

# Australian and New Zealand College of Anaesthetists

ACN 055 042 852

Faculty of Intensive Care  
Faculty of Pain Medicine



# Bulletin

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

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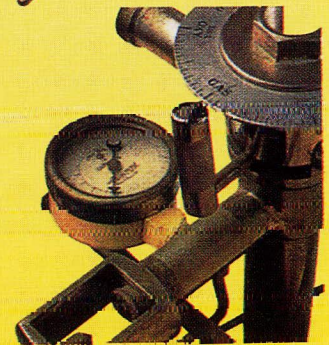
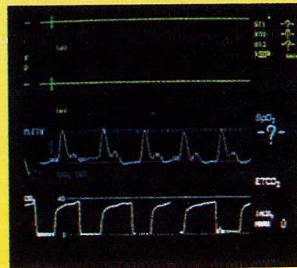
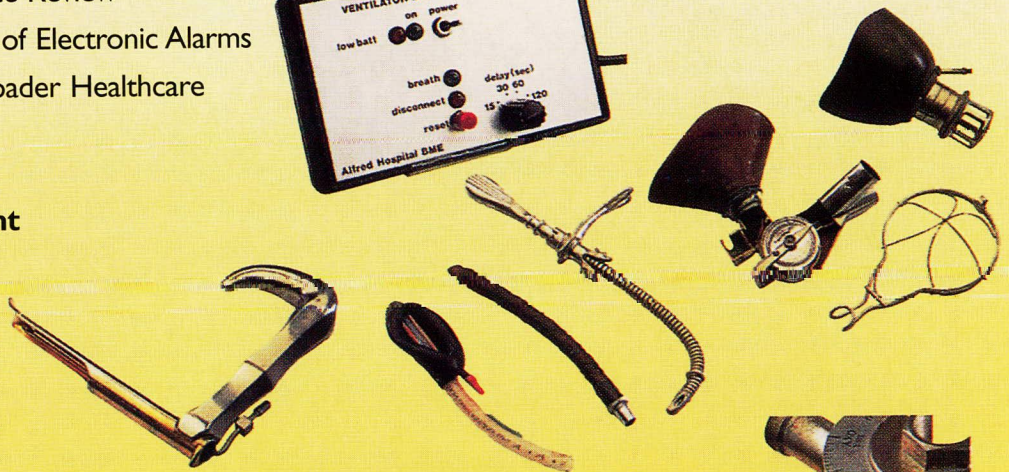
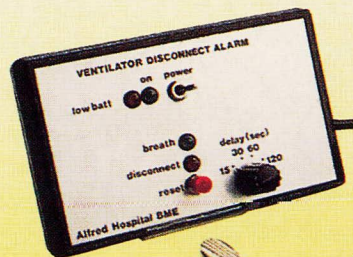
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# PRESIDENT'S MESSAGE

In completing my term as President and a Councillor of the College, I take this opportunity to reflect on the developments that have occurred within our professions over the past decade or so. I also speculate on the future directions of the College and the profession generally.

I joined the Board of the Faculty of Anaesthetists of the RACS in 1988 and much has been achieved since that time. In 1992, the College of Anaesthetists was formed as a completely independent body and the Faculties of Intensive Care and Pain Medicine were established, significantly and publicly progressing



the professions of anaesthesia, intensive care and pain medicine as specialties in their own right. Moreover, sub-specialties, especially within anaesthesia, are now firmly recognised in the form of Special Interest Groups (covering a great range of interests) and these play a major role in College and Society activities such as continuing education and establishing relevant health care standards. Now at an all time high is the cooperation

and communication between the College and specialist Societies (Australian Society of Anaesthetists, New Zealand Society of Anaesthetists, ANZ Intensive Care Society, Australian Pain Society), other Colleges, the Committee of Presidents of Medical Colleges and many other government and non-government authorities. By example, ANZCA and the ASA now have cross-representation on many committees (from the respective Councils down) and have joint committees on various issues, such as Continuing Education, Overseas Aid, National Anaesthesia Day and others. The profession has become increasingly united in its approach to issues as they arise and advancing future developments, a great change from what I perceived it in 1988.

Of particular importance since establishment of ANZCA in 1992 has been the achievement of a strong financial base to the College, particularly following the costs of College formation. This resulted from a professional approach to asset accumulation of the College under leadership from successive Faculty of Anaesthetists and College Treasurers, in particular Assoc Prof Michael Davies, Dr Richard Walsh and Dr Richard Willis. Expert financial advisers and specialist College staff were employed and the College is now approaching a healthy financial status, without ever having imposed a levy on Fellows or raising subscriptions higher than that of most other Colleges. Significantly, through this forward planning, the College is now able to expand its headquarters in Melbourne to meet its current needs and the needs of the professions for several decades to follow. Having been closely

associated with the roles and functioning of the College (and the ASA) for over eighteen years, I strongly defend the notion that Fellows and all members of our professions have always seen their dollars responsibly spent, justified and never wasted.

In this short space it is impossible to list all the other very significant activities and gains achieved by the College over the past decade, and for this I apologise to those who have made enormous individual contributions during that time. Let it be simply said that our professions are truly on their feet and can only develop further from now. Training, education, continuing education, medical research and establishing standards of health care will always be the main focus of College activities and major expansion in these areas will undoubtedly occur in the future.

Over the next few years, I believe that specific further advances, already in train, will be made in the areas of Trainee education and assessment, expansion of research funding, and particularly communication. As Communications Officer, Dr Mike Martyn has been a tower of strength and innovation in bringing our College and our professions into the new century with a wide range of activities, particularly in the IT field. Communication with and between Trainees, Fellows and the general public (the consumers) must and will expand rapidly and it is incumbent on the whole College community to embrace this advance with enthusiasm and application. Beyond the next few years, I personally harbour desires to see our professions increasingly united from an organisational viewpoint, including that of Intensive Care training and representation, and especially the old and extremely controversial (but logical to me!) chestnut of amalgamation of the functions of ANZCA and the ASA.

I leave the College Council with great satisfaction over what has been achieved on behalf of the profession. I finally pay special and personal tribute to an individual who I believe has been one of the greatest assets of our College, indeed professions, over the past 20 years or so. Mrs Joan Sheales, current Chief Executive Officer of the College, has been a brilliantly efficient administrator of the College and one who is the envy of all other medical colleges and similar organisations. I believe that the most difficult of all CEO positions is in an organisation where members, including the "Directors", are all unpaid and volunteer to serve the organisation in their own time. In my extensive experience of observing and dealing with such persons in CEO roles (both nationally and overseas), Joan Sheales is second to none. Through her extensive attributes, including her personality, people management skills, broad knowledge and just common sense, she has brought to the College enormous benefits, stability and growth that would never have been achieved otherwise.

I look forward to greeting all Fellows and many others to what promises to be a hugely successful College Annual Scientific Meeting in Melbourne next May.

*Richard Walsh*

# ADMISSION TO FELLOWSHIP BY EXAMINATION

NOVEMBER 1999 — FEBRUARY 2000

Pasquale	BELPERIO	SA	Peter John	LANE	TAS
Michael Alan	BOQUEST	VIC	Bassanio Cheuk-Wah	LAW	HK
Stuart Mackay	BOTTRELL	NSW	Richard Creighton	LEONARD	WA
Guy Robert	BUCHANAN	ACT	Benjamin Teik-Beng	LOH	QLD
Bernadette Theresa	BURKE	QLD	Gregory James	LUMSDEN	WA
Darren James	BURNS	SA	Neville Glen	MAIDEN	NZ
Matthys Jacobus Johannes	CAMPHER	NZ	John Zdzislaw	MALCZEWSKI	QLD
Anne Miu Han	CHAN	HK	Graham Paul	MAPP	QLD
Bernard John	CREATI	VIC	Marc Daniel	MCINTYRE	FRA
Michael John	DAVIS	NSW	Yvette Susan	MCKELLAR	QLD
John Peter	EDINGTON	VIC	Gregory Philip	MORRIS	NSW
John Grant	ELLINGHAM	NSW	Susan Jane	O'REGAN	NSW
Ginette	FALCONE	VIC	Lena Bee Leng	ONG	SA
Stephen Andrew	FORD	NSW	Brett Antony	PEARCE	VIC
John Edward	FOY	NZ	Robert	POPOVIC	VIC
Antony Michael	GANENDRAN	QLD	Clive Robin	RACHBUCH	VIC
Ramin	GHARBI	WA	Jonathon Matthew	RILEY	USA
Peter Anthony	GLEW	NZ	Andrew Lewis	RODBERT	QLD
Robert Peter	GRAUER	VIC	Daniel David	RUBENS	USA
Paul Douglas	GRAY	QLD	Alan	RUBINSTEIN	NSW
Alistair Joh	GRAY	NZ	Marc Andrew	RUSSO	NSW
Robert Oliver Sean	GRIEVE	NZ	Peter Howard	SCOTT	QLD
Pradeera Oshadhie	GUNAWARDANE	NZ	Ann U-Lin	SEE	NSW
Steven Charles	HAMS	NT	Nora	SOON TAK CHE	HK
Pauline Anne	HARMAN	WA	William Arthur Low	SOONG	QLD
Matthew	HAYHOE	VIC	Jeffrey Cheng Hwa	SUEN	SING
Brien	HENNESSY	VIC	Paul Michael	TEMPLER	NZ
Malcolm Noel	HOGG	NSW	Shane Christopher	TOWNSEND	QLD
Jeffrey Keith	JAMES	QLD	Adam Paul	TUCKER	VIC
Christopher Peter	JONES	NSW	David Anthony Paul Francis	VOTE	USA
Charlotte Engelbrecht	JORGENSEN	WA	Linda Christine	WELLS	NSW
Michael David	KIRTON	VIC	Sean David	WELLS	NSW
Ajay	KUMAR	NSW	John Reginald	WHITTLE	QLD
Wing Hong	KWOK	HK	Paul John	WRIGLEY	NSW
Mark Yu-Han	LAI	QLD	Jacqueline Claire	YAP	HK

# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS MEDAL

*'The Australian and New Zealand College of Anaesthetists Medal is awarded at the discretion of the Council of the College in recognition of major contributions to the status of Anaesthesia, Intensive Care or related specialties.'*

John and Jill (Mainland), Rod (Westhorpe), members of the Mainland family and friends, I am deeply honoured to be asked to present this citation for the award of the ANZCA Medal to John.

I have known John for approximately 35 years and as a consequence this citation will be very much a personal citation rather than a formal one.

I arrived at The Alfred in 1965 when John Mainland had left the department and transferred to the Department of Surgery at Monash University under Professor Hugh Dudley, Professor of Surgery. This academic appointment was the first in anaesthesia in Victoria, indeed the only one for many years. John's major contribution at that time was to point out that the operating theatre was not necessarily a safe place for either staff or patient and that this had nothing to do necessarily with the standards of anaesthesia or surgery that were practised. John, with Hugh Dudley, convened a meeting entitled 'Safety in the Operating Theatre' and a large range of safety issues were discussed for the first time. Following this meeting a book was published entitled 'Safety in the Operating Theatre' under the editorship of John Mainland and Hugh Dudley. We in the specialty of anaesthesia have much to be grateful to you for the help you gave us in these safety issues.

John raised many other important issues in the early days of my practice. Issues such as the importance of an appropriate pre-operative consultation. I had prevented a Resident from going to see the patients he was going to anaesthetise with you on the following day and you

## JOHN FRANCIS MAINLAND — CITATION



made it very clear to me that this was unacceptable practice—patients needed to be seen and assessed in an appropriate pre-operative manner.

I have many other very fond memories of John. Amongst your friends who will forget the time when, having to give up smoking because of a cardiac scare, you took to chewing matches as a substitute and left a trail of chewed matches all around the place. On another occasion when I had a particular problem I bumped into you in a carpark and told you my tale of woe, expecting some deep sympathy. You took one look at me and said 'Rechtman, you are being precious' and then proceeded to point out to me why my behaviour was 'precious' and

that night I had the first good night sleep I had had for two weeks since this particular problem arose.

I, and all my colleagues, have much to be grateful to you for your extraordinary contribution to the specialty of anaesthesia and it is with great honour that I ask my fellow Councillor Rod Westhorpe to present you with the ANZCA Medal for services to the College and the specialty of anaesthesia.

IAN RECHTMAN

*The presentation of the Australian and New Zealand College of Anaesthetists Medal took place at John and Jill's home at Harkaway.*

# HIGHLIGHTS OF FEBRUARY 2000 COUNCIL MEETING

## WELCOME

The President welcomed Professor Ian Fraser, President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists; Ms Kate Moore, former Executive Director of the Consumers' Health Forum, Australia's peak consumer organisation; Dr Alan Rainbird, Chairman, South Australian Regional Committee; Dr Malcolm Futter, Chairman, New Zealand National Committee.

## ELECTION OF PRESIDENT - ELECT

Professor Teik Oh, WA, was elected President-Elect to take office of President following the Annual General Meeting in May.

## Presentations by Professor Ian Fraser

Professor Ian Fraser, President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, was welcomed to the Meeting. During his presentation, the following points were highlighted.

- College structure and functions are being reviewed with training, examinations and continuing education under consideration.
- Interaction between the Colleges and other organisations—Professor Fraser regards this as a major role for the CPMC.
- Use of simulators and advanced IT systems for teaching purposes is being considered by the College. It was recognised that RANZCOG is some way behind ANZCA in this regard, but is keen to maintain links in this area.

- Education Unit—it was noted that the College employs an Educational Development Officer and that the person originally employed as Director of Education had been appointed CEO and is maintaining an overview in the Education Unit.

## PROFESSIONAL

### Australian Council on Healthcare Standards

ANZCA has now been included on the Council of the ACHS. Associate Professor Greg E Knoblanche, New South Wales, will represent ANZCA on this Council.

### Policy Documents

The following new policy documents were promulgated:

PS39 – 'Intrahospital Transport of Critically Ill Patients', a copy of which is published elsewhere within this *Bulletin*.

PS40 – 'Guidelines for the Relationship Between Fellows and the Healthcare Industry', a copy of which is published elsewhere within this *Bulletin*.

TE15 - 'Guidelines for Trainees and Departments Seeking College Approval of Posts for the Certificate in Pain Management' was withdrawn.



*L to R: Professor Ian Fraser, President of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists; Ms Kate Moore, Former Executive Director of the Consumers' Health Forum; Dr Richard Walsh*

### Pre-operative Care Clinical Practice Guidelines

It was noted that the NHMRC has developed a template to have guidelines NHMRC endorsed and that the College should consider such endorsement for

the Preoperative Care Clinical Practice Guidelines when developed.

## EDUCATION

### Guidelines for the Selection of ANZCA Trainees

For some time, the Education Committee has been preparing a brochure with regard to the selection of trainees. Areas covered include Statement of Principles, Eligibility and Selection Criteria, and Process for Selection. This document will be released shortly to assist Regional and National Committees and rotations.

### Recognition of Training beyond Year 2

Council approved an amendment to Regulation 15.5.5.3, emphasising that any training, including training recognised towards the Diploma of Fellowship of the Faculty of Intensive Care, will not be recognised towards the Diploma of Fellowship of the College beyond two years, unless the trainee has been successful at the Primary Examination or exempt from such examination.

### Anaesthetic and Acute Care Skills Curriculum

It was noted that the Queensland Postgraduate Medical Education Committee has developed a nationwide skills curriculum, the template of which is published on its website for hospitals to use or modify as they choose. The aim of this curriculum is to equip trainees in their first and second years post medical school with necessary course skills and is adaptable to individual hospitals and doctors.

### Care of the Critically Ill Surgical Patient Course

Council noted that the CCrISP Course would be of assistance to second or third year residents dealing with critically ill patients in the wards. It uses many techniques adapted from ATLS and EMST courses and contains critical scenarios which are medical problems in surgical patients. The course is very

instructor-intensive which results in higher course fees. The course has value as one of the generic courses which might be offered to PGY2 trainees, or residents about to enter specific training programs.

### **Working Party on Courses**

At the recent teleconference of the Working Party on Courses, consideration has been given to ANZCA offering courses as modules which could be combined in hospital courses, or at skills centres. These could be defined as core or elective to guide trainees in their selection of courses. It was noted that the issue of having mandatory courses was considered, but there was reluctance to have any mandatory components. There was support for a system similar to MOPS whereby courses might be defined as suggested/desirable/highly desirable and graded core/elective. The Working Party had considered the possibility of ANZCA offering courses to non-anaesthetists and there had been support for this, particularly for rural anaesthetists and those in emergency medicine programs.

### **Part-Time Training Regulation**

Regulation 15 has been amended to permit part-time training in any year of training towards the Diploma of Fellowship of ANZCA. Each trainee must obtain prospective approval for the part-time program from the College Assessor.

### **Workshops**

Three half-day workshops were held at the College Headquarters just prior to the Council Meeting, comprising sessions on in-training assessment, train-the-trainer (with assistance from Dr Jenepher Martin, Director of Education, RACS) and selection of trainees and interviews. Participants included Regional Education Officers and a selection of Supervisors of Training with the aim that these participants could then provide local workshops within their Regions to disseminate this information.

