

Australian and New Zealand College of Anaesthetists

ACN 055 042 852

and Faculty of Intensive Care



Bulletin

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

Inside...

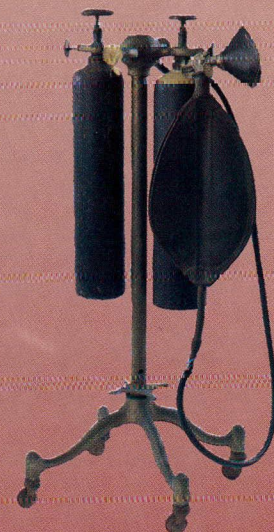
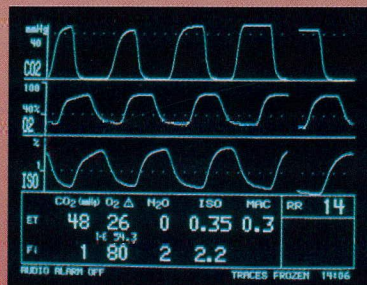
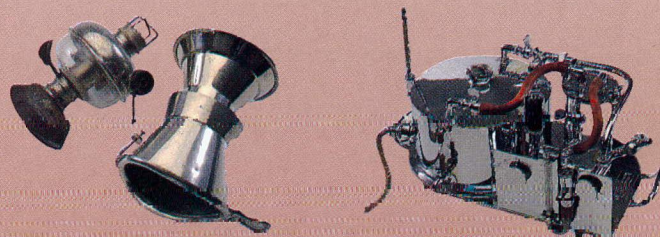
- President's Message
- Major Changes in Medical Research
- MASTER Trial
- NAD 1999 Report
- Medicine Against the Odds

Faculty of Intensive Care

- Dean's Message
- Younger Fellows' Report
- Annual Report

Faculty of Pain Medicine

- Dean's Message
- Election to Fellowship
- Fellowship Examination Format



Volume 8

Number 3

August 1999

CONTENTS

Page	
1	President's Message
2	Major Changes in Medical Research
4	Staff Profiles – J Talty and M Benjamin
5	Rural Anaesthetic Recruitment Service
6	Research Awards 2001
7	Douglas Joseph Professorship
7	Academic Anaesthesia Enhancement Grant 2000
7	Deaths
	Law Report
8	Challenges for the Future
10	Appointment – Dr Michael J H Hodgson, AM
11	ANZCA Foundation Donations
12	J H Overton, OAM
13	Letter to the Editor
14	MASTER Trial – Alfred Hospital
15	Admission to Fellowship by Examination
16	Library Report
19	Medicine Against the Odds – S. Maclaurin
21	Younger Fellows' Conference
30	National Anaesthesia Day Report
32	Fellowship Profile – Gerald James Flynn, FANZCA

Faculty of Pain Medicine

23	Dean's Message
24	Highlights from the July Board Meeting
26	Examination Format
26	Election to Fellowship
26	Examination Preparation Course
27	Selection Criteria for Examiners
28	Training in Pain Medicine
29	Further Training Exemption
29	1999 Examination Dates

Faculty of Intensive Care

37	Dean's Message
38	Items of Interest from the June Board Meeting
42	Younger Fellows Conference Report – Dr Helen Opdam
45	Annual Report
48	Administrative Instructions – Training and Examination
52	Policy Documents Index
52	2000 Examination Dates

53	Fellows' Apparel
54	Future Meetings
64	Policy Documents Index

EDITORIAL

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

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

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

Regional Committee offices can be contacted via email as follows:

VIC: victoria@anzca.edu.au
 NSW: nsw@anzca.edu.au
 SA: sa@anzca.edu.au
 QLD: qld@anzca.edu.au
 WA: anaesthesia.wa@hcn.net.au
 TAS: surgeons.tas@racs.edu.au
 NZ: anzca@actrix.gen.nz

Copyright 1999 by the Australian and New Zealand College of Anaesthetists, all rights reserved. None of the contents of this publication may be reproduced, stored in a retrieval system or transmitted in any form, by any means without the prior written permission of the publisher.

Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the author's personal observations and do not imply endorsement by, nor official policy of, the Australian and New Zealand College of Anaesthetists.

PRESIDENT'S MESSAGE



At last, construction at the College headquarters in Melbourne has commenced! It is expected that the new seven-storey building and its basement carpark, which are additions at the rear of the current building, will be completed by the middle of 2000. For up to 12 months, there will be difficulties at "Ulimaroa" for the staff, trainees and Fellows, but careful planning will result in minimal disruption to College functions during that time. I personally head towards the end of my twelve year tenure on the Council, and during that time have seen an extraordinary growth of the College, its activities and its status and influence. This may seem an overstatement to some but as I live with the everyday functions of the College, you have to believe me! Given this and careful consideration of all the options, I and my fellow Councillors firmly believe that the new building at "Ulimaroa" is the wisest and the most sound investment (\$7 million of currently held College funds) for both the present and especially the long-term needs of the College.

The recent launch of the NHMRC Acute pain management: scientific evidence document attracted extensive media exposure on the subject. Professor Michael Cousins, Dean of the Faculty of Pain Medicine of our College and also an elected Councillor of ANZCA, has publicly led the call for improved management of pain for many years. As an NHMRC Councillor, he has appropriately featured heavily in the recent publicity. Some of his statements have been misinterpreted by a few anaesthetists who seem threatened that their role in postoperative and other forms of pain management would be taken over by Fellows of the Faculty of Pain Medicine. This is

certainly not the case. In the June 1999 issue of the College Bulletin, Professor Cousins clearly stated that "the majority of (ANZCA Fellows) will continue to work... in the postoperative pain area, using their entirely appropriate FANZCA qualification. It is important to emphasise that such individuals will in no way be disadvantaged by the formation of the new Faculty". The Council strongly believes that anaesthetists have a major role to play in all forms of pain management and encourages those with a special interest to further their career opportunities by considering Fellowship of the Faculty. Pain medicine is an important part of the College curriculum in the training and examination of anaesthetists, and the formation of the Faculty of Pain Medicine within our College of Anaesthetists (rather than outside it) is a major gain for the College, anaesthetists and our profession.

Finally, I again urge all to carefully read this issue of the Bulletin and keep informed on issues as they affect our College and the professions it represents.

I welcome feedback on any matter from all Fellows and Trainees, that being a major method by which the Council guides the future of the College and professions.



RICHARD WALSH
President

MAJOR CHANGES IN MEDICAL RESEARCH

Michael J Cousins AM Councillor

**Chairman ANZCA Research Committee, NHMRC,
Deputy Chair Discipline Panel NHMRC Research Review System**



The most wide-ranging review of medical research in Australia has just culminated in the publication of the "Health and Medical Research Strategic Review" (Wills Report) in December 1998. The major recommendation of the Report, now accepted by the Federal Government, is that the NHMRC's research budget will be doubled over the next five years. This major increase in funding is important enough, however the way that the funding will be distributed will have major implications for all medical specialties, particularly our own. It is worth noting that anaesthesia and intensive care were at the bottom of the list of medical specialties receiving NHMRC funding under the old system. Thus this is a pivotal time for our specialty to come to grips with the new system and to make the most of it. The ANZCA Research Committee will be studying the Wills Report very closely and attempting to align ANZCA's research efforts strategically with those of the new NHMRC initiatives. Following is a summary of some of the key points from the Wills Report that are destined to be introduced over the next five years.

Priority-driven research

One of the key philosophies of the Wills Report was to place an emphasis on "priority-driven research" which refers to "strategic, development and evaluation research that contributes directly in the short to medium term to population health and the effectiveness, efficiency and equity of the health system. These areas of research require a priority-driven research agenda, the commitment of a wide range of stake holders including Commonwealth and State health authorities and the capacity to integrate research-based knowledge into policy and practice." This approach emphasises very much the linkage of basic and clinical research and the emphasis on research which will truly contribute to improve patient care added to the development of the improved strategy and policy. There are substantial opportunities in our specialty areas of anaesthesia, intensive care and pain medicine.

Research Fellows

Currently there are a relatively small number of Research Fellow Awards made by the NHMRC each year (20). This will be dramatically increased to 100 Research Fellows over the next five years. The salary scales for Senior Research Fellows will be increased. A crucial decision is that barriers to mobility of Research Fellows will be removed so that they may move between institutions, taking their funding with them.

Basic Research Recommendations

- Block funding to major research institutes will be removed. Such institutes will now compete for the range of funding options that will be introduced beginning in the year 2001.
- Large multidisciplinary investigator initiated projects, research programs and "network grants" will be developed.
- An increased amount of funding will go into larger projects and there will be more programs of this type employing a variety of grant sizes and durations up to seven years.
- Project grants will still be provided for individual projects, however they will be fewer in number, but their duration will be extended from 3 to 5 years.
- There will be an emphasis on "network grants" which will aim to promote cross disciplinary collaboration. There will be an emphasis in such grants of gaining Industry and State Government partnerships as a prerequisite to receiving NHMRC funding.
- There will be incentives for researchers to come together as a collaborative group and with strong links between teaching, research and patient care.
- There will be a promotion of training of clinician researchers involved by encouraging combined MBBS/PhDs and MDs/PhDs: by offering NHMRC fractional fellowships to allow clinical fellows to continue to practice and exposing clinicians to quality research through greater interaction with Centres of Research Excellence. It should be noted that the NHMRC has already negotiated an arrangement with the RACS whereby RACS would hand over to NHMRC the evaluation of research fellowship applications and the RACS would be able to supplement NHMRC funding levels for those individuals who were successful in obtaining NHMRC funding. The ANZCA Research Committee is considering a similar mechanism.

- A portion of NHMRC funds will be quarantined for three year project awards to new investigators. This will hopefully overcome the existing problem of "track record" which has precluded many individuals from obtaining NHMRC support at an early stage of their career.

Fundamental Research

Priority-driven research

- A process is being developed to identify priority areas of research which will fit within the strategic framework of the NHMRC in Department of Health and Aged Care. (It will be important for ANZCA to assemble material to make a case for the development of priority of areas which are of importance to our specialty).
- There will be a focus on areas with high potential for financial return to facilitate the increased investment in such research.
- There will be a development of several Multidisciplinary Centres of Excellence for strategic development and evaluation research as focal points for building capacity and visibility in this area. There will be an emphasis on clinical research in such centres.
- There will be a strong emphasis on interface between research policy and practice in the work of such centres.

A place for private industry

Much of the basic research of pharmaceutical and technical companies is currently carried out "in house". From the year 2000 onwards, there has been a deliberate decision by such companies to start farming out such research. Worldwide this will result in a massive increase in funding available to support basic laboratory research in Universities and other institutions. Another crucial step in Australia will be changes to capital gains tax laws which will greatly increase venture capital availability for research and development in Australia. An early example of this approach is the offer by County Investment Management to match dollar for dollar all NHMRC funding from the year 2000 onwards. This will potentially provide an extraordinary enhancement of NHMRC funding. The change in attitude of the NHMRC to the involvement of private industry is a very major departure from the previous attitude which tended to shy away from projects with commercial support.

Changes in NHMRC Administration and Research Grant procedures

The NHMRC has taken the unprecedented decision of appointing a full time Chief Executive Officer who will be an eminent scientist with leadership and management skills. This individual will lead and reshape the NHMRC, to take it into the century with new impetus and effectiveness. The NHMRC has already begun to introduce a new process for reviewing research grants which will eliminate the regional interviewing committees and

will substitute a much fairer and more rigorous reviewing process. Former categories of research will be scrutinised and there will be an opportunity to develop new designated areas. Some major decisions have already been taken:

- There will be an initial \$50M for priority-driven research.
- \$20-30M a year will be allocated to several Multidisciplinary Centres of Excellence for strategic, development and evaluation research.

Why are these changes occurring?

The Wills Report identified a number of key imperatives which were used in its argument with the government for the doubling of funding over the next five years:

- Improved health outcomes in quality of life. There is now substantial evidence that high quality medical research does indeed result in improved health outcomes and quality of life. Such advances will only continue to be possible with continued and increased support for health and medical research.
- Reduced pressure on the health system. In the USA a recent study estimated that annual savings from health and medical research were almost US\$70B per year. This compares with the research budget of the NIH of now approximately \$15B a year.
- Economic return and jobs boost. Economic studies reviewed by the Industry Commission have shown estimated returns from research and development of between 10 and 55%. Research is recognised as essential for computer economic growth. A submission to the Wills Report from Walter and Eliza Hall Institute stated "the growth of scientific knowledge and the generation of new technology have permitted the market economies of the Western nations to achieve unprecedented prosperity. A recent analysis of the link between US technology and publicly funded science found that 73% of publications sighted in US industry patents as 'prior art' (a fundamental requirement of patent law) were from 'top flight' basic research organisations heavily supported by public agencies such as NIH and that this trend was increasing ". A recent study in the USA found that 10 major biomedical discoveries created non medical spin-offs worth over US\$90B for the economy annually.

It is clear that the Australian Government has now recognised the enormous potential of medical research in Australia, which has previously been of high quality, but poorly supported and poorly capitalised. Thus we are entering a new era in medical research in Australia and it is vital that our specialties becomes a major player in this area. There is no doubt that the Federal Government's view of any specialty is currently significantly coloured by the specialty standing in research. This will be even

more so because of the imperatives referred to above and it is now crucial that we develop a much stronger profile so that we may contribute to improve health outcomes and quality of life for Australians and play our part in helping develop the economy and job opportunities in this country. In contributing to these very worthwhile objectives, the status of our specialties will also be immeasurably enhanced.

Summary of Timetable

August to January 2000 consultation with research community and NHMRC Research Committee review of consultation outcome.

January to November 2000 communication with the research community about new the process and preparation of supporting documentation for each grant type.

December 2000 new system commences with advertisement for new grant categories for application in 2001 and beginning of funding in 2002.

It is likely that there will be some modifications to the above proposals as a result of feedback from the research community during the next few months, however the broad structure outlined above is very likely to go ahead.

LAW REPORT

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

CHALLENGES FOR THE FUTURE

(Extract from speech given by Michael Gorton to the Australian and New Zealand College of Anaesthetists Annual Scientific Meeting in Adelaide, May 1999 – “Challenges for the Future – Medico Legal Issues”)

“In discussing medico-legal challenges for the future, and for anaesthesia in particular, it would be so much easier if we knew what the future held.

You can imagine my surprise when I found in my ANZCA linen recyclable Convention shopping bag issued for this meeting, notes from the ANZCA Conference in Dili, East Timor in the year 2010. East Timor had apparently become the eighth Australian State and ANZCA had become the Australasian College of Anaesthesia by that time.

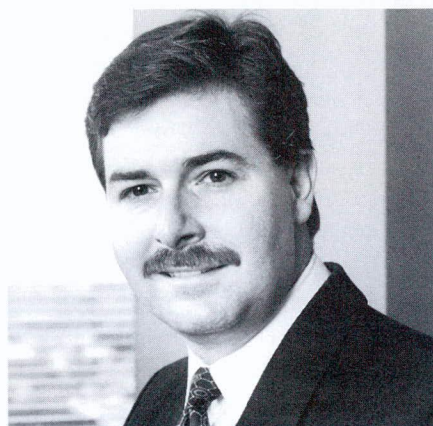
Apparently New Zealand was so taken by the devolution of powers in the United Kingdom, given to Scotland and Wales, that it applied and was accepted as a devolved autonomous region of the United Kingdom. Apparently the New Zealanders felt more at home with the English than with the Australians. England was only too happy to finally get a cricket team and rugby team that could beat the Australians.

But I digress...

The 2010 Convention of the Australasian College of Anaesthesia was opened by the then Prime Minister Natasha Stott Despoja-Downer. Her husband, Alexander, had recently been appointed President.

Apparently, following the success of the Republic Referendum in 1999, the debate exposed great rifts in both of the major political parties. A new force, the Republican Party, forged an alliance of like-minded Liberals, Labour members and Democrats which stormed to power in the Federal Elections of 2002. Whilst originally lead by Prime Minister Barry Jones, he retired in 2005 to make way for his talented Cabinet Minister, Ms Stott Despoja-Downer. She and Alexander apparently found that they had more in common than just republican views and were married in 2004.

Unfortunately, despite their electoral success, the Republican Party was unable to achieve a majority in the Senate. The balance of power in the Senate was maintained by the very elderly Brian Harradine, the then leader of the Rainbow Alliance, and the other Senator, the elderly Mal Colston, who in 2010 was apparently dying and unlikely to live to the next half Senate election in 2012.



But I digress...

According to the notes of the 2010 Conference, the medical scene was quite different to that ten years prior.

Competition Policy and Deregulation

Following the Government review of “Competition Policy”, especially in Victoria, and following deregulation of optometrists and dentists (where anyone could offer optometric and dental services), the exclusive recognition of anaesthetists was deregulated to also allow trained general practitioners, nurses and other health providers the right to administer some anaesthetics. The MediCare rebates were extended to these practitioners.

The College was also forced to admit a new category of “Associates” in addition to Fellows, to recognise the growing number of minor proceduralists, in an endeavour to preserve standards, education and training for the profession generally.

Apparently, the Royal Australasian College of Surgeons were even harder hit by competition policy reviews, with a range of general practitioners and other specialists able to carry out a broad range of surgical procedures.

Rather than being forced to admit these newcomers to the College, the RACS disbanded in 2005 and nine smaller Colleges were created, based on surgical specialities. The new Australian College of Orthopaedic Surgery, under its inaugural President, Bruce Shepherd, still only accredited 50% of the training positions then available.

“Competitions Policy” also forced deregulation of those who could own businesses of specialists doctors. In particular, anaesthetists who had grouped together in practice, formed new incorporated structures and shared fees through these new companies. Because the companies offer the services at fixed rates, with anaesthetists employed by the company, it was able to overcome price fixing restrictions, which had previously been challenged by Professor Fels and the Trade Practices Commission.

However, in 2006, large private health companies embarked on an acquisition program, offering huge sums to acquire these anaesthesia companies. The anaesthetists were paid handsomely for the sale of their practice, but now over 60% of anaesthetists in Australia are employed by, or contracted to, the three major private health companies (two of which are now internationally owned).

In 2010, the practice of anaesthesia had also changed substantially. After the threat of large numbers of anaesthetic nurses and general practitioners competing in hospitals, many entrepreneurial anaesthetists set up private practices which employed banks of anaesthetists’ assistants.

The anaesthetists became supervisors of the work of these lesser qualified assistants, but, of course, would undertake many more important decisions. The model of the entrepreneurial anaesthetist, assisted by several anaesthetic nurses and assistants, had become the practice in the USA some years earlier – but was now becoming very profitable and wide spread in Australia.

Litigation

According to the 2010 notes, the early years of the twenty-first century also saw the rise in medico legal threats to levels previously endemic in the USA.

Personal injury lawyers who had lost work in the motor vehicle and workers compensation areas following Government changes, turned to the medical arena. They developed flying hit squads, ready to pounce on the merest sign of doctor failure, lack of informed consent, new treatments, new equipment, etc.

Insurers and medical defence organisations in the late 1990s had warned of significant increases in both the number of claims and the dollar value of claims. Consumer patients were becoming more demanding and more prepared to complain or seek compensation.

Lawyers on a no-win/no-fee deal enabled many more patients to pursue claims against doctors than would otherwise be the case.

The issue of informed consent hit the anaesthesia profession substantially.

The Australian High Court case of *Rogers v. Whittaker* in the early 1990s confirmed that all doctors must warn patients of all material risks of procedures. It determined the need by doctors to take into account the special circumstances of each patient in advising of such risks. It was not just a question of the percentage risk involved, but what might actually affect the patient’s decision to proceed with the procedure or not.

In the further case of *Kalokerinos*, a general practitioner referred a patient to a specialist and made an appointment for the patient, which was not kept. The doctor was successfully sued for failing to advise the patient of the risks of not attending the referral appointment with the specialist.

Evidence at the time in the late twentieth century also confirmed that, with better communication to patients, doctors were less likely to be sued. Few doctors, however, heeded the warning, and improved their communication skills.

At the turn of the century, many anaesthetists thought that they were largely immune to these claims. Anaesthetists thought it was the responsibility of the hospital or the surgeon to get informed consent and to properly inform the patient. Some anaesthetists thought the use of simple easy to read brochures would overcome the needs of informed consent, such that they did not need to go further. Many anaesthetists in high pressured hospital situations, rarely had time to see patients for the necessary informed consent discussions before procedures.

However, the case of *Byrne v. Winter* in 2002 became the leading case of claims against anaesthetists. A complication arose with an epidural during labour, resulting in the death of the mother and child. Toxic levels were involved in a new drug being used. The case created great publicity, media outcry and public clamour for an enquiry. The then Health Minister, Poppy King, from the Republican Party, called for an inquiry. A jury awarded a record sum of \$7.5m. in damages to the surviving father and other children.

Lawyers embarked on a feeding frenzy, and convinced medical defence organisations and hospitals to undertake radical new procedures in relation to informed consent and negligence. In order for anaesthetists to maintain their insurance cover, patients would be required to attend a consultation with their lawyer present. The patient would be required to sign an agreed statement of risks; that was explained to the patient in the presence of their lawyers. The patient and lawyer would be required to sign forms acknowledging the risks and releasing the anaesthetists from further claims.

These new procedures, of course, increase the costs of legal advice, and the costs to the health system as a whole.

Similarly, swarming lawyers sought evidence of negligence and errors in the systems of doctors, their practices and hospitals. In 1998 in a South Australian case, a surgeon had been successfully sued for failure to follow up test results, which were adverse to the patient. The surgeon did not have in place an adequate system of checking whether test results were returned to his office, once ordered.

The case served to warn all doctors, hospitals and medical practices to check their systems, ensure fail-safe mechanisms to identify any test results which may be delayed or not returned. Doctors were put on notice that they should always warn patients to attend for a further consultation to receive the results of their tests. Again, these procedures added a considerable dollar burden to the health system.

These developments were followed by the *McGarvie* Case in 2004, in which an anaesthetist signed forms requesting testing for a patient on behalf of a surgeon, whilst the surgeon was scrubbing in theatre. The laboratory, out-sourced during the rush of privatisation of 1999-2000, sent the result in error to the anaesthetist's rooms. The anaesthetist's secretary did not recognise the mistake and assumed that the test results were not meant for the anaesthetist.

As a consequence, a positive test result went missing and there was no follow up with the patient for some months. The patient successfully sued the anaesthetist, who by signing the request form for the tests, accepted some liability for the complications which subsequently arose.

Patient Records

The High Court in Australia had, in the late 1990s, confirmed that doctors own their own patient records. There were some inroads on this principle, including:-

- Some access through Freedom of Information legislation, particularly for public hospitals.
- AMA policy, which, at least, required doctors to provide detailed advice of the information held in the patient's records.
- ACT legislation - which gave a legislative right of access for patients to records and information held by doctors, and the requirement for doctors to interpret that information.

Other States followed the example set by the ACT Government, with the Federal Government ultimately legislating for all health providers early in the twenty-first century.

Under current legislation in 2010, doctors are required to maintain detailed notes, which must be available and readily understood by patients. With the move to computer storage, data is now stored and available by computer access. Data is date imprinted to prevent any subsequent amendment of records, or at least identify, any amendment which is made. Copies are emailed to a central Federal Government Records Storage Area, for access by other authorised health providers and patients themselves. A copy of the medical records of the patient is imprinted on the patient's health card chip, held by the patient at all times.

"Good Samaritan" Legislation

Additionally, in 2004, legislation was enacted throughout Australia for universal coverage of "good samaritan" laws. This legislation recognised the reduced liability for negligence or civil claim, where doctors came to the assistance of patients in emergency situations. Some doctors were becoming afraid to assist with car accidents, on airlines, or any other off-duty emergencies.

This problem was exacerbated by the death of a passenger on a Qantas flight from Perth to Melbourne in 2004, when a call was made for a doctor's assistance. Despite thirty surgeons returning on the flight from the last ASM of the RACS before it was disbanded, no doctor responded to the call. All were fearful of accepting legal liability if they answered the call and gave treatment.

Based on similar legislation which had previously existed in Queensland, legislation was enacted Federally in 2004, giving doctors protection for assistance given in emergency situations.

Conclusion

It can be concluded from these notes of the situation in 2010, that doctors face substantially increased pressures, demands and risks. Many students are choosing to avoid undertaking Medicine as a study. More are becoming Internet Service Provider Specialists. Doctors are still practising under great stress. Many are choosing to exit the profession, with some visiting the recently franchised Dr Phillip Nietske Clinics for voluntary euthanasia. (There was no truth to the rumour that the Clinics were paying kick-backs to health providers who were members of the new Faculty of Pain Medicine, established by ANZCA in 1999.)

It is clear from these notes, that in 2010, there are many challenges and medico-legal risks for medical practitioners. All I can safely conclude is that - it is safer to be a lawyer."

APPOINTMENT

Congratulations are extended to

Dr Michael J H Hodgson, AM, Tas upon his election – President, Medical Council of Tasmania

JOHN HERBERT OVERTON

OAM MB BS DA FFARCS FANZCA FFICANZCA

In the recent Queen's Birthday honours list, Assoc. Prof. John H Overton was awarded the Medal of the Order of Australia for his services to medicine and to the welfare of children as a paediatric anaesthetist.

Those who know John realize that these words are a little understated when it comes to what he has contributed to anaesthesia and medicine in Australia.

He first worked at the Royal Alexandra Hospital for Children in Sydney in 1968, becoming a staff specialist in 1970. Apart from anaesthesia he subsequently had major input into cardiopulmonary perfusion, intensive care and became Director of the department in 1978. He remained Director for 20 years, also becoming Clinical Associate Professor of Paediatric Anaesthesia within the University of Sydney in 1991.

John developed many aspects within his department such as cardiac anaesthesia and bypass, the National Liver Transplant Program, the Vincent Fairfax Pain Unit and the Ulco Fellowship to name a few.

Within the hospital, he has played a large role in the hospital administration always representing the best interests of anaesthesia. He has been Deputy Director of Medical Services, Director of Clinical Services, Director of Standards and Performance. John is now Deputy Executive Director and Director of Clinical Outreach which involves liaising with other hospitals and health care units about appropriate paediatric services within the New South Wales.

However JO's contributions have been equally great outside the department. He has been a Faculty examiner, served on the Editorial Board of *Anaesthesia and Intensive Care*, Senior Medical Adviser to the NSW Ambulance Services, a member of the Australian Resuscitation Council, and served with the NSW Medical Board.

One of John's life interests has been the Australian armed forces. He was Consultant in Anaesthesia to the Royal Australian Navy



and the Army, became Colonel RAAMC, and Consultant in Anaesthesia to the Surgeon General, Australian Defence Force. John, as always, does not rest on his laurels and continues with clinical anaesthesia and hospital administration at the New Children's Hospital, Westmead, Sydney.

This award is richly deserved and is a credit to John, his family, his department, and the specialty of anaesthesia.

MICHAEL G COOPER
New Children's Hospital, Sydney.

LETTER TO THE EDITOR

Dear Mrs Sheales,

Dr T.G. Coupland's letter in your June issue concerning paediatric anaesthesia outside "specialist hospitals" prompts me to raise a matter which is almost always neglected by those who advocate confinement of children's care to such exclusive institutions.

In Australia, there are many young people, especially recent arrivals from areas of conflict and social breakdown, who need major restoration of their ruined dentition. Anything more than one or two teeth requiring filling and/or extraction cannot be accomplished in a single session on a conscious five year old, no matter how co-operative. Below age 3, even this degree of tolerance is rare. Language barriers and previous traumatic experiences combine to destabilise older children, whilst behavioural problems such as Attention Deficit Disorder also contribute to the problem. General anaesthesia enables complete restoration of dental health in one sitting.

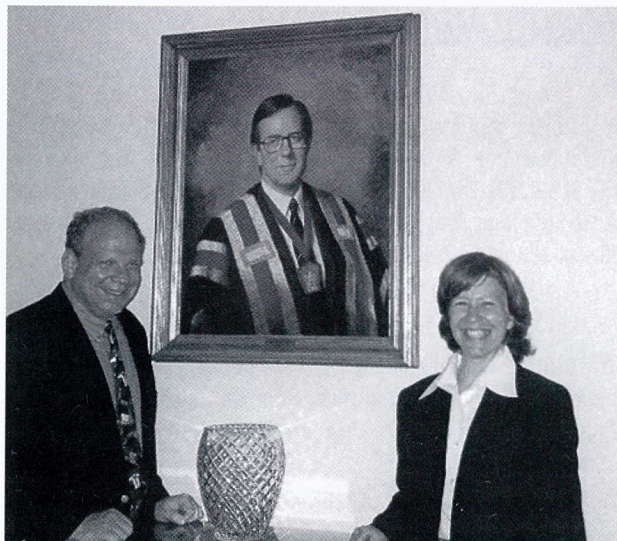
Major paediatric institutions seem unable or unwilling to meet this clinical obligation – indeed some of them even lack the

necessary dental equipment. None ranks dental care highly compared with more "interesting" cases.

A small number of our Fellows, of which I am one, have anaesthetised *thousands* of these children in stand-alone dental facilities with a remarkable record of safety. Mortality in my hands has been zero, and the files of the NSW Committee on Anaesthetic Deaths show that overall, statistics in these environments compare very favourably with those of "specialist institutions", provided that the anaesthetists concerned know what they are doing.

The College is both wise and prudent in not succumbing to the strident demands of vested interests whose experience is limited to major institutions, or worse still, whose principal activity is planning gardens for others to dig.

Ross Holland



Dr Stephen (Butch) and Mrs Ellen Thomas during a recent visit to Ulimaroa.



The Honourable John Howard, Prime Minister, Geoff Renton CEO Microsurgery Foundation and Margaret Benjamin, Executive Officer, Faculty of Pain Medicine at the opening of the Barbara Walker Centre for Pain Management at St Vincent's Hospital.

THE MULTICENTRE AUSTRALIAN STUDY OF EPIDURAL ANAESTHESIA

(“MASTER Trial”)

Dr. Paul Myles and research staff (Jenny Hunt and Helen Fletcher) from the Department of Anaesthesia and Pain Management at The Alfred have recently celebrated the 100th patient recruited into the MASTER Trial.



The **MASTER** Trial, the largest study ever to be conducted in anaesthesia in Australia, commenced at The Alfred in May 1995. It is a multicentre randomised controlled trial investigating the role of epidural anaesthesia in 900 high risk patients undergoing abdominal surgery. Dr. Myles is conducting the trial in collaboration with researchers from the University of Western Australia, and the Austin and St. Vincent's Hospitals in Melbourne. The trial was initially funded by the Australian and New Zealand College of Anaesthetists, and then received a three year \$508,000 research grant from NHMRC in 1997. This was the largest research grant ever awarded in the speciality of anaesthesia.

Two recent meta-analyses found that epidural anaesthesia is associated with a better outcome, but Dr. Myles explains that this approach is problematic. It is imperative to confirm meta-analytic findings with a large definitive study and this was one of the goals of the **MASTER** Trial. A large multicentred trial not only demonstrates clinical effectiveness in the routine clinical setting, but also encourages collaboration in future research endeavours.

Two pre-planned interim analyses by an independent data monitoring committee from the University of WA have been done and these have recommended continuation of the trial. To date, the **MASTER** Trial has recruited over 580 patients from all over Australian and South East Asia. This makes it the largest study investigating the role of epidurals in the world.

A further **MASTER** Trial Symposium is planned for the College ASM in Melbourne next year.

The **MASTER** Trial group has already published seven papers in peer-reviewed journals on related topics, and Dr. Myles has an Editorial appearing in the December issue of the British Journal of Anaesthesia.

Dr. Myles points out that with the growing trend towards evidence – based medicine, large trials such as the **MASTER** Trial are essential to demonstrate effectiveness in day to day clinical practice. He thanks Dr Tony Weeks and all members of the Department of Anaesthesia, as well as the surgeons of The Alfred, for their cooperation with this important study.

MEDICINE AGAINST THE ODDS

By Simon Maclaurin,
Royal Perth Hospital, MB ChB, Dip Obs, DA, FANZCA

Australian and New Zealand volunteer medical teams nowadays are fairly regular and welcome visitors to the myriad developing island nations of the Pacific Ocean.

They travel under varying auspices, and provide useful training for local medical staff as well as delivering a wide range of surgical and allied services to local people.

There is quite a learning curve, too, and thought provoking experience to bring home.

While there have been improvements in facilities over the years, most Pacific nations have small budgets and limited resources and there are still plenty of challenges left during such visits.

They include unreliable power supplies, the risk of virulent gastric upsets, erratic air services, limited time and resources, and an endless supply of patients.

My opportunity came through an invitation to join a surgical team specialising in ear, nose and throat problems.

We were to work under a new Australian Government foreign aid initiative called Pacific Islands Project (PIP), which sends volunteer surgical teams to more than 10 Pacific island nations to provide specialised medical and surgical services.

It was the middle of a busy day's operating at Royal Perth Hospital when the phone call came through: "Would you like to spend two weeks anaesthetising in Micronesia?"

Having missed out on a similar mission to Papua New Guinea, I was eager to accept, but this trip spanned the weekend we were to move house.

My wife loyally said, "go" and, as it happened, she actually enjoyed the opportunity to supervise the move on her own.

Few Australians will have heard of the Federated States of Micronesia (FSM), let alone know where the country is located.

The FSM is a collection of tiny islands north of the Equator and east of the Philippines and Japan and spreads out over thousands of square kilometres of the Pacific Ocean. Yap and Pohnpei, two of the four main islands, were our destinations.

The team of two Ear Nose and Throat (ENT) surgeons, myself, and an ENT nurse, was to spend just a week in each place.

The remoteness is brought home by the journey there. Perth to Singapore and then on to Manila was relatively routine. There, I met the rest of the team, and we flew on for another four hours to the US territory of Guam, for a three hour wait for a two-hour flight to Yap. In total, a sapping 24-hours en route.

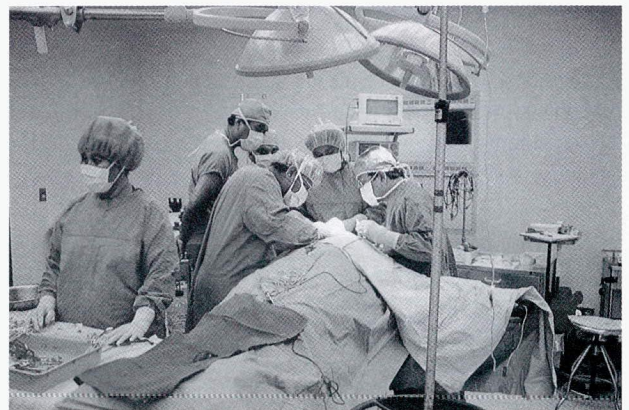
Yap is a small collection of tropical islands and home to about 10,000 people, with lush vegetation, brilliantly coloured flowers and birds and turquoise seas. When you add the easy-going Yapese people, it seems like a paradise. Yet there are problems in its dependence on American funding, the relative lack of other sources of income, with American beer and fast food contributing to the rising incidence of diabetes among other concerns.

One of the two surgeons in the team recalled that a previous trip to Yap had seen the anaesthetist and the nurse become so ill from a local stomach "bug" that they required intravenous rehydration. Their operating schedule had to be aborted.

Yap Hospital, a single storey concrete building was in good condition, considering the heat and humidity, but there were dark red stains everywhere. They were not bloodstains, but expectorated betel nut which is chewed with lime and a particular local leaf to provide a slight "high".

Underway

The team planned to see as many ear, nose and throat outpatients as possible on the first day, to identify those who most needed surgery. Operations then could start on the second day, while one surgeon continued to see and assess more outpatients.

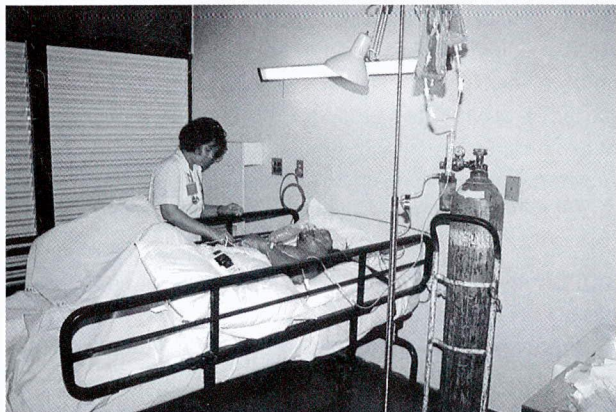


Classical operating scene on Yap

We had taken 10 cases of equipment crammed with anaesthetic and surgical gear with us. Once unpacked, we got under way.

Local realities soon made themselves obvious - electricity is sometimes in short supply and may have to be turned off at the hospital to allow the runway lights to operate at the airport.

The main hospital power supply broke down and the team lost a full day's operating. Using the back-up generator is acceptable in an emergency operation where there is no other choice. But should that break down we would have been left in theatre with no lights, no electronic patient monitoring, no suction and no air conditioning.



Swordfish injury patient recovering in Yap Hospital

Maintaining all the elements of modern anaesthesia delivery proved another problem. Pre-operative assessment of patients was sometimes done through a series of interpreters, with consequent dilution of both questions and answers.

Very often, 'eyeballing' the patient and assessing them on the basis of what they did in their daily lives - paddling and fishing all day in a dugout canoe - was both more available and more relevant than the latest fancy cardiac test we might use in Australia.

Drugs and equipment that we use daily in Perth are unavailable in Micronesia. Basic electronic monitors, without which we would not anaesthetise a patient in Australia sometimes are broken, or are simply not available. The same emergency drug in the same syringe must sometimes be used on sequential patients when supplies are marginal.

Patients turned up with more serious conditions than those who had already been offered an operation, so we had to keep on adjusting decisions on where the highest priority lay. Normally, an overly sleepy patient would be safely left with an experienced recovery nurse while we moved on to the next case, but in Yap we had to recover patients ourselves in theatre or a nearby corridor, before starting the next operation.

Most operations were for severe and painful ear disease, and lasted from one to three hours. I also anaesthetised for two operations performed by the local surgeon - one on a young man who had been speared in the side by a flying swordfish while he was fishing from a canoe. The sharp snout of the fish had penetrated the man's abdominal wall and lacerated his bowel.

Despite his serious injuries and the limited facilities, the man survived the operation. In Australia, he would have been placed in Intensive Care for at least 24 hours, but on Yap he had to recover in a general hospital ward.

The aim of this aid program is to provide high quality specialist medical care to individual patients and to help local staff with ongoing education in their specialty. The educational experience is often two-way, since those of us who practice 'high tech' medicine have little experience working in conditions where resources are so scarce.

It is a tribute to human ingenuity and the commitment and helpfulness of local staff that patients got operated on at all under some of the conditions we encountered. My experience also reinforced how trivial complaints can be in Australian hospitals, which are basically very well resourced.

Travel troubles

The team packed its 10 cases and flew back to Guam, bound for Pohnpei.

The plane was delayed at Yap by mechanical problems, and we arrived in Guam with only minutes to make the connecting flight, only to find it was overbooked and we didn't all have seats. The ENT nurse and I stayed in Guam while the two surgeons went on to Pohnpei so they could start assessing patients.

Back at the airport at 6 am next morning, we were astonished to find our surgeon colleagues waiting for us.

Their flight the previous evening had developed mechanical problems en route and had returned to Guam at 4am.

We finally flew to Pohnpei that morning, but the two surgeons didn't get there until midnight - and we were without all our personal and anaesthetic/surgical luggage. But there were still patients available, and a steady stream of residents with ear, nose and throat problems came to see us.



Kolonia Hospital, Pohnpei



An "older" ambulance on Yap

It was a case of assessing priorities and being prepared to re-assess the most urgent, as our time on the island began to run out. The boxes of equipment finally turned up, and the operations began, with just three days left.

Pohnpei Hospital had a well qualified resident anaesthetist, trained at the Fiji School of Medicine, but again we found drugs and equipment underfunded. To speed the work, one anaesthetist

handled the pre-operative assessments while the other was in theatre, anaesthetising.

Despite all this, our surgeons saw nearly 250 patients, 161 on Yap and 85 on Pohnpei, and operated on about 30.

At home, I work in a department with 40 specialist anaesthetists and the collegial and educational environment is both stimulating and supportive. For the anaesthetist working as a sole practitioner, life is not just professionally lonely, but it is isolating and counter-productive to good, modern medical practice.

One of the most useful functions I felt I performed was an informal support role. We were able to discuss local anaesthetic problems and, working alongside each other, exchanged views on options, techniques, drugs, equipment and associated 'grass roots' matters.

The Australian Pacific Islands Program is an excellent way of medically assisting less well off neighbours.

We, too, can learn from our neighbours - seeing what can be done with so little, observing creative approaches to common problems, and generally how very differently people construct their lives in different parts of the world.

FACULTY OF PAIN MEDICINE

DEAN'S MESSAGE



The Faculty is continuing to develop in a very constructive way, with strong participation of the component specialty bodies. I have had feedback from office bearers in key specialty bodies in the United States, United Kingdom and Europe expressing their admiration for the course that the new Faculty has taken and wishing us well with our endeavours.

In this issue of the Bulletin, a further list of Fellows elected under Article 4.3 of the Initial Board Regulations appears. It is pleasing to note that a healthy cross section of the participating specialty bodies is represented. The Board intends to harness the interest and energy of its new Fellows which has been strongly expressed to our Executive Officer, Margaret Benjamin. It has been most encouraging to the Board to receive such a positive message from a very large number of new Fellows.

Presentation to Health Ministers

A submission package has been developed for the Federal Health Minister and State Health Ministers to make them aware of the needs of this new specialty area. Letters of support have been obtained from Presidents of the participating specialty bodies. The first of a number of planned visits has been made to the Victorian Health Minister, Mr Rob Knowles on 28th July. The Minister was well informed about the pressing need to develop clinical resources and training programs in this new field. A specific request was made that at least one, but preferably more, Pain Centres be consolidated in Victoria to meet ANZCA's Policy Document TE16 requirements, and that training positions be funded within such centres on an urgent basis. Similar visits will be made to Health Ministers of other States to encourage the development of Pain Centres, training programs and training positions. During such visits, there will be an emphasis on creating positions which will be suitable for trainees from all of

the participating specialty bodies. The future of this field will be critically dependant on the development of strong training programs with adequate numbers of training positions. There is currently a major deficit in manpower which will be identified in a meeting to be held with the Federal Health Minister.

Approved Training Programs

The Hospital Accreditation Committee (HAC), under the chairmanship of Dr Terry Little, has begun inspecting training programs. Directors of Pain Centres are encouraged to apply to the Executive Officer for inspection, to enable them to be considered for approval as a training program. This could be beneficial, even if deficiencies currently exist, since our experience to date has been that health authorities and hospitals have frequently addressed deficiencies following a visit by Faculty inspectors. The Board aims to assist in any way it can in developing more training programs. In some instances, the HAC may be able to assist in encouraging the development of joint training programs between institutions.

First Fellowship Examination

In the adjoining pages, information is provided concerning the first examination on November 25 and 26, 1999. This is an exciting stage in the development of the Faculty. The Examination Committee and the Board have been working hard to ensure that the first examination will be of very high quality. Fortunately the Examination Committee has a wealth of experience in conducting examinations within ANZCA and other specialty bodies. The examination venue will be given a "dry run" prior to the examination and candidates will be given an opportunity to experience various components of the examination during a refresher course immediately prior to the examination, which is advertised in the adjoining pages.

In conclusion there is usually a right time to take any initiative forward. Judging from the response from governments, health insurers, specialty bodies, Fellows and patients, this is clearly the right time to move ahead with the field of Pain Medicine. All Fellows are encouraged to participate strongly in the development of *your* specialty. It has been my privilege and honour to serve the new Faculty during this initial phase of its development and I look forward to seeing the specialty grow rapidly in the near future.

MICHAEL J COUSINS AM

FACULTY OF PAIN MEDICINE

HIGHLIGHTS FROM BOARD MEETING

HELD ON JULY 29, 1999

EDUCATION

Education Committee

The Education Committee, chaired by Professor Milton Cohen has identified the following major areas which will be the initial focus of activity:

- a revision of the current curriculum
- updating of the reading list
- development of new modules on evidence-based medicine and medico/social issues of relevance to pain.

These issues will be pursued over the coming months. The current Education Committee is composed of Dr Pam Macintyre FANZCA, Dr Suellen Walker FANZCA, Dr Graham Rice FRANZCP, FANZCA, Dr Ray Garrick FRACP, Dr Ben Marosszeky FAFRM (RACP), Mr Richard Vaughan FRACS and Professor Nik Bogduk FAFRM (RACP).

NHMRC

NHMRC Document "Acute Pain Management: Scientific Evidence"

The Board of Faculty has agreed to participate in a working party which will be organised jointly by ANZCA and the Faculty to revise this document. The working party will utilise the NHMRC "Guidelines for Guidelines" and aim to obtain NHMRC endorsement of the revised version. The Board believes that this document will be of continued value to trainees and Fellows, as it will no doubt also be to ANZCA trainees and Fellows. The ANZCA Acute Pain SIG will also participate in the working party.

APPOINTMENT OF EXAMINERS

Appointment of Examiners

The Board has made some minor revisions to the "criteria for appointment of examiners". A copy of the amended document is published in this Bulletin. There is also a call for expressions of interest from Fellows who wish to be considered for appointment to the panel of examiners. The examination committee will consider all such expressions of interest and will make recommendations to the Board.

Hospital Accreditation Committee

The following individuals have been appointed to the Hospital Accreditation Committee under the chairmanship of Dr Terry Little FANZCA, Mr Leigh Atkinson FRACS, Professor John Gibbs FANZCA, Dr David Jones FANZCA, Dr Roger Goucke FANZCA, Dr Ben Marosszeky FAFRM (RACP), Dr Bruce Rounsefell FANZCA, Dr Bruce Kinloch FAFRM (RACP).

Guidelines for Accreditation of Hospitals

The HAC has developed a questionnaire which is forwarded to all Pain Centres wishing to be inspected for accreditation. This questionnaire will be used in conjunction with inspections of Pain Centres. The Board has decided that all approved Pain Centres will be inspected every five years. Centres which have a cessation of training for more than 18 months will be required to resubmit a Faculty of Pain Medicine Multidisciplinary Pain Centre questionnaire before approval is given for continuation of training.

Private Pain Facilities

The Board has agreed that training can be carried out in private pain facilities which are associated with ANZCA approved Policy Document TE16 Multidisciplinary Pain Centres. Such private pain facilities will be inspected as part of the inspection process for the main centre and the conditions of training in the private pain facility will be determined during the inspection.

ANZCA COMMITTEES

Representation on ANZCA Committees

The Faculty has been invited to have representation on a number of ANZCA committees which will facilitate cross fertilisation and appropriate utilisation of ANZCA resources. These ANZCA Committees include: Education, General Examinations, CE and QA, Communications, Constitution Review, Workforce, Information Technology, ASM Scientific Program, ASM, Research and House Committees.

Scientific Program

A report on the forthcoming scientific program in Melbourne in May 2000 is included within the adjoining pages. I hope that as many Fellows as possible will attend the Melbourne meeting and, where appropriate, take this opportunity to be presented at the ceremony for the Faculty.

RESEARCH

Research

ANZCA has developed a Foundation for Research in Anaesthesia, Intensive Care and Pain Medicine. The Research Committee considers applications each year for research projects with a closing date of 28th February. Fellows of the Faculty are eligible, as are registered trainees of the Faculty. The ANZCA Foundation will be making strong attempts to increase the funding base from various sources.

ANZCA CERTIFICATE

ANZCA Pain Management Certificate

Certificate holders who had completed their training and who applied prior to the closing date of 28th February, 1999, were eligible for induction as Foundation Fellows. Certificate holders who complete their training and are awarded this Certificate, subsequent to the closing date for Foundation Fellowship, are eligible to present for the Fellowship examination without further training. All residual materials from the remaining Certificate trainees must be submitted no later than December 15, 1999. These Certificate holders must present for the examination prior to the end of 2001.

Eligibility to Present for Examination Without Formal Training

The Censor has received enquiries from a number of individuals who have substantial experience relevant to Pain Medicine but who have not had the opportunities that now exist for formal training. A small number of such individuals have already been approved for entry to the first examination and others are encouraged to contact the Faculty Executive Officer prior to the closing date of 30th September, 1999. It should be noted that this option for presentation at the examination without training, will only be open until the examination of the year 2001. Subsequent to this time, the only method of entry to the Faculty will be by meeting the training and examination requirements or by election.

FINANCE

Finance

The Board of Faculty has made a commitment to making the Faculty financially independent as soon as possible. Thus a discrete budget for the Faculty has been developed within the ANZCA financial system, in association with Mr Bill Peachey, ANZCA Business Manager. Counter balancing this aim, is the Faculty's intention to keep the annual subscription at a reasonable level, in view of the fact that Faculty members are already responsible for annual dues to their principal specialty bodies. For the year 2000, it has been decided by the Faculty Treasurer, Mr Leigh Atkinson, in consultation with the Board, that the annual subscription will be \$400. This subscription fee, together with training and examination fees will permit the Faculty budget to come close to self sufficiency within the next 1-2 years.

FACULTY WEB PAGE

Faculty Web Page

It is anticipated that the Faculty Web Page will be set up shortly which will include information regarding the training program, the Annual Scientific Meeting and links to other useful pain sites.

FORMAT OF THE FELLOWSHIP EXAMINATION

NOVEMBER 25 AND 26, 1999

Written Section

This will consist entirely of short answer questions, with the duration of the examination being 2½ hours. Candidates will be required to answer 10 out of 15 short answer questions. Five of the ten questions to be answered will be from a compulsory set of five questions. The remaining five questions can be chosen from ten questions which are optional and which provide candidates with an opportunity to choose questions that may be aligned with their particular areas and/or knowledge. In developing a bank of short answer questions, the examination committee has identified questions which they regard as being relevant to "core knowledge" which all candidates must possess; the five compulsory questions will be relevant to this core knowledge. The short answer question section of the examination will be held on Thursday morning 25th November.

Long case

Candidates will have one hour with a patient for history and examination. Twenty minutes will then be provided for making notes and organising the material. There will then be a 30 minute viva with a pair of examiners.

Short cases

There will be five stations, three of which will have patients and two of which will have diagnostic imaging, test results and other materials. Each candidate will visit each of the five stations and will spend ten minutes at each station. At the three stations with cases, there will be a mixture of "cold" cases with patients who have an established condition that has been previously diagnosed and treated. There will be at least one "hot" case which may be a patient brought from a ward or recent clinic who has a condition about to be treated, or currently under treatment.

Structured Oral Vivas

Each candidate will do three structured oral vivas 10 minutes each. The structured oral vivas will follow a predetermined format with a scenario previously developed and scrutinised by the Examination Committee. One of the three vivas will be aimed at acute, chronic and cancer pain respectively.

Court of Examiners Meeting

The Court of Examiners at the conclusion of the examination. Results will be posted and the successful candidates presented to the Court of Examiners.

ELECTION TO FELLOWSHIP

The following individuals were elected to Fellowship of the Faculty on 22 June 1999

John AGAR-WILSON, QLD, FRCA
 Frances BESWICK, NZ, FAFRM (RACP)
 Nikolai BOGDUK, NSW, FAFRM (RACP)
 Paul CHRISTIE, ACT, FANZCA
 Richard CHYE, NSW, FRACP
 John COLLINS, NSW, FRACP
 John CORRY, ACT, FRACP, FAFRM (RACP)
 Philip FINCH, WA, FRCA
 Alex GANORA, NSW, FAFRM (RACP)
 Raymond GARRICK, NSW, FRACP
 Jack GERSCHMAN, VIC, B.D.Sc, Phd
 Paul GLARE, NSW, FRACP

Colin GOODCHILD, VIC, FANZCA
 David GORMAN, NSW, FRACP
 Attila GYÖRY, NSW, FACRM
 Michael JENNINGS, NSW, FRANZCP
 George MERRIDEW, TAS, FANZCA
 Alan MERRY, NZ, FANZCA
 Michael PAECH, WA, FANZCA
 Anthony SCHWARZER, NSW, FRACP
 Peter SLATTERY, SA, FANZCA
 Siu Lun TSUI, Hong Kong, FANZCA
 Bronwyn WILLIAMS, QLD, FRCA

SELECTION CRITERIA FOR EXAMINERS

DIPLOMA OF FELLOWSHIP IN PAIN MEDICINE, FINAL EXAMINATION

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

PRINCIPLES

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

CRITERIA FOR EXAMINERS

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

available for oral examinations. **ESSENTIAL**

GENERAL CONDITIONS OF APPOINTMENT

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

NON-FELLOW EXAMINERS IN PAIN MEDICINE

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

NATIONAL ANAESTHESIA DAY REPORT

WEDNESDAY, 7 JULY 1999

Mike Martyn
Communications Officer

"Just saw you on the tele news – you looked good!", was the greeting I got on 7 July Wednesday night visiting the parents of a very sick adolescent I had just anaesthetised at Calvary Hospital in Hobart. My pre and post anaesthesia round that followed brought the same response from many patients. An 82 year old WWII veteran, five days post hip replacement, who had also featured in the TV news item, was delighted. He sent me a "With Sincere Appreciation" card after his discharge commenting on the personal positive responses that he had received from all over Tasmania.

All we had done was use the National Anaesthesia Day kit material supplied by the College in setting up a display and utilised the hospital Public Relations facility to contact local media. Our story was a new preoperative service but the focus was the expanding role of the anaesthetist providing care before, during and after anaesthesia. Two TV stations, local newspaper and a radio interview provided an excellent media view of our specialty. The veteran provided an excellent personal touch to the story.

This public education opportunity was taken up all around Australia, New Zealand and Malaysia this year for National Anaesthesia Day. Over 200 kits were sent out and the reports to date indicate considerable success.

The follow-up questionnaires so far received indicate that 80% of hospitals set up displays. There were also eight displays set up in shopping centres, including in Rundle Street, Adelaide, and Casuarina in Darwin.

In Canberra the Minister for Health unveiled a plaque and this was covered on TV news.

In Sydney Brendan Nelson launched the pre-admission clinic at the Sydney Adventist Hospital.

In Melbourne Brendan Flanagan moved his simulator into the Foyer of the Monash Medical Centre. There was "lots of interest from the public - several of whom got to "give" their first anaesthetic"! The event was well advertised beforehand by one of their registrars, Andy Schneider, on Melbourne's top-rating talk radio station.

Regional TV in Victoria ran good stories originating from Wangaratta and Ballarat. Both also featured in the local newspaper and on the radio. Geelong Hospital also placed a story in the local newspaper.

In Adelaide Dick Willis and Lisa McEwin broadcast their story in three radio sessions. Modbury hospital produced a video that animated the "Anaesthetists Care" leaflet.

Professor Teik Oh featured in the West Australian newspaper. There was also an education night held by the West Australian Society of Technicians.

The Gold Coast Hospital had a very successful display which attracted around a 1000 people. They also featured stories in the local newspaper and two TV stations.

Townsville, once again, promoted the day in the local newspaper and on the radio. Cairns Base Hospital managed full-page feature coverage in the local paper on the day.

Alice Springs used the event to launch some new equipment and also received print and radio coverage.

Mike Miller, in Wanganui, organised a press article for his local newspaper in Wanganui. He commented that he "got positive feedback from the local populace who found the article interesting".

Tauranga Hospital had a display in an Exhibition Hall as part of a whole hospital expo and had hundreds of people visit. They also managed "lots of radio interviews and a couple of two page spreads in the newspaper".

On a lighter note an article by Hugh MacKay (from the Melbourne Age) was reproduced in other capital cities – he noted all the important points relating to Perioperative Medicine but was somewhat critical of the self-promotion nature of the exercise. His article in the West Australian had an attached graphic depicting "National Dunny Day"! I have corresponded with Hugh following his article and his reply is very understanding of our situation.

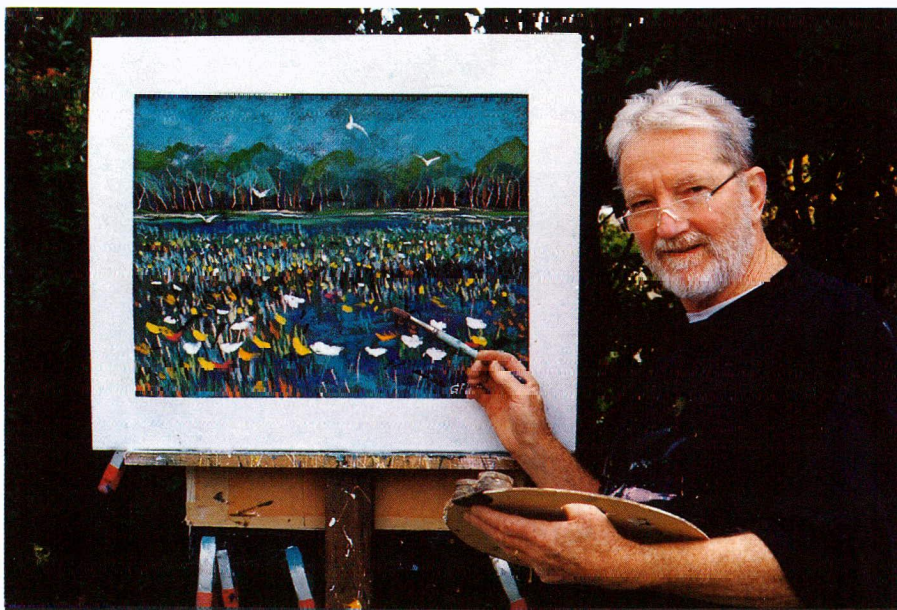
If you have not completed your follow-up questionnaire please do so as the feedback is important in planning for next year. The enthusiasm exhibited by many is contagious and helps such events become successful. Obviously not all are attracted to this method of public education, but there is little doubt that it has been extremely successful over the last five years in improving the understanding by the community of our important speciality.

Our successful initiative has now been exported with the UK planning their first National Anaesthesia Day planned for May 25, 2000.

Thank you all for your support and hard work – plans are already underway for next year – and we have got the message that you want the kit material earlier!

FELLOWSHIP PROFILE

GERALD JAMES FLYNN, FANZCA



Gerald Flynn obtained his Fellowship in 1965, commenced clinical practice in Wagga Wagga, NSW, and moved to Canberra in 1981 where he now lives and remains in busy anaesthesia practice. On arrival in Canberra, he became heavily involved in extra-clinical activities. He instigated and became Chairman of the ACT Section of the Australian Society of Anaesthetists, and later coordinated with others the establishment of the ACT Regional Committee of the Faculty (now College) of Anaesthetists. His involvement with the Australian Medical Association has also been extensive, being an AMA (ACT) Branch Councillor for 10 years and uses his journalistic skills as a regular contributor to monthly issues of "Canberra Doctor", a newspaper for doctors in southeastern New South Wales and the Australian Capital Territory. He was awarded Fellowship of the AMA in 1993 for meritorious service to the profession.

Gerald's workaholic lifestyle came at a price and his General Practitioner found him to have hypertension and depression (once again demonstrating that all doctors should have a GP). His GP insisted that Gerald should find an active interest outside medicine. For him, it was a question of what? Golf was discussed but rejected as impractical. Gerald's wife, Miriam suggested art classes, offered at night and weekends at the Australian National

University. He embarked on the course and was amazed with a "a magical opening where one could produce on a flat surface, using simple materials, a world of three-dimensional images. These images could be representative or surreal, emotive or dispassionate, warm or cold it was a revelation!". Gerald Flynn became an artist, and his appetite for painting forever increased. He attended many weekly in-house tuition courses at both Charles Sturt University (NSW) and the University of Southern Queensland, read and researched the history of art, and developed a special passion for the Impressionist Period of the late 19th century. In similar style, he began to use colour lavishly

and whimsically – and to his surprise, his works were praised by people in the know and this was an enormous boost to his then jaded ego.

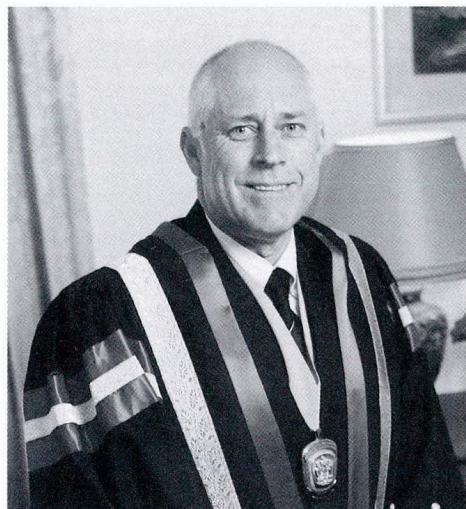
A hobby had become Gerald's life interest and his "clinical work became a happy sidelight". He noted that his clinical skills of observation, response times and mood swings in the clinical setting all changed for the better. He believes that anaesthetists are continuously exposed to the knife-edge of stress and fatigue, and that painting was a lifeline which turned him around from a threatened personal disaster.

Gerald Flynn has sold many works in Canberra by way of public exhibitions and other means, and now teaches at the Mitchell School of Creative Arts in Bathurst. He plans his first solo exhibition later this year. He strenuously recommends the value of painting to anyone for many reasons, foremost being the relaxation and expressiveness it can provide. Now aged 64, Gerald practices anaesthesia "full-time" at The Canberra Hospital and Calvary Hospital in the Australian Capital Territory.

RICHARD G WALSH

FACULTY OF INTENSIVE CARE

DEAN'S MESSAGE



The Board of Faculty has nominated representatives to the Younger Fellows Conference since 1995. Each year a Faculty Younger Fellow reports to the Board on the outcome and recommendations from the Conference. The Board takes these recommendations seriously and has resolved to keep them at the forefront of deliberations and to action them when feasible.

The 1996 YFC focused on communication and conflict resolution. The importance of communication skills is stressed in the Objectives of Training in Intensive Care and forms part of In-Training Assessment. Communication skills will also be included as a desirable attribute in the Recommendations concerning Trainee Selection and Registration. Communication under stressful situations such as patient death and brain death was also mentioned along with crisis management and debriefing skills. A Medical ADAPT Program specifically directed at trainees is currently being developed and will provide training in these areas.

In 1997 the YFC was entitled "Looking After Ourselves". Once again the report discussed the need for training in the approach to death and dying and the need for departmental critical incident debriefing protocols. It was also suggested that there should be a "Train the Trainer" program for Supervisors of Training. This has started to occur with a recent meeting of Supervisors of Training in New South Wales. The Royal Australasian College of Physicians has also been very active in this area over the last two years and the Faculty should accept opportunities to be involved in their program.

In 1998, the YFC focused on "The Ethical Challenges Facing Anaesthetists and Intensivists in the Closing Years of the Millennium". One recommendation was that the College and

Faculty establish a course with workshops on Ethics and the Law. Whilst the Board believes that such a course is currently outside its reach, it has commissioned a reading list with selected papers that will be provided to trainees. Such topics are examinable and this is likely to encourage self-directed learning. Another recommendation was that the Faculty should provide guidelines to assist intensivists in setting up a procedure for withdrawal or withholding of life support therapy. Many will be aware that ANZICS in conjunction with the Faculty is currently developing a consensus statement on "Withdrawing and Withholding Treatment".

The 1999 YFC theme was "Striving for a Job Well Done". The group discussed the issue of job satisfaction and ways to improve it. It should be noted that the AMWAC Report on "The Intensive Care Workforce in Australia" accepted that there is considerable dissatisfaction from many intensivists regarding working conditions, physical and emotional demands and level of remuneration for effort and commitment. The climate has been set for improvements in staffing levels in particular to redress this situation. YFC participants also thought that the profile of the specialty amongst colleagues, patients and the community was not high. A recommendation for further Intensive Care Days has been accepted by the Board and the next such day is scheduled to be held in 2001 in proximity to the World Congress.

Finally, a number of Faculty Fellows are currently involved in the development of a Medical Australian Donor Awareness Program (ADAPT) course. Although the ultimate aim of this course is to improve organ donation rates in Australia to international benchmarks, it is being developed to have a strong educational focus. It has become obvious from the original ADAPT program that despite the ANZICS "Recommendations Concerning Brain Death and Organ Donation", there remains significant variations in clinical practice in both Australia and New Zealand. The course will aim to encourage uniform practice and to address issues such as organ maintenance using an evidence based approach. Hands-on training in the requesting of organ donation, counselling of relatives and provision of debriefing will be included. Once again this is an examinable topic which should encourage trainee involvement. It is hoped that the course will also attract specialists as there is some evidence that although the vast majority strongly support organ donation and transplantation programs, some pay lip service to this when faced with personal involvement.

Alan Duncan

A.W. DUNCAN, DEAN

ITEMS OF INTEREST FROM THE JUNE 1999 BOARD MEETING

HONOURS AND APPOINTMENTS

The Board congratulated the following Fellows on their recent honours and appointments:

Professor K. Hillman, NSW – Professor of Intensive Care, University of New South Wales
 Professor T.E. Oh, WA – Inaugural Chair in Anaesthesia, University of Western Australia
 A/Professor J.H. Overton, NSW – Order of Australia in the General Division
 Professor J.H. Havill, NZ – Honorary Clinical Associate Professor in Intensive Care,
 Waikato Academic Division of Auckland Clinical School of Medicine

EDUCATION AND TRAINING

Supervisors of Training in Intensive Care

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

Dr Andrew Holt, Flinders Medical Centre
 Dr Dorothy Breen, Royal Prince Alfred Hospital
 Dr Trevor Dobbison, The Canberra Hospital
 Dr Geoffrey Shaw, Christchurch Hospital

Survey of Trainees

The Board agreed to conduct a survey of trainees, to seek feedback on quality and quantity of teaching and supervision, relationships with supervisors and to increase awareness of the responsibilities of supervisors. The survey form has been revised following feedback from Regional Committees. The Joint Specialist Advisory Committee – Intensive Care has recommended the form be circulated to all intensive care trainees.

Formal Project

The Board noted a review of Faculty policy regarding the Formal Project is continuing, to ensure consistency with the RACP and ANZCA Formal Project policies.

Simulators

The Board has investigated the use of simulators and their possible applications to intensive care training and/or examinations. It has been agreed that the Board will continue to monitor this issue and await developments of Australian and New Zealand Simulator programs.

Academic Intensive Care Database

The development of a database detailing academic appointments in intensive care has been finalised and will be forwarded to the Intensive Care Medical Liaison Committee for information.

Selection of Trainees

A draft policy statement on the selection of trainees has been developed and following the incorporation of comments from Regional Committees, will be circulated to hospitals. The policy has been developed in response to recommendations made by the Medical Training Review Panel which suggested that a formalised framework be adopted for the selection and review process for entry into training programs accredited by medical colleges.

Ethics Reading List

The Board is considering the development of an ethics reading list for trainees, following recommendations from the 1998 Younger Fellows Conference.

Approval to proceed to Training Year 3 without the Primary Examination

The Board has resolved that trainees who have completed two years of approved training may proceed to their third year of approved training, without success at the Primary Examination. Trainees who have still to complete the ANZCA Primary Examination will therefore be permitted to gain more than two years approved training in intensive care. Previously, the Faculty has required trainees to pass or be exempted from the Primary Exam in order to proceed to their third year of training. The revised Administrative Instructions have been amended accordingly.

Requirement for Six Months of Clinical Medicine Training

Following consideration of posts suitable for the six month period of medicine required as part of the intensive care training program, the Board resolved that:

1. the post should involve day to day clinical management of patients.
2. the post cannot be undertaken until completion of at least two years of general hospital appointments.
3. it must be in a hospital approved for training by the RACP.

Under exceptional circumstances other medical training may be approved by the Censor.

EXAMINATIONS

Report of April/May 1999 Examination

The Chairman of Examinations reported the introduction of the new format of the Examination had been successful, with a total 12 candidates presenting and seven successful. The successful candidates are:

R.M. Calcroft, HK	N.A. Edwards, SA	P.W. Harrigan, WA
K.H. Anne Leung, HK	C.P. Nolan, NSW	A.H. Stewart, NSW
N.J. Widdicombe, SA		

Paediatric Intensive Care Examination, August/September 1999

It was noted that the second Paediatric Intensive Care Examination would be held at the New Children's Hospital, NSW, in September 1999.

Dates for 2000 Examinations

The Board ratified the dates for the Fellowship Examinations to be held in 2000. It should be noted that these dates are set approximately one month earlier than the usual calendar dates, in view of the Olympics being held in Sydney.

The dates are published elsewhere in the Bulletin.

ADMISSION TO FELLOWSHIP

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

- Michael Anthony Corkeron, WA
- Cyrus Edibam, WA
- Nicholas Andrew Edwards, SA
- Cathal Patrick Nolan, NSW
- Vincent Alfred Pellegrino, Vic
- Neil James Widdicombe, SA

PROFESSIONAL AFFAIRS

High Dependency Units

A further draft of a policy document defining minimum standards for High Dependency Units was reviewed and will now be circulated to Regional Committees for comment.

Policy Documents

The Board agreed that policy documents would be reviewed every five years.

The Board supported the College Policy Document "Intrahospital Transport of the Critically Ill" being promulgated as a joint document with the Faculty.

It was agreed that the ANZCA Policy Document "Statement relating to the Relief of Pain and Suffering and End of Life Decisions" would also be promulgated as a joint Policy Document with the Faculty.

Following acceptance of the Faculty's policy on accreditation by the RACP's Committee for Physician Training, the Faculty will promulgate Policy Document IC-3 "Guidelines for Intensive Care Units Seeking Faculty Accreditation for Training in Intensive Care" as a joint Faculty/RACP document.

Committee for Presidents of Medical Colleges

The Board noted the appointment of the Faculty of Intensive Care to the CPMC as an Associate Member.

Intensive Care Workforce

The Board received the published report "The Intensive Care Workforce in Australia – Supply and Requirements 1997 – 2008" produced by the Australian Medical Workforce Advisory Committee.

Hours of Work for Hospital Doctors

The Board received the report of the "AMA National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors", which recommended for safe working hours of less than 50 hours per week. A submission from the Faculty to the AMA had indicated that in view of the requirement for shiftwork, a minimum of 50 – 55 hours is the preferred amount of hours for intensive care doctors. Nonetheless the Board supports awareness of reasonable working hours for hospital doctors.

Younger Fellows Conference May, 1999

Dr Helen Opdam presented the Board with a report of the Younger Fellows Conference held in the Barossa Valley in May, 1999. The theme 'Striving for a Job Well Done' involved discussions on the importance of job satisfaction, the perception of the profession and assessment of performance.

A College of Intensive Care Medicine

The Board noted that the discussion document and survey relating to a separate College of Intensive Care Medicine had been approved by the JSAC-IC and will be circulated to all intensive care specialists and trainees.

Maintenance of Professional Standards

The Board noted that the revised MOPS program will be introduced in January, 2000.

INTERNAL AFFAIRS

New Zealand National Committee

In response to a request from the New Zealand Regional Committee, the Board agreed to rename this committee the New Zealand National Committee, and to reserve a separate agenda item for discussion of matters relevant to national medical issues in New Zealand.

Administrative Instructions

The revised Administrative Instructions were accepted by the Board and will now be promulgated. They are printed elsewhere in the Bulletin. These relate to training and examinations and incorporate a number of changes:

- the new system of classification of intensive care units accredited for training, with particular reference to how long trainees may spend in the varying levels of units, and how rotations may be incorporated into training programs
- changes to the Fellowship Exam
- introduction of the paediatric intensive care training program
- exemption from the Primary Examination
- interrupted and part-time training

Election of Office Bearers of Board of Faculty, June 1999 – June 2000

The following were elected to the new Board for 1999 - 2000:

Dean	A.W. Duncan
Vice-Dean	F.H. Hawker
Censor	F.H. Hawker
Assistant Censor	D.J. Cooper
Education Officer	N.T. Matthews
Treasurer	P.D. Thomas

The following appointments were made:

Communications Officer	R.V. Trubuhovich
ASM Officer	R.V. Trubuhovich
MOPS Officer	G.F. Bishop

Invitation to the RACP for Observers on the Board

The Board amended its Regulations to allow for the co-option of two representatives of the RACP as observers, one being a member of the Division of Paediatrics.

COMMUNICATIONS

National Intensive Care Day

The Board resolved that a second National Intensive Care Day will be held in 2001.

1999 YOUNGER FELLOWS CONFERENCE – REPORT

“STRIVING FOR A JOB WELL DONE”

Dr. Helen Opdam

1) Venue

The Conference was held this year in the Barossa Valley at the Chateau Yaldara Motor Inn. The accommodation provided the convenience of on-site dining and individual rooms for delegates. The conference began with afternoon sessions on the Thursday followed by the conference dinner. An otherwise busy Friday program included an opportunity to visit the local wineries. The Conference closed after breakfast on the Saturday after which many delegates left to attend the ANZCA Annual Scientific Meeting in Adelaide.

2) Attendees

There were eighteen ANZCA Younger Fellows and seven Faculty of Intensive Care Younger Fellows with representation of all Australian states, New Zealand and Hong Kong. These numbers were considered representative of the numbers of specialists practising within the respective fields. There was in addition a representative from the Surgeons Younger Fellows.

Professor Teik Oh and Dr. Rob Barnett were the Council and Board Members-in-residence, and Dr. Lisa McEwin the Convenor.

Dinner guests for the Thursday night were Dr. Richard Walsh and Dr. Alan Duncan.

3) Timetable and structure of sessions

The conference was divided into 90 minute sessions and a final summary session. Each session was dedicated to a particular topic during which delegates gave brief talks on related subtopics allocated in advance. Time at the end of each session was available for open discussion.

4) Topics discussed: Summary

A wide range of topics were covered in relation to the theme, “Striving for a Job Well Done”.

Session 1 – Job Satisfaction

The importance of job satisfaction was discussed, in terms of work being a major component of life and defining to a large extent one's sense of self. Job satisfaction was felt to have numerous components including recognition, autonomy, remunerative rewards, esteem, and having a sense of making a difference and performing useful work. Ideally work should provide the opportunity for people to utilise and develop their innate talents and creativity.

The advantages and disadvantages of working in private versus public practice were discussed from an anaesthetic practice viewpoint. Choosing the right job was discussed in terms of

balancing commitments to career with those outside work, including family and personal interests. The importance of teaching and research for furthering knowledge and providing improved care was emphasised, though it was agreed that there is difficulty doing so in a climate of ever-increasing economic constraint. Involvement in anaesthetic affiliations was discussed in terms of one of many demands on time. The importance of taking on what you have time to do well, rather than becoming overcommitted was emphasised.

• Discussion and recommendations:

Discussion centred on the apportionment of time, clinical versus non-clinical sessions, mainly from an anaesthetic viewpoint. It was recommended that the policy of 30% of time being allocated to non-clinical duties be adhered to. There was a view that involvement in committees is vital to leading to greater control in the workplace, though there should be fairness in distribution of workload. Also, skills for participating in management and committees are not necessarily innate and could be addressed in teaching sessions.

Session 2 – It's a Matter of Respect

The importance of appearance on both the patient's and one's colleague's perception of the profession was noted. Topics such as ‘Status within the hospital – Is the peri-operative physician a reality?’, ‘Pre- and post-operative visits’ and ‘Status within the general community’ were discussed mainly from the anaesthetic perspective.

It was generally felt that the profile of our specialities is not high and that it is in our interest to improve patient and community knowledge of our role. Raising the public profile was covered in terms of various media options. The possibility of an annual Intensive Care Day distinct from Anaesthesia Day was raised. It was felt that there is a reluctance and inexperience within the profession in dealing with the media as well as concerns about being misrepresented by the media.

• Discussion and recommendations:

Pre-anaesthesia clinics were discussed and felt to have a role but not as an alternative to pre-operative visits, and it was felt that the College in a Policy Document could address this issue. The need for increased emphasis on the post-operative visit was also covered. Concern was expressed about anaesthetics being administered by insufficiently experienced Emergency doctors to very sick patients. Individuals can make a difference in

addressing the status of the profession within the hospital by participating in hospital committees, inter-disciplinary teaching and research.

Session 3 – A Job Well Done

The difficulty in assessing performance and how to and who should assess performance was discussed. It was commented that feedback is generally of a negative nature occurring when there are problems and positive feedback is rare (hence, 'no news is good news').

The value of quality assurance was discussed - mortality and morbidity meetings, critical incident monitoring, MOPS, etc. Intensive Care was discussed in terms of appropriateness of some admissions and therapies for particular patients, gate-keeping. It was noted that there are several groups to satisfy when considering admission to, and when managing patients in Intensive Care – the patient, the relatives, the parent unit and Intensive Care clinicians. It was agreed that survival was not the only good outcome – a good death may be the right outcome for a certain individual. The need to take responsibility for educating other clinicians as to the role of Intensive Care was stated.

The MOPS (Maintenance of Professional Standards) program was discussed though whether this makes a positive difference to actual patient care was disputed.

From the surgical viewpoint, it was considered that successful working relationships impacted strongly upon job satisfaction for all concerned and that a team approach with mutual respect was important.

- **Discussion and recommendations:**

The issue of competence and its three aspects – knowledge, performance and practice, was discussed. Knowledge can be assessed with exams and improved with professional development ventures but does not equate with competent practice. The performance of consultants, who basically work independently, is difficult to assess and the potential role registrars could have in providing feedback to consultants was discussed, though this has problems in that the registrars' view may be limited by their inexperience.

The assessment of 'a job well done' was difficult though it was felt that professional development and review programs may be useful in terms of self-assessment, review of individual goals and short term career plans, and identifying perceived or actual problems in a timely manner to allow early remedy.

Session 4 – Ideal or Idealistic

Role models were discussed in terms of personal (interpersonal skills, communication which includes listening, values and personality) and professional (clinical, teaching, research, administrative abilities) characteristics. It was appreciated that there is no ideal role model and that role models may change

over time. Discovering one's own strengths and abilities, without being hindered with concern for what one's role models would do or think, was also considered valid.

Improving skills of the individual/department/profession by a myriad of avenues (colleagues, junior staff, formal programs - MOPS/conferences, developing business and administrative skills) was considered important, but likely to be undertaken by the already conscientious rather than those most in need – "preaching to the converted". The desire to improve, acceptance that there is room for improvement and an open mind to new ideas, as well as time availability were considered crucial factors. The role of teaching and lack of formal training in teaching was noted. The demands of non-clinical duties were discussed in terms of limited time available. Considered of value was maintaining perspective, being 'active' rather than 'passive' in organisation of non-clinical duties, and being helpful and constructive even if unable to take on a requested task. "If you're not part of the solution you're part of the precipitate".

- **Discussion and recommendations:**

It was recommended that formal instruction in teaching methods be part of Fellowship training. "Training the Trainers" sessions could be part of the Annual Scientific Meeting and/or a separate ANZCA sponsored program for a core group of individuals who would then return to their regions and propagate the ideas. This idea of formal teaching received strong support from delegates. The mentor system was discussed – thought to be a good idea in principle but logistics and availability of mentors can make the program non-viable.

Session 5 – Younger Fellows Conference

The value and importance of the Younger Fellows Conference was unanimously agreed, in providing a means of having within the College representation of new Fellows, and encouraging the participation of new Fellows in College activities.

Many delegates had not heard of the Younger Fellows Conference prior to being invited to attend.

Current system of selection:

Up to 8 years post Fellowship

Chosen by Regional Committee, advertised in Bulletin.

Various recommendations for future Younger Fellows Conferences were made.

5) Recommendations for future Younger Fellows Conferences

Suggestions to increase awareness of the Younger Fellows Conference:

Inform new Fellows at graduation.

Direct mail out in January to all relevant Younger Fellows

Topics advertised in advance in the Bulletin, and on the website.

The mode of selection should be the same with the Regional Committee selecting those who will be sponsored and these candidates will be expected to present a nominated topic. Those not selected (and not presenting) may attend and would be self-funded.

Should be open to all new Fellows of less than 8 years (not just the younger ones!)

Continue to have the following representation:

Anaesthesia	2 per region
Intensive Care	1 per region
Pain	1-2 new (younger) Fellows

Care to avoid too large a group, as discussion becomes difficult. Having an occasional (every 4-5 years) combined ANZCA/FIC and RACS Younger Fellows Conference was suggested, perhaps with some common and some separate sessions. Choose a theme that year which is relevant to both.

Program should not be too ambitious – individual presentations should be brief to ensure plenty of time for discussion at the end of the session.

Most of the delegates felt the title should be changed to the “New Fellows Conference” rather than the “Younger Fellows Conference”, to reflect the presence of older, though recently admitted, Fellows.

Having joint Anaesthesia and Intensive Care convenors could be considered, and perhaps schedule some separate sessions.

Suggested future topics:

- Teaching the teachers
- Promoting the profession
- How to achieve success
- How to make committees work for you
- Interpersonal communication
- Economic rationalisation

6) Acknowledgments

The Younger Fellows would like to congratulate Dr. Lisa McEwin for preparing and convening a very successful conference this year. Lisa ensured, through excellent organisation and attention to all participants, that the entire process ran smoothly and was enjoyable for all.

We would also like to extend our warm appreciation to the Council and Board members in residence, Professor Teik Oh and Dr. Rob Barnett, who stimulated debate and offered additional valuable insights. We would like to also thank Dr. Richard Walsh and Dr. Alan Duncan for their presence at dinner on the Thursday night, further enhancing an already enjoyable evening.

*The case is complete,
I sigh with relief,
Now whence come those fine words of praise,
That steals my resolve
And gives me the strength
To carry on through other such days.
A fear of failure
Drives us on,
With time that wears quite thin.
The patient's kind words,
The support of our peers,
Or should it come from within.
When I'm hard at work
And feeling quite good,
Theatre's running like a well-rehearsed play.
I look for the reward
That makes me go on,
Need I wait 'til the end of the day?
Though many jobs end
When it's time to go home,
There's many more that carry right on.
The finished product
Is just not there,
How do we judge a job not done?
Perhaps Rene Descartes
Meant more when he said:
"I think therefore I am".
Perhaps in doing our job
We should seek our reward,
Not simply when it is done!*

DAVE WILKINSON
Royal Adelaide Hospital

REPORT FROM THE DEAN

TO FELLOWS OF THE FACULTY OF INTENSIVE CARE, ANZCA

AS AT 24 JUNE 1999

It is my pleasure to report on behalf of the Board on the affairs of the Faculty since the last Annual General Meeting.

AWARDS, HONOURS AND APPOINTMENTS

I am pleased to report the following awards and appointments:

Dr J.E. Gilligan was awarded the Order of Australia, Officer in the General Division.

Professor G.D. Phillips has been appointed Visiting Professor in Anaesthesia at the University of Papua New Guinea.

Professor K. Hillman has been appointed Professor of Intensive Care of the University of New South Wales.

Professor T.E. Oh has been awarded the Inaugural Chair in Anaesthesia at the University of Western Australia.

Dr R.V. Trubuhovich was awarded the Priory Vote of Thanks, Order of St John of Jerusalem, NZ.

The Board welcomed the appointment of Professor Garry Phillips as Director of Professional Affairs at the College.

EDUCATION AND TRAINING

Review of Accreditation of Training

After much deliberation by the Board and its Regional Committees, the revised system of accreditation of training was introduced. As part of the review the Board revised its Policy Document IC-3 "Guidelines for Intensive Care Units Seeking Faculty Accreditation for Training in Intensive Care". The Faculty will continue to conduct site visits of accredited Intensive Care Units to ensure an appropriate training environment and to assist in maintaining standards. However as from 1999, units accredited for training no longer have a restriction on the number of training posts.

Trainees are now required to register with the Faculty in order to have core intensive care training accredited, prompting trainees from anaesthesia, medicine or other specialties such as emergency medicine to identify their path of training earlier than was necessary in the past. As from 1999, Intensive Care Units are accredited for core training for 6, 12 or 24 months and classified accordingly as C6, C12 or C24. An additional S3 classification allows for secondments from major tertiary hospitals to smaller private, rural or specialist units, as well as access to such specialised experience as retrieval services or hyperbaric units.

It is hoped that the changes will allow increased flexibility for trainees; it is acknowledged however that there will need to be greater involvement from Directors and Supervisors to ensure

experience of trainees is not diluted and that the standard of diplomates is consistent.

The Administrative Instructions for trainees have been revised to accommodate these and other changes.

Trainee Selection in Australian Medical Colleges

Prompted by recommendations in the Brennan Report, the Board has developed policy which contains selection criteria and details of a suggested process for the selection of trainees.

Courses for Trainees

The Board resolved that the Early Management of Severe Trauma (EMST) Course is no longer a mandatory requirement for training. It is however, strongly recommended, along with the Advanced Paediatric Life Support (APLS) Course.

Trainees

The Faculty has a total of 168 registered trainees of whom 146 are active. 37 are completing intensive care training only, 20 are undertaking dual certification with the RACP and the Faculty, and 86 are undertaking dual certification with ANZCA and the Faculty. This represents an increase of 100% in active, registered trainees since last June.

ADMISSION TO FELLOWSHIP

From June 1998, the following were admitted to Fellowship by examination:

Cheng Ai Yu, Claudia	HK	Michael Anthony Corkeron	WA
Cyrus Edibam	WA	Manivannan Gopalakrishnan	NSW
Stuart Russell Green	QLD	Myrene Carol Kilminster	NSW
Daniel Vincent Mullany	QLD	Cathal Patrick Nolan	NSW
Michael James O'Leary	NSW	Helen Ingrid Opdam	VIC
Hugh Richard Playford	QLD	Vincent Alfred Pellegrino	VIC
TAN Yuen-heng, Peggy	HK	Neil James Widdicombe	SA
Anthony Brendan Williams	NZ	Clive Bernard Jonathan Woolfe	NSW

The following were admitted to Fellowship by election:

Simon Finfer	NSW	Jeffrey Lipman	QLD
David Hugh Stephens	QLD		

The Faculty now has a total of 241 Fellows.

EXAMINATIONS

Introduction of changes to the Fellowship Examination

The April/May 1999 Examination saw the introduction of the most comprehensive changes to the structure of the Examination since

its introduction in 1979. The Examination Committee has been diligent in pursuing a fair, reliable and valid assessment for our trainees.

The former Investigation Section has been incorporated into an Objective Structured Clinical Examination (OSCE), where candidates rotate through ten to twelve 'stations', covering performance of procedures, common ethical or management problems in addition to investigations. The Clinical Section is now divided into medical and ICU cases. Another significant change is the structuring of the cross table vivas, with each candidate encountering standardised scenarios and questions at each of the six tables.

A further initiative has been to appoint an Examiner Assessor, to observe and provide feedback on the performance of examiners.

Initial feedback from Examiners and Candidates indicate that the changes were successful. Dr Richard Lee and the members of the Fellowship Examination Committee are to be congratulated for their efforts.

August/September 1998 Fellowship Examination

The written section was held in Adelaide, Auckland, Canberra, Hong Kong, Melbourne, Newcastle, Perth and Sydney and the Viva Section was held at the St George Hospital, Sydney with a record number of nineteen candidates. This was the last Examination held under the original format. Eleven of the nineteen candidates were successful.

Successful candidates

S.R. Green, Qld	M.C. Kilminster, NSW
Manivannan Gopalakrishnan, NSW	M.J. O'Leary, NSW
Cheng Ai Yu, HK	S.J. Fletcher, NSW
M.A. Corkeron, WA	Cheung Po Wa, HK
V. Pellegrino, Vic	P.H. Sharley, SA
J.M. Torrance, NZ	

April/May 1999 Fellowship Examination

The written section was held in Adelaide, Hong Kong, Newcastle, Perth and Sydney. The OSCE and Viva Sections were held at the Royal Australasian College of Surgeons, and the Clinical Section at the Alfred Hospital. Seven of the eleven candidates were approved.

Successful candidates

R.M. Calcroft, HK	N.A. Edwards, SA
P.W. Harrigan, WA	K.H. Anne Leung, HK
C.P. Nolan, NSW	A.H. Stewart, NSW
N.J. Widdicombe, SA	

Exemption from the ANZCA Primary Examination

The Board has resolved that Fellows of the Royal Australasian College of Surgeons and the Australasian College for Emergency

Medicine would be granted exemption from the requirement to sit the Primary Examination. It is considered that this important change now provides another pathway to 'supra-specialty' training in intensive care.

JOINT SPECIALIST ADVISORY COMMITTEE – INTENSIVE CARE

The JSAC-IC continues to meet twice yearly to review all intensive care trainees on behalf of the Faculty and the Royal Australasian College of Physicians, and to assess requests for specialist recognition. It also continues to play an important role in ensuring progress towards a single training program. In the past year the Committee has investigated the issue of logbooks, a survey of trainees and reviewing the criteria for specialist recognition.

Of major significance on its agenda is the working group established to consider the issue of an independent College of Intensive Care Medicine (covered below).

The terms of reference for the New Zealand JSAC-IC were approved, enabling the New Zealand Medical Council to have a single body to contact regarding specialist recognition.

Professor Napier Thomson has replaced Dr Robin Mortimer as a representative of the RACP, and Dr Katrina Williams has been co-opted as an additional representative of the Division of Paediatrics (corresponding member).

ACCREDITATION OF INTENSIVE CARE UNITS

A total of 10 Units were visited by representatives of the Board and Regional Committees since the last Annual Report. In nearly all cases a representative of the Royal Australasian College of Physicians joined the accreditation teams.

PROFESSIONAL

An Independent College of Intensive Care Medicine

As all Fellows will be aware, a discussion document and survey regarding a single body for intensive care certification and standards was circulated to all Fellows last year, with the results of the survey published in the November issue of the Bulletin. Ninety per cent of Fellows who responded favoured the ultimate formation of a separate College, with a majority of these responses favouring a 2-5 year time frame. Following a motion that was strongly supported at the ANZICS ASM, the JSAC-IC agreed to convene a joint working party comprising members of the Faculty and the RACP to prepare a further document and survey, which will be circulated to all intensivists and trainees.

Committee of Presidents of Medical Colleges

Following a revision of the Regulations of the CPMC, the Faculty has been accepted as an Associate Member of this body.

Australian Medical Workforce Advisory Committee

The AMWAC Working Party on Intensive Care has published its report which will be considered by the Australian Health Ministers' Advisory Committee. Representatives of the Faculty, the RACP and ANZICS played an important role. The report recommends an increase in the number of intensive care specialists and therefore trainees. It is acknowledged that there are sufficient training positions to cope with the required increase. The report has recommended that JSAC-IC and the Intensive Care Medical Liaison Committee develop strategies to attract junior doctors to a career in intensive care to achieve a total of 24 to 26 graduates per year.

CONTINUING EDUCATION

Annual Scientific Meeting

The Annual Scientific Meeting in Adelaide was a great success. Record numbers of registrants ensured good attendances at all the intensive care sessions. The Foundation Visitor, Professor Rick Albert contributed a number of high quality lectures, with 'Management of ARDS' a highlight. Andrew Bersten is to be congratulated on his contribution as Faculty Scientific Convenor and in ensuring the smooth organisation of the Faculty component of the meeting.

Dr Megan Robertson is our Convenor for 2000 in Melbourne and has already planned an exciting meeting featuring Professor Paul Pepe and Associate Professor Paul Hebert, and a satellite meeting on CPR.

A record number of Younger Fellows of the Faculty enjoyed the Conference held this year in the Barossa Valley with the topic 'Striving for a Job Well Done'.

Maintenance of Professional Standards

Following on from a review of the College MOPS Program which included the introduction of an electronic diary, the Faculty Maintenance of Standards Program has also been reviewed and the revised program will be introduced in 2000. At present, there are 175 participants registered for the Program.

DEATH

It is with regret I report the death of Faculty Fellow Dr Douglas Geoffrey Tabrett, NSW, FFARACS (IC) 1981, FANZCA 1992, FFICANZCA 1993.

FACULTY AFFAIRS

National Intensive Care Day, 1998

National Intensive Care Day was held on Wednesday 1st July 1998 and was a great success, with over 170 Units in Australia and New Zealand taking part. Activities included public displays both in hospitals and in the community, lectures to schools and a high level of media coverage in national and local print, radio and television.

Our thanks go to the College Council for dedicating the event to the theme of intensive care, and also to Ron Trubuhovich and Neil Matthews, our two Board representatives, and Eddie Dean, the College Media Consultant for their enormous contributions to the success of the event.

A number of enquiries regarding a future National Intensive Care Day have been received, and the Board of Faculty will be considering this issue.

Faculty Website

I would like to thank Dr Mark Finnis, the Faculty's new Webmaster for his work on the Faculty's Website. The appearance of the site has greatly improved and it is hoped that with the input of all Fellows, it will become a useful and popular resource.

Physical Facilities

Arrangements are now well underway for the extension to Ulimaroa. The Faculty has been assured of appropriate space and facilities.

Addition to Staff

The Faculty this year welcomed an additional staff member. Ms Severine Monnet-Gearon was appointed in September 1998 as the Faculty's Administrative Assistant.

Review of Regulations and Administrative Instructions

A comprehensive review of the Administrative Instructions have been completed and the Regulations will now be reviewed.

Board of Faculty

There has been no requirement to hold an election of the Board this year. The Board is fortunate to have Professor Teik Oh appointed for a further term as the Council's co-opted member. Dr Richard Lee continues as Co-opted Representative as Chairman of the Fellowship Examination. At its meeting in February the Board of Faculty elected A.W. Duncan Dean-elect for a further year from June 1999.

In February it was agreed that a member of the Royal Australasian College of Physicians should be invited to join the Board as a co-opted Observer.

In closing, I would like to thank Members of the Board, Regional Committees, Supervisors of Training, Examiners, and representatives on Hospital Visits for their efforts over the past year. The support of the Council and in particular Dr Richard Walsh, and Professor Garry Phillips is also gratefully acknowledged. Lastly I would like to thank the Executive Officer and Administrative Assistant, the Chief Executive Officer of the College, and regional staff for their support and assistance.

A.W. DUNCAN (DR)
Dean, June 1999

ADMINISTRATIVE INSTRUCTIONS

ADMISSION TO FELLOWSHIP OF THE FACULTY OF INTENSIVE CARE, ANZCA BY TRAINING AND EXAMINATION

GENERAL STATEMENT

A registered trainee may be admitted to Fellowship of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists by completing successfully the training and examination requirements of the Faculty. The program consists of a Primary Examination, a five year vocational training program and a Fellowship Examination.

DEFINITIONS

A trainee in intensive care is a registered medical practitioner who has completed 24 months of general hospital appointments and who has registered with the Faculty.

General hospital appointments refers to the period of 24 months spent in other clinical appointments prior to the commencement of vocational training (in intensive care).

Vocational training in intensive care is a five year program. It consists of mandatory periods totalling 42 months in intensive care, anaesthesia and medicine. The remaining 18 months of the five year program is undertaken in these and related areas and is termed **elective** training.

Core intensive care training refers to the mandatory period (24 months) of intensive care training undertaken by a trainee in an intensive care unit approved by the Faculty in accordance with Administrative Instruction 4.1.

A candidate is a trainee who has been approved to present for the College Primary or Faculty Fellowship examination.

TRAINING AND EXAMINATIONS

To be awarded Fellowship of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists, a registered medical practitioner must be a trainee of the Faculty, pass or be exempted from the Primary Examination, pass the Fellowship Examination and complete the training requirements of the Faculty.

1. Registration

- 1.1 Prospective trainees may register with the Faculty after graduating from a medical school and completion of 12 months of general hospital appointments. The date of graduation is taken as that on which there is formal completion of the undergraduate medical course and the candidate becomes eligible for award of the graduating degree.

- 1.2 Trainees must be registered with the Faculty, have provided necessary documentation and have paid the appropriate Registration and Training Fees before being eligible to apply to present for an Examination.

- 1.3 Unless otherwise determined, trainees must have paid the Registration and Training Fees in order for core intensive care training to be accredited (see Administrative Instruction 4.3.3).

- 1.4 Medical practitioners not registered with the Faculty who make enquiry about matters related to recognition of experience for training purposes may be required to pay an assessment fee.

2. Program for Training and Certification in Intensive Care

Fellowship of the Faculty requires completion of a five year vocational training program. In order to be eligible for admission to Fellowship of the Faculty of Intensive Care, ANZCA, trainees must:

- Pass or be exempt from the ANZCA Primary Examination
- Undertake a five year training program consisting of:
 - 24 months of core intensive care training
 - 12 months of anaesthesia
 - 6 months of medicine
 - 18 months of elective training
- Pass the Faculty Fellowship Examination
- Complete a Formal Project

3. The Primary Examination

- 3.1 Candidates for the ANZCA Primary Examination must have completed 24 months of general hospital appointments in accordance with Administrative Instruction 4.1.

- 3.2 Candidates must pass or be exempt from the ANZCA Primary Examination.

- 3.3 Primary Examinations will be held at times determined by the ANZCA Council.

- 3.4 The subjects for the Primary Examination will be:

- 3.4.1 Physiology including Clinical Measurement.
- 3.4.2 Pharmacology including Statistics.

- 3.5 The examination comprises:

- 3.5.1 A written section, which may be taken in cities in Australia, New Zealand, Singapore, Malaysia or Hong Kong as determined by ANZCA Council.

3.5.2 An oral section normally held in Melbourne or in other cities as determined by ANZCA Council.

3.6 Exemption from the Primary Examination for the purposes of gaining Fellowship **in intensive care only** will be granted to trainees who:

- (a) have completed basic physician training and have passed the written and clinical FRACP (adult or paediatric) examination; or
- (b) are Fellows of the Royal Australasian College of Surgeons (FRACS) or Fellows of the Australasian College for Emergency Medicine (FACEM); or
- (c) have passed an examination which is accepted by the Board as having a curriculum and assessment process which results in the trainee having a knowledge of the subjects of the ANZCA Primary Examination to a standard which is comparable to that required for its own trainees. The onus will be on the applicant to produce evidence which would allow the Faculty to evaluate the basic sciences content of that examination.

3.7 Candidates for the ANZCA Primary Examination must fulfil the requirements as outlined in the College Regulations.

4. The Vocational Training Program

4.1 Vocational training in intensive care cannot commence until at least 24 months of general hospital appointments have been completed. General hospital appointments may include no more than six months spent in any combination of intensive care, anaesthesia, and/or pain management.

4.2 Vocational training commences from the date that the trainee:

- 4.2.1 Has completed 24 months experience as defined in Administrative Instruction 4.1, and
- 4.2.2 Occupies a vocational training post in intensive care, anaesthesia or medicine; or
- 4.2.3 Occupies another post recognised for elective training when it is part of a formally organised training program.

Retrospective recognition may be given for other training which complies with the Faculty Administrative Instructions (eg. clinical medicine, surgery, research etc.) but this retrospective recognition will not alter the official date of commencement of Vocational Training.

The training program **MUST** include:

4.3 Two years of core intensive care training in units approved by the Faculty in accordance with Administrative Instruction 8.1.

4.3.1 The period of core intensive care training may be undertaken in more than one unit, but must comply with the following:

4.3.1.1 At least 12 months must be undertaken in a unit or units classified as C24.

4.3.1.2 One year must be continuous and undertaken in one unit and cannot include an S3 rotation.

4.3.1.3 With the exception of a rotation to a unit classified as S3, core intensive care training must be undertaken in minimum periods of six months.

4.3.1.4 No more than one rotation to a unit classified as C6 or S3 is permitted during core intensive care training without prior approval of the Censor.

4.3.2 At least one year of core intensive care training must be undertaken after 36 months of vocational training have been completed.

4.3.3 As from the commencement of the 1999 Hospital Year, core intensive care training will only be approved if the trainee is either:

- (a) registered with the Faculty of Intensive Care. Registration must take place within three months of commencing core training; or
- (b) registered with the RACP and undertaking advanced training in intensive care, or
- (c) registered with ANZCA and undertaking the Provisional Fellowship Year.

This period of training must be accompanied by in-training assessments in accordance with Administrative Instruction 4.8.

4.4 Twelve months exclusively in clinical anaesthesia, not necessarily continuous.

4.5 Six months in an approved medical post that is not in intensive care. In their interests, trainees should seek from the Censor prior approval of training in medicine.

4.6 The elective component of eighteen months may be spent in any combination of:

- (a) intensive care
- (b) clinical anaesthesia
- (c) pain medicine
- (d) general medicine
- (e) specialist medicine
- (f) emergency medicine
- (g) surgery
- (h) research (limited to one year)
- (i) other disciplines related to intensive care

This period of training must comply with the requirements of Administrative Instruction 9.

- 4.6.1 Intensive care training in overseas intensive care units may be approved for elective training. In their interests, trainees should seek prior approval from the Censor.
- 4.6.2 In their interests, trainees should seek prior approval from the Censor of elective training in research.
- 4.6.3 In their interests, trainees should seek prior approval from the Censor of elective training in other disciplines related to intensive care.
- 4.7 For Endorsement of the Fellowship in Paediatric Intensive Care, the vocational training program must comply with Administrative Instruction 2 and must include the following:
 - 4.7.1 At least eighteen months of the two years of core intensive care training (Administrative Instruction 4.3.1) must be spent in a paediatric intensive care unit approved for core training. Twelve months of this period of training must be undertaken in a paediatric intensive care unit classified as C24.
 - 4.7.2 Twelve months of clinical anaesthesia (Administrative Instruction 4.4), not necessarily continuous, in any combination of paediatric and adult anaesthesia.
 - 4.7.3 The six months of clinical medicine (Administrative Instruction 4.5) must be spent in an approved paediatric medical post that is not in intensive care.
 - 4.7.4 The elective component of eighteen months (Administrative Instruction 4.6) may be spent in any combination of adult or paediatric posts.
- 4.8 All trainees must participate in the Faculty's in-training assessment process and comply with requests from the Faculty for information relating to their training performance.
 - 4.8.1 A minimum of four assessments are required for the core component of intensive care training.
 - 4.8.2 A satisfactory assessment in at least three out of the four six monthly assessments, including the final assessment, is essential for the award of Fellowship.
 - 4.8.3 The Censor may rule that further training is required in the event of unsatisfactory in-training assessment.
- 4.9 Trainees commencing the core component of intensive care training from the beginning of the 2000 Hospital Employment Year must complete a Formal Project in

accordance with the guidelines outlined in the Joint Specialist Advisory Committee – Intensive Care document 'Formal Project Requirements'.

- 4.10 All trainees must sign any declaration required to permit the Faculty to have access to all information necessary for training purposes.

5. The Fellowship Examination (Adult or Paediatric)

- 5.1 Fellowship Examinations in adult and paediatric intensive care will be held at times to be determined by the Board.
- 5.2 The subjects for the Fellowship Examinations will be the theory and practice of intensive care, including relevant aspects of the basic sciences, anaesthesia and clinical medicine.
- 5.3 The examinations will comprise written and oral sections. The written section may be taken in cities of Australia and New Zealand or other areas at the discretion of the Board. The oral sections will be held in Sydney or Melbourne or other cities at the discretion of the Board.
 - 5.3.1 The written section of the Adult and Paediatric Examinations is made up of two papers; one consisting of fifteen short answer questions (two and a half hours), and the other consisting of two long answer questions (two hours).
 - 5.3.2 The oral section of the Adult Examination comprises an Objective Structured Clinical Examination (OSCE) of two hours, two half hour clinical examinations of intensive care and general medical cases, and one hour of vivas.
 - 5.3.3 The oral section of the Paediatric Examination comprises a half hour of investigations, two half hour clinical examinations of paediatric intensive care cases and general paediatric medical cases, and one hour of vivas.
- 5.4 Candidates applying for admission to the Fellowship Examination must:
 - 5.4.1 Have passed the ANZCA Primary Examination or have been granted exemption from the Primary Examination by the Board under Administrative Instruction 3.6.
 - 5.4.2 Have satisfied the requirements of Administrative Instruction 1.2 and have completed 36 months of vocational training by the date on which the written section of the examination commences, provided that at least 12 months of core intensive care training have been completed in accordance with Administrative Instruction 4.3.

5.4.3 Be in a vocational training post, or such other post as the Board may approve, at the time of application or have been in such a post for an uninterrupted period of at least one year no longer than two years prior to the date of the written section of the examination.

5.5 Applications to present for the Fellowship Examination must be made on the approved form together with the required documents and the prescribed fee which will be delivered to the Executive Officer at least 56 days before the commencement date of the written examination.

6. Interrupted Training

6.1 Vocational training must include two continuous years interrupted only by normal holiday or short-term special (eg study or conference) leave.

6.1.1 If training is interrupted for between one and two years, there must be a minimum of one further continuous year undertaken in order to complete training.

6.1.2 If training is interrupted for between two and four years, one further year of continuous vocational intensive care training in approved units must be completed.

6.1.3 If training is interrupted for more than four years, two further continuous years of vocational training must be completed, one of which must be a continuous year in intensive care in approved units.

6.1.4 Under exceptional circumstances, the Censor may allow interrupted training without the need for additional training.

7. Part Time Training

Part time training may be approved as vocational training and must meet the following requirements:

- 7.1 Must have prospective approval of the Censor.
- 7.2 Must be supported by the trainee's Head of Department and the Hospital Administration.
- 7.3 May commence at Training Year One.
- 7.4 Must result in the same training in content and duration as for full-time trainees.
- 7.5 Must comprise a minimum of 50% of the commitment of a full time trainee, including both in-hours and emergency duties.
- 7.6 Requires registration with the Faculty and pro-rata payment of the Annual Training Fee.

8. Intensive Care Units Approved for Training

8.1 The Board will approve intensive care units as suitable for core intensