bernard Xavier Kehoe, QLD

Dr MacKillop was recorded as resident from New South Wales and Dr Kehoe resident in Western Australia

Gifts to the College

"An antique Sheffield plate on copper basket with swing handle in the Adam style, circa 1790 - donated to the College by Dr Susan Kelly in memory of Dr Loraine Hibbard 1916 - 2002, Emeritus Consultant, St George Hospital, Kogarah."

Dr Michael Hodgson, ASA President, presenting Dr Willis with a German "Kieninger" wall clock on behalf of the Society, on the occasion of the opening of ANZCA House.

"Endoscopy of the Airway"

Professional Document PS17 (1997)
Council withdrew this document at its October 2002 meeting.
ANZCA and Research – New Initiatives

Fellows will be aware that the image of a medical specialty in the eyes of the public and governments is significantly influenced by successes in research. This is particularly so if research gains media attention because of potential or actual improvements in patient care.

Judged against the largest Colleges, ANZCA has not fared well in gaining NHMRC funding, although there have been notable successes over the last years. (For an example see the related articles on Paul Myles and his large Clinical Research grant and the Basic Research award to the Pain Management and Research Centre.)

ANZCA Council, on the recommendation of the ANZCA Research Committee has decided to give research in Anaesthesia, Intensive Care and Pain Medicine a major boost by means of:

- Increased direct research funding by ANZCA. This will be achieved by fundraising activities of the ANZCA Foundation which now has a Board comprised of prominent members of the Community (this will be discussed in a forthcoming article in the Bulletin).

- Increased support in developing grant submissions with the aim of increased NHMRC grant success rate (and success with other Bodies).

- Development of an ANZCA Multicentre Clinical Trial Secretariat – this will be the main focus of this article.

A working party has been appointed by ANZCA Research Committee to consider whether an ANZCA Multicentre Clinical Trial Secretariat would benefit research by ANZCA Fellows, and if so, how would such a resource operate?

All Fellows are now invited to provide input to ANZCA concerning:

- Their views on the value of such a resource;
- Suggestions for infrastructure required; and
- Suggestions for most effective mode of operation.

To date, the Working Party has met only once so it is a good time for Fellows to provide input. The following is a summary of the main areas of discussion to date:

- It is increasingly agreed that important questions in clinical care frequently require large multicentre studies to achieve sufficient power, so that a definitive answer will be provided by the study.

- Such well designed multicentre studies have a much higher chance of obtaining funding (eg NHMRC funding for the Master Trial and recently for the Enigma Trial) compared to smaller, lower powered studies at single sites.

- An ANZCA Multicentre Trial Secretariat (AMTS) would provide an excellent opportunity to increase participation of ANZCA Fellows in Clinical research - partly funded by ANZCA, but increasingly by NHMRC and other bodies including the N.I.H, USA.

What would AMTS do?

- Develop a ‘core group’ of highly experienced clinical investigators (including those with epidemiology qualifications).

- Utilise the core group to receive from ANZCA Fellows, and to develop, key questions of clinical importance, suitable for multicentre studies.

- Retain involvement of ANZCA Fellows who propose key questions and develop protocols for multicentre studies.

- Develop the sites for multicentre studies, in collaboration with ANZCA Fellows.

- Formulate research submissions for funding (eg by NHMRC)

- Guide proposals through various institutional Ethics Committees.

- Provide centralized expert resources for:
  - Randomization of study subjects
  - Receipt and management of data
  - Study site monitoring
  - Data analysis and manuscript preparation for publication.

- In all of the above, maintenance of strong involvement of ANZCA Fellows conducting the research at the study sites.

What type of resources might ANZCA provide?

The Working Party draws upon experiences of some members with a U.S based group run by Prof Dan Sessler ‘Outcome Research Group’ Prof Sessler has generously offered to help ANZCA in the setting up phase and then to collaborate with ANZCA. Based upon the experience of Outcome Research and the Working Party’s input, the following resources seem likely to be needed:

- A ‘core group’ as described above, with leadership that would probably be a rotating position.

- A Research Administrator/Data Manager

- A Biostatistician – possibly on a contract basis
- Appropriate equipment to receive faxed data and then to process via computer by direct linkage
- Some type of University affiliation, with the aim of lending academic weight to the AMTS. (Not yet clarified by the Working Party)

Where to go from here?

ANZCA Council has supported the development of AMTS in principle. Further consideration will occur soon, so the input of Fellows now is important.

The Working Party will hold a videoconference in February 2003 and a face-to-face meeting during the ASM in Hobart in May 2003.

This initiative represents a major opportunity to boost clinical research by ANZCA Fellows, to raise the profile of our specialty and to assist the ANZCA Foundation in attracting funds for all types of research by ANZCA Fellows (basic and clinical). So please, let us hear your ideas on this initiative.

Michael J Cousins
Chairman Research Committee
Vice President ANZCA

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**ANZCA Fellows NHMRC funding success:**

**PAUL MYLES AND JAMIE COOPER**

Assoc Prof Paul Myles has been awarded a prestigious NHMRC Practitioner Fellowship. This funds half of his salary allowing him to devote half time to research. The Fellowships are part of a work initiative by NHMRC to make it possible for clinicians with a research higher degree to devote substantial time to research.

Another of Professor Myles colleagues at the Alfred Hospital, Melbourne, Assoc Prof Jamie Cooper, an Intensive Care Medicine Specialist has also received an NHMRC Practitioner Fellowship.

Further signs of an upswing in NHMRC funding for clinical research is the award to Paul Myles of an NHMRC Grant of $465,000 (2003-2005) for a multi-centre clinical trial entitled “Valuation of Nitrous Oxide in the Gas Mixture for Anaesthesia; a randomized controlled Trial (The ENIGMA Trial). Paul Myles is joined in this study by collaborators Kate Leslie, Michael Paech, Brendan Silbert and Phil Peyton. The trial involves about twenty centres, with many ANZCA Fellows participating.

The aim of this trial is to investigate the effectiveness and safety of nitrous oxide (N\textsubscript{2}O) in anaesthesia. There are some compelling reasons to question the routine use of N\textsubscript{2}O. Despite being the first anaesthetic drug introduced, and still widely used, there is sufficient doubt as to the risk-benefit profile. Level I evidence identifies exposure to N\textsubscript{2}O as a major risk factor in postoperative nausea and vomiting. It is clear that (even) brief exposure to N\textsubscript{2}O impairs methionine synthetase, DNA production, red and white blood cell formation. Tissue hypoxia may be more common. These adverse effects are enhanced in “sick” patients (ie. Those at highest risk, increased hospital length of stay and healthcare expenditure), and will be more likely in longer surgery. The extent of wound infection and cardiac morbidity associated with N\textsubscript{2}O is not known. Large outcome trial data are lacking.

Patients will be randomly allocated to either 70% N\textsubscript{2}O in oxygen (Fi\textsubscript{O\textsubscript{2}} 0.3) or oxygen with or without nitrogen (Fi\textsubscript{O\textsubscript{2}} 0.8-1.0). The study will take three years and will be the major focus of the Lennard Travers Professorship awarded to Paul Myles in 2002.
## 2003 Research Grant Awards

The following Research Grants for 2003, recommended by the Research Committee, were awarded by Council at the October Council Meeting:

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Amount</th>
<th>Project Description</th>
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<tbody>
<tr>
<td>Dr David Andrews (Vic)</td>
<td>$30,000</td>
<td>Blood cardioplegia enhancement with L-arginine and its effects on the ischaemic myocardium.</td>
</tr>
<tr>
<td>Professor Laurence Mather (NSW)</td>
<td>$46,000</td>
<td>New analgetic and anti-inflammatory treatment strategies related to NMDA receptor antagonism.</td>
</tr>
<tr>
<td>Dr Larry McNicol (Vic)</td>
<td>$25,000</td>
<td>Effectiveness of a combined post-operative pain and clinical intervention program.</td>
</tr>
<tr>
<td>Dr John Morgan (Qld)</td>
<td>$28,000</td>
<td>Optimal crystalloid strong ion difference for acute haemodilution to prevent dysoxia.</td>
</tr>
<tr>
<td>Associate Professor Paul Myles (Vic)</td>
<td>$36,000</td>
<td>A pilot study for the evaluation of nitrous oxide in the gas mixture for anaesthesia: a randomised controlled trial (the ENIGMA trial).</td>
</tr>
<tr>
<td>Dr Philip Siddall (NSW)</td>
<td>$30,000</td>
<td>Magnetic resonance imaging of the brain in patients with diabetic neuropathy and neuropathic pain.</td>
</tr>
<tr>
<td>Associate Professor Bala Venkatesh (Qld)</td>
<td>$25,000</td>
<td>Critical tissue oxygenation and acidosis: Implications for dysoxia and apoptosis in the critically ill.</td>
</tr>
<tr>
<td>Dr Russell Vickers (NSW)</td>
<td>$12,000</td>
<td>Development and validation of an analytical method for endomorphin-1, -2 using liquid chromatography - mass spectrometry.</td>
</tr>
<tr>
<td>Dr Rob Watson (Vic)</td>
<td>$10,000</td>
<td>Milrinone for the prevention of vasospasm during free flap surgery.</td>
</tr>
</tbody>
</table>

The Harry Daly Research Award was awarded to Professor Laurence Mather for his project "New analgetic and anti-inflammatory treatment strategies related to NMDA receptor antagonism".

The Organon Research Award was awarded to Associate Professor Paul Myles for his project "A pilot study for the evaluation of nitrous oxide in the gas mixture for anaesthesia: a randomised controlled trial (the ENIGMA trial)".
Lennard Travers Professor for 2003

The Lennard Travers Professorship was established by the Faculty of Anaesthetists, RACS in 1968 and is awarded quadrennially at the discretion of Council to provide support for a Fellow to work in an area of his/her choosing toward the advancement of knowledge in a nominated area of anaesthesia in Australia or New Zealand.

Council awarded the 2003 Lennard Travers Professorship of $30,000 to Associate Professor Paul Myles (Vic) “to encourage and develop the conduct of large, multi-centre clinical trials in anaesthesia to enhance collaborative projects in our region and improve evidence-based medicine”.

2003 Simulation/Education Grant Awards

The following Simulation/Education Grant awards for 2003, recommended by the Research Committee, were awarded by Council at the October Council Meeting:

**Professor Alan Merry (NZ)**
$18,825

A simulator model to evaluate safety interventions to reduce error in anaesthesia

**Professor Harry Owen (SA)**
$16,175

Developing valid and reliable assessment of airway management for caesarean section under general anaesthesia

Major NHMRC Award to Senior Member of University of Sydney RNSH Basic Pain Research Group

In early November 2002, the NHMRC announced that Professor Christie had been awarded an NHMRC Senior Principle Research Fellowship. This will pay Professor Christie’s salary for five years, allowing him to do full time research. The Fellowship has a value of approx $750,000.

In early 2003, Professor Christie will take up an appointment as Director of the Basic Pain Research Program in the PMRC. Professor Christie has an international reputation for his work on opioid receptors and ovolgivi tolerance ion channels and analgesia, cannabinoid receptors and analgesic actions. He holds numerous NHMRC and also NIH grants and is keenly interested in focusing on research of clinical relevance, and interaction with the PMRC clinical research group.

Michael J Cousins

Bulletin Vol 11 No 4 November 2002
Twenty new ANZCA fellows from Australasia and an invited anaesthetist from Papua New Guinea attended the new fellows conference held in conjunction with the ANZCA ASM 2002. The conference was held at O'Reilly’s Rainforest Guesthouse at Canungra, close to the Queensland/New South Wales border. With no television, radio, or mobile phone reception, this isolated venue provided the ideal location for the conference.

In keeping with the theme of the ASM, this meeting was convened around the 'challenge of change'. The Australian Medical Indemnity Crisis just weeks before the conference, and developments in New Zealand shortly afterwards highlighted the topics chosen as being issues that would confront anaesthetists in the near future.

The conference was divided into five ‘working’ sessions, each allocated a different topic to be discussed. Many of the topics discussed in one session had implications or were relevant to other sessions.

The first session looked at working hours, as applied to both fellows and trainees. Amongst the issues discussed were the AMA safe hours statement, and the implications that it would have for future training of anaesthetists. It was recognised by the new fellows that the expectations of working long hours had changed, and that patient and anaesthetist safety were becoming increasingly relevant.

The second session looked at rural and remote anaesthesia and intensive care, looking at the advantages and disadvantages of the practice of rural medicine, and the issues currently addressing this group of practitioners. It was noted the difficulty in determining the exact number of specialists working in various disciplines throughout Australia and New Zealand. The issues of covering other disciplines in rural hospitals was discussed, and the issues of attraction and retention of staff. CME remains a problem with isolated practitioners, and the role of the teaching hospitals in addressing this concern was discussed.

The third session discussed ethics as applied to Anaesthesia, Intensive Care, and Pain Medicine. After general discussion, three specific situations were discussed: major operations in the elderly, new surgery, and anaesthetising for the surgeon with borderline results. Possible strategies for dealing with these situations were discussed.

The fourth session looked at the health system, and the role of continuing medical education. Discussion focussed on who controls the health system, risk management, and methods of continuing education. It was noted that workshops were becoming increasingly favoured as a method of continuing medical education, and the cost and personnel implications of running workshops as opposed to traditional didactic teaching, were significant.

The fifth session was a debate entitled ‘Should we introduce nurse anaesthetists into Australia and New Zealand?’. Both the debate and the discussion afterwards focussed on factual rather than emotional issues, and raised the question from some delegates as to whether we should pre-empt what some see as inevitable.

In addition to these sessions, there was also time for relaxation, with a late afternoon walk through the rainforest to enjoy a magnificent sunset.

It is important to reflect on the value of the New Fellows' Conference. Although there were many issues discussed, there were no easy solutions found to the problems. This is to be expected, in that if there were easy solutions, these topics would not need to be discussed. It did however provide a forum for the new fellows to become aware of issues that will increasing impact upon the profession in the near future. There was also the opportunity to discuss the way departments, training, and anaesthesia is managed in the different regions. Lastly, there was the fellowship that occurred amongst the delegates, an important part of working in what can be a relatively isolated medical profession.

The new fellows would like to thank the Queensland Regional Committee for organising the conference, in particular Dr Gerard Handley and Dr Chris Anstey for convening the meeting; the college councillors in residence Dr Tony Weeks and Dr Ranald Pascoe; and the then President of the College Professor Teik Oh and the current Dean of the JFICM Dr Felicity Hawker for visiting the conference, and the College for sponsoring what was considered a very worthwhile event.

Andrew Gardner
The Cecil Gray Prize for the period ending 31st December 2002 was awarded to Dr Robert Andrew Gordon Gray of Queensland.

In line with Council's decision to recognise candidates who have achieved excellence in their examination results, the following candidates were awarded a Merit Certificate for their performance at the September 2002 Final Fellowship Examination.

Amanda Jane Harvey  
David Andrew Costi  
Paul John Gardiner  
Jeremy MacFarlane  

QLD  
SA  
NZ  
WA
Obituaries

Dr Cecil Dixon
South Australia FFARACS 1966, FANZCA 1992

Cecil Dixon died, aged 69, on the evening of Thursday, 21st February doing one of the many things he loved: shopping at the market for ingredients for another gourmet delight.

Cecil was born in Gateshead Newcastle, the eldest son of a Newcastle miner, and after being educated there, won a scholarship to attend at the University of Birmingham. He graduated in Medicine in 1956 after a busy and social university career during which time the Dean of the University is reported to have said to him “Ability alone, Dixon, will not get you through this medical school”. He obtained his Diploma of Anaesthesia in the UK in 1960 and arrived by assisted passage to Australia. He was appointed RMO at the Cairns Base Hospital where, because of his qualifications, took over the provision of anaesthetics to the hospital. In 1962 he entered private practice as a general practitioner and was appointed visiting anaesthetist to the Cairns Base Hospital. As well as being the only specialist anaesthetist, he established a colourful local reputation for enjoying life to the full. It is an indication of his intellectual capacity that during this time in private practice he obtained the FFARACS by examination, passing both parts at the first attempt. He was an enthusiastic and painstaking teacher of the junior resident staff and in later years he reflected with pride that his influence at that time spawned the careers of three people in particular, two of whom held high office both in ANZCA and the ASA, and the third became the Director of a major pain unit.

He moved to Adelaide in 1967 to a Staff Specialist position at the Royal Adelaide Hospital. Here with his colleague and friend Dr V Dreosti, he initiated the trainee tutorial system which has developed into the current extensive and successful anaesthetic trainee educational program that it is today. He was subsequently appointed to Visiting Medical Officer positions at Repatriation General Hospital and Flinders Medical Centre where he was an inaugural member of the anaesthetic team. He continued his teaching and professional interests of regional analgesia techniques and the development of day surgery.

He subsequently moved into exclusive private anaesthetic practice and continued to pursue both professional and private life with his usual intense enthusiasm.

The surgeons with whom he worked closely, and who became his close personal friends, could expect no less than 100% commitment to both patients and his anaesthesia. During this time he was Secretary of the South Australian branch of the ASA, but there is no doubt that his overriding professional interest was in providing a meticulous clinical anaesthetic service, including both pre and post operative visits and assessments. He was the first anaesthetist in Adelaide to provide patients with a comprehensive information brochure about anaesthesia. As mentioned previously, teaching was yet another love and he was pleased and proud that he had influenced so many people to embark on a career in anaesthesia.

In 1981 he married his third wife, Helen, and they had a long and loving relationship. He achieved all of the above despite experiencing angina intermittently for twenty years (which he regarded as particularly irritating), one cardiac arrest, one quadruple and one double cardiac bypass procedure and with his history and a disabling arthritic condition he was eventually forced to retire from work in 1996, but in no way retired from the enjoyment of life.

During his life he was admired for being able to complement his professional life with an ongoing love of and enjoyment of family, good friends, fine cuisine (at which he was most adept) and fine wine. He leaves a loving wife, a son Tom, and an extended family. The sympathies of all his friends and colleagues go out to them. No more appropriate quotation could echo our feelings than that which appeared as an epitaph on the family death notice – “He will be missed”.

I am indebted to Assoc Prof David McConnel for his help and recollections.

Bruce Rounsefell
Dr Loraine Claire Hibbard  
New South Wales, FFARACS 1961, FANZCA 1992

Loraine - 'with one r' - Thompson was born into a family of teachers in 1916. It was a household of devout Presbyterians who loved reading, music and poetry. It gave her a faith that sustained her, an appreciation of good literature and a mind well stocked with quotations.

She was Dux of Haberfield Public School, Dux of Fort Street Girls' High School and went on to win one of the few exhibitions available to Sydney University in 1931. She planned to study for a BA degree and teach like her parents, but it was the depth of the Depression and the Education Department would or could not guarantee a teaching post at the end of the course. With one wage and four children in the family, the uncertainty was too great; she gave up her exhibition, a cause for great regret, and accepted a teacher training course at Sydney Teachers College instead. This gave her a stipend and a bonded job at the end.

She taught for some ten years in city and country schools. Whilst teaching in Albury in 1941, she met Ray Hibbard, a Lieutenant in the Armoured Corps. They married in 1942 and he returned to active service. He was never to return, dying of wounds incurred in a battle at Wewak in 1945. 

This tragic event changed her life and she sought a new direction. In 1946, she enrolled in Medicine at Sydney University, helped by a scheme for returning soldiers and their dependants. It must have been a fascinating year, with a mixture of returning service personnel, older students such as Loraine and school leavers. Their graduation year book makes compelling reading as an historical and social document. It could not have been easy to return to science subjects that she had last studied some 10 years previously, but her determination was rewarded with the prize for Zoology at the end of first year.

After graduation in 1951, Loraine spent two years as a resident at St George Hospital before embarking on post graduate training in Anaesthesia. In 1954, she went to Melbourne for further training with Dr Greta McClelland and Dr Kevin McCaul. It was unusual to travel interstate for training in those days, and overseas training was especially difficult for a woman; ships were few (no one flew) and jobs were not easy to arrange - a far cry from today's sponsored exchanges.

She returned to St George Hospital in 1956 with the DA as an Honorary Anaesthetist, and began private practice in the Hurstville area in the Hodge-Morgan group. After the formation of the College, she obtained her FFA in 1961.

For those unfamiliar with the term 'Honorary', it meant just that! Doing lists, teaching students, residents and nurses, serving on committees without remuneration whilst picking up private work along the way. There were fewer registrars, so the on-call commitment was onerous. Often only very junior staff were available to help, so fortnightly on-call and private call meant a busy week. Most private hospitals required you to bring your own equipment - gas cylinders, drugs, and even a machine. Those were the days!

Loraine's main public hospital commitment was St George and it was here that she patiently taught generations of junior and senior residents basic anaesthesia. Graduates of those terms are now to be found in all branches of Medicine, and include two Professors of Anaesthesia.

Her example and practice were remarkable. Trainees learnt safe careful anaesthesia with attention to detail and total concern for the patient's welfare.

Long before the word mentor became fashionable, Loraine showed and taught how the complete professional behaved. Dress, approach to patients, seriousness about work were all part of the picture. It included premeds on Sunday, punctuality, and careful record keeping, and your failings were politely conveyed to you as a resident.

Loraine loved good English and lively conversations turned into battles of quotations. Grammatical errors were firmly corrected with the understanding that precision in speech was part of the professional approach.

She was always interested in people; patients adored her, and she encouraged shy residents to speak out in the tea room where life was much more formal than today.

She taught us to be organised and careful in our anaesthetic planning and her quiet voice and calm presence in times of stress in the theatre were an education for all. She was generous in supporting the junior staff, sometimes taking them to her holiday house and directing work to them as they started their practices. Above all, she was scrupulous and ethical in everything that she did.
Apart from all of this, she served on the usual hospital committees – no one could run a meeting like Loraine! Her equanimity was due in no small measure to her many outside interests – tapestry, cryptic crosswords, gardening, especially with Australian natives, music, her family and friends and reading, reading and reading. She was devoted to her mother and nursed her in her last illness.

She had a mastectomy in 1980 and was so organised that she arrived in hospital with a few empty vases. She thought she might receive some flowers. Her room resembled a florist shop.

In 1982, she gave up work completely, believing there was no place for a part-time anaesthetist.

Her retirement was frantic – learning Italian, coaching in French, teaching English to migrants from South America, travelling, reading books onto tape for the print impaired, looking after her neighbours and spoiling her many god-children.

No review of her life would be complete without emphasising her deep Christian faith and her fidelity to her upbringing. She embraced the Uniting Church with enthusiasm, was an active parishioner, an elder, and as chairman of committees her advice was often sought and thoughtfully given.

Her last years were blighted by illness which she bore patiently and with great dignity. She moved reluctantly to a retirement village with her books, radio, Herald crossword and her voluminous correspondence. She continued to coach students and welcomed visitors. Her final days were spent in a nursing home following a fractured neck of femur.

A link with the past has been lost, but such a life will be celebrated and remembered.

Susan Kelly
Barbara Slater
Final Oral Examination

SEPTEMBER 2002

Front Row: Drs Judy Branch, Maggie Bailey, Roman Kluger, Vanessa Beavis, Moira Westmore, Andrew Puddy, Kersi Taraporewalla, Michelle Mulligan, Brian Trainer, Mark Priestley, David Scott (Chairman), Megan Gray, Michele Joseph, A/Prof Tony Weeks, Drs Greg Purcell, Penny Briscoe, Philip Ragg, Leona Wilson, Mary O'Reilly, Ed Loughman, Tim Costello.

Back Row: Dr Michael Jones, A/Prof Vic Callanan, Drs Peter Gibson, Craig Morgan, Cameron Buchanan, Patrick Farrell, Michael Bujor, Vida Viliunas, Kerry Gunn, David Jones.

A/Prof. Tony Weeks presenting gift to Dr David Scott upon his retirement as Chairman, Final Examination Committee.
6TH ANNUAL REGISTRARS' AWARDS

A most successful 6th Annual Registrars' Meeting was held at College House in Brisbane on Saturday 9 November.

The 'Tess Cramond Prize' was awarded this year to Dr Cameron McAndrew. Emeritus Professor Cramond presented that prize.

The Axxon Health sponsored prize, named this year 'The Mary Daly Prize for 2002' was awarded to Dr Sean McManus and was presented by Dr Daly.

Dr Mary Daly presenting the Axxon Health Award for the Best Technical Presentation, named the Mary Daly Prize for 2002 to Dr Sean McManus

Professor Cramond presenting the Tess Cramond Prize to Dr Cameron McAndrew

Drs Johnathan Shirley, Sean McManus, Cameron McAndrew, Nicola Ackworth, David Probert and Tony Bergin, presenters at the Registrars' meeting.

Drs Anthony Kelly, Paul Mead and Martin Culwick attending the 6th Annual Registrars' meeting.
At the conclusion of the Joint Faculty's second Board meeting, Dr Felicity Hawker concluded her period as Dean. Having been intimately involved in the embryonic formation of the original Faculty, Felicity was able to draw on the corner stones established by Geoff Clarke and Alan Duncan to lead discussions and debate on the formation of a single training program and the Joint Faculty, which are now established. The Board congratulated Felicity on her significant achievements, and on behalf of all Fellows and the Board I thank her, and look forward to her continued involvement on the Board.

One important role for the new Board is to develop strategies to solve important manpower issues in our Specialty with regard to rural areas, numbers of Trainees and workloads. Fewer Australian graduates see Intensive Care as an attractive proposition and many Units rely on overseas Trainees. Rural Units are rightly asking for more support. The revisions of Joint Faculty Policy Documents IC-1 (Minimum Standards for Intensive Care Units) and IC-3 (Guidelines for Intensive Care Units Seeking Accreditation for Training in Intensive Care Medicine) will be the first step in establishing an acceptable framework. Work practice issues and provision of acceptable lifestyles are among a number of additional strategies for discussion.

The Joint Faculty has been involved in the ANZCA accreditation process by the Australian Medical Council, who have been reviewing our training and professional development programs. The review was an intense process involving on site visits to Intensive Care Units and to the College and Joint Faculty, and I look forward to sharing the outcomes.

In conclusion, as the new Dean I very much look forward to working with the Board, Regional and National Committees, and RACP and ANZCA Councils. I especially welcome our collaborative relationship with ANZICS and John Santamaria, ANZICS President. ANZICS and the Joint Faculty will be mutually supporting each other's distinctive roles, and strengthening initiatives in which there are common goals, scientific meetings being an example.

On behalf of the Board, I wish you all a happy and safe Festive Season.
EDUCATION

New JFICM Program

The Board received and considered correspondence relating to the new JFICM program. This proposed new program of 3 basic training years and 3 advanced training years is being further developed by Assoc Professor Jack Havill, Education Officer.

Role of Regional Education Officers

There has been much discussion about the role of Regional Education Officers and it is likely that this role will be downgraded or dispensed with as the role of Supervisors of Training is enhanced. To facilitate the work of Supervisors of Training an SOT Manual has been developed. In addition, it is hoped that SOT workshops will become a regular feature of the ASM.

The Role of the Senior Registrar

A survey was recently sent out by the Joint Faculty of Intensive Care Medicine to all Intensive Care Units in Australia, New Zealand and Hong Kong. The purpose of this questionnaire was to determine the prevalence of the Senior Registrar role in Intensive Care Units in Australia and New Zealand, as well as to determine how this role is defined in various units. It is also hoped that there will be some indication of the desirability of making a Senior Registrar position a part of the training scheme.

Medical Ethics

The Board reviewed a document detailing a postgraduate medical ethics course, to be run in conjunction with several other Faculties and Colleges. The concept of a course in medical ethics is supported by the Board and the concept of a modular course available to trainees and Fellows will be further investigated.

EXAMINATIONS

August/September 2002 Fellowship Examinations

The following candidates were successful at the August/September 2002 examinations:

- S Baker
- S Bhonagiri
- R Brockett
- G Comadira
- A Cross
- K Ellim
- J Johnston
- N Kavanagh
- N Orford
- L Padayachee
- J Shen
- M Ziegenfuss

Congratulations go to Dr Neil Orford, winner of the G.A.(Don) Harrison Medal for 2002.

ADMISSION TO FELLOWSHIP

The following were admitted to Fellowship of the Joint Faculty of Intensive Care Medicine by election under Regulation 5.1 for Foundation Fellowship:

- A. Ajani
- P.G. O'Callaghan
- C. Motherway
- P. Sargent
- P.G. Moore

Professor GSY Ong was admitted to Honorary Fellowship under Regulation 5.2 and Dr Michael Parr was admitted to Fellowship under Regulation 5.3.

PROFESSIONAL AFFAIRS

Assessment of Overseas Trained Intensive Care Specialists

The process for assessment of OTS's in Intensive Care is now well established and several overseas trained intensivists have been assessed via this pathway. An OTS assessment is conducted at the request of the AMC. Following assessment, the OTS is advised of the requirements to gain specialist recognition in Intensive Care in Australia and New Zealand. These requirements will usually include a period of supervised practice, and an examination.

Area of Need

The Board also reviewed the process of assessment of Area of Need (AON) posts. Applications for AON posts are ordinarily received from institutions, which are unable to or have difficulty filling positions.

AMC Accreditation

The Joint Faculty of Intensive Care Medicine recently underwent AMC accreditation. A final report on this accreditation visit is awaited.

CME/RESEARCH

Annual Scientific Meeting 2003 – Hobart

Planning for the 2003 ASM in Hobart is well advanced. The Foundation Visitor in Intensive Care will be Professor Dennis Maki. In addition, there are eminent Australasian and overseas speakers invited to the meeting. This promises to be an exciting event and all Fellows and Trainees are urged to attend.

The 2004 ASM will be held in Perth.

Results of a recent questionnaire to the Fellowship
Regarding the format of future ASMs are being considered.

Research
The Board congratulated the following Fellows who have been successful in their grant applications to the ANZCA Foundation:

Dr John Morgan, Qld
*Optimal crystalloid strong ion difference for acute haemodilution to prevent dysoxia*
$28,000

A/Prof Bala Venkatesh, Qld
*Critical tissue oxygenation and acidosis: Implications for dysoxia, and apoptosis in the critically ill*
$25,000

**INTERNAL AFFAIRS**

Finance
The Joint Faculty of Intensive Care Medicine continues to strive for financial independence. Based on the current Fellowship, and assuming receipt of annual subscriptions from all Fellows, a financially independent JFiCM is now a possibility.

Election of Regional/National Committees
Recent elections were held for regional committees of the Joint Faculty of Intensive Care Medicine. A list detailing the office bearers of the Regional Committees as ratified by the Board are printed elsewhere in this section of the Bulletin.

Constitution of the Board
The Board of the Joint Faculty of Intensive Care Medicine welcomed Dr Ranald Pascoe as the representative from Queensland and Dr Tony Bell as the representative from Tasmania.

The Board passed a resolution to amend the existing requirement for the Board to be constituted of ten Fellows, eight of whom were FFICANZCA and two of whom are FRACP. This requirement has been removed and replaced with ten ‘Fellows of the Joint Faculty’.

Following the resignation of the Dean from office, new office-bearers were elected. Dr Hawker remains an elected member of the Board.

Dean
Dr N.T. Matthews (taking office from 25th October)

Vice-Dean, Education Officer
A/Professor J.H. Havill

Censor
Dr R.P. Lee

Assistant Censor and Chair, OTS Committee
Dr F.H. Hawker

The remaining Board is constituted as previously:

Dr P.D. Thomas
Treasurer

Dr G.F. Bishop
Chairman, Rural Matters

Dr J. Gillis
MOPS Officer

Dr P.T. Morley
Chairman of Examinations

Dr J.A. Myburgh
ASM Officer

Dr R.F. Raper
Chairman, Hospital Accreditation Group and Co-ordinator of Advanced Training

Dr P.V. van Heerden
Assistant Treasurer and Communications Officer

Dr R.J. Willis
ANZCA Council representative and President

Dr N. Thomson
RACP Council representative

Communication
The Joint Faculty website is currently being revised and promises to be very informative. In addition, electronic mailing lists for Trainees and for Fellows will “go live” within the next few weeks.

A Careers booklet in Intensive Care is being developed for use by medical students and junior doctors. It is hoped this booklet will provide information to young medical graduates about a career in Intensive Care Medicine.
Results of JFICM Regional and National Committee Elections 2002

New South Wales
Chairman: E. Stachowski
Vice-Chair: Y. Shehabi
Hon. Secretary and Treasurer: G.F. Bishop, E. Fugaccia, D. Breen
Ex-officio Board Members: R. Lee, R. Raper, J. Gillis, J. Myburgh, I. Seppelt, J. Gowardman, M. Davis

Western Australia
Chairman: D. Simes
Deputy Chairman: C. Edibam
Hon. Secretary: B. Ng
Treasurer: B. Power
Ex-officio Board Member: P.V. van Heerden

Queensland
Chairman: R.L.S. Pascoe
Hon. Secretary and Treasurer: R. Boots
SOT Supervisors/Regional Education Officer: B. Venkatesh, C. Anstey, J. Morgan
Co-opted Member: D. Mullany

New Zealand National Committee
Chairman: R. Freebairn
Vice Chair: S. Henderson
Hon. Secretary and Treasurer: T. Williams
Ex-officio Board Member: J. Havill

Victoria
Election of office-bearers to be advised by D. Ernest, C. French, D. Green, F. Hawker

South Australia
Chairman: S. Peake
Vice Chairman, Regional Education Officer: R. Young
Hon. Secretary: G. O’Callaghan
Treasurer: E. Everest
Ex-officio Board Members: N. Matthews, P. Thomas

Board 2002


Australian and New Zealand College of Anaesthetists
Successful Candidates Fellowship Examination
AUGUST/SEPTEMBER 2002

From left to right: Drs Iain Johnston, Gregory Comadira, Marc Ziegenfuss, Rodd Brockett, Satyadeepak Bhonagiri, Niall Kavanagh, Judith Shen, Katrina Ellem, Neil Orford, Laven Padayachee, Anthony Cross and Stuart Baker

Winner of the G.A (Don) Harrison Medal 2002

Congratulations to Dr Neil Orford of Victoria, who is the recipient of the G.A. (Don) Harrison Medal for 2002.

This award was established by the Board of Faculty of Intensive Care, ANZCA in 1994, to be awarded annually to the candidate who achieves the highest mark in the Fellowship Examination in that calendar year, provided the candidate's performance is of sufficient merit. The award honours Professor Don Harrison, who has made outstanding contributions to education and to the development of the Intensive Care Examination.
STATEMENT ON THE ETHICAL PRACTICE OF INTENSIVE CARE MEDICINE

Professional codes and guidelines impose **ethical responsibilities** on Intensivists. In addition, Intensivists must be aware that they also have **legal responsibilities** relating to the ethical practice of Intensive Care medicine. This Statement is not intended to replace or supersede these ethical and legal responsibilities. It is the responsibility of each Intensivist to be aware of all ethical and legal requirements relating to their practice which have been recommended by their relevant professional and regulatory bodies. This document is intended to set professional standards of practice at the highest level and to document the ethical and professional responsibilities of Intensivists. It does not presume to inform Intensivists of their legal obligations.

The Joint Faculty of Intensive Care Medicine aims to maintain the highest standards of practice, teaching and research in Intensive Care. The Joint Faculty also recognises that the overall welfare of the patient is the principal goal of Intensive Care management.

The relationship between the Intensivist and the patient must have regard to the following concepts:

- **patient autonomy**, meaning the patients have the right to decide their own treatment, with Intensivists respecting the principles of truthful disclosure and informed consent;
- the principle of **beneficence**, or the obligation to do good;
- the principle of **non-maleficence**, or the duty to do no harm; and
- the principle of **social justice**, as it applies to the fair distribution of resources.

Other important ethical principles include:

- **Fidelity** (faithfulness) to duties and obligations. This principle underlies confidentiality, truthfulness, a commitment to ongoing education, vigilance and devotion to patient care.
- **Paternalism**, which may be justified or unjustified, but always tends to negate patient autonomy.
- **Utility** or the principle of achieving maximum benefits, with the best use of resources.

**Informed consent:**

Many Intensive Care patients, as the result of illness, injury or the side effects of medication, may not be competent to make legal decisions. Management must then fully involve the patient's legally recognised representative, unless precluded by an emergency.

1. **Patients' Rights**

Patients themselves (or through their legally recognised representatives) have the right to:

1.1 Expect that the services provided are of optimal quality and that they will receive the most appropriate care available.
1.2 Be treated with care, consideration and dignity including the respect for personal, religious, cultural and social beliefs.
1.3 When realistically possible, know the identity and professional status of all attending medical and other staff.
1.4 When realistically possible, be informed, with a clear, concise and understandable explanation of the principles of truthfulness, a commitment to ongoing education, vigilance and devotion to patient care.
1.5 Give verbal or written consent for a procedure, after explanation and before treatment, unless precluded by an emergency.
1.6 Know what services are available in the hospital.
1.7 Receive a second opinion when requested, without prejudice to any aspect of future treatment.
1.8 Be provided with appropriate information and give appropriate consent for involvement in teaching or research activities, and to understand that non-involvement will not prejudice treatment.
1.9 Refuse treatment without the requirement to justify that decision, and to be informed of the consequences of such refusal.
1.1 Expect that all aspects of care will remain confidential, including personal privacy relating to conversations and physical examinations.

1.11 Know the financial implications to themselves of therapy.

2. Patients' Responsibilities

Patients themselves (or through their legally recognised representatives) have a responsibility to:

2.1 Inform the Intensivist fully of all relevant medical history.

2.2 Consider the recommended treatment plan and if agreeable, comply with this plan or alternatively inform the Intensivist of their intention not to comply.

3. Clinical Research

When Intensive Care patients are to be involved in research, the Intensivist must recognise:

3.1 The need for further medical knowledge through research, but respect that the well being of the individual patient takes precedence over the proposed benefits to society.

3.2 The requirement for providing appropriate information and obtaining, where possible, written consent, whenever considered appropriate by Human Research Ethics Committees, before patient participation.

The Joint Faculty recognises that unconscious, semiconscious or critically ill patients from whom or on behalf of whom consent for treatment or other interventions cannot be obtained, because of the urgency of their condition, merit special attention.

4. Clinical Teaching

4.1 The Intensivist has an obligation to pass on professional knowledge to junior and other colleagues.

4.2 Whenever teaching involves elective situations or conscious patients, consent should be obtained from the patients themselves (or through their legally recognised representatives).

5. Professional Conduct

Intensivists should:

5.1 Conduct themselves at all times with integrity and honesty.

5.2 Accept responsibility for the physical and mental health of both themselves and their colleagues, especially when impairment of health affects patient care and professional conduct.

5.3 Participate in continuing medical education, and recognise the need for ongoing professional development.

5.4 Participate in the establishment and updating of appropriate professional standards.

5.5 Not undertake procedures and treatment known not to be of benefit to the patient.

5.6 Understand that the decision to withhold or withdraw treatment does not imply termination of care. Implicit in these decisions is an understanding of the ethical principles involved in “not for resuscitation” orders, orders related to foregoing life sustaining treatment, and care of the dying patient.

5.7 Comply with so-called “Privacy legislation” in Australia and New Zealand which relates to the disclosure of patient information to third parties.

5.8 Familiarize themselves with the relevant statutory requirements in Australia and New Zealand regarding refusal of medical treatment and the appointment of Medical Powers of Attorney, Enduring Guardians or equivalent.

These guidelines should be interpreted in conjunction with the following Documents of the Joint Faculty of Intensive Care Medicine and the Australian and New Zealand College of Anaesthetists:

PS 38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions


PS 45 (2001) Statement on Patients' Rights to Pain Management

Promulgated: October 1997

Revised: November 2002

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 document in each case.

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

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Faculty Website: http://www.jficm.anzca.edu.au/

Australian and New Zealand College of Anaesthetists
Dean's Message

Leigh Atkinson

Access to Multidisciplinary Pain Clinics

It is fortunate for most normal human beings that the experience of acute pain can within months fade into an eternity. This cannot be said for our patients with chronic recurrent pain or cancer pain. For each Fellow of our Faculty, the care of the pain patient is our focus. Yet young and old clinicians in Australia and New Zealand know that many of our needy patients face third world levels of access to multidisciplinary pain clinics.

Pain is the most common symptom that patients relate to their clinicians. Individuals in pain clog our court systems with endless litigation. Workers in pain frustrate our compensation systems. Patients beaten by the system retire prematurely to social security pensions and often an aimless existence.

Not surprisingly, in 1995 the Minister for Health Dr Michael Wooldridge, said chronic pain was one of the three most costly conditions for which health services were provided in Australia (1995 Norman Cooper oration). It was the migrant from Filicudi, John Bonica who alerted us to the fact that no individual clinician has the clinical and psychological reserves to manage alone, the chronic pain patient. Bill Noordenbos echoed the same sentiments; "These patients need access to multidisciplinary pain clinics".

In 1999 the International Association for the Study of Pain released the publication "Epidemiology of Pain". Countless worldwide studies were collected to establish the prevalence of pain in our communities. Michael Von Korff established that severe persistent pain has a prevalence of 8% while others rated it as high as 40%. Migraine varied between 2 and 50%. Back pain prevalence rated at 8-40%. One of our Fellows, Rob Helme found a prevalence of chronic pain in the aged at a level of 32-34%.

Fibromyalgia in another series varied between levels of 2-20%. Cancer pain occurred in 40% of our patients. These studies indicated levels of chronic recurring pain that calls for better management.

Despite this volume of facts in Australia the insurance companies, the work cover suppliers and the health departments have remained blind in many instances to the need for research and improved management. Health administrations have expanded their budgets for cardiac surgery, oncology and spinal fixation with doubtful evidence of the value of this change while multidisciplinary pain clinics have been neglected.

While in Western Australia and South Australia the major hospitals have a long history of pain clinics, the states of Victoria, Tasmania and to a lesser extent Queensland have avoided the problem of the chronic pain patient. Large teaching hospitals such as The Alfred and the Royal Melbourne Hospital in Victoria, the Royal Prince Alfred Hospital in Sydney and the Princess Alexandra Hospital in Brisbane have not found budget space for these services.

This is a generation after John Bonica first established the need for these clinics. Many of the established clinics in our public hospitals lack a budget for implantable pumps and electrical stimulators for the 66% of patients in the Australian community who are uninsured. The catchcry of universal access to health care begins to lose its credibility. On the other hand the 44% of patients insured in Australia have access to these implantable pumps and stimulators but the number of private pain clinics are small. The Medicare procedures do not allow conferencing of the different specialists involved in the management of these patients.

Hopefully, the decade of economic rationalism is coming to an end leaving us an opportunity to offer more accessibility for our patients to appropriate pain
management and real rehabilitation. We have a small Faculty of 150 Fellows and a growing number of graduates who need to work at the levels of their hospitals and health administrations in both Australia and New Zealand to improve access to the benefits of comprehensive multidisciplinary pain clinics.

Leigh Atkinson

References:

Successful Candidates at the 2002 Examination

Drs David Heathouse, Ming Chi Chu, Stephan Neff, Jennifer Morgan, Martin McNamara, Charlotte Wilsey, Alex Yeo (not in photograph: Pradeepa Gunawardane, Stephanie Keel, Nicholas Plunkett, Wai-Ning Tong)

Barbara Walker Prize Winner

Dr Jennifer Morgan with the Dean, A/Prof Leigh Atkinson

Admission to Fellowship

The following have completed all requirements for admission to Fellowship of the Faculty of Pain Medicine, ANZCA, by examination and were admitted by the Board:

Stephen Bruce Gibson  NSW
Henry Wai-Fung Lam  NSW
Highlights from the Board Meeting
HELD ON AUGUST 1, 2002

Education
MOPS
It is recommended that:
- initially the Faculty use the ANZCA template, to which all Faculty Fellows have access, including on-line, CD or paper.
- it be an annual return
- there be a total of 75 points per year of which 25 are in QA; the issue of QA requires further work (see below).
- Faculty Fellows be encouraged to participate in the Faculty MOPS Program
- the Faculty contact the participating Colleges to seek advice as to whether they would require Fellows who wish to participate in the Faculty MOPS Program also to complete the MOPS Program of their primary specialty College.

Psychological Assessment
This document now requires only minor modification before becoming an educational document and resource. The Board is indebted to Faiz Noore and Frank New, members of the Education Committee, for producing this excellent document.

Educational Materials
The Board noted the Education Committee is considering producing an audio-visual instrument mainly for the examination of behaviour and pain related signs in the pain patient.

Examination
The Board noted that arrangements are well under way for the examination preparation. Closing date for registrations is September 16.

Election to Fellowship
The Board resolved that an alternative pathway for Fellowship be introduced. This is to cater for individuals who have not had formal training in Pain Medicine during their primary specialty training and who are not in a position to enrol prospectively in the Faculty training program, but who have been actively engaged in Pain Medicine practice since obtaining their primary specialty Fellowship.

The following is to cater for individuals who:
1. Have not had formal training in Pain Medicine during their primary specialty training, and
2. Are not in a position to enrol prospectively in the Faculty Training Program, but
3. Have been actively engaged in Pain Medicine practice since obtaining their primary specialty Fellowship -
Individuals will not be required to undertake the full Faculty of Pain Medicine Training Program as outlined in Faculty Professional Document PM1 Guidelines for Trainees and Departments Seeking Faculty Approval of Posts for Training in Pain Medicine.

However, they will be required to:
4. Have been actively engaged in Pain Medicine practice for at least two years full-time equivalent since obtaining their primary Fellowship.

Applications for admission to Fellowship by Election, will be assessed to determine whether the criteria have been met or whether this alternative pathway may be offered, in which case the applicant will be additionally required to:
5. Register as a trainee and complete at least six months training prior to the examination. Such trainees must pay the registration fee but are exempt from the annual training fee.
6. Satisfy the following Summative Assessment criteria:
   6.1 A case report as outlined in the Training Manual.
   6.2 Examination pass as specified in the Training Manual.

This alternative pathway for admission to Fellowship will cease following the 2005 examination.

Professional Documents
The Board adopted Lumbar Epidural Administration of Corticosteroids as a Faculty document.

Hospital Accreditation
It was noted that some Pain Management Centres may require revisiting prior to the commencement of the 2003 training year if trainees are appointed to these units.

I Fleming will be holding a meeting within the next few weeks with the Directors of the various Pain Management Centres in Melbourne with a view to establishing a rotational training program.

Annual Scientific Meeting
Brisbane 2002
The Board noted the report from G Rice and congratulated him on organising the meeting.

Hobart 2003
A draft scientific program was developed.
Refresher Course

Arrangements have been made to hold this one day meeting on 2nd May, 2003 at the Old Woolstore, Hobart. A draft program was developed.

Dinner

It was noted that arrangements are under way to hold the dinner on Friday, 2nd May. A speaker from the Tasmanian Art Gallery is confirmed.

Combined Faculty/Acute Pain SIG Meeting

The Board agreed in principle to holding a combined Faculty and Acute Pain SIG meeting in 2003.

AMC

The Board noted the Centres the accreditation team will be visiting. It was noted that it was unfortunate that these visits coincide with the IASP Meeting is San Diego.

Performance Assessment

This document was adopted.

Composition of the Board

The Board adopted the following amendment to Administrative Instruction 1.1.1.1

Ten Fellows of the Faculty, elected or nominated in accordance with these Administrative Instructions, of whom at least four shall be Fellows of the Australian and New Zealand College of Anaesthetists (ANZCA), at least one shall be a Fellow of the Royal Australasian College of Physicians (RACP), at least one shall be a Fellow of the Royal Australasian College of Surgeons (RACS), at least one shall be a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP), and at least one shall be a Fellow of the Australasian Faculty of Rehabilitation Medicine (RACP) (AFRM RACP). The remaining two Fellows can be from any of the five participating specialties and are elected by gaining the highest number of votes.

2002 Court of Examiners

Back L to R: Prof George Mendelson, Dr Bruce Rouncefell, A/Prof Milton Cohen, Prof Robert Helme, Drs Carolyn Arnold, Paul Grazzitti, Matthew Crawford, Roger Goucke
Front L to R: Drs Penny Briscoe (Chair, Court of Examiners), David Gronow, A/Prof Leigh Atkinson, Prof Michael Cousins, Dr Lindy Roberts
1. INTRODUCTION

1.1 Persistent pain is an extremely prevalent problem, with an associated disability that is increasing exponentially in most developed countries \(^1,2\).

1.2 In all patients with severe persistent pain, appropriate evaluation requires assessment of physical, psychological and environmental factors in each patient \(^2\).

1.3 Treatment of only one dimension of the patient's pain may result in sub-optimal outcome.

1.4 Pain of spinal origin may be experienced in the back, legs or both. Leg pain of spinal origin may be either referred (eg from facet joint or disc) or may arise from nerve root involvement, termed lumbar radicular pain (LRP) which replaces the non-specific term "sciatica" \(^3\).

1.5 LRP has a number of causes \(^3\), some of which may be amenable to treatment of the underlying condition. Thus initial assessment should focus on distinguishing serious pathology ('red flag conditions' eg fracture, infection, tumour, cauda equina syndrome) from the more benign causes that constitute 90\% of cases.

1.6 Serious pathology must be excluded before LRP is treated symptomatically.

1.7 Lumbar epidural injections of corticosteroids (LEC) is one of the symptomatic treatments for LRP. This document refers to 'single shot' epidural injections performed either by lumbar (translaminar or transforaminal) or caudal routes. The risks appear to be similar for the various options, except that there may be an increased risk of infection with the caudal route, because of the closer proximity of potential sources of infection.

1.8 The document does not refer to the use of indwelling epidural catheters.

1.9 The concomitant injection of local anaesthetic epidurally poses additional risks regardless of the route of injection – such risks include total spinal anaesthetic. Thus cross reference to ANZCA Professional Document PS3 is essential \(^9\).

2 PRINCIPLES OF USE

2.1 LEC is an invasive form of treatment for LRP and should be reserved for patients whose pain is not adequately controlled by less invasive treatments.

2.2 Red Flag conditions and yellow flag conditions (major psychological and environmental problems) must be identified and, if possible, treated \(^2\).

2.3 There is evidence for the efficacy of LEC in patients with LRP \(^4,5\) (level II – III): numbers needed to treat (NNT) for short term relief of up to 2 months is 7.3 and for long-term relief of 3 months – 1 year is 13 \(^3\).

2.4 The evidence has largely been obtained from studies of lumbar epidural injection. Alternative methods include caudal epidural, extra (or 'pencil') foraminal injection or transforaminal injection.

2.5 There is no evidence that LEC is effective for back pain without LRP. The evidence for LEC in spinal stenosis indicates a very low success rate, particularly if neural claudication is the principal symptom \(^6\).

2.6 Anecdotal claims have been made about a potential of LEC to cause neurotoxicity and/or arachnoiditis, however there is no systematic evidence to support such claims \(^8\).

2.7 An NHMRC report of 1994 recommended that epidural steroid injections only be used for radicular pain, after informed consent has been obtained \(^8\).

3. METHODS OF ASSESSMENT

3.1 Radicular pain is defined as: "Pain perceived as arising in a limb caused by ectopic activation of nociceptive afferent fibres in a spinal nerve or its roots, or other neuropathic mechanisms" \(^3\).

3.2 Clinical features that may be used to identify patients with radicular pain include: neuropathic pain descriptors (see NHMRC 1999) \(^2\) and a pain radiation pattern that approximates to a narrow band, reminiscent of but not identical to the bands of dermatomes.
3.3 Appropriate assessment, as noted in 1.2 is necessary.

3.4 'Red Flags' if identified require further investigation (eg medical imaging) and assessment (eg neurosurgical)\(^2\).

3.5 Patients should be clinically reviewed after LEC with respect to pain relief, neurologic function and side effects. Patients should be instructed to report back if they experience any new symptoms.

4. CLINICAL USE OF LUMBAR EPIDURAL STEROIDS

4.1 The technique of LEC should only be carried out by medical practitioners with appropriate knowledge and training.

4.2 The doctor planning to perform LEC must take a history and examine the patient to determine that there are appropriate indications for LEC, and that there are no contraindications.

4.3 The procedure of LEC should be carried out in accordance with PS3 (Major Regional Analgesia)\(^9\) which is mandatory to the safe use of LEC. Attention is particularly drawn to the necessity for aseptic technique and the need for competency in advanced resuscitation and access to appropriate patient monitoring.

4.4 LEC should be avoided if there is concern about localised infection or systemic infection or coagulopathy. The added risk of infection should be considered in the diabetic and other immunocompromised patients.

4.5 The wisdom of repeating LEC should be questioned if, as a result of any previous injection, there is worsening of pain and/or deterioration in function.

4.6 Even if LEC provides relief, only in exceptional cases can more than 3 injections be justified in a 3 month period\(^6,8\).

4.7 Medical imaging may assist in needle placement for LEC, based upon patient factors, previous treatments (eg surgery) and the technique to be used.

4.8 There are potential complications of epidural steroid injections such as: epidural haematoma or abscess, nerve root and/or spinal cord damage, dural puncture headache; temporary increase in pain; steroid associated fluid retention or compression; elevation of blood sugar in diabetes; ACTH suppression and Cushingoid symptoms\(^6\), (see also 2.6).

4.9 Generally LEC should not be performed, without good reason, in patients whose conscious level is depressed by sedation, or whose mental state is impaired, making it difficult to determine if adverse effects are occurring during LEC.

4.10 If local anaesthetic has been injected epidurally in the LEC procedure, monitoring of cardiorespiratory and neurologic function is mandatory (see ANZCA PS3)\(^9\). In particular there should be assessment of lower limb motor function and ability to pass urine prior to discharging the patient from the procedure recovery area.

4.11 The patient must be given post procedure instructions, including a method of contacting the treatment team if a problem should arise. Follow up is essential (see 3.5).

5. FUTURE DEVELOPMENT

5.1 The precise mechanism for analgesic efficacy of LEC requires clarification. Current suggestions for efficacy in LRP include: (a) inhibition of ectopic discharge in areas of axonal damage in spinal nerve roots; (b) an anti-inflammatory effect against leaked disc material which triggers phospholipase activated arachidonic acid cascade.

5.2 Further controlled studies of LEC are required in relation to:

- Clearly defined patient populations with LRP
- Confirmation of placement of LEC in the epidural space
- Randomised prospective placebo-controlled double blind design
- Appropriate follow-up of pain, functional outcome and side effects
- Controlled studies to compare different techniques of LEC.

REFERENCES:

8. NHMRC "Epidural use of steroids in the management of back pain". NHMRC, Australia 1994
Footnotes:

1. Levels of Evidence Ratings

Level I Evidence obtained from systematic review of relevant randomised controlled trials (with meta-analysis where possible).

Level II Evidence obtained from one or more well-designed randomised controlled trials

Level III Evidence obtained from well-designed non-randomised controlled trials; OR from well-designed cohort or case-control analytical studies, preferably multicentre or conducted at different times

Level IV The opinions of respected authorities based on clinical experience, descriptive studies or reports of expert committees

NOTE: In this document Level III and above quoted.

2. NNT - NHMRC "Acute Pain Management" 1999 p.159
"The number of patients needed to treat to achieve eg 50% pain relief or more, which would not have been achieved with placebo".

3. This document must be used in conjunction with Australian and New Zealand College of Anaesthetists Professional Document PS3 (2001) "Major Regional Anaesthesia and Analgesia".

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.

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Promulgated: 2002
Date of current document: August 2002

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Faculty Website: http://www.fpm.anzca.edu.au
RECOMMENDATIONS FOR TRAINING AND PRACTICE OF DIAGNOSTIC PERIOPERATIVE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY IN ADULTS

INTRODUCTION
Transoesophageal echocardiography (TOE) is a complex monitoring and diagnostic modality requiring specific cognitive and technical skills. Indications for TOE in the perioperative period have been clearly stated by the Task Force of the American Society of Anesthesiologists and the Society of Cardiovascular Anesthesiologists (Task Force 1996). Information derived from a diagnostic TOE examination is made available to other medical practitioners and may be used to guide or assist their management decisions.

I. THE TRANSOESOPHAGEAL ECHOCARDIOGRAPHY EXAMINATION
A diagnostic TOE examination comprises:

1.1 A full diagnostic study including spectral and colour Doppler analysis (Shanewise, Cheung et al. 1999), unless this is not achievable in a specific clinical situation.

1.2 Pre and post bypass studies in those cases involving cardiopulmonary bypass.

1.3 Video-taping, or equivalent, of key elements of the investigation and archival storage of all study recordings.

1.4 A formal written report with patient identification and including the name of the person conducting the examination, with one copy archived and one copy in the patient records.

1.5 A mechanism for peer review of study recordings.

2. TRAINING
Appropriate training for the use of transoesophageal echocardiography in the peri-operative setting is essential. (Cahalan and Foster 1995; Savage, Licina et al. 1995) Training guidelines have been published by other organisations (Intercollegiate Consensus Statement; Cardiac Society of Australia and New Zealand; Cahalan, Abel et al. 2002)

2.1 Training should be under the direct supervision of experienced practitioners, who shall have met standards equivalent to those outlined in this document. Such training should include both performance and interpretation of TOE examinations with no concurrent clinical responsibilities for the trainee.

2.2 The period of training should be at least the equivalent of 50 days full-time (based on Intercollegiate Consensus Statement) over a minimum period of ten weeks to a maximum period of two years. An initial two week period of full-time training is strongly recommended.

2.3 During the period of training, the trainee should perform:

2.3.1 Initially, a number of supervised TOE procedures to achieve and demonstrate competence to perform and report complete diagnostic TOE examinations. This would usually be expected to require 50 complete examinations.

2.3.2 At least 50 unsupervised TOE examinations that have been reviewed with a supervisor.

2.3.3 At least 100 additional supervised reviews and reports of pre-recorded TOE examinations. The trainee must be exposed to a wide range of cardiovascular pathology and at least 50% of TOE examinations should be undertaken in the operating theatre.

2.4 Prior to completion of TOE training, practitioners are encouraged to use TOE in a clinical environment to further develop their skills. In such circumstances, diagnostic information should only be used with caution to guide anaesthetic management. Information gained from the TOE examination should only be used to guide or assist other medical practitioners in their management decisions in consultation with an experienced practitioner.

2.5 Attendance and participation in post-graduate courses, workshops and continuing medical
education programs dedicated to peri-operative TOE is strongly recommended during the training period and thereafter.

3. DOCUMENTATION OF TRAINING

3.1 A log book (or equivalent database) must be maintained during the training period to record:

3.1.1 the number and case-mix of TOE examinations performed and/or reviewed.

3.1.2 training courses attended.

3.2 The logbook should be available for review by a supervisor both during and on completion of the training period.

4. SAFETY

4.1 TOE is a semi-invasive procedure and appropriate skill and judgement is required when placing and manipulating the probe to reduce the risk of injury to the patient or damage to the probe.

4.2 If intraoperative TOE is performed by the patient's anaesthetist, an experienced assistant may be required to assist in monitoring patient parameters. This is particularly the case when there is the combination of a very unstable clinical situation and particularly complex TOE interpretation issues.

4.3 TOE must always be used in an environment where there are adequate facilities and staff to decontaminate and clean the TOE probe after use. There must be a documented protocol for cleaning the probe and a log to record compliance.

5. SUPERVISORS

Where trainees must be supervised and their reports reviewed by an "experienced practitioner", then such a practitioner must have documented training equivalent to that described in 2.1 to 2.5 or in 5.1 to 5.3. Supervisors must comply with Maintenance of Standards as specified in 6.

5.1 Medical practitioners who can demonstrate by log book or other verifiable means, 100 completed diagnostic TOE studies and have passed the Perioperative Transesophageal Echocardiography Examination (PTEeXAM) which is administered by the National Board of Echocardiography in the USA.

5.2 Practitioners who have satisfied the requirements of the Australian Society of Ultrasound in Medicine (Intercollegiate Consensus Statement 1995) and are regular practitioners of TOE in a tertiary medical institution.

5.3 Practitioners who have satisfied the requirements of the Cardiac Society of Australia and New Zealand for training in echocardiography.

6. MAINTENANCE OF STANDARDS

After appropriate training in transoesophageal echocardiography has been undertaken, practitioners must maintain appropriate standards of proficiency in TOE examinations. This should include:

6.1 Performance of at least 30 TOE examinations every year.

6.2 Reviews of at least 50 TOE study recordings with qualified colleagues every year.

6.3 Attendance and participation in post-graduate courses, workshops and continuing medical education programs on peri-operative TOE and related subjects.

REFERENCES


COLLEGE PROFESSIONAL DOCUMENTS

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Promulgated: 2002
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Supervisors of Training are the College's representatives on training in anaesthesia in its approved hospitals. They have an important role and must have a broad understanding and experience in College affairs. They provide liaison between trainees and Hospital authorities (in respect of matters related to training) as well as with Regional Education Officers and the central administration of the College.

1. APPOINTMENT AND TENURE

1.1 The Supervisor of Training in Anaesthesia shall be nominated by the Director of the relevant Department of Anaesthesia. The appointment shall be ratified by the College Council after receiving support from the relevant Regional/National Committee.

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

1.3 The appointee shall hold the Diploma of FANZCA or a comparable qualification acceptable to the College Council and should not be a candidate for any College examination.

1.4 The Department shall be responsible for notifying the Chief Executive Officer of the College of the recommendation for appointment.

1.5 The College Council, at its discretion and after consultation with the relevant Regional Education Officer, may not approve the appointment of the Supervisor recommended by a Hospital. In that case, the Chief Executive Officer shall notify the Hospital and request the recommendation of an alternative Supervisor.

1.6 The appointment of a Supervisor of Training shall be for an initial term of five years with a review by the Regional/National Committee after three years. Supervisors will be eligible for reappointment by the Council after advice from the Regional/National Committee.

1.7 In hospitals with a large number of trainees, the College Council may approve more than one Supervisor of Training.

2. DUTIES OF SUPERVISORS

2.1 Within the Hospital

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

2.1.2 To provide a list (on Forms RI and R2) to the Regional Education Officer with:

2.1.2.1 The names of all trainees in nominated by the Director of the relevant College approved posts.

2.1.2.2 The numbers of occupied service posts which are not approved by receiving support from the relevant Regional/National Committee. These lists are to be forwarded to the Regional Education Officer.

2.1.3 To notify the Regional Education Officer of any changes to the list referred to in 2.1.2.1 created by trainees joining or leaving the rotational training scheme during the hospital employment year. It is particularly important that the date of such changes is noted to allow independent verification of training by the Assessor.

2.1.4 To notify the Regional Education Officer of any senior staffing or workload changes likely to impact on training programs. To provide information when requested for a Hospital Data Sheet or for a Trainee Workload Survey.

2.1.5 To advise the Regional Education Officer if there are significant changes in their hospital such that it may no longer be suitable for training.
2.1.6 To advise potential and current trainees on their training, registration requirements, fee payments and examination preparation.

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

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

2.1.9 To liaise with the Director of the Department in respect of trainee duties, supervision, rest and study time and release for approved courses.

2.1.10 To oversee the Department's compliance with the College's requirements for In Training Assessment.

2.1.11 To complete and despatch promptly trainees' training certificates to the College with particular emphasis on the accuracy of the dates of specific training experiences or specialty attachments.

2.2 Within the Rotation
Within each rotation, one of the Supervisors of Training or another suitable person shall be nominated as the "rotational supervisor". The duties of the rotational supervisor are:

2.2.1 To monitor the progress of trainees within the rotation.

2.2.2 To monitor the sub-specialty experience offered by the hospitals in the rotation to ensure that the requirements of College Professional Document T1 are met, and notify the Regional Education Officer of any deficiencies.

2.3 Outside the Hospital

2.3.1 To establish and maintain liaison with the Regional Education Officer and with other Supervisors of Training.

2.3.2 To participate as a member of the Regional Education Sub-Committee.

2.3.3 To attend training courses for Supervisors of Training.

2.3.4 To refer any difficulties in respect of training programs or trainees to the Regional Education Officer.

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

2.3.6 To maintain a calendar of examination dates, and dates of closure for entries.

3. RESOURCES
The Supervisor of Training shall be provided by the Department with the resources needed to fulfil his or her responsibilities. In larger Departments this will require a time allocation of approximately one session per week.

Each Supervisor of Training should have:

3.1 Access to private space for meeting with Trainees.

3.2 Access to appropriate secretarial and administrative assistance.

3.3 Access to appropriate information technology.

3.4 Appropriate office equipment, including a secure cabinet to store trainee data.

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

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College Website: http://www.anzca.edu.au/
RECOMMENDATIONS ON ESSENTIAL TRAINING FOR RURAL GENERAL PRACTITIONERS IN AUSTRALIA PROPOSING TO ADMINISTER ANAESTHESIA

1. INTRODUCTION

There are areas of Australia where geographical circumstances preclude referral of certain types of surgery, and where there are no specialist anaesthesia services. Such areas require general practitioners (GPs) to be administering anaesthesia. Where possible, general practitioner anaesthetists should work in co-operation with resident and visiting specialist anaesthetists.

The College acknowledges the role of rural GPs by its membership of the tripartite Joint Consultative Committee of Anaesthesia (JCCA), in partnership with the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

The JCCA oversees the training, examination, and ongoing accreditation of rural GP anaesthetists. These practitioners must have appropriate training and must be administering anaesthesia safely. This training is fully outlined in the Rural Training Curriculum endorsed by the JCCA.

It should be clearly understood that this College Professional Document is not intended in any way to endorse, reflect on, or prejudice the issue of surgery being undertaken in rural and remote areas. Furthermore, the question of hospital facilities and infra-structure is crucial to this matter, and anaesthesia is only one of a number of considerations which must influence any management decisions to be made in the best interests of the patient.

2. OBJECTIVES OF TRAINING

The objectives of the training of rural general practitioners proposing to administer anaesthesia are as follows:

2.1 To provide general knowledge, experience, skills and competence in the management of common anaesthesia procedures, especially anaesthesia for obstetrics, in resuscitation, in pain management, and in the early management of severe trauma.

2.2 To provide specific knowledge and practical skills as they relate to a rural general practitioner anaesthetist, including relevant aspects of general medicine, surgery, pediatrics, obstetrics, intensive care and pain management.

2.3 To provide understanding and insight for decision-making about local management, further consultation and referral for anaesthesia and related procedures.

2.4 To develop skills to act appropriately as a member or leader of a therapeutic team, to contribute to the education of nursing, paramedical and medical staff, and to conduct clinical audits, research and quality assurance activities in their anaesthesia practices.

2.5 To ensure a commitment to self-directed learning and other forms of continuing education in anaesthesia, to adaptability to changes in anaesthesia practice relevant to safer management of patients, and to act according to ANZCA recommendations on rural general practitioner anaesthesia practice.

2.6 To foster a commitment to rural general practice anaesthesia where sufficient specialist anaesthesia services are unavailable.

3. TRAINEE SELECTION CRITERIA

The following criteria are recommended for selection of trainees:

3.1 Completion of two years of the Rural Training Program, which may have included a three month term in Anaesthesia, Emergency Medicine or Intensive Care.

3.2 Successful completion of the Early Management of Severe Trauma Course (EMST), the Effective Management of Anaesthetic Crises (EMAC) course, or a secure position within a future course.

3.3 Demonstration of relevant anaesthetic knowledge, skills and experience including, or similar to, a resident medical officer at the end of a term in anaesthesia.

3.4 Demonstration of a commitment to rural general practice, including experience of at least one term in rural general practice.
4. MINIMUM TRAINING EXPERIENCE

A minimum period of experience under instruction is required. This should preferably be part of the four year Rural Training Program of the Rural Faculty, Royal Australian College of General Practitioners. This experience should be:

4.1 At an accredited training post of the JCCA or a hospital accredited by ANZCA. [Some posts in the UK have been utilised for this training, subject to certain conditions being met by the trainee on returning to Australia.]

4.2 Of twelve or more months duration.

4.3 As per the curriculum requirements (Advanced Rural Skills Curriculum in Anaesthesia, Rural Faculty, Royal Australian College of General Practitioners). The curriculum is designed for two periods of attachment:

4.3.1 attachment to an anaesthetic department in a Rural Training Unit (nine months minimum), three months of which may have been in the first two years of the Rural Training Program;

4.3.2 three months of the twelve months may be an attachment to Accident and Emergency, Intensive Care, or a rural anaesthesia practice.

5. ACCREDITATION AND MAINTENANCE OF KNOWLEDGE AND SKILLS

General practitioners should maintain their anaesthesia skills and knowledge, by undertaking an on-going case-load, and by participating in Continuing Medical Education (CME) in the field of anaesthesia. This should be in accordance with the Maintenance of Professional Standards (MOPS) program(s) endorsed by the Joint Consultative Committee on Anaesthesia.

Relevant documents:

- Advanced Rural Skills Curriculum - Anaesthetics. Royal Australian College of General Practitioners; Rural Faculty Training program. April 1998
- Joint Consultative Committee on Anaesthesia: Quality Assurance and Continuing Professional Development Requirements; 2002-2004 Triennium

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STATEMENT ON ANAESTHESIA CARE OF CHILDREN IN HEALTHCARE FACILITIES WITHOUT DEDICATED PAEDIATRIC FACILITIES

1. INTRODUCTION

Anaesthesia for children is an area of practice in which the College strongly recommends specific training and experience. The College therefore recommends that a healthcare facility which is not dedicated to paediatric care but which proposes to manage children for anaesthesia and surgery should develop a policy which details criteria for management of anaesthesia, surgery and nursing care.

This policy should be developed and documented jointly by representatives of the anaesthesia, surgical and nursing staffs and should be reviewed at intervals of not more than five years.

It must always be recognised that the initial treatment of paediatric emergencies may be necessary in facilities and under circumstances where paediatric care is not normally provided. In this situation the child should be transferred to a specialist paediatric centre at the earliest opportunity.

2. FACTORS TO BE CONSIDERED WHEN DEVELOPING A POLICY INCLUDE:

2.1 Age. There should be a specified age at which any restrictions on management and referral policies come into effect. Children of less than 12 months of age are classified as infants and when less than 28 days as neonates. Risks associated with anaesthesia are greater in smaller children thus the policies are more likely to apply to infants and neonates.

2.2 Staff training and experience. Specialist anaesthetists are expected to have training in the care of infants and children. However individual anaesthetists may have varying recent experience in managing anaesthesia for children. They should not be required to provide anaesthesia care without regular clinical exposure to an extent necessary to maintain and be comfortable with their competence. It will often be of benefit for a second anaesthetist to be present, to act as a skilled assistant for the care of infants and children classified as ASA 3 or greater. Anaesthesia assistants and nursing staff providing care in the perioperative period must be trained in the care of children. Regular experience and tuition is essential if care of appropriate standard is to be provided. Sufficient numbers of staff must be available whenever children are managed in the facility. A liaison should be established with a specialist paediatric facility so that authoritative advice is available at all times.

2.3 Equipment and facilities. Anaesthesia equipment must comply with College Professional Document T1 Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites. Specific requirements will include:

2.3.1 Appropriate equipment for the needs of infants and children.

2.3.2 Climate control and equipment designed to meet the special needs of small children so that body temperature is maintained throughout the perioperative period.

2.3.3 Monitoring equipment which complies with College recommendations on Professional Document PS18 monitoring during Anaesthesia and is suitable for use with infants and children.

2.3.4 A separate ward area in the facility, staffed by appropriately trained personnel and able to cater for children and their families, separate from adult patient areas.

2.3.5 An area where the parents and child can be seen privately in the perioperative phase, to discuss any intraoperative surgical or anaesthetic issues.

2.4 Criteria for transfer to a Specialist Children's Hospital or Facility. The distance to the nearest appropriate centres will be an important factor in determining the need for transfer. The following groups of patients should be considered for transfer:

2.4.1 Neonates
2.4.2 Infants born at less than 37 weeks gestation and with a post-conceptual age of less than 52 weeks.

2.4.3 Infants with a history of apnoeic episodes.

2.4.4 Infants and children with unusual and/or complex medical or surgical problems classified as ASA3 or greater.

Related Documents
T1 Recommendations on Minimum Facilities for safe anaesthesia practice in operating suites.
PS18 Recommendations on monitoring during anaesthesia.

COLLEGE PROFESSIONAL DOCUMENTS
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TE Training and Educational
EX Examinations
PS Professional Standards
T Technical

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GUIDELINES FOR HOSPITALS SEEKING COLLEGE APPROVAL OF POSTS FOR VOCATIONAL TRAINING IN DIVING AND HYPERBARIC MEDICINE

1. GENERAL

1.1 A training post in Diving and Hyperbaric Medicine is one that has been approved by the College as appropriate to be occupied by a Diving and Hyperbaric Medicine trainee who is registered as such with the College.

1.2 Training posts will only be approved by the College if they comply with its educational requirements and are part of a recognised training program.

2. THE RECOGNISED TRAINING PROGRAM

2.1 A training program may involve a rotation between two or more hospitals such that the program can provide an appropriate range of experience of Diving and Hyperbaric Medicine.

2.2 For a single facility to satisfy the experience requirements of trainees, each trainee must be exposed to more than one Diving and Hyperbaric Medicine Physician who meets Australian Standard 4774.2.

2.3 Facilities recognised for training must have an annual case load of at least 20 patients with Diving Injuries and at least 40 with Non Diving Injuries.

2.4 Training programs will be regularly reviewed at intervals determined by Council. Hyperbaric Units will be visited by the College.

2.5 Additional posts will not be recognised without the prior knowledge and consent of Council. This will generally require the inspection of the hospital and consideration of the effect of the increase on the training program.

3. THE FACILITY

3.1 The recognised hospital must be under the direction of a senior qualified Diving and Hyperbaric Medicine Specialist who is responsible for the organisation, teaching and service requirements of that facility.

3.2 Training posts may be full or part-time but must include normal, emergency and out-of-hours duties. Part time posts are subject to the requirements of the relevant College regulations.

3.3 The number of posts approved will be specified with regard to the availability of experience and training.

3.4 There must be adequate supervision of trainees by specialist Diving and Hyperbaric Medicine Medical staff who hold the College Certificate or another qualification acceptable to Council. Specialist Diving and Hyperbaric Medicine Medical staff must be familiar with the College's training program.

3.5 Job descriptions for the Diving and Hyperbaric Medicine staff must be acceptable to the College.

3.6 When specialist Diving and Hyperbaric Medicine staff are appointed, the advice of a properly constituted committee capable of evaluating the applicants must be sought. College nominees for appointments committees may only assist with advice on the qualifications of applicants.

3.7 A Supervisor of Training in Diving and Hyperbaric Medicine may be appointed by the facility on the advice of the Director of Diving and Hyperbaric Medicine. This appointment requires ratification by Council.

3.8 The Diving and Hyperbaric Medicine Unit must agree to inspection by representatives of the College.

3.9 Posts approved for training in Diving and Hyperbaric Medicine by the College must be advertised with that approval being noted. Where the number of training posts is less than the number of posts being advertised, the number of training posts should be specifically indicated.

3.10 The hospital must agree to notify Council (through the Director or Supervisor of Training) of any changes that might affect training. Importance is placed on changes such as alterations in workload and increases or decreases in the number of senior staff working in the Department.
3.11 The Diving and Hyperbaric Medicine Unit must have:

3.11.1 A minimum of one full time equivalent (FTE) Diving and Hyperbaric Medicine Specialist with qualifications acceptable to Council.

3.11.2 At least half an FTE Diving and Hyperbaric Medicine specialist for each trainee.

3.11.3 Timely access to appropriate diagnostic equipment including but not limited to:- Audiology, Tympanometry, Transcutaneous O2 Analysis, Digital Photography and Printer, Respiratory Function testing facilities.

3.11.4 Adequate secretarial staff. Most departments will require at least one full-time Secretary/Receptionist.

3.11.5 Adequate office space for the specialists.

3.11.6 A suitable room for trainees to study.

3.11.7 Access to a suitable conference room for quality assurance, clinical review and educational activities.

3.11.8 Regular programs of quality assurance and teaching appropriate to the size of the department.

3.11.9 Adequate library facilities with information sources appropriate.

3.11.10 Ready access to appropriate computer facilities.

3.11.11 Access to clinical support services appropriate to the role of the hospital.

3.11.12 Diving and Hyperbaric Medicine specialists participating in a Maintenance of Professional Standards Program or its equivalent.

3.11.13 An active research program.

3.12 In addition to matters noted above, the hospital and department will take note of and comply with all relevant College Professional documents and Australian Standards.

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POLICY ON DUTIES OF REGIONAL EDUCATION OFFICERS IN ANAESTHESIA

1. GENERAL

Regional Education Officers occupy an important position in the College’s educational network. They have responsibilities to provide liaison between trainees, Supervisors of Training, their Regional Committee and the central administration of the College. Specific duties include:

1.1 Maintaining a list of approved hospitals in each region. Notifying the Regional Committee and the College Council of any changes in senior Anaesthesia staffing or department workload which have the potential to affect the training programmes.

1.2 Obtaining a list (on Form R1 or R2) from Supervisors of Training with:

1.2.1 The names of all trainees in College approved posts.

1.2.2 The numbers of occupied service posts which are not approved by the College for training purposes. These lists should be forwarded to the College within two months of the commencement of the hospital employment year in each region.

1.3 Obtaining notification from Supervisors of Training of any changes in the list referred to in 1.2.1 caused by trainees joining or leaving a rotational training scheme during the hospital employment year. It is particularly important that the dates of such changes are noted to allow independent verification of training by the Assessor.

1.4 Co-ordinating In-Training Assessments.

1.5 Assisting Supervisors of Training with monitoring of staffing and trainee supervision in each approved hospital. When considered necessary by Council or the Regional Committee, a survey of staffing and workload (using Form HA-2) should be conducted. Results should be forwarded – with any relevant recommendations – to the Hospital Accreditation Committee of the College.

1.6 Understanding College Regulations relating to training and examinations.

1.7 Maintaining a calendar of dates relevant to College examinations.

1.8 Maintaining contact with Supervisors of Training with advice as appropriate on matters related to training and examinations.

1.9 Co-ordinating and facilitating the provision of continuing education for Supervisors of Training in their region.

1.10 Ensuring that courses for Primary and Final Examinations are held on a regional basis.

1.11 Keeping the Chair of Education and Training informed of regional activities and problems. Providing a report to the Education Committee by 1st July each year.

1.12 Attending or nominating a representative to attend the annual meeting of Regional Education Officers with the Chair of Education and Training held during the ASM.

1.13 Providing advice as appropriate to trainees and prospective trainees.

2. REGIONAL EDUCATION SUB-COMMITTEE

2.1 This sub-committee will include the Regional Education Officer, the Regional Education Officer of the Joint Faculty of Intensive Care Medicine, the Regional Committee Chairman, and the Supervisors of Training within the region.

2.2 The Regional Education Officer will convene and chair the sub-committee.

2.3 The sub-committee will assist the Chair of Education and Training with all matters related to educational activities within the region and will report to the Regional Committee.
COLLEGE PROFESSIONAL DOCUMENTS

College Professional Documents are progressively being coded as follows:

TE Training and Educational
EX Examinations
PS Professional Standards
T Technical

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

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

Promulgated: 1987
Date of current document: October 2002

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Australian And New Zealand
College Of Anaesthetists
ABN 82 055 042 852

PROFESSIONAL DOCUMENTS

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TE1 (2001) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia Bullettin June 2001, pg 92


TE7 (1999) Secretarial and Support Services to Departments of Anaesthesia Bulletin November 1999, pg 69


EX1 (2001) Policy on Examination Candidates Suffering from Illness, Accident or Disability Bulletin November 2001, pg 75


PS6 (2001) Recommendations on the Recording of an Episode of Anaesthesia Care (the Anaesthesia Record) Bulletin November 2001, pg 77