### **Skills Laboratories**

The College will join the RACS in the establishment and administration of the Eastern Collaborative Health, Teaching and Education Centre to be housed in the Anatomy School, University of Sydney.

The College is also a partner in Centre for Anaesthesia Skills and Medical Simulation (CASMS) which is to be opened in the near future within the University of Western Australia.

### **EXAMINATIONS**

#### **Assessment of Overseas Trained Specialists**

Council has reviewed the College assessment for overseas trained specialists.

A document setting out the form of assessment has been forwarded to Regional/National Committees and the Australian Medical Council for comment.

### **CONTINUING EDUCATION AND QUALITY ASSURANCE**

#### **ASM – 2000, Melbourne**

Following the ASM in Melbourne, Professor Dan Sessler (USA) will visit Tasmania, Professor James Bovill (The Netherlands) will visit Perth and Dr Paul Pepe (USA) will visit Adelaide.

#### **ASM – 2001, Hong Kong**

Professor Martin Tramèr, Switzerland, has accepted an invitation as Foundation Visitor to this meeting and will also visit South Australia and Queensland following the ASM in Hong Kong.

#### **ASM – 2002, Brisbane**

Dr Stephen Bruce has been appointed Convenor of the Scientific Program for this Meeting.

#### **Report of Medical Boards and Councils Seminar "Fit to Practice"**

This seminar included a session on professional competency, during which it was suggested that Colleges should have responsibility for the identification of competence at the conclusion of training, and also for its continuation through a Fellow's career. The question

of Medical Boards being given access to credentialing data was also raised. One of the contributors to the Seminar was Dr Steve Bolsin who gave a presentation on an assessment system which he had been developing at the time of events in Bristol. Dr Bolsin will make a presentation to the next Education and CE & QA Committee Meetings on 25 February.

### **INTERNAL AFFAIRS**

#### **Regional Training Committees**

Council approved the Terms of Reference under which Regional Training Committees in Hong Kong, Singapore and Malaysia will operate.

#### **Area of Need Assessment**

Council is currently reviewing its process for assessment of applicants to work in declared areas of need. It is anticipated this document will be completed for the May Council.

#### **Professional Practice Review**

Following a revision of the ANZCA MOPS Program, a Professional Practice Review activity has been established as part of the MOPS Program. PPR is a process by which, at the request of an applicant, a Fellow nominated by ANZCA visits such applicant for a day to observe and review the applicant's practice. A maximum of two participants in the same practice may be reviewed on the same day. This process is carried out at the request and expense of the Fellow being reviewed. The objective of PPR is to provide an opportunity for Fellows to gain feedback on their practice which will lead to further self development so as to maintain the best possible standard of practice. It is intended to provide insight into the strengths and weaknesses of practice so that plans may be developed for self improvement.

#### **PPR IS NOT AN AUDIT on competence.**

Professional Practice Review, within the MOPS Program, is registered under the Australian Federal Government Quality Assurance legislation and in New

Zealand under Section 68 (1) of the Medical Practitioners Act 1995. Documents pursuant to the program cannot be revealed to third parties or in legal proceedings.

The full PPR process is published elsewhere in this *Bulletin*.

### **Rural Anaesthetic Recruitment Service**

Following a grant from the Australian Government to assist with the establishment and administration, a Rural Anaesthetic Recruitment Service was set up in collaboration with the Australian Society of Anaesthetists. This service does not attract fees from either the employer or anaesthetist. It is a service to fill permanent positions in rural and remote areas, and provide locum service when requested.

The results of the service to date are:

Expressions of Interest from Recruits	87
Expressions of Interest from Principals	28
Positions Filled	6

### **ANAESTHESIA CONTINUING EDUCATION CO-ORDINATING COMMITTEE**

#### **Medical Education and Simulation and Skills Training Special Interest Groups**

The Medical Education SIG and the Simulation and Skills Training SIG were ratified as Special Interest Groups under the revised Constitution approved by ANZCA, the ASA and NZSA, with ANZCA as the parent secretariat provider.

### **FINANCE**

Council reaffirmed College policy that as it is not obligatory for trainees to attend pre-Fellowship courses, nor is it possible for all candidates to attend every course, all pre-Fellowship courses run on behalf of the College for trainees should be self-funding. Funding of courses is not budgeted within the Annual Training or Registration Fees for trainees.

### **COMMUNICATION**

#### **College Bulletin**

Council has requested each Officer of the Council provide a report/article on activities in an endeavour to improve communication in their area for Fellows information.

Items of interest from Fellows or Trainees would be most welcome and is a way of expanding the communication of College Fellows and Trainees activities to the Fellowship.

#### **National Anaesthesia Day**

The topic for this year's National Anaesthesia Day is the broad one of 'Anaesthesia'. Two activities were suggested by the IT Committee—targeting schools regarding an essay writing and/or poster competition, and targeting the internet giving consideration to public material on anaesthesia, particularly related to schools.

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## **HONOURS AND APPOINTMENTS**

Congratulations are extended to the following Fellows on their honours and appointments:

**Professor Michael Vickers**, UK – Officer of the Order of the British Empire (OBE)

**Professor Tom Torda**, NSW – Medal of the Order of Australia (OAM)

**Dr Michael Davies**, Vic – Associate Professor, Division of Surgery, Faculty of Medicine, University of Melbourne

**Dr Peter Kam**, NSW – Clinical Associate Professor, Department of Anaesthesia and Pain Management, University of Sydney, Royal North Shore Hospital.

**Professor Hugo van Aken**, Germany – President-Elect (Vice Chairman), European Academy of Anaesthesiology

**Professor Michael J Cousins** AM, NSW – Honorary Member, Intractable Pain Society UK (UK Chapter of IASP)

**Dr Cedrick Hoskins**, NZ – Life Member, New Zealand Society of Anaesthetists

**Dr George M Boffa** – Master of Bioethics, University of Technology, Sydney



# PROFILE OF RURAL ANAESTHESIA

My wife and I visited Roma in July 1995 during the drought. Eight years of sun had burned the country to a barren brown. We moved to the town in early February of the next year and what struck us was the difference January rains had made. The country was green and refreshed. Within weeks the sun was burning green foliage back to brown and the talk in the town turned to when more rain was coming. Weather was discussed all year. Hot summers with occasional storms were followed by winter with cold nights and warm sunny days. The sunsets followed by brilliant stars were stunning all year.

People made us welcome. Neighbours came over to introduce themselves and those whom you met only once would say hello and chat in the street. The barber in the Queen's Arms hotel was an endless source of information. He prayed for better wheat prices so he could charge the farmers more. Alas, in 1996 it was not to be as wheat prices, and thus haircut charges, were still down.

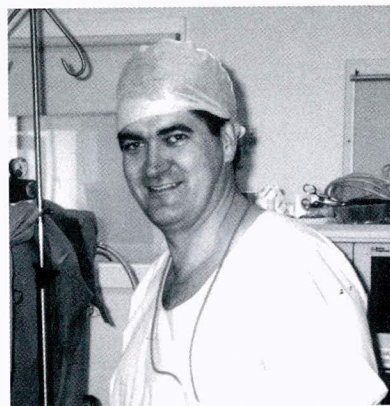
My work as a flying anaesthetist took me to many outback towns. There I noticed the difference between working in a large city hospital and country anaesthetics. In the towns I was greeted as someone offering an expertise they were grateful to have. This gratitude for coming to help them was always present even after I became a regular visitor over the year. Doctors are a bit egocentric but it is nice to be wanted and feel useful. Back now in Toowoomba, as one of many anaesthetists, those daily feelings of appreciation are missed.

I went to 28 hospitals. On the whole, equipment was not a problem but you could never take anything for granted. You quickly realise how spoilt you get in the larger hospitals but I use to enjoy the little challenges that came along. We carried some equipment to make up any deficiencies.

Pathology, radiology and blood banking facilities were often not immediately

available. Six hospitals have on-site laboratories and all others send blood away. This was up to five hours by car at isolated hospitals. Requirements could be anticipated and if patients needed a battery of tests before anaesthesia we wouldn't be doing them at isolated centres anyway. In emergencies we relied on clinical acumen.

The problem of providing safe blood was overcome with the help of the Red Cross. Elective cases blood were cross-matched at regional centres and the bloods transported to the hospital prior to the operation. Emergency Donor



Panels (EDP's) of local blood donors were established to deal with emergencies. Each panel member is confidentially interviewed and screened every three months. This resulted in a safe supply of super fresh blood 'on the hoof'. I had occasion to use these panels twice in 12 months and the response time was 20 minutes. City anaesthetists were envious of this quality blood service.

Most small rural anaesthetic services don't have the degree of isolation I experienced but many of the problems are similar. One of these was professional isolation. Telephones and internet discussion groups are useful but not a complete substitute for daily contact with other anaesthetists. Through the College I had easy and rapid access to a quality anaesthetic reference library and this was a great boon.

On call for me was one in one. This was not a major source of problems for me, nor has it been reported as a problem by subsequent flying anaesthetists. You learn to live with it and it is usually not onerous. (With one or two memorable exceptions.)

The recruitment of staff was difficult. In the past the position was only intermittently filled by an anaesthetist with a Fellowship. To keep operating, flying surgical services have had to recruit overseas and the resulting anaesthetists were usually satisfactory but often inexperienced. This approach to recruitment, born out of desperation, did not result in a good standard of anaesthetic service. This touches on the broader issue of severe doctor shortages in rural areas. This crisis is currently attracting much media and government attention. Our College is taking a proactive approach on the subject and I received much support.

Obtaining locums was the biggest problem I faced and this placed considerable strain on myself and family. While in most major centres 'someone' can generally be found to fill in for the majority of lists while you are away the solitary practitioner has no such option. On one occasion a locum cancelled with one week's notice. This left me with three options. Find another locum, shut the flying anaesthetic service (including emergency service) for four weeks or cancel my holiday to Canada. (Upon enquiry the airfare insurance would not cover this cancellation and therefore I would lose my airfares). None of these options were palatable and my wife's

understanding nature was stretched to the limit. Until then I had naively thought that with the many people who expressed an interest in doing locums for me that getting relief would be easy. I soon learnt that there was a big difference between an enthusiastic expression of interest and someone turning up.

I personally believe that this lack of relief is the biggest threat to the viability of rural anaesthetic services. Many larger rural centres can organise themselves so they need minimal, if any, locum support. Smaller centres cannot. They depend on locums. No locums mean no relief for education or recreation. Lack of access to education or recreation means that rural anaesthesia in small centres will not be sustainable.

This highlights the importance of the Rural Anaesthetic Recruitment Service. It is not about 'giving the guys in the bush a break while having a bit of fun'. The service was established to try and save rural anaesthesia in Australia. The hope is that we as a College will see this a worthy cause for support. The fear is that unless we help preserve rural services on a voluntary basis the government's intervention will be a distasteful inevitability.

Wal Grimmett  
Toowoomba

# MAINTENANCE OF PROFESSIONAL STANDARDS

# PROFESSIONAL PRACTICE REVIEW

## *Guidelines for Participants to be Reviewed*

### **Introduction**

Professional Practice Review (PPR) is a process whereby a Fellow nominated by ANZCA visits a participant for a day to observe and review the participant's practice. The participant must be registered with ANZCA's Maintenance of Professional Standards (MOPS) program. A maximum of two participants in the same practice may be reviewed on the same day.

PPR will look at aspects of:

- Continuing education and MOPS activities
- Professional knowledge
- Work practice
- Interpersonal and communication skills
- Humanistic qualities
- Record keeping and management
- Compliance with College policies and guidelines

### **Objective**

The objective of PPR is to provide an opportunity for you to gain feedback on your practice that will lead to further self-development, so as to maintain the best possible standard of practice. PPR is intended to provide insight into the strengths and weaknesses of your practice, so that you can develop plans

for self-improvement. PPR is not an audit on competence. The MOPS program is registered under the Australian Federal Government QA legislation, and pursuant to Section 68(1) of the New Zealand Medical Practitioners Act 1995, and documents pursuant to the program cannot be revealed to third parties or in legal proceedings.

### **PPR and MOPS**

When the visit has been completed and PPR is approved, the participant will be awarded 25 MOPS points for CME and 75 points for QA under code 411. Reviewers will be awarded 30 QA points for reviewing one participant (code 412) and 50 QA points for two participants (code 413). A PPR qualifies the reviewer and successful participant for MOPS' QA requirements for two consecutive years. However, a participant given *provisional approval* qualifies for MOPS' QA requirements for only one year initially (see *Process* paragraph 8 below). Both participant and Reviewer should enter their PPR details in their MOPS diary for these two years. Participants in PPR will be exempt from the MOPS audit for the remainder of their 5-year cycle.

### **Process**

If you wish to be a participant, PPR will entail:

1. A written application to the College, following which a PPR kit will be sent to you. If there is another applicant from the same practice, please state his/her name.
2. Submission of completed required documents. These are the PPR application form, Pre-Visit Questionnaire, the MOPS Annual Return form for the last calendar year, and evidence of MOPS activities as recorded in the above Annual Return form.
3. Appointment of your Reviewer by the College. The Regional Committee or the New Zealand

National Committee will normally recommend the Reviewer.

4. Notification by the College of date of PPR and the name of the Reviewer.
5. A full day's on-site visit of the practice by the reviewer. This involves
  - 5.1 *An Interview with (i) the Operating Theatre Manager OR Clinic Supervisor and (ii) a Senior Consultant nominated by the participant*

The Reviewer will discuss your practice setting and its compliance with ANZCA policies and guidelines and your practice as a specialist anaesthetist.

- 5.2 *A Review of Practice Records* – (at least 45 minutes per participant)

The Reviewer will select for review the records of 5 patients from a list of 25 patients managed by you in recent months. These may be anaesthetic records, or if your practice has a component of duties in clinics (e.g. pre-anaesthetic clinics, pain clinics), may include patient case notes. Patients should not be identified and names on records can be deleted. The Reviewer will review record keeping and care given (including where relevant, preoperative investigations and consultation, the anaesthetic technique, and the postoperative care).

- 5.3 *A Review of Practice Setting*

The Reviewer will review the setting of your practice. This is most commonly the operating theatre suite but may include clinics in which you provide perioperative or pain management care. He/she will assess whether your practice setting (in terms of the physical environment and equipment) contributes to good patient care

and complies with relevant College policies. The review of practice setting is undertaken during the review of clinical practice. It must be noted that PPR is not a hospital inspection.

5.4 *A Review of Clinical Practice* - (at least 90 minutes per participant)

The Reviewer will observe you attending to patients and note your:

- Interaction with patients and colleagues
- Management of patients
- Skills in performing technical procedures
- Organization of work and practice

5.5 *A Confidential Discussion between the Reviewer and Participant* (at least 30 minutes per participant)

The discussion on your practice will centre on your practice setting, record keeping, patient management, and continuing education and MOPS activities. Your achievements in College Clinical Indicators and compliance with College policies will also be discussed. The objective of the discussion is for the Reviewer to provide insight into the strengths and weaknesses of your practice. As a result, a plan for future self-development and where applicable, practice improvement, can be formulated by mutual agreement.

6. A written report of the PPR by the Reviewer to the QA/MOPS Officer. A copy will be forwarded to you.
7. A written feedback by you on the process and the Reviewer's report to the QA/MOPS Officer. A copy will be forwarded to the Reviewer.
8. Notification by the College of the outcome of the PPR. The outcome may be approval or provisional approval. If you are given a provisional approval, you are

approved to meet MOPS' QA requirements for only one year. You will need to submit after the year, details on how you implemented your self-development plans in order to be approved for QA requirements for the second year.

### **Responsibilities of Participant**

You should undertake the following necessary actions for PPR:

- Complete and submit the application form, in which you agree to subject yourself to PPR according to the guidelines, provide information as requested, and release the College and Reviewer from liability.
- Submit the Pre-Visit Questionnaire and all other required Pre-Visit documents (see Pre-Visit Documentation)
- Plan and submit a visit program (Templates as a guide will be provided)
- Nominate a Senior Consultant for interview by the Reviewer
- Obtain the approval of the Head of Department and the hospital, or your practice colleagues where applicable, for the visit and review of patient records.
- Notify all staff who may be involved in the visit
- Arrange the meeting of the Reviewer with the Operating Theatre Manager or Clinic Supervisor and the Senior Consultant
- Make all necessary arrangements for the visit of your practice setting (e.g. allocate change-room locker for Reviewer etc.)
- Organize your schedule for the day of visit to fit in with the program, especially arranging clinical work in theatre (part of an operating list) or clinic during the time shown in the program for the Review of Clinical Practice.
- Arrange for immediate access on the day of visit, the 25 records of patient management that you have submitted in the Pre-Visit documentation. Of these, 5 records will be reviewed and

must be immediately available upon the Reviewer's request. All records must include results of investigations and ECG and imaging records. Photocopies are acceptable. Patients should not be identified.

- Organize a quiet place for the Reviewer to work and to discuss the visit with you.
- On the day of the visit, notify your patients of the presence of an observer.

### **ANZCA Policy Documents**

The following policy documents are relevant in PPR:

- P16 The Standards of Practice of a Specialist Anaesthetist
- E6 The Duties of an Anaesthetist
- P26 Guidelines on Providing Information about the Services of An Anaesthetist
- PS7 The Pre Anaesthetic Consultation
- P18 Monitoring During Anaesthesia
- P19 Monitored Care by An Anaesthetist
- P6 Minimum Requirements for the Anaesthetic Record
- P4 Guidelines for the Care of Patients Recovering from Anaesthesia
- P20 Responsibilities of the Anaesthetist in the Post-Operative Period
- P15 Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery
- T1 Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites
- E3 Supervision of Clinical Experience for Trainees in Anaesthesia
- TE9 Quality Assurance
- P2 Privileges in Anaesthesia
- P22 Statement on Patients' Rights and Responsibilities

As a lead-up to the Virtual Congress in May 2000, the Victorian Regional Committee presented a first for the College: A Virtual CME Meeting. The Physical Meeting was held at the Carlton Crest Hotel in Melbourne on February 24, 2000. The meeting was well attended with approximately 70 attendees. Professor Bill Runciman, Professor and Chairman of the Department of Anaesthesia and Intensive Care, Royal Adelaide Hospital and President of the Australian Patient Safety Foundation gave an excellent presentation. The topic was "Iatrogenic Injuries and the Anaesthetist". His talk gave several insights into the relative risks of anaesthesia, how the Australian Patient Safety Foundation is tackling the problem and how we as Anaesthetists can make a difference. Afterwards, questions were taken from the floor and from the online discussion forum.

The presentation was pre-published on the Virtual Congress website  
<http://virtualcongress.anzca.edu.au>

The online presentation contains slides, text and an audio recording of Prof. Runciman's presentation at the physical meeting, using Realaudio© technology. It will remain online until the Virtual Congress in May and Professor Runciman will continue to contribute to the online discussion forum until then. All Trainees and Fellows are encouraged to visit the website free of charge. You will need your ANZCA webgroup password, which can be obtained from the ANZCA website [www.anzca.edu.au](http://www.anzca.edu.au)

Registrants to the Annual Scientific Meeting at the Crown Hotel on May 6-11, 2000

[www.anzca.edu.au/asm2000](http://www.anzca.edu.au/asm2000)

are also entitled to free registration to the virtual congress website.

Joe Novella,  
Convenor VC2000

## THE FIRST ANZCA VIRTUAL CME MEETING



*Professor Bill Runciman, Professor and Chairman of the Department of Anaesthesia and Intensive Care, Royal Adelaide Hospital and President of the Australian Patient Safety Foundation.*

# THE 4TH NATIONAL FORUM ON PRE-VOCATIONAL EDUCATION

18-19 NOVEMBER 1999

This annual Forum focuses on medical education and training up to the time of commencement of specific vocational training. For most doctors this means the period until the end of the second postgraduate year. It brings together representatives of Australian Medical Schools, Postgraduate Medical Councils, the specialist Colleges, the Australian and New Zealand Medical Council and a selection of enthusiastic junior doctors.

The major themes for this particular Forum were:

- the second postgraduate year (PGY2);
- the poorly performing intern; and
- training the trainers.

Much of the discussion was relevant to matters currently under consideration within ANZCA.

Professor Nick Saunders set the stage with an opening address summarising a variety of factors affecting junior doctors, their training and the effects on the workforce. These include:

- older at graduation;
- increased rural representation;
- increased debt incurred during training;
- five per cent don't ever intend to practice;
- 65 per cent intend working part time at some stage;
- work 'safe' (shorter) hours;
- face drive for increased throughput efficiency;
- face expectations of greater accountability;

- provider number issues;
- need for flexibility and portability of qualifications; and
- 12 per cent of hospital workforce comprises temporary resident doctors.

The keynote speaker at the Forum was British-based Professor Janet Grant, by training an educational psychologist, Professor of Education in Medicine at the Open University Institute of Educational Technology and Director of the Joint Centre for Education in Medicine. Professor Grant proved to be a dynamic, entertaining and provocative speaker. Dr Grant reviewed the recent history of developments in medical education in the United Kingdom, particularly as these have impacted on the early postgraduate years, and was highly critical of much recent policy. She expressed the view that the uncritical and superficial importation of educational theory into the way in which training programs operate, with a misplaced emphasis on teaching rather than the learning environment, had resulted in 'throwing the baby out with the bath water' in that it was abandoning the essential and unique characteristics of learning within a profession. This misguided approach casts post-graduate doctors in the role of students and ignores the fundamentally different and essentially apprenticeship character of professional learning, where trainees can observe the clinical skills and decision-making processes of experts.

Professional skill can be acquired only by participation in the professional process. She was also very critical of the inappropriate adoption of competency frameworks. The major requirements are approachable supervisors who provide constructive feedback and practical advice, together with a busy clinical job providing wide experience. Good supervision should provide guidance and feedback on personal,

professional and educational development, in the context of the trainee's experience of providing safe and appropriate patient care. Training must be characterised by immersion into professional practice in a controlled and graduated manner.

Supervisors and role models are crucial and must explicitly value professional learning, avoid an inflexible formal curriculum, encourage the responsibility of the trainee for learning, focus on learning rather than teaching, and ensure ongoing feedback. Professor Grant was dismissive of most of the claimed benefits of logbooks, except that she believed that they can improve the educational climate if used in ways that encourage feedback.

This address was followed by a representative panel which described the current approaches of CPMC, RACS, RACP and RACGP to the second postgraduate year. This panel included Dr Jenepher Martin who outlined the new approach taken by the RACS which from January 2000 will permit formal training to commence in PGY2. The desirability of this initiative prompted considerable discussion.

A free paper session on Assessment and Evaluation provided a repeated emphasis on the importance of a system of in-training assessment that focuses primarily on and fosters self-assessment.

There was an interesting workshop session on the poorly performing student or doctor, with examples of poor performance described in doctors at different levels of training. The importance of environmental and personal factors was emphasised; eg fatigue, career uncertainty, personality, age, health and culture. Primary or secondary alexithymia (unawareness of one's own feelings or the feelings of others) frequently plays a role. The management of the persistent poor performer was discussed. It was

reassuring to learn that this was a challenging issue for clinical supervisors in all areas. There was confirmation of the need for time allocation for supervisors of clinical training.

A workshop on the Clinical Training Portfolio, developed recently in Queensland for PGY1 and PGY2, emphasised the benefits of this formalised approach in fostering life-long learning. Personal education goals are developed by the trainee at the start of each term and are addressed in the context of an ongoing collection of evidence of learning. While primarily intended for the learner him/herself, the Portfolio can form a useful basis for providing structured feedback on progress in training. Junior doctors who are using such Portfolios spoke enthusiastically in their support. A useful website is <http://meded.qmcc.uq.edu.au>.

A second keynote address from Professor Grant on 'Training Trainers for Service Based Learning' strongly emphasised the latter four words of the title. She again criticised the British GMC which in her view had mistakenly imagined that focusing on the skills and attributes of trainers was the key to improving training. This approach ignores the 'real problem' that professional learning is acquired only through experience, not simply through being taught. Postgraduate medical training is fundamentally quite different from university-based higher education, and relevant principles from the latter sphere

should not be applied uncritically to the former. She emphasised that doctors are in fact very good learners when in an appropriate supportive setting. The major need of trainers is being able to provide 'support' for trainees rather than in training to teach. Trainers require flexible time provision and resources for regular feedback meetings which focus on the trainee's own self-assessment. Rather than 'trained trainers' junior doctors need exposure to a wide clinical experience, undertaken in an environment where supportive and interactive senior clinicians provide regular feedback in ways that encourage habitual self-assessment. She saw the widespread movement which is encouraging 'Train the Trainer' courses, etc, as probably 'unstoppable' but claimed there was no evidence whatever of their effectiveness in enhancing the quality of the trainees produced, and little evidence that such courses encouraged the adoption of an appropriate model of professional learning.

A final summarising session produced a number of agreed positions and resolutions. It was widely agreed that the objective of PGY2 should be the development of the generalist doctor. PGY2 should be complementary to and build on experience gained from PGY1. Availability of PGY2 positions should be based on educational value rather than service. There should be emphasis on topics such as communication, ethics and

professionalism, and there should be more freedom for independent clinical practice. Feedback should be frequent, specific and relevant. Rural terms should be encouraged but not compulsory. Professor Saunders suggested that current developments in postgraduate medical education and training might indeed be antithetical to the way the medical profession actually learns. The focus should be on apprenticeship learning, quality feedback and trainee/trainer support. In considering the relationship between education and service, what is required is not the separation of the two, nor greater emphasis to be given to the educational component, but rather better 'leverage' for education in the context of service provision.

This interesting and stimulating Forum discussed many matters of relevance to ANZCA's own training program and its relationship with the early postgraduate years. The question may be asked as to whether ANZCA training should (like the RACS) be able to commence in PGY2. The risk of not doing so is that many better RMOs could be lost to other specialties. Our view is that on balance this is not a good direction, unless perhaps total training time is extended to six years with an explicitly broad base being obligatory in PGY2. We do not favour such a move at the present time.

Stuart Henderson  
Richard Willis

## DEATHS

Council noted with regret the death of:

Professor John F Mainland, Victoria – FFARACS 1963, FANZCA 1992

Dr George Tay, Singapore – FFARACS 1972, FANZCA 1992

Dr Mary Clarenza Salvaris (nee Irvine), Greece – FFARACS 1960, FANZCA 1992

# THERAPEUTIC DEVICE RECALL FOR PRODUCT CORRECTION

Please find below a Therapeutic Device Recall for Product Correction for the AS/3 ADU (Anaesthesia Delivery Unit).

Datex-Ohmeda is initiating this advice as a precaution while we finalise the thorough investigation of the reported problems and plan for a corrective action. For more than 100 years, we have set the standard of care in anaesthesia. I know that you rely on our products to perform accurately and reliably. I want to assure you that resolving these issues is receiving the highest priority and management attention throughout our organisation, both in Australia and globally.

Because patient safety is our highest priority, please take time to familiarise yourself and your staff with the notice. It describes some of the problems that have been reported, as well as recommendations for procedures to minimise their occurrence and severity.

We want to minimise your inconvenience. If you experience any problems, please contact us immediately. Our National Service Organisation is available to support you and priority will be given to AS/3 ADU customers. We will do whatever is possible to get your product back in service should a failure occur.

You have my full commitment to providing a solution to these problems and I would like to apologise in advance for any disruption that this may cause you. Please contact your local Datex-Ohmeda Regional Manager if you have any questions regarding the Therapeutic Device Recall Notification. You are also welcome to call me directly on telephone (02) 9735 7263 regarding this letter.

Please be assured we value you as a healthcare partner and appreciate your co-operation while we address these concerns.

Sincerely  
Hannu Syrjala  
Managing Director

*Datex-Ohmeda Regional Managers*

Andrew Forrest	SA/WA
Mobile 0417 482 369	
Stephanie Martin	Vic/Tas
Mobile 0418 438 756	
Damien Linnett	Qld/NT
Mobile 0419 418 672	
Wendy Abbott	NSW
Mobile 0419 257 940	

## **Therapeutic Device Recall for Product Correction**

*Datex-Ohmeda AS/3 ADU Anaesthesia Delivery Unit  
Serial Number Range 40022203 and above  
Aust L No: 65796*

After consultation with TGA, Datex-Ohmeda has initiated a recall of the AS/3 ADU Anaesthesia Delivery Unit, Serial Number range 40022203 and above, following reports stating reliability problems with the fresh gas delivery, agent delivery and ventilation functions of ADU units within the above serial number range. The majority of these reports occurred during system start-up and pre-operative checkout, however some reports did involve clinical use but without serious patient injury.

An investigation has determined that the problems have been in newly manufactured and serviced fresh gas control units (A-FGC1) and electronic ventilator units (A-EV1 of Datex-

Ohmeda AS/3 Anaesthesia Delivery Units (ADU) within the serial number range of 40022203 and above. The serial number is located on the back of the ADU (number starting with A-AUF S/N : 400 (B..)) or can be identified by our service representative.

Users have reported problems that include the following:

- Inability to pass the system start-up and self-check procedures.
- Changes in fresh gas composition, (Anaesthetic Agent and Nitrous Oxide delivery may be interrupted. If this occurs, the system alarms and continues to deliver oxygen and air).
- Cessation of the ventilator (alarms are provided and manual ventilation may be utilised).

Reports typically indicate an ADU or monitor, audible and/or visual, alarm condition alerted the user of the problem. A corrective action is currently not available, but is being developed. It is anticipated this free of charge corrective action will be initiated within three months.

We recommend that you continue using any correctly functioning AS/3 ADU machines, however all users should be made aware of this notice. This notice is not the result of any one report, but the potential cumulative affect of the problems reported. Reports to date have not involved serious patient injury. The use of an appropriate monitor and the timely intervention by a medical professional will enhance patient safety.

As a result, Datex-Ohmeda recommends that clinicians exercise increased vigilance when using the AS/3 Anaesthesia Delivery Units (ADU). This includes the following actions to minimise the likelihood and severity of problems.

- Conduct the Datex-Ohmeda AS/3 ADU pre-operative checkout procedures prior to each use as recommended. The checkout procedures can be found in the User's Reference Manual. If the



system fails the checkout procedures, do not use the AS/3 ADU, as stated in the User's Reference Manual.

- Only use the Datex-Ohmeda AS/3 ADU when equipped with properly functioning Datex-Ohmeda AS/3 monitor or equivalent, as stated in the User's Reference Manual.
- Should problems occur during use, discontinue use and provide alternative means of ventilation and

anaesthesia. Contact your service representative for service.

A Datex-Ohmeda sales or service representative will be contacting facilities with an AS/3 ADU to schedule a visit to implement the corrective action, when available. Additional information on system disposition or corrective action will be provided shortly. The Therapeutic Goods Administration has been informed of this notice.

If you should have any further questions regarding this notice, please contact your Datex-Ohmeda sales or service representative or the undersigned at your convenience.

Alex Leung  
Manager—Customer Support/Quality  
and Regulatory

Direct Telephone: +61 2 9735 7266  
Direct Fax: +61 2 9746 1796

## MEETING AN ICON



College Honorary Solicitor, Michael Gorton, recently met Nelson Mandela in South Africa. Michael, as Victorian President of the United Nations Association of Australia, presented the UNAA Peace Award to Nelson Mandela in Johannesburg in October.

Michael noted, 'It was a great privilege to meet Mr Mandela, who has clearly been one of the world's outstanding leaders. His grace and presence were clearly felt. The United Nations Association of Australia recognised his pivotal role in the transition of South Africa to democracy and his influence on other world events.'

Michael took the opportunity to tour Johannesburg and Soweto to see how South Africa was performing in its transition to a modern economy and democracy. He noted that the black township of Soweto remained a huge social problem, although there were signs of some improvement in health, housing and employment.

He was also able to visit the Kruger National Game Park and noted that working at Russell Kennedy was more of a 'jungle'. He has now returned to reality.

*Reproduced courtesy of Russell Kennedy Solicitors*

# ANAESTHETIC SIMULATORS: TRAINING FOR THE BROADER HEALTH CARE PROFESSION

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## 1600 Friday

The scheduled surgery was a laparoscopic cholecystectomy. The patient was a challenge. He was obese with Atrial fibrillation. The day had been long and the operating team was suffering from fatigue. The lap chole was technically difficult, and this was compounded by problems with the insufflator. The blood pressure monitor was struggling because of the patient's

irregular pulse, and there was no access to an arm to perform a manual reading. The last measured BP was more than 10 minutes ago. The anaesthetist considered her options and concluded that at the risk of becoming unpopular, it was probably time to interrupt the surgery for a few minutes and sort it out. The surgeon obliged. The room was dark and the laparoscopic gear assembled around the head of the bed left little more than shoulder room for circulation. 'What now?' she thought to



*Australian Defence Forces team training exercise*

herself. Through the darkness came a signal suggesting a sudden increase in heart rate. She fumbled with the drapes with the intention of palpating the carotid artery. 'Unfortunately, we couldn't wait with this one' apologised her surgical colleague. 'How is he going?' 'You had better stop what you are doing' she replied. 'I can't feel a pulse'. The crisis had begun.

Whilst this situation is far from routine, it does represent part of a routine day at a high-fidelity Simulation Centre. Our anaesthetic colleague is one of four

specialist anaesthetists who have presented for the course, Anaesthesia Crisis Resource Management (ACRM). Over the course of the day, the participants of this course will encounter a series of uncommon and potentially catastrophic perioperative events, which will be orchestrated on a full-scale patient simulator, within a highly realistic operating-room environment.

The simulator comprises a life-size mannikin whose vital signs are generated by an electromechanical cart. The cart acts as an interface between the mannikin and the computer, which in turn controls it. The mannikin is wired with fully integrated cardiovascular and respiratory systems. His central nervous system is modelled to express level of

consciousness through speech, arm movement and eye signs. An anaesthetic monitor displays many aspects of his physiology, which reflects an integrated autonomic nervous system. Pharmacokinetic modelling allows the mannikin to respond automatically to a large range of drug administrations. He manifests in the order of thirty discrete pathophysiological events, which can be individualised to behave along a spectrum of presentations and responses. The outcome of any event will be determined by the system's

interpretation of the timeliness and appropriateness of the management achieved by the user. In addition, the simulator software has powerful editing capabilities and is able to generate physiologic profiles more or less from first principles. This allows an infinite range of scenarios to be generated.

Emergencies are typified by uncertainty, complexity and time pressure. Uncertainty exists regarding both the nature of underlying disease process and of the patient's response to it. Within the operating room environment, incidents can relate to not only the

process, the appropriateness of the clinical response, the ability of the individual staff members to coordinate their activities as a team, and the functionality of the equipment, environment and system in which the event is occurring.

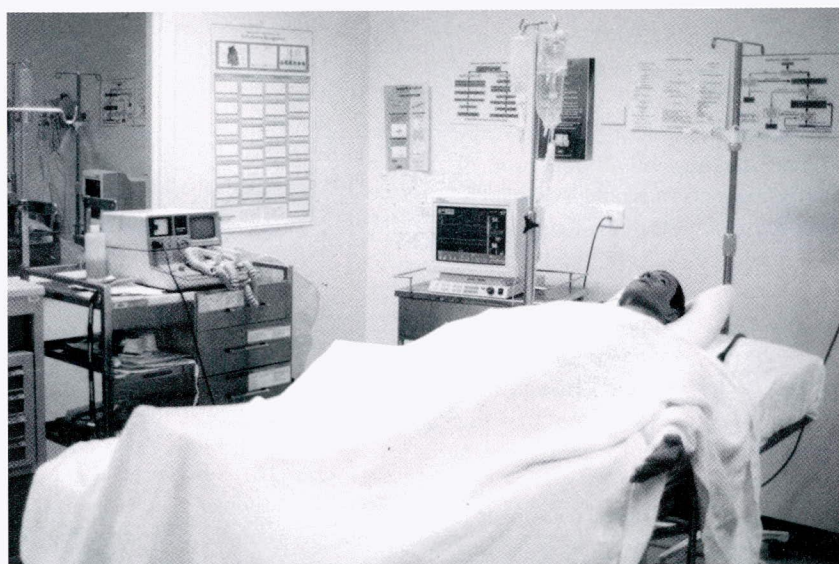
During a simulated event, the 'emergency conditions' described above are generated in order to maximise the realism of the event. 'Full-immersion scenarios' of this kind are a vehicle for the paradigm that poor 'behavioural management' has the capacity to reflect back and undermine otherwise

'human' error in the form of technical mistakes, omissions, memory lapses and errors of judgement to occur and compound the management problem<sup>1</sup>.

Figures obtained for anaesthesia suggest that serious unplanned incidents occur in five per cent of all anaesthetics administered<sup>2</sup>. The Australian Incident Monitoring Study (AIMS) revealed that human error contributed at some level to 83 per cent of volunteered reports describing critical incidents<sup>3</sup>. This is consistent with that described within other high-risk, complex and dynamic domains which include aviation, nuclear energy, and fire-fighting. Preliminary data available from the health care arena suggest that an extrapolation to other disciplines within medicine will be feasible<sup>4</sup>.

ACRM utilises the high-fidelity simulation environment to reproduce unplanned serious events coupled with the complex, stressful conditions with which they are usually associated. The scenarios are videotaped, and the recordings are used to facilitate a group debriefing of the event. This provides the participants with an opportunity for self-critique and to reflect upon the complex nature of their workplace within a constructive and non-judgemental setting. In addition, the debriefings are used as an opportunity to explore the nature of critical incidents and the contribution of system and human failure to the evolution and outcome of them. Finally, generic principles of complex problem solving, decision-making, resource management and teamwork behaviours are workshopped<sup>5</sup>.

The medical profession has been a relatively late subscriber to this form of training. Training which has the objective of developing global management skills and effective behaviours is well established outside of the health care profession. The use of high fidelity simulators within the medical domain has steadily increased in recent years and are used in approximately 150 centres



anaesthesia and surgery, but also to the immediate environment as well as events that have taken place prior to the patient arriving in the operating suite. Complexity may be associated with an atypical presentation, the occurrence of simultaneous problems or the clouding of the clinical presentation by other factors. These may relate to environmental conditions or other situations which are absorbing the attention of the staff. The effectiveness of management is conditional upon being achieved within an appropriate time frame. The rapidly changing status of the patient will accentuate the interdependence between the disease

acceptable clinical management. The medical team may be unable to achieve a reasonable standard of care because their response is poorly organised and managed ineffectively. Critical delays may result because relevant clinical signs are neglected; important tasks are awarded a low priority and initiatives are delayed because resources are not accessed appropriately. Fundamentally, these problems occur because of poor leadership, failure to distribute the workload and communication failures. Performance failures may affect every individual involved and importantly, their interactions as a team. Under such conditions, the potential increases for

internationally. Team training for the operating theatre environment is conducted in several centres in Europe and Canada<sup>6</sup>. ACRM training has been available to Australian anaesthetists since 1997 and is an accredited activity within their Maintenance of Professional Standards Program (MOPS). The Australasian region presently has four full-scale anaesthetic simulators. These are located in Sydney, Melbourne, Perth and Wellington New Zealand. To date, courses for anaesthesia user groups have not involved team training. Instead, experienced simulator faculty act out the roles of the surgeon and anaesthetic nurse, whilst a participant acts in the role of scrub nurse. The possibility of true team training in this arena is presently being explored.

Not surprisingly, the relevance of training opportunities available on these systems has impressed a number of non-anaesthetist user groups. CRM type training is presently conducted for nurses and medical staff from the specialty disciplines of intensive care, paediatrics, emergency and retrieval medicine, hyperbaric medicine, dentistry and the Armed Defence Forces (ADF). In this regard training is distinguished by workplace context. For example, the Army Reserve will train within a mobile military hospital and will encounter relevant field injuries, whilst intensivists will operate within the setting of an ICU, and so on.

The medium is best suited to small group training with optimal group sizes falling between four and 20 participants. Programs can be individualised to address specific training objectives. For instance, for some groups, CRM training is blended with basic sciences, procedural skills and integrated clinical skills training.

Future research and training activities may result in further expansion of this field. Training opportunities will be made available for a broader scope of users. This may involve adopting a

'modulated' approach whereupon topics are developed as independent generic modules and presented in context across user groups. Neonatal resuscitation is an example of such a module that is currently applied in this way.

Research activity will address several issues. It will endeavour to expand understanding regarding iatrogenic injury and medical mishaps; to obtain objective measures of clinical performance; to evaluate the validity of simulator-based training, and to explore the role of simulators as instruments of assessment. Early data has been obtained as a result of voluntary reporting and quality assurance activities. This has revealed a perception by health care professionals that system and human factors contribute in a significant way to the evolution and amplification of critical incidents within their domain<sup>7,8</sup>. Prospective simulator-based studies have reproduced these effects<sup>9</sup>. Furthermore, prior training on a simulator has been demonstrated to improve management of emergency events when assessed within this environment<sup>10</sup>. Investigators in this area are of the view that the dynamic and stressful conditions that exist during emergencies have the capacity to degrade clinical performance. To date, no objective measures have been obtained which describe any difference between realtime performance and levels of competency that have been achieved and measured using traditional assessment techniques. High-fidelity simulators can capture a greater component of those contextual factors which prevail during emergencies. They may continue to be useful tools in our understanding and preparation for them.

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To convert an in-patient procedure to one done in Day Care: Do we need guidelines?

For many social, medical and financial reasons, more procedures or operations that have been traditionally performed as an in-patient are being increasingly performed in a day care setting. This conversion to day care setting for some procedures is easy. However as the boundaries are pushed more widely, the possibility of diminishing the quality of care for patients becomes increasingly relevant. These boundaries may be anaesthetic, surgical, medical or social in origin.

The Day Care Anaesthesia Special Interest Group (DCA SIG) is considering issues related to these developments. This problem has been raised at meeting sessions related to Day Care Anaesthesia. Rather than attempting to diminish the scope of day care anaesthesia, the DCA SIG wishes to promote the orderly and considered transfer of procedures from an in-patient setting to that occurring in a day surgery setting.

To further this discussion the DCA SIG has developed an initial draft set of

guidelines covering this conversion process. These guidelines are a compilation of points from many sources, reflecting the collective knowledge of numerous clinical and administrative colleagues. They cover areas which many will regard as commonsense. They indicate processes that have been successful within individual centres, and in doing so, aim to avoid potential problems that could be revealed if the proposed project is not adequately researched by those involved in making the transition from overnight care to day stay. The guidelines aim to steer between the twin hazards of the over enthusiastic proponent and the inhibitory attitudes of the unyielding traditionalist. It is not intended that this document be a strict protocol, but an indication of how to achieve a safe result for the patient and job satisfaction for the medical, nursing and administrative staff involved.

These draft guidelines are open for discussion in as wide an audience as is possible. The views of the College Executive and Regional Committees are being sought. The Day Care Anaesthesia SIG welcomes any comments. We may

## GUIDELINES FOR CONVERSION OF IN-PATIENT TO DAY CARE PROCEDURE

be contacted via your local representative on the DCA SIG Executive. This Executive looks forward to your input.

DAVID KINCHINGTON  
Chairman, DCA SIG

### *Day Care SIG Executive*

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

# LETTER TO THE EDITOR

## Allergy Testing

For some years now we have provided a service to investigate patients after adverse response during anaesthesia which might have been anaphylaxis. A number of recent factors have meant we have to alter the way this service is provided. Firstly, we are no longer able to obtain funding at North Shore Hospital for the measurement of mast cell tryptase results and antibodies to anaesthetic drugs. A mast cell tryptase, performed with serum between 1-4 hours after the onset of a reaction, is perhaps the most important investigation that can be done. These tests are available at Royal Prince Alfred

Hospital and John Hunter Hospital in New South Wales. Because, for some time, there has been more than one centre providing this information, it has become extraordinarily difficult to track these results down and I am unable to provide the time to do this.

If anaesthetists have patients who have reactions that might be anaphylaxis that they wish us to investigate, 10 mls of serum should be sent to one of the aforementioned hospitals for measurement of mast cell tryptase results. It is essential that the time of the reaction and the time that the test is performed be notified. It would be very helpful when the test is requested to note on the form if a copy of the result could be sent to Malcolm Fisher, ITU RNSH St Leonards, NSW 2065. A detailed letter describing the drugs administered,

dosage, details of the reaction and response to treatment should also be sent to me, if you wish me to investigate the patient. We will only see patients who have a mast cell tryptase result with the appropriate times. When the letter is sent the mast cell tryptase results should be obtained and included in the letter. There are other doctors who now have some experience with the investigation of anaphylactic reactions. They include Dr RJ Mullins in Canberra, Dr Connie Katelaris at Westmead Hospital, and Dr David Sutherland, Department of Immunology at John Hunter Hospital.

Yours sincerely

Professor Malcolm Fisher  
Head, Intensive Therapy Unit  
Royal North Shore Hospital

NEW ZEALAND

The first full year of the new MOPS program has now concluded. Annual Returns for 1999 should be submitted by the end of February 2000 so that the College can provide feedback, a key element of MOPS. Participants can then be informed of the pattern of activities, by region and by hospital or private practice, to enable them to compare their activities with those of their peers.

The current program replaced the MOS program, introduced in 1995, which required participants to accumulate a minimum total of points over five years. Satisfactory completion of five years' activities entitled participants to a certificate 'which will be valid for five years'. This implied that the certificate entitled holders to take 'time off' from MOS for the following five years. As MOPS was introduced last year, before the completion of the first 5-year cycle of MOS, the 'five year on-five year off' principle was retained. Hence all current participants who complete five years' of participation in MOS/MOPS will be issued with a *Maintenance of Professional Standards Certificate*. Holders of this certificate will not be required to submit an annual MOPS return for the following five years. However, the College will issue a *Statement of Participation* each year only to participants who submit an annual return, irrespective of whether one holds a *Maintenance of Professional Standards Certificate*.

Continuing education implies on-going participation in educational activities,

and benefits are not realised by 'on-off' participation. I urge Fellows to continue to participate in the MOPS program after receiving their *Maintenance of Professional Standards Certificate*. A *MOPS Renewal of Participation* form will be provided to those completing their 5-year cycle and should be returned to the MOPS Office when re-enrolling.

The College will soon introduce the *Practice Peer Review* component of MOPS (in page 12 of the MOPS Program Manual). However, it will now be called *Professional Practice Review* (PPR) to better reflect its purpose; ie, to give feedback to the participant on his/her practice that will lead to further self-development. Details of the process whereby a Reviewer visits the participant at his/her practice will be made known when ready. It is not an objective of PPR, and indeed of MOPS itself, to audit competence. MOPS is registered under Australian and New Zealand legislations relating to QA activities, and documents pursuant to the program remain confidential to third parties or in legal proceedings. Nonetheless, in today's complex world, no professional activity can come with a 100 per cent litigation-free guarantee and Fellows should be aware of this. The College is cognisant of these implications and has sought legal advice and taken the necessary recommended steps.

MOPS differs from MOS in that it requires participants to attain minimum core points every year. These are 50 points in CME (equivalent to 17 hours'

activities per year) and 25 points in QA (equivalent to nine hours' activities per year). It is interesting to note that the ASA's submission in the Australian Relative Value Study indicates participation by anaesthetists in continuing education of an average of 200 hours each year. In comparison then, the core MOPS requirements are quite modest. MOPS was designed to encourage motivated self-learning; the concept of Local Meetings for CME and QA reflects this. Participants can earn core CME and QA points with their own group Local Meetings, an activity which appears under-utilised.

Finally, participation in MOPS remains voluntary. Presently over 60 per cent of Fellows are enrolled. Increasingly, hospitals require evidence of participation to accredit specialists. Medical boards may require mandatory MOPS participation, among other considerations, in their quest for annual re-certification of doctors. The College encourages all Fellows and practising anaesthetists to participate. MOPS will help you to keep at 'the cutting edge' of anaesthesia.

PROFESSOR TEIK OH  
QA/MOPS Officer

# THE STANDARD DEVELOPMENT OF ELECTRONIC ALARMS

By Dr Chris Thompson

In the 1970s, the diathermy machine was the only electronic noise in the operating room. The pneumatic oxygen supply failure whistle was there to let us know when our oxygen pipeline or cylinders ran out; but the rest of our equipment made no alarm sound.

Development of the piezo-electric 'Sonalert' allowed a transistor the size of a 20 cent piece to give a loud alarm tone. Almost overnight, electronic alarms became commonplace but they all made exactly the same tone. The volume was not adjustable, and worse still, the Sonalert's pure, high-pitched tone bounced off the walls and you couldn't find where it was coming from. Many anaesthetists preferred to disable the alarms rather than put up with the racket they made and this is exactly what happened.

In an effort to improve the situation, an Australian Standard (AS2901) was published in 1986. This specified acceptable volume ranges, easily audible pulses with at least four harmonics (to aid localisation) and suggested that modulation be used to indicate priority.

Six years later, an International Standards Organisation (ISO) Committee published requirements for alarms in anaesthesia and respiratory care equipment (ISO 9703-1, -2, and -3). Input advice came from many clinicians, particularly from anaesthesia and intensive care. Other experts included the person most responsible in Britain for systems alarms, Roy Patterson from the MRC Applied Psychology Unit in Cambridge. The goal was to standardise

both visual and auditory alarms in the operating theatre, so that they would be a more consistent help to the anaesthetist.

A basic concept was three levels of alarm priority. High level alarms indicated the need for immediate operator response, and used a flashing red light and a five-pulse 'beep-beep-beep, beep-beep' pattern that was repeated twice (in case you missed it the first time). Medium level alarms indicated the need for a prompt response from the operator and used a yellow or orange flashing visual signal and a slower three-pulse 'beeeep-beeeep-beeeep' pattern. Low priority alarms had to be different from and less intrusive than the others. Requirements for harmonic content and alarm volume were the same as the trail-blazing Australian standard. All of us will have heard these sounds recently—even if we didn't know what they meant—since Datex and several other manufacturers quickly adopted this standard.

The aim is that standardisation and prioritisation would improve the situation in the OR. Certainly visual alarms are much better, however the changes to auditory alarms have had some unanticipated consequences. No longer can a ventilator have its own distinctive alarm sound; the standard requires exactly the same sound from everything. While manufacturers can vary pitch and harmonic content, few have chosen to do so. On the other hand, some have created 'melodies' by varying the pitch of the notes (while retaining the rhythm). Each manufacturer can invent any melody they like, so they have—and some devices use different melodies for different types of alarms! Followed to its logical conclusion, every device could make a different melody (or melodies) but no particular melody will have any reliable meaning! In the end, we may have a lot of devices making exactly the same sound and a lot of other devices making sounds in the same pattern but with meaningless melodies.

For the last three years, the International Electrotechnical Commission (IEC), has been revising 601-1, the 'parent' standard which specifies the basic electrical requirements for all types of medical equipment. This revision specifies basic standard requirements for alarm systems for the first time. Specialised 'part 2' standards will then be written for individual device categories, and by this means some of the basic 'parent' alarm requirements can be customised to better meet the differing requirements, for example, of ventilators as compared to home oxygen concentrators.

A committee called the 'Joint Working Group on Medical Alarms' has been created between IEC and ISO (which writes standards for anaesthesia and intensive care) to write these new alarm requirements. For the last three years I have provided Australian expertise on this committee—thanks to the support of the College, the Society and Standards Australia.

The committee is chaired by John Hedley-Whyte, a retired anaesthetist from Boston. It includes representatives from government regulatory bodies (FDA etc), manufacturers, national standards associations, clinicians (three anaesthetists) and other experts. Typically about 35 people sit around a table and examine each clause of the standard at length.

One of the most difficult tasks has been to define a standard nomenclature. For example, the word 'alarm' itself has so many meanings that it cannot be used at all. In order to define 'false alarms' or 'nuisance alarms' we have needed to define 'alarm trigger event' (the actual event in the patient or the equipment which should cause an alarm), 'alarm condition' (the state that occurs when a monitored variable meets its alarm criteria) and 'alarm signal' (the auditory or visual signal that announces the alarm condition). Standardising what should happen when the 'silence' button is pressed has not been easy. How should



that differ from a 'suspend', 'reset' or a 'mute' function? What are the requirements for a 'disabled' system? How would these states be indicated to the operator?

Many of these issues are being resolved. Hopefully, the final document will provide:

- a robust standard vocabulary for alarm functions and states;
- better sound quality by ensuring adequate harmonic content and improving pulse contour;
- enhanced flexibility in alarm tone to differentiate one manufacturer from the next;
- standardised melodies based on the cause of the alarm; eg cardiac, ventilation, drug, oxygen etc;
- standardised means to temporarily or permanently silence or disable alarms;

- standard visual indications that the alarms have been silenced or disabled;
- encouragement of automatic alarm volume adjustment if background noise changes;
- standardised icons for on-screen buttons or displays relating to alarms;
- standardised visibility and legibility requirements for visual alarms;
- support for 'smart' alarms; eg functions like auto-enable, escalation if unattended, etc;
- suggestions for remote alarm systems; eg central stations, pagers, etc;
- different alarm requirements for continuously attended versus unattended equipment; and
- suggestions for customised default alarm sets in complex equipment.

These efforts should ensure that alarms provide real benefits for the operator. We hope to minimise false or nuisance alarms, to prevent them from being startling or intrusive and to ensure that alarms provide helpful clinical information before patient injury occurs. This is not a simple task but nonetheless agreement has nearly been reached on most of the major issues. The next step is a draft standard for public comment and should come out this year.

If any member of the College is interested in seeing the current draft of our work, please e-mail me (clt@mail.usyd.edu.au) and I can send it to you as a PDF document.

Please feel free to discuss any 'alarming' issues with me either by e-mail, fax (02) 9519 2455 or pager via RPA on (02) 9515 6111.



### **The IT Committee met recently at the First ANZCA Virtual CME meeting.**

*L to R: Prof Teik Oh, President Elect; Ms Maureen Henninger, Coordinator of Continuing Education School of Information, Library and Archive Studies, The University of New South Wales; Miss Karen Monette, Administrative Officer (IT); Dr Joe Novella, Convenor VC2000; Ms Lisa Greig, Solutions Manager Med-E-Serv; Dr Mike Martyn, Communications Officer and Chairman IT Committee; Ms Beth Hendy, Projects Officer Med-E-Serv.*

# OBITUARIES

## DR JOHN FRANCIS MAINLAND

VICTORIA — FFARACS 1963,  
FANZCA 1992

The recent death of John Mainland has taken from us a man who was the epitome of a quiet achiever. In everything he did—and the list is remarkably long—he put in a total effort, and found time to inspire and encourage many others of us to do the same.

He first graduated from the University of Melbourne in 1950 as a Bachelor of Science, majoring in biochemistry, chemistry and physiology. The latter was to play a determining interest in his subsequent career, as Professor Douglas Wright arranged an appointment as a Research Fellow in the fledgling Department of Pharmacology, under Professor Frank Shaw. It was my good fortune also to have a grant for part-time research in Professor Shaw's department in 1953, and a life-long association and friendship began. John went on to complete his medical degree in 1957 and training in the Royal Hobart Hospital where he met Jill. They married in 1959.

In 1959 he entered training as an anaesthetic registrar at the Royal Women's and Royal Children's Hospitals and later The Alfred Hospital. He was appointed a Senior Lecturer in Hugh Dudley's Monash University Department of Surgery at the Alfred, and in 1972 became Associate Professor (Anaesthesia) the first anaesthetist to be appointed with the title of Professor in Victoria. In 1987 when he entered into private practice with the Victorian Anaesthetic Group until he retired from practice in 1997.

Although this record would suggest a full professional life, it is only part of the story. Starting with the development of a foetal phonocardiograph in 1950, John continued to develop his substantial electronic and mechanical skills and knowledge. This led to John becoming a leading authority on, and a major contributor to, the development of standards for medical electrical equipment of all kinds, especially those used in the operating room. He served

on the Standards Medical Equipment Committee from 1977 to 1999; was advisor to several private hospitals and the Victorian Health Commission; was appointed to the Board of the Mercy Private Hospital; and was President of the Society for Medical and Biological Engineering (Victoria). His most remarkable invention was a respiratory monitoring module, developed with Bruce Cornell, which was adopted by the National Aeronautics & Space Administration (NASA, USA) for use in space exploration. Meanwhile, with Gabby Jenes and Bruce, he adapted the standard 'cow prod' stimulator to make a calf muscle stimulate for use during surgical anaesthesia: this contributed materially in lessening the risk of deep vein thrombosis in surgical patients. He also devised a sophisticated blood infusion monitor.

There is yet a further side to his attainments. In 1965 he was awarded the Gilbert Brown Prize for the best contribution to the session devoted to Recent Local Studies and Developments at the General Scientific Meeting. His knowledge of pharmacology led to his being appointed a Primary Examiner to the Faculty of Anaesthetists, Royal Australasian, College of Surgeons, and to the University of Singapore. If I may digress, a special comment must be made about his role as an examiner for the Faculty. The Primary was held initially in Melbourne and Sydney and then in New Zealand. With a growing demand, it was resolved to hold it in Perth, Singapore, Kuala Lumpur and Hong Kong. With his fellow examiners Maurice Sando, Bill Crosby, John Hankey and Noel Cass, all four centres were visited in about ten days, with a hectic program of travel, paper marking, oral exams and, of course, the generous hospitality of our colleagues. But this did not preclude some duty-free shopping, and at this John really excelled: items for his family and home, electronic gear, clothing and travel equipment were avidly pursued and acquired, and the fellow examiners voted him 'the Ace' (of shoppers!).

As would be expected, John was elected to the governing Board of the Faculty of Anaesthetists where he served for eight years, including appointments as Assessor of Training and Chairman of the Primary Examination Committee. He represented the Faculty on the Australian Resuscitation

Council, and he was Pharmaceutical Officer, Technical Officer and member of the Executive. He was a member of the Victorian Chairs of Anaesthesia Committee, and a member of the Editorial Board of the Journal *Anaesthesia and Intensive Care*. He co-authored six papers in leading journals and contributed to national and international meetings. His most influential publication was *Safety in the Operating Theatre*, co-authored with Hugh Dudley in 1976, and a landmark in the systematic pursuit of safety in this increasingly complex environment. The Australian and New Zealand College of Anaesthetists conferred its Medal for outstanding contributions to the College and to anaesthesia shortly before his death.

John was essentially a family man. He and Jill had three daughters and a son, and their daughter Phoebe became an anaesthetist. Their home in Highfield Road was a centre of welcoming hospitality, and members of his Journal Club spent many enjoyable and informative hours there. The goat farm they bought and developed reflected his innovative skills and standards of perfection. More recently he and Jill bought their delightful property at Harkaway where their friends were again made most welcome. He equipped his four-wheel drive with the most sophisticated systems, and enjoyed these to the full with extensive travel in central and northern Australia.

Above all he was a man of unshakeable integrity and loyalty, a mentor and friend of colleagues and a wonderful person to know. He accepted the news of his serious illness with equanimity and bore the burden of it with optimism and without complaint. I know he would want me to thank Jill for her unwavering support in this as in so many other parts of their life together, and I speak for his many friends when extending to her, Phoebe, Rosalyn and Bruce, Roderick and Georgina, Bridget and their grandchildren John and Hugo our deepest sympathy at this sad time. He has left a legacy of which they can be very proud indeed. Even his remarkable modesty and humility cannot disguise his signal contributions in so many fields.

NOEL CASS

## **DR GEORGE TAY**

**SINGAPORE – FFARACS 1972,  
FANZCA 1992**

Dr George Tay's exposure to anaesthesia started in 1952, when as a surgical houseman in Singapore, he had to administer anaesthetics for emergencies. He was persuaded by the specialist anaesthetist, Dr EG Hudson (who later emigrated to Perth) to follow the path. He subsequently left for training in Liverpool, UK, and in that great centre, his teachers included the giants of anaesthesia: John Dundee, Cecil Gray and Jackson-Rees. He obtained the FFARCS and returned to Singapore in 1958, and with other pioneers like Drs Brian D'Bras, Fred Pais, Tan Seng Huat,

Chiu Hock Heng, Sivagnaratnam, Raymond Pereira, and GS Yeoh, built up the teaching, infrastructure, and practice of anaesthesia in Singapore.

George Tay was a member of the first Anaesthesia Department in Singapore, at the Outram Road General Hospital. He was a founder member and President-Elect of the Singapore Anaesthetic Society in 1964, and was President again when Singapore hosted the 4th Asian-Australasian Congress of Anaesthesiologists in 1974. He was a founder member and the first Chairman of the Chapter of Anaesthetists, Academy of Medicine of Singapore. He also helped to establish the first M.Med Anaesthesia examinations conducted by the Committee of Anaesthesia, School of Postgraduate Medical Studies of the National University of Singapore. He was conferred FFARACS in 1972 and FANZCA in 1992.

George Tay was a friend and mentor to many, especially his younger colleagues. He was known affectionately by one and all as 'Uncle George'. He was a great teacher in pharmacology (a dedication he acquired from Dundee) and he continued to teach after he entered private practice in 1962. He was an active supporter of the Singapore anaesthetic community, ANZCA, and of the specialty itself. George had a multitude of friends all over the globe.

He was a great host, who took you to the best Thai restaurants and made sure that ample liquid refreshments were freely available. Many of us will miss Uncle George, a giant in anaesthesia in this region of the world.

Teik Oh, SS Dhara, TL Lee

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## **DR MARY CLARENZA SALVARIS (NEE IRVINE)**

**GREECE – FFARACS 1960,  
FANZCA 1992**

Mary Salvaris was a quiet pioneer who brought love and courage to all the events of her varied life: from country practice in Gippsland, army service, a multicultural marriage and anaesthetic practice in Melbourne, to life in a Greek village and terminal illness.

At St Mary's in Perth Dr Salvaris was an outstanding student and a keen swimmer and lifesaver. She had set her heart on medicine, but in the 1930s female doctors were rare and there was no medical faculty in Western Australia. So, in 1936, she enrolled at

Melbourne University, graduating in 1940. After a year's hospital residence, she served with distinction as a captain in the Australian Army Medical Corps. After her marriage Mary continued to practice medicine in her maiden name, Irvine.

After the war, Mary and her husband Michael Salvaris, set up general practice together in the Gippsland town of Maffra, becoming a popular team. Dr Mary, as she was widely known, was a much-loved figure, specialising in home visits to outlying dairy farms, sometimes in an amphibious army vehicle during floods.

In the mid-1950s Michael decided to specialise in urological surgery, Mary took a complementary specialty in anaesthesia, training in London and the United States, and returning to Melbourne in 1959 to join what was then a small band of female medical specialists. Thus the family general

practice was reborn as a husband and wife surgical team.

In 1978, she and Michael retired to Greece, to the coastal village of Galaxidhi near Delphi. There they bought The Anthi, a former guesthouse. But within a year, tragedy struck: Michael died of a heart attack. Mary decided to stay on in Greece—for nearly 20 years.

Last October Mary was diagnosed with liver cancer and passed away on 5 January. She made sure her last months with her family were as happy and memorable as possible.

Mary had a special kind of wisdom and dignity that inspired affection and admiration, but all her life she retained a stubborn humility.

# CHANGE TO COLLEGE REGULATIONS — PART TIME TRAINING

In the past, part-time training was not permitted in the first two years of approved training. Part-time training is now permissible in any year of training provided prospective approval is granted by the Assessor and training is completed within ten calendar years.

## 15.7 Part-time Training

- 15.7.1 Is acceptable for training but will be considered only on an individual basis subject to the items noted below.
- 15.7.2 Must have prospective approval and be for reasons acceptable to Council whose authority will be delegated to the Assessor.
- 15.7.3 Must be supported in writing by the trainee's Head of Department with the agreement of the Hospital Administration.
- 15.7.4 Is permissible in any year of training. No time beyond two years of effective full-time training will be recognised until the Primary Examination has been passed.
- 15.7.5 Must result in the same training in time and content as is required for full-time trainees. Regulation 15.6.5 requiring completion of training within ten years still applies.
- 15.7.6 Requires a commitment to both in-hours and emergency duties. These duties must be assigned on a pro rata basis and must comprise a minimum of 50% of the commitment of a full-time trainee.
- 15.7.7 Must involve participation in regional and/or hospital teaching programs.
- 15.7.8 Requires registration with the College and normal payment of the Annual Training Fee. Part-time trainees should maintain a log book so that their workload and training time can be accurately evaluated.

# FACULTY OF PAIN MEDICINE DEAN'S MESSAGE



Looking back on 1999, it is apparent that the Faculty has come a long way in a very short space of time. That this has been accomplished with very few, if any, hitches is a tribute to the representatives of participating specialty bodies on the Board, and the key committees: Examination, Education and Hospital Accreditation.

## **Education Committee**

This Committee has been very active in carrying out a major update of the Manual on Training and Reference List. For example, particular attention has been given to the need for additional material on:

- Headache
- Musculoskeletal Pain
- Medico-social Aspects of Pain
- Psychiatry/Psychology and Pain
- Imaging and Assessment of Pain Problems

## **Examination Committee**

This Committee worked hard over a very short time frame to develop the structure for the first examination. This included a review of appropriate specialty examinations in Australia/New Zealand and overseas. The Chairman was greatly helped by observing the Final Examinations in Intensive Care and Rehabilitation Medicine, both examinations having significant ingredients of relevance to the Faculty examination. The **first examination** was held at Royal North Shore Hospital on 25 and 26 November 1999 (see adjacent item).

## **Hospital Accreditation Committee (HAC)**

The HAC is in the process of evaluating a number of submissions for recognition of new training programs. Also in 2000 all existing training programs will be reviewed.

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

The Faculty and the SIG on Acute Pain will jointly revise this document, using NHMRC guidelines for preparing such documents. Drs Suellen Walker, Pam Macintyre and Penny Briscoe will represent the Faculty on the working party.

## **American Academy of Pain Medicine**

The Faculty has been invited by the Academy to consider an involvement in the new AAPM journal *Pain Medicine*.

## **Pain Medicine Trainees in Palliative Medicine Positions**

It has been agreed that our trainees are encouraged to seek experience in Palliative Medicine programs. However such programs should have a formal attachment to an ANZCA approved Pain Centre and the rotation must be prospectively approved by the Faculty Censor.

## **Palliative Medicine Chapter Formation**

The RACP has accepted the development of a training program in Palliative Medicine. Our Faculty has formed a Working Party to liaise with the Chapter. Dr Paul Glare FRACP has accepted the invitation to Chair this Working Party.

The Chapter has recently called for nominations for Foundation Fellowship in Palliative Medicine (closing date is 31 March 2000).

## **Paediatric Pain Medicine Practitioners**

Dr Suellen Walker has commenced discussions with Paediatric Pain Medicine Practitioners.

## **Web Site**

The Faculty now has a web site. Access is obtained by [www.fpm.anzca.edu.au](http://www.fpm.anzca.edu.au). Fellows and trainees are encouraged to begin using the site. Dr Terry Little deserves our thanks for his hard work in establishing the site.

## **ASM 6 – 10 May 2000 Melbourne**

I hope that all Fellows will attend this meeting. Professor Dan Carr from Tufts University School of Medicine in Boston is our first invited speaker from overseas and Dr Terry Little has put together an excellent program. Recently elected Fellows and successful candidates from the examination who have met all criteria for Fellowship will be invited to be presented at the College Ceremony on Saturday 6 May 2000.

MICHAEL J COUSINS AM

The structure of the first examination was described in the last *Bulletin*. In brief the format was:

#### Day 1 am **Written Examination**

Short answer questions: five 'core knowledge' questions compulsory and five out of ten non-compulsory questions. Duration was 2.5 hours. Total marks 25.

assemble material. 30 minutes viva with two examiners. Total marks 25.

#### Day 2 pm **Structured Interviews**

Three stations (10 minutes each) with two examiners; interviews focussed on acute, chronic and cancer pain respectively. Total marks 25.

The Court of Examiners unanimously agreed that the structure of the



#### **Successful Candidates:**

*Drs Will Howard, Larry Kahn, John Henshaw, Eric Parisod, Henry Lam, Leah Power, Anne Chan, Winnie Hong, Geoffrey Needham, Martin Kennedy, Jennifer Stevens*

#### Day 1 pm **Short Cases**

Three stations (10 minutes each) with patients with acute, chronic and cancer pain respectively. One station with medical imaging and one station with an actor role playing an ethical consultancy issue. Two examiners assessed candidates at each station. Total marks 25.

examination was appropriate and should be retained, the examination conduct was of a high standard and represented a very rigorous process for the candidates.

As is the case in the Final FANZCA and Final FICANZCA, the FFPMANZCA examination was criterion based, with an overall pass requiring a pass in at least two sections and more than 50 marks out of 100 overall.

All 12 candidates in the initial

#### Day 2 am **Long Case**

One hour history taking and physical examination. 20 minutes to



#### **Court of Examiners:**

*Back L to R: Drs Newman Harris FRANZCP, Matthew Crawford FANZCA, Richard Chye FRACP, David Jones FANZCA, Bruce Rounsefell FANZCA, John Corry FRACP, FAFRM (RACP), Paul Glare FRACP  
Front L to R: Pam Macintyre FANZCA, Prof Tess Cramond FANZCA, Dr George Mendelson FRANZCP, Michael Cousins FANZCA (Chair, Examination Committee), Mr Leigh Atkinson FRACS, Drs Penny Briscoe FANZCA (Deputy Chair), David Gronow FANZCA*

The National Health and Medical Research Council has awarded a substantial new grant of \$211,000 for 2000 and 2001 to the MASTER Trial investigators—Paul Myles, John Rigg, Konrad Jamrozik, Brendan Silbert and Phil Peyton—to complete the Multicentre Australian Study of Epidural Anaesthesia (MASTER) Trial over the next two years.

This project began with a grant from the Australian and New Zealand College of Anaesthetists in 1995. From January 1 1997, the Trial has been supported primarily by a large project grant from the NHMRC. More than 665 patients have been randomised in 23 hospitals in Australia, Hong Kong, Malaysia and Thailand since 1995. At the current rate of recruiting eligible patients, the projected sample size of 900 will be achieved in the first four months of 2001.

The results of the MASTER Trial will provide a substantial addition to the body of contemporary level one evidence to bear on the question of the role of perioperative epidural block in improving outcome in high risk patients undergoing major surgery. A recently published review (Ballantyne et al. *Anesth. Analg* 1998;86:598-612) found some evidence of benefit leading the authors to conclude that 'at the very least, these data provide the rationale for a very large randomised trial'. A more recently completed, but as yet unpublished, historical meta-analysis of all randomised trials conducted in the past 30 years, suggests a substantial and important reduction in morbidity and mortality associated with the use of spinal and epidural block. This study included only 1200 patients randomised in the abdominal surgery group, and the MASTER Trial data will therefore make a major contribution to the sum of the database in this important subgroup. A manuscript recently submitted 'Rigg JRA, Jamrozik K, Myles PS, Silbert B, Peyton P, Parsons RW, Collins K. Design of the Multicenter Australian Study of

Epidural Anesthesia and Analgesia in Major Surgery: The MASTER Trial' has been accepted for publication this year in *Controlled Clinical Trials*.

Details of the ANZCA meeting satellite symposium immediately following the ASM, are given elsewhere in this issue of the *Bulletin*.

The MASTER Trial investigators acknowledge the substantial contribution made in the past five years by participating hospitals in the MASTER Trial group (listed below) and would welcome additional hospitals in Australia, New Zealand and South East Asia to contribute to the database. Further details about the trial and the protocol can be obtained by contacting:

Dr John Rigg  
0417 186 457  
jrarigg@cyllene.uwa.edu.au  
Dr Konrad Jamrozik  
(08) 9380 1254  
konrad@dph.uwa.edu.au  
Karen Collins, Trial Co-ordinator  
(08) 9380 1354  
karen@dph.uwa.edu.au  
Fax (08) 9380 1188  
Dr Paul Myles  
(03) 9276 3176  
P.Myles@alfred.org.au  
Dr Brendan Silbert  
(03) 9288 2211  
SILBERBS@svhm.org.au  
Dr Philip Peyton  
(03) 9496 5704  
phil@austin.unimelb.edu.au

The MASTER Trial Study Group consists of:

*Department of Public Health, The University of Western Australia*  
John Rigg; Konrad Jamrozik, Richard Parsons, Karen Collins  
*Data Monitoring Committee*  
Michael Hobbs, Richard Parsons  
*Alfred Hospital, Melbourne, VIC*  
Paul Myles, Helen Fletcher, Jenny Hunt  
*Austin and Repatriation Medical Centre, Heidelberg, VIC*  
Philip Peyton, Stephanie Poustie

## NHMRC FUNDS MASTER TRIAL FOR A FURTHER 2 YEARS

*Ballarat Hospital, Ballarat, VIC*  
Mark Tuck  
*Box Hill Hospital, Melbourne, VIC*  
John Paull  
*Chiang Mai University, Thailand*  
Yodying Punjasawadwong  
*Dandenong, Hospital, VIC*  
Susannah Sherlock, Maryanne Sparrow  
*Geelong Hospital, VIC*  
Mark Colson  
*Hollywood Private Hospital, Perth WA*  
John Storey, Jenny Bassatt  
*King Edward Memorial Hospital, Subiaco, WA*  
Michael Paech, Tim Pavy  
*Lismore Base Hospital, NSW*  
Chris Lowry, Jenny Prince  
*Mater Misericordiae Hospital, QLD*  
Heinz Rodins, Angela Skirving  
*Northern Hospital, VIC*  
Glen Burgin; Pamela Youde  
*Nethersole Eastern Hospital, Hong Kong*  
Guek Swee Teoh  
*Penang Hospital*  
S.H. Ng, Tan Wooi Bee  
*Princess Alexandra Hospital, QLD*  
Janine Solomos  
*Rockhampton Base Hospital, QLD*  
Melanie Nicolson, Jenny Pocock  
*Royal Melbourne Hospital, VIC*  
Marianne Wallace, Jenny Pang  
*Royal North Shore Hospital, NSW*  
Stephen Barratt, Alexandra Zammit  
*Royal Perth Hospital, Perth, WA*  
Chris Cokis, Susan March  
*Prince of Wales Hospital, Hong Kong*  
Phoebe Mainland, BB Lee, WD Ngan  
Kee, Eliza Wong, Justina Liu  
*Singapore General Hospital*  
Chee Seng KONG  
*St Vincent's Hospital, VIC*  
Brendan Silbert, Carolyn Blythe  
*University of Malaya Hospital, Malaysia*  
Gracie Ong, Ng Kwee Peng, Ramani Vijayan, Alexius Delilkan

# FACULTY OF INTENSIVE CARE

## DEAN'S MESSAGE

At its February meeting, the Board of Faculty accepted a proposal to introduce a separate Faculty subscription from the 2001 year. The Board appreciates that additional financial imposts are rarely popular and particularly at a time when other financial constraints are occurring. This action, however, is essential to the future of the Faculty.

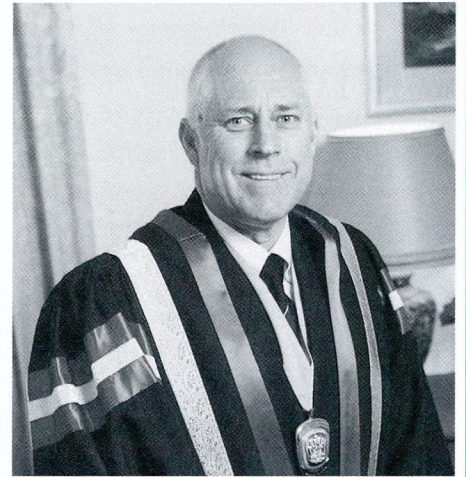
When the Faculty of Intensive Care was formed in 1993, a decision was made not to introduce a separate subscription. In retrospect, this was probably unwise. It contrasts with the Faculty of Pain Medicine which was formed de novo and where a separate subscription was struck from the outset. This current situation represents an anomaly within the College. It is also clear that the Faculty of Intensive Care is subsidised by the College to some extent and this needs to be addressed.

The Faculty must become self-funding and indeed be in a position to expand activities in areas such as education and research. Currently, the Faculty has no assets of its own. It is the view of a majority of Fellows that the Faculty should ultimately evolve to become a College of Intensive Care Medicine. In the meantime, therefore, it is essential that the Faculty begins to accumulate reserves and to operate independent accounting structures.

A proposal regarding a fee structure has been passed to the ANZCA Executive for consideration.

The complete details of the subscription package will be communicated to Fellows as soon as they are finalised and have been accepted by Council.

Fruitful discussions occurred at the Board Meeting regarding the proposal for a Joint Faculty of Intensive Care Medicine in conjunction with the Royal Australasian College of Physicians. Whilst there are many issues to be resolved, we believe that it would be possible to develop a Joint Faculty without dissolving the current Faculty and without jeopardising trainees in any way. The involvement of the Board's RACP co-opted observers has been crucial to the Board's understanding of issues from an RACP perspective and in further developing this proposal. Although bringing this task to a conclusion is some way off, I am now confident that there is light at the end of the tunnel.



Details of the proposal will be published when they are further developed. Intensive care specialists are clear about their aspirations in this area and dialogue is continuing at a number of levels to ensure that these aspirations are satisfied. Ultimately the resolution of this matter will require the support of both Colleges and which I am sure we will receive.

Last but not least I wish to remind all Fellows to register for the ASM in Melbourne in May. The scientific program promises to be stimulating and the social aspects of the meeting exciting. Remember that this is a combined meeting with the Victorian Branch of ANZICS. I hope that Fellows will therefore encourage all intensive care specialists and trainees regardless of background to participate in the meeting.

A.W. DUNCAN, DEAN



# FACULTY OF INTENSIVE CARE, ANZCA ANNUAL SCIENTIFIC MEETING

MELBOURNE MAY, 2000

This year, the Annual Scientific Meeting of the Faculty of Intensive Care is being held in the sumptuous surroundings of the Crown Towers Complex in the Southbank precinct on the banks of the Yarra River, Melbourne. However, delegates will have little time to enjoy the stunning views of the city skyline, or watch the river traffic, as the Intensive Care scientific and social program is sure to keep everyone on their toes.



The Foundation Visitor, **Professor Paul Pepe**, is the Chairman of Emergency Medicine for the University of Texas Southwestern Medical Center in Dallas where he will head emergency services for Parkland Memorial Hospital. His innovative research in the areas of emergency medical services and resuscitation has gained international recognition and his dynamic presentations will be a highlight of our Meeting.

**Professor Paul Hebert**, our Invited International Visitor, is Associate Professor of Medicine (Critical Care) and Epidemiology at Ottawa University, Canada. As a key member of the Canadian Critical Care Trials Group, he is heavily involved in collaborative research in Critical Care Medicine, most recently including the controversial Transfusion Requirements in Critical Care (TRICC) study. His broad research experience spans areas of direct clinical relevance to Intensive Care Medicine and, like Professor Pepe, he has also been involved in resuscitation medicine research.

**Professor David Hoyt** from San Diego, in Melbourne as a speaker at the concurrent RACS ASM, will also join us to present his work on hypertonic saline. In addition to the international guests, a broad array of national speakers including many Fellows, will combine to provide a balanced but exciting scientific program relevant to the practising intensivist.

**The Scientific Program** will commence with the Refresher Course on Saturday morning (May 6) covering six core topics where recent advances have altered practice. This will be followed by the main ASM program, commencing with a thought-provoking plenary session exploring the position of Australian medicine in research in the next millenium. The Intensive Care program will cover areas of transfusion practice, fluid resuscitation, trauma management, advances in ventilation and Intensive Care research.

For those Fellows with an interest in resuscitation or those simply wishing to update their knowledge of current CPR practices, a **Satellite Meeting** CPR-State of the Art will be held on Friday 5 May at the Royal Melbourne Hospital, with speakers including Prof Pepe, Prof Hebert, Prof V Callanan (Townsville) and Dr I Jacobs (Perth) plus local experts.

No discussion of the Faculty Meeting is complete without reference to the social

highlight—the **Intensive Care Dinner**. As an internationally recognised sporting arena, the MCG has hosted many exciting events and the Intensive Care Dinner on Sunday May 7 will certainly be a memorable night. Delegates will meet for drinks and canapes in the Australian Gallery of Sport before being taken on a guided tour of the historic Melbourne Cricket Club Pavilion including the famous Long Room and the Members' Stand before venturing down to the hallowed turf itself. Dinner will be held in the Landy-Cuthbert Room with panoramic views of the Ground.

The Faculty of Intensive Care program has been designed to ensure stimulating presentations covering diverse clinical areas of relevance to practising intensivists. The Victorian Regional Committee, FICANZCA, and the Organising Committee for ASM 2000 would like to extend a warm invitation to all Fellows to join us in Melbourne and we look forward to your participation in this exciting Meeting.

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## ADMISSION TO FELLOWSHIP OF THE FACULTY OF INTENSIVE CARE, ANZCA

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

Orlando Agostinho Monteiro	NSW
Christian Hermann Böhringer	NSW
Peter William James Harrigan	NSW
Mark John Hayden	UK
(endorsed Paediatric Intensive Care)	

The following Fellow was admitted by election under Regulation 5.3:

Daryl Richard Catt	SA
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# ITEMS OF INTEREST FROM THE FEBRUARY 2000 BOARD MEETING

## INTERNAL AFFAIRS

### Honours and Appointments

The Board congratulated Professor Teik Oh on his election as President-elect. The award of the Order of Australia Medal (OAM) to Professor Tom Torda in the recent Australia Day Honours List was also recognised.

### Election of Dean-elect

Dr Felicity Hawker was elected Dean-elect and will take office from June 2000.

## EDUCATION AND TRAINING

### Joint Specialist Advisory Committee – Intensive Care

The Board noted the election of Dr Ray Raper, FRACP, as Chairman of the JSAC-IC, and extended its thanks to Dr Felicity Hawker for her chairmanship. Under the auspices of JSAC-IC a further trial of logbooks is being conducted around Australia.

The results of the survey of trainees and recent graduates on quality and quantity of supervision and training have been referred to the next meeting of the Committee.

### Accreditation of Training

The Board reconfirmed its view that for the core component of intensive care training, one year must be continuous and undertaken in a single Intensive Care Unit. The requirement to complete 12 months training in a C24 Unit (ie one with unrestricted training) may be fulfilled in the other year of training, and may be done in two six-month periods.

### Careers document

The Board agreed to prepare a careers document for medical practitioners and undergraduates to promote the specialty and provide information on intensive care training.

## EXAMINATIONS

### Eligibility to sit the Fellowship Examination

The Board has amended its Administrative Instructions regarding eligibility to sit the Fellowship

Examination in Intensive Care. Candidates are no longer required to be in a training position at the time of application to sit the Examination, or to have occupied a training post up to two years prior to the date of the Exam.

### Oversight for candidates not occupying training positions

The Board resolved that candidates for examinations who are not in a training position should be appointed a mentor. The mentor may be a local Supervisor of Training or the Regional Education Officer. He or she will be able to provide advice to candidates in this situation regarding opportunities for teaching and exam preparation, and other matters relating to training.

## PROFESSIONAL AFFAIRS

### A single body for intensive care training and certification

Discussions regarding a joint Faculty of Intensive Care were pursued at the Board meeting in anticipation of a meeting with representatives of the Royal Australasian College of Physicians.

### Policy Documents

The following document was approved by the Board:

IC-13 Minimum Standards for High Dependency Units Seeking Accreditation For Training in Intensive Care

The following policy documents were reviewed and amended:

IC-4 The Supervision of Vocational Trainees in Intensive Care

IC-7 Secretarial Services to Intensive Care Units

The following joint statements by the College and Faculty were recently approved by Council:

PS39 Intrahospital Transport of Critically Ill Patients

PS40 Guidelines for the Relationship between Fellows and the Healthcare Industry

These documents are published elsewhere in the *Bulletin*.

### Maintenance of Professional Standards

The Board is continuing to investigate the possibility of an electronic diary for Fellows. The Paper Diary was distributed in January.

### Vocational Registration in New Zealand

It was noted that as from October 1999, Intensive Care Medicine is a separate Branch of Medicine in New Zealand, following the introduction of the Medical Practitioners' (Vocational Registration) Order of 1999.

### Care of the Critically Ill Surgical Patient Course

The Board supported continuing involvement of the Faculty in the development of the CCrISP course of the Royal Australasian College of Surgeons.

## FINANCE

The Board produced a number of recommendations relating to the introduction of a separate intensive care subscription, in the interests of future financial independence. These recommendations have been referred to ANZCA Council for consideration.

## CONTINUING EDUCATION

### ASM Melbourne 2000

The Board noted that the Foundation Visitor Professor Paul Pepe, will visit Adelaide in addition to the Annual Scientific Meeting in Melbourne.

# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

AND

## FACULTY OF INTENSIVE CARE

A.C.N. 055 042 852

### POLICY DOCUMENTS

- IC-1 (1997) Minimum Standards for Intensive Care Units *Bulletin Aug 94, pg 44*
- IC-2 (1994) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts *Bulletin Aug 94, pg 49*
- IC-3 (1998) Guidelines for Intensive Care Units seeking Faculty Accreditation for Training in Intensive Care *Bulletin Nov 98, pg 70*
- IC-4 (1994) The Supervision of Vocational Trainees in Intensive Care *Bulletin Aug 94, pg 54*
- IC-5 (1995) Duties of Regional Education Officers in Intensive Care *Bulletin Nov 95, pg 50*
- IC-6 (1995) Supervisors of Training in Intensive Care *Bulletin Nov 95, pg 46*
- IC-7 (1994) Secretarial Services to Intensive Care Units *Bulletin Aug 94, pg 57*
- IC-8 (1995) Ensuring Quality Care - Guidelines for Departments of Intensive Care *Bulletin Mar 95, pg 32*
- IC-9 (1997) Statement on Ethics and Patients' Rights and Responsibilities *Bulletin Nov 97, pg 68*
- IC-10 (1996) Minimum Standards for Transport of the Critically Ill *Bulletin Mar 96, pg 42*
- IC-11 (1996) In-Training Assessment of Trainees in Intensive Care *Bulletin Mar 96, pg 46*
- IC-12 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin May 96, pg 66*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
- PS39 (2000) Intrahospital Transport of Critically Ill Patients *Bulletin Mar 2000, pg 53*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin Mar 2000, pg 55*

# POLICY DOCUMENTS

PS39 (2000)

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

Critically ill patients have absent or small physiological reserves. Adverse physiological changes in these patients during intrahospital transport are common and can be life-threatening. Ventilator-dependent and haemodynamically unstable patients are at particular risk. Careful planning is required to move these patients between hospital facilities such as operating theatres, ICU, Emergency, imaging rooms, and wards. Such intrahospital transport is usually elective, but a need for urgency must also be anticipated (such as moving the patient to the operating theatres after a diagnostic procedure).

### 2. PROTOCOL

- 2.1 Relevant staff should formulate their hospital's protocol of intrahospital transport of critically ill patients. The protocol should be made widely known and available.
- 2.2 The transport itself must be justified. Whatever benefits of proposed interventions must outweigh the risks of moving the critically ill patient and those posed by the interventions themselves.

### 3. EQUIPMENT

- 3.1 Equipment must be dedicated to intrahospital transport.
- 3.2 The equipment should be durable, and trolley-linked devices must be able to enter lifts and pass through all doorways en route.
- 3.3 All equipment must be able to function in the specific intervention area (e.g. a magnetic resonance imaging room) and facilities for remote patient monitoring should be available where required. Gas, suction, and electrical supplies at the destination must be present and compatible.
- 3.4 No equipment should be placed on the patient; specially designed receptacles or transport trolleys are useful.
- 3.5 Basic monitoring of ECG, heart rate, blood pressure by invasive or an automated non-invasive monitor, and oxygen saturation by pulse oximetry must be available for all patients.
- 3.6 A defibrillator and a suctioning device must be available.
- 3.7 A portable ventilator with a disconnect alarm is recommended for ventilator-dependent patients.

None-theless, a manual resuscitator bag must always be available. Facilities to deliver PEEP and different modes of ventilation are necessary for some patients with pulmonary pathology.

- 3.8 Infusion pumps and monitoring of end-tidal CO<sub>2</sub> and minute volume are highly recommended.
- 3.9 Appropriate fully charged, spare battery packs for electrically driven devices must be available.
- 3.10 Equipment to secure the airway, and emergency drugs, analgesics, sedatives, and muscle relaxants must be available; these are best carried in a dedicated emergency box.
- 3.11 A procedure must be implemented to ensure that all intrahospital transport equipment is readily accessible and regularly checked.

### 4. STAFF

- 4.1 Key personnel for each transport event should be identified. The transport team should consist of a nurse, an orderly, and an appropriately trained doctor. Additional staff may be necessary for patients with haemodynamic instability.
- 4.2 Each team must be familiar with the equipment and be sufficiently experienced with securing airways, ventilation of the lungs, resuscitation, and other anticipated emergency procedures.

### 5. PRE-DEPARTURE PROCEDURES

- 5.1 The transport team must be freed from other duties.
- 5.2 The receiving person or staff at the destination must be notified, and the arrival time must be clearly understood.
- 5.3 All pieces of equipment must be checked, and notes and imaging films gathered. An example of a checklist is listed below. Individual responsibilities for checking equipment must be defined.
  - 5.3.1 The ECG and invasive pressure monitors (when used) function properly; alarm limits are set.
  - 5.3.2 The non-invasive blood pressure monitor functions properly; alarm limits are set.

- 5.3.3 The pulse oximeter functions properly; alarm limits are set.
- 5.3.4 The capnometer functions properly; alarm limits are set.
- 5.3.5 The manual resuscitator bag functions properly.
- 5.3.6 The ventilator (if used) functions properly; respiratory variables are set.
- 5.3.7 The ventilator disconnect alarm (if a ventilator is used) functions properly.
- 5.3.8 The suction device functions properly.
- 5.3.9 Oxygen ( $\pm$  air) cylinders are full.
- 5.3.10 A spare oxygen cylinder is available.
- 5.3.11 Airway and intubation equipment are all available and working.
- 5.3.12 Emergency drugs, analgesics, sedatives, and muscle relaxants are all available.
- 5.3.13 Additional drugs are made available if indicated.
- 5.3.14 Spare IV fluids, inotropic solutions, or blood are available if needed.
- 5.3.15 Spare batteries are available for all battery-powered equipment.
- 5.3.16 Chest tube clamps (if an underwater chest drain is present) are available.
- 5.3.17 Patient notes, imaging films, and necessary forms (especially the informed consent form) are available.

## 6. PATIENT STATUS

- 6.1 Final preparations of the patient should be made before the actual move. Examples include giving appropriate doses of muscle relaxants or sedatives, replacing near-empty inotropic and other IV solutions with fresh bags, and emptying drainage bags.
- 6.2 The patient must be briefly assessed before transport begins, especially after being placed on monitoring equipment and the transport ventilator (if used). Transport preparations must not overshadow or neglect the patient's fundamental care. An example of a brief check on the patient is listed below.
  - 6.2.1 Airway is secured and patent.
  - 6.2.2 Ventilation is adequate; respiratory variables are appropriate.
  - 6.2.3 All equipment alarms are switched on.
  - 6.2.4 PEEP/CPAP (if set) and FIO<sub>2</sub> levels are correct.
  - 6.2.5 All drains (urinary, wound, or underwater seal) are functioning and secured.
  - 6.2.6 Underwater seal drain is not clamped.
  - 6.2.7 Venous access is adequate and patent.
  - 6.2.8 IV drips and infusion pumps are functioning properly.
  - 6.2.9 Patient is safely secured on trolley.
  - 6.2.10 Patient is haemodynamically stable.
  - 6.2.11 Vital signs are displayed on transport monitors and are clearly visible to transport staff.

## 7. IN-TRANSIT PROCEDURES

- 7.1 A best route should be planned. Lifts should be secured or reserved beforehand. Relatives and non-hospital staff should be shepherded so as not to obstruct the patient trolley.
- 7.2 Adequate communication facilities during transit and at the destination must be available.
- 7.3 The status of the patient must be checked at intervals, especially if the journey takes considerable time. Any change in the patient's condition, unexpected event, or critical incident, must be acted upon immediately and so recorded.

## 8. ARRIVAL PROCEDURES

- 8.1 On arrival at the destination, the receiving monitoring, ventilation, gas, suction, and power facilities are checked if the patient is to be transferred from the transport facilities.
- 8.2 The patient must be briefly assessed when the new monitors, ventilators (if used), gas and power supplies are established.
- 8.3 If another team assumes responsibility of care, a complete hand over is given to the doctor in charge. The transport staff must remain with the patient until the receiving team is fully ready to take over care.

## 9. QUALITY ASSURANCE

The process of intrahospital transport of patients should be continually evaluated.

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

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

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

Promulgated: 2000  
Date of Current Document: Feb 2000

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# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

## FACULTY OF INTENSIVE CARE

### AND

## FACULTY OF PAIN MEDICINE

### GUIDELINES FOR THE RELATIONSHIP BETWEEN FELLOWS AND THE HEALTHCARE INDUSTRY

These guidelines are intended to assist Fellows of the College including the Faculties of Intensive Care and of Pain Medicine with professional and ethical matters which can arise from their involvement with the healthcare industry. It must always be recalled that while the healthcare industry generally makes its approaches to doctors or their professional organisations, the ultimate beneficiary of the approach must be the patient(s) for whom - directly or indirectly - the individual doctor and/or the professional organisation provides clinical care and services.

#### 1. GENERAL PRINCIPLES

- 1.1 There should be formal and open acknowledgement by the Fellow or group receiving financial or material support from the healthcare industry for any activity with which they are involved.
- 1.2 Fellows should not allow their names to be associated with any form of direct advertising unless the commercial nature of their involvement is clearly stated.
- 1.3 An association between the College and the healthcare industry does not imply endorsement of the product or service being promoted by the industry. A specific disclaimer to this effect should be included with brochures or other advertising of healthcare industry promotions.
- 1.4 Professional benefits to colleagues and/or trainees and ultimately to patients should form the basis for any association with the healthcare industry.
- 1.5 During the negotiation of any agreement with which the College is directly or indirectly involved, all correspondence must refer to the College status of the negotiator. The final agreement must be subject to College approval. When negotiations are conducted in a personal capacity, no mention of a College affiliation can be made.

#### 2. TRAINING PROGRAMS

- 2.1 Support from healthcare industry sources should be directed to the educational activity as a whole. Normal College guidelines should be followed for the development of the program which must not be under the control of the commercial organisation concerned.
- 2.2 If a prize is offered for work performed by a Fellow or trainee, the selection of the prizewinner must be entirely under the control of an appropriately constituted and independent Committee.
- 2.3 Where funding is provided in whole or in part for a training position, it is essential that this be paid through a neutral third party such as the Hospital or University responsible for employment of the trainee. All matters related to employment must be subject to the normal rules of the employer.

#### 3. COLLEGE MEETINGS

- 3.1 The nature and extent of support for meetings should be negotiated by the organising committee and must form a part of the report from and the accounts of that meeting. It is entirely appropriate that such support be acknowledged but there must be a disclaimer to separate that support from endorsement (by the College) of any service and/or products being promoted by the commercial organisation(s) involved.
- 3.2 Any profit resulting directly or indirectly from support by the healthcare industry must be devoted to further educational or research activities.
- 3.3 Normal College guidelines for control of the meeting or any session of the meeting must be observed. It is not permissible for primary control of the meeting or any session of the meeting and its advertising to be taken over by a commercial organisation who may not use the event for promotion of its products or services.

#### 4. WORKSHOPS, SEMINARS AND MEETINGS SPONSORED BY COMMERCIAL ORGANISATIONS

- 4.1 The activity must be under the control of a College based organising Committee with appropriate representation from the healthcare industry.
- 4.2 It is entirely appropriate that support by the healthcare industry be fully and formally acknowledged by the organising committee.
- 4.3 When a commercial organisation takes responsibility for a meeting, the College should not be associated with that meeting and specifically should not endorse any service or product being promoted by the meeting.
- 4.4 When Fellows or trainees are invited to attend commercially sponsored meetings (often with associated social activity), the decision to attend or not should be made having regard to the General Principles.
- 4.5 Fellows and trainees speaking at commercially sponsored meetings should consider the General Principles. They should be aware that they are not representing the College, and should not purport to represent the College. Their views are not necessarily those of the College.

#### 5. RESEARCH PROJECTS

- 5.1 It is accepted that the healthcare industry is a major sponsor of research. It is essential that a written contract be established between all parties involved. The contract should involve a neutral third party such as a University or a Research Foundation. The Anaesthesia, Intensive Care and Pain Medicine Foundation (of the College) would be an appropriate organisation. The contract should be subject to the rules of the third party with all financial arrangements being channeled through them.
- 5.2 Normal Ethical Committee procedures must be followed and must include full prospective disclosure of the proposed commercial association. This will also apply when seeking patient consent for their participation in any such study.

#### 6. TRAVEL

- 6.1 Funds offered on a personal basis to facilitate attendance at an educational activity should be carefully considered having regard to the General Principles noted above. Funding should always be acknowledged in any presentation or report. A letter of thanks may be useful and should be copied to the organisers of the educational activity.
- 6.2 Travel and tour expenses for a commercially sponsored educational visit to other centres should be considered

in terms of the likely professional benefit to all involved. It is essential that talks or lectures are presented in an unbiased manner while acknowledging the support given. A specific disclaimer in respect of the sponsor's services or product may be appropriate.

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# FACULTY OF INTENSIVE CARE

## AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

### THE SUPERVISION OF VOCATIONAL TRAINEES IN INTENSIVE CARE

Supervision must be available at all times and this should be performed by a person who possesses the FFICANZCA, or a qualification acceptable to the Board. This supervision should include not only clinical situations but also record-keeping, audit and quality assurance programs, teaching, and preparation of scientific material such as for the Formal Project or for presentation at a conference. It should encompass the skills, knowledge and attitudes desirable in an intensive care specialist.

#### 1 CATEGORIES OF SUPERVISION

During training it is expected there will be a progression of responsibility allowed to the trainee. Four categories have been defined. The category under which each trainee works depends upon individual circumstances, and the trainee's experience and development of skills. viz:

- 1 A supervisor working directly with one trainee in a clinical situation involving the examination and/or treatment of a patient.
- 2 A supervisor in the same department/unit as a trainee, and available for immediate assistance and consultation.
- 3 A supervisor present elsewhere in the hospital, but immediately available for consultation and assistance.
- 4 A supervisor not in the hospital, but readily contactable and, if necessary, available within reasonable travelling time, who is specifically rostered for the period in question.

#### 2 MINIMUM SUPERVISION LEVELS

Supervision must be available at all times, without distinction between ordinary hours and out-of-hours times.

- 2.1 Early in training, a high proportion of supervision must be as in Category 1 or 2.
- 2.2 Later in training, supervision may be as in Category 3 or 4 when appropriate, but it is expected that patient review will be held each day with the on-call specialist and that new patients will be discussed with this supervisor soon after admission.

Closer supervision and direct help must be available when sought by the trainee.

#### 3. SPECIAL CONDITIONS

- 3.1 Consultation with a supervisor is especially relevant in the following situations:

- 3.1.1 Reception of new patients into a unit, and discharge of patients from the unit.
- 3.1.2 Unexpected or unexplained changes in a patient's condition.
- 3.1.3 Performance of complex procedures on a patient.
- 3.1.4 Treatment of children in a non-paediatric unit.
- 3.1.5 Changes to management which have serious ethical implications (eg. with-drawal of life support).
- 3.1.6 Discussion with referring clinicians on major treatment policies.
- 3.1.7 Proposed refusal of a request for admission to the unit.
- 3.1.8 Mobilisation of intensive care resources for inter-hospital transfer.

- 3.2 An intensive care unit should have a written list of guidelines and general policies, in which the requirements of the Faculty for supervision are included.

These guidelines should be interpreted in conjunction with the following Policy Document of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists.

IC-3 "Guidelines for Hospitals seeking Faculty Accreditation for Training in Intensive Care"

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# FACULTY OF INTENSIVE CARE

## AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

### SECRETARIAL SERVICES TO INTENSIVE CARE UNITS

All intensive care units require administrative support by adequate secretarial services to allow the medical, nursing and technical staff within the unit to perform their duties effectively. For those intensive care units accredited for training in intensive care, the secretarial, administrative and educational support needed will require the appointment of appropriate secretarial staff. In general, access to a typing pool is inadequate for this purpose.

#### DUTIES OF SECRETARIAL STAFF

The duties of the secretarial staff will fall into three main areas:

##### 1. INDIVIDUAL SECRETARIAL SUPPORT DUTIES

Provision of general secretarial services to individual specialists, trainees and other members of the department.

##### 2. ADMINISTRATIVE SUPPORT DUTIES

Preparation, circulation and updating of departmental duty rosters, maintenance of departmental and medical records and general administration.

##### 3. EDUCATIONAL SUPPORT DUTIES

Co-ordination of the administrative aspects of the continuing medical education, clinical review and quality assurance activities of the department for all medical, nursing and technical staff.

3.1 Preparation and distribution of material for departmental meetings, including tutorials, peer review, clinical audit and quality assurance meetings.

3.2 Maintenance of the departmental library of books, journals, slides and other audio-visual material and preparation of visual display material.

3.3 Performance of literature searches, photocopying and circulation of documents from within the department, other departments of the hospital and other libraries.

3.4 Facilitation of the exchange of correspondence between the Faculty, Trainees and Supervisors of Training. See Faculty Policy Document IC-6 "Supervisors of Training in Intensive Care".

These guidelines should be interpreted in conjunction with the following Policy Documents of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists.

IC-1 "Minimum Standards for Intensive Care Units"

IC-3 "Guidelines for Hospitals seeking Faculty Accreditation for Training in Intensive Care"

IC-6 "Supervisors of Training in Intensive Care"

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# FACULTY OF INTENSIVE CARE

## AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

### MINIMUM STANDARDS FOR HIGH DEPENDENCY UNITS SEEKING ACCREDITATION FOR TRAINING IN INTENSIVE CARE

#### INTENSIVE CARE TRAINING

Faculty of Intensive Care trainees can be involved in routine patient care in a High Dependency Unit (HDU) which meets all the criteria described in this document.

The supervision of trainees in the HDU will comply with Faculty Policy Document IC-4, "The Supervision of Vocational Trainees in Intensive Care". Trainees must work adequate hours in the Intensive Care Unit (ICU) as opposed to HDU or other activities. If inadequate hours are worked in intensive care, the Censor may rule that the trainee must extend the duration of core training (refer Faculty Policy Document IC-3 "Guidelines for Intensive Care Units Seeking Faculty Accreditation for Training in Intensive Care"). HDUs in which intensive care trainees' work will be reviewed by the Faculty during a site inspection of the ICU.

#### INTRODUCTION

An HDU is a specially staffed and equipped section of an intensive care complex which provides a level of care intermediate between intensive care and general ward care.

Patients may be admitted to the HDU:

- (a) from the ICU as a step-down prior to transfer to the ward,  
or
- (b) directly from the ward, recovery or emergency areas.

Typically patients in HDU will have single organ failure and are at a high risk of developing complications.

An HDU should have resources for immediate resuscitation and management of the critically ill. Equipment should be available to manage short term emergencies, eg. a need for mechanical ventilation.

In stable patients routine monitoring and support may include ECG, oximetry, invasive measurement of blood pressure, low level inotropic support and non-invasive ventilation.

#### MINIMUM STANDARDS GUIDELINES

##### 1. OPERATIONAL

The HDU must:

- 1.1 Be geographically part of the intensive care complex of that hospital.
- 1.2 Be operationally linked to the ICU which must be a level II or III ICU (refer Faculty Policy Document IC-1 "Minimum Standards for Intensive Care Units").
- 1.3 Have all patients admitted to the HDU referred to the attending intensive care specialist for management.
- 1.4 Have defined admission, discharge, management and referral policies.
- 1.5 Have twenty-four hour access to pharmacy, pathology, operating theatres and imaging services and appropriate access to physiotherapy and other allied health services.

The HDU should have:

- 1.6 Formal audit of its activities and their outcome.
- 1.7 Suitable infection control and isolation procedures.
- 1.8 Support services eg. technical and clerical.

##### 2. STAFFING

The HDU staffing must include:

- 2.1 A medical director who meets the Joint Specialist Advisory Committee – Intensive Care (JSAC-IC) criteria for specialist recognition.
- 2.2 In addition to the attending intensive care specialist, at least one registered medical practitioner with an appropriate level of experience immediately available at all times.
- 2.3 A nurse in charge of the HDU who has a post registration qualification in intensive care.

The HDU staffing should include:

- 2.4 At least one other specialist who meets the JSAC-IC criteria for specialist recognition.
- 2.5 Sufficient specialist staff to provide reasonable working hours and leave of all types to allow the duty specialist to be rostered and available to the HDU.
- 2.6 All nursing staff in the HDU responsible for direct patient care being registered nurses and the majority of all senior nurses having a post registration qualification in intensive care or high dependency nursing.
- 2.7 A nursing staff to patient ratio of 1:2.
- 2.8 A minimum of two registered nurses present in the unit at all times when there is a patient present in the unit.
- 2.9 Educational programs for both medical and nursing staff, and access to a nursing educator.
- 2.10 An orientation program for new staff.

### 3. STRUCTURE

The minimum size for an HDU should be four beds.

HDUs covered by this document are geographically and operationally linked to a level II or III ICU. Both the parent ICU and the HDU should meet the minimum standards in Faculty Policy Document IC-1 paragraph 7 for structure with the following changes:

#### *Patient Area*

- 3.1 At least 16m<sup>2</sup> floor area is required for each bedspace in an open area exclusive of service areas.
- 3.2 A typical HDU will require at least two oxygen, one air and two suction outlets, and at least eight power points for each bedspace.

Many facilities may be common between the ICU and the HDU eg. seminar room, library, staff offices, isolation area.

### 4. EQUIPMENT

The type and quantity of equipment will vary with the size and function of the HDU and must be appropriate to its workload, judged by contemporary standards.

There must be a regular system in force for checking the safety equipment.

Protocols and inservice training for medical and nursing staff need to be available for the use of all equipment, including steps to be taken in the event of malfunction.

Basic equipment should include:

- 4.1 Hand-ventilating assemblies.
- 4.2 Suction apparatus.

- 4.3 Airway access equipment.
- 4.4 Vascular access equipment.
- 4.5 Monitoring equipment, both non-invasive and invasive.
- 4.6 A defibrillator.
- 4.7 Equipment to control a patient's temperature.
- 4.8 Chest drainage equipment.
- 4.9 Infusion and specialised pumps.
- 4.10 Portable transport equipment.
- 4.11 Specialised beds.
- 4.12 A ventilator.

### 5. MONITORING

The level of monitoring should be appropriate to the role of the HDU and the physiological status of the patient and should comply with the minimum standards guidelines of Faculty Policy Document IC-1 paragraph 9.

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

IC-1 "Minimum Standards for Intensive Care Units"

IC-3 "Guidelines for Hospitals seeking Faculty Accreditation for Training in Intensive Care"

IC-4 "The Supervision of Vocational Trainees in Intensive Care"

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# FACULTY OF PAIN MEDICINE

## AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

### ACUTE PAIN MANAGEMENT

#### 1. Introduction

- 1.1 Effective treatment of acute pain is a fundamental component of quality patient care.<sup>1</sup>
- 1.2 Education and practical experience in acute pain management are essential components of training programs for Fellowships of ANZCA and FPMANZCA.

#### 2. Principles of Acute Pain Management

- 2.1 Adverse physiological and psychological effects may result from unrelieved severe acute pain.<sup>1</sup>
- 2.2 Effective treatment of postoperative pain may reduce the incidence of postoperative morbidity (e.g. epidural analgesia has been shown to reduce postoperative pulmonary complications - Level I evidence, NHMRC Statement of evidence No 6)<sup>1</sup>
- 2.3 More aggressive and/or preemptive treatment of postoperative pain may reduce the incidence of chronic pain. (Level II evidence, NHMRC Statement of evidence No 3)<sup>1</sup>
- 2.4 Effective management of acute pain requires tailoring of treatment regimens to the individual patient.<sup>1</sup>
- 2.5 Effective management of acute pain depends on education and training of all staff, and involvement and education of the patient and their carers.<sup>1</sup>
- 2.6 Effective management of acute pain depends on formal protocols and guidelines covering acute pain management which are relevant to each institution; and formal quality assurance programs to regularly evaluate the effectiveness of acute pain management.<sup>1</sup>
- 2.7 The following groups of patients have special needs that require particular attention:
  - 2.7.1 Children
  - 2.7.2. Obstetric patients
  - 2.7.3. Elderly patients
  - 2.7.4. Patients with cognitive or sensory impairment
  - 2.7.5. Patients with pre-existing or chronic pain
  - 2.7.6. Patients at risk of developing chronic pain
  - 2.7.7. Patients with cancer or HIV/AIDS
  - 2.7.8. Patients dependent on opioids or other drugs/substances

#### 3. Education

- 3.1 Education regarding acute pain management should be part of the medical undergraduate core curriculum. Knowledge should be supplemented at the postgraduate level for all medical and other staff.
- 3.2 Nursing staff has a key role in the management of acute pain. Appropriate ongoing education and accreditation of relevant nursing staff are essential.
- 3.3 Patient attitudes and beliefs have been shown to modify pain perceptions and analgesic requirements, and patient and carer education can therefore positively influence the outcome of acute pain management.<sup>1</sup>
  - 3.3.1. A discussion regarding analgesia, its role in recovery and rehabilitation, and options available (pharmacological and non-pharmacological), is an essential aspect of an acute pain management consultation.
  - 3.3.2. Availability of appropriate reading material will enhance patient and carer understanding and expectations of available pharmacological and non-pharmacological therapies.

#### 4. Assessment of Pain

- 4.1 Proper assessment and control of pain require patient involvement and measurement using self-reporting techniques, and frequent assessment and reassessment of pain intensity and effect of any intervention.<sup>1</sup>
- 4.2 Pain should be assessed both at rest and during activity. In addition to patient comfort, pain relief should be assessed with respect to adequate function including physical therapy requirements and mobilisation.<sup>1</sup>
- 4.3 Unexpected levels of pain, or pain that suddenly increases, may signal the development of a new medical, surgical or psychiatric diagnosis.<sup>1</sup>

#### 5. Pharmacological Therapies

- 5.1 Drugs that may be used include opioids, non-steroidal anti-inflammatory drugs and local anaesthetics, as well as adjuvant agents such as antidepressants, anticonvulsants and membrane stabilisers.

5.2 In order to obtain the best therapeutic effect while minimising side effects, many analgesic drugs require careful titration and individualisation of dose regimens. When opioids are used, this requires appropriate initial doses (in the adult patient this should be based on patient age), dose intervals appropriate to the route of administration, and regular monitoring of pain and sedation scores, respiratory rate, and occurrence of other side effects.<sup>1</sup>

5.3 Multimodal analgesia (i.e. the concurrent use of different classes of analgesics) improves the effectiveness of acute pain management. (Level II evidence, NHMRC Statement of evidence No 2)<sup>1</sup>

5.4 Drug administration can be by oral, subcutaneous, intra-muscular, intravenous, epidural, intrathecal, inhalational, rectal, transdermal or transmucosal routes.

5.5 Some specialised analgesia delivery techniques require greater medical and nursing knowledge and expertise, as well as some complex equipment and the use of established protocols and guidelines. Such techniques include:

#### 5.5.1 Patient-controlled analgesia

5.5.1.1 Patient-controlled analgesia provides greater patient satisfaction compared with conventional routes of opioid administration.<sup>1</sup>

5.5.1.2 Patient-controlled analgesia allows patients to more easily overcome the wide interpatient variation in opioid requirements, and to rapidly titrate the amount of opioid delivered according to increases and decreases in pain stimulus and/or any opioid related side effects.

5.5.1.3 Patient-controlled analgesia may be more effective when supervised by an Acute Pain Service.<sup>1</sup>

#### 5.5.2 Epidural and Intrathecal analgesia

5.5.2.1 Postoperative epidural analgesia can significantly reduce the incidence of pulmonary complications. (Level I evidence NHMRC Statement of evidence No 6)<sup>1</sup>

5.5.2.2 Large audits have shown that epidural analgesia, coordinated by an acute pain service and managed in general hospital wards with regular review and using appropriate protocols and monitoring, can be as safe as traditional analgesic techniques. (Level III evidence NHMRC Statement of evidence No 7)<sup>1</sup>

5.5.2.3 Epidural and intra-theatal analgesia remain the responsibility of the anaesthetist instituting the technique, or their delegate.

#### 5.5.3. Other regional analgesic procedures

5.5.3.1. Regional analgesia remains the responsibility of the anaesthetist instituting the technique, or their delegate.

5.5.4. *Continuous infusions of opioids, local anaesthetics, ketamine and other drugs*

5.6. Other drugs may be required for the treatment of any analgesia-related side effects; or other symptoms.

## 6. Non-pharmacological therapies

6.1 Non-pharmacological therapies must be considered as complementary to pharmacological therapies

6.2 Cognitive/behavioural therapies (e.g. relaxation and distraction) increase tolerance to pain but may require training prior to admission (e.g. antenatal classes).

6.3 Physical therapies (eg. massage, heat, acupuncture, and transcutaneous electrical nerve stimulation) may be useful as an adjunct to analgesia.<sup>1</sup>

## 7. Acute Pain Services

7.1 A multidisciplinary approach to the management of acute pain, such as with an acute pain service, can lead to improved pain relief and patient outcomes.<sup>1</sup>

7.2 Such an approach is recommended for all patients, especially those with complex medical or psychological pathology.

7.3 Features of such a service should include:

7.3.1. Staffing by medical personnel, particularly anaesthetists and nurses with special expertise in acute pain management.

7.3.2. Close liaison with physiotherapists, psychologists and other paramedical personnel.

7.3.3. Close collaboration with surgical and other specialties involved in the patient's overall acute perioperative care.

7.3.4. Development of specific policies, protocols and guidelines for treatment and monitoring.

7.3.5. Review of all patients under the care of the service at least once daily, and liaison with appropriate medical and nursing staff.

7.3.6. Provision of a consultation service for other patients with acute or acute-on-chronic pain problems.

7.3.7. Provision of an after-hours service with appropriate consultant involvement.

- 7.3.8 Involvement with management plans for analgesia after discharge, where appropriate.
- 7.3.9. Research.
- 7.3.10. Education of medical, nursing and other staff and students.

## 8. Quality Assurance

- 8.1 Regular audits of acute pain management should be instituted to assess continuing effectiveness of any treatment and incidence of side effects and adverse effects.

### **Reference**

<sup>1</sup> Acute Pain Management: Scientific Evidence, National Health and Medical Research Council, Canberra, 1998.

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# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

## POLICY DOCUMENTS

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

- E1 (1996) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
- TE3 (1999) Supervision of Clinical Experience for Trainees in Anaesthesia *Bulletin Nov 99, pg 67*
- TE4 (1997) Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg 88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
- E6 (1995) The Duties of an Anaesthetist *Bulletin Nov 95, pg 70*
- TE7 (1999) Secretarial and Support Services to Departments of Anaesthesia *Bulletin Nov 99, pg 69*
- TE9 (1999) Quality Assurance *Bulletin June 99, pg 94*
- TE11 (1999) Formal Project Guidelines *Bulletin Mar 99, pg 70*
- E13 (1996) Guidelines for the Provisional Fellowship Year *Bulletin Nov 96, pg 66*
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, pg 62*
- TE16 (1998) Requirements for Multidisciplinary Pain Centres Offering Training in Pain Medicine *Bulletin Nov 1998, pg 83*
- TE17 (1999) Advisors of Candidates for Anaesthesia Training *Bulletin Nov 99, pg*
- EX1 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 96, pg 70*
- T1 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites *Bulletin Nov 95, pg 52*
- T3 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities *Bulletin Nov 95, pg 56*
- T5 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries *Bulletin Nov 95, pg 65*
- T6 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites *Bulletin Nov 95, pg 61*
- P1 (1997) Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin May 97, pg 81*
- P2 (1996) Privileges in Anaesthesia *Bulletin Nov 96, pg 72*
- PS3 (1998) Major Regional Anaesthesia and Analgesia *Bulletin Nov 98, pg 85*
- P4 (1995) Guidelines for the Care of Patients Recovering from Anaesthesia *Bulletin Aug 95, pg 64*
- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
- PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
- PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 98, pg 75*
- P9 (1996) Sedation for Diagnostic and Surgical Procedures *Bulletin Nov 96, pg 73*
- PS10 (1999) Handover of Responsibility During an Anaesthetic *Bulletin Nov 99, pg 62*
- P11 (1991) Management of Cardiopulmonary Bypass *Bulletin May 91, pg 43*
- PS12 (1996) Statement on Smoking as Related to the Perioperative Period *Bulletin Nov 97, pg 78*
- P13 (1992) Protocol for The Use of Autologous Blood *Bulletin Aug 92, pg 49*
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin Nov 98, pg 81*
- P15 (1995) Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Aug 95, pg 62*
- P16 (1994) The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 94, pg 45*
- PS17 (1997) Endoscopy of the Airways *Bulletin Nov 97, pg 80*
- P18 (1995) Monitoring During Anaesthesia *Bulletin Nov 95, pg 68*
- P19 (1995) Monitored Care by an Anaesthetist *Bulletin Nov 95, pg 60*
- P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 96, pg 52*
- P21 (1996) Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
- P22 (1996) Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
- P24 (1997) Sedation for Endoscopy *Bulletin May 97, pg 78*
- PS26 (1999) Guidelines on Providing Information about the services of an Anaesthetist *Bulletin Nov 99, pg 63*
- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion *Bulletin Nov 94, pg 46*
- P28 (1995) Policy on Infection Control in Anaesthesia *Bulletin Mar 95, pg 38*
- PS29 (1997) Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin Nov 97, pg 82*
- PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg 84*
- PS33 (1999) Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT) *Bulletin Nov 99, pg 61*
- PS36 (1997) Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg 93*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 98, pg 79*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 1999, pg 93*
- PM1 (1999) Guidelines for Trainees and Departments seeking College Approval of Posts for Training in Pain Medicine *Bulletin Mar 99, pg 73*
- PS39 (2000) Intrahospital Transport of Critically Ill Patients *Bulletin Mar 2000, pg 53*
- PS40 (2000) Guidelines for the Relationship Between Fellows and the Healthcare Industry *Bulletin Mar 2000, pg 55*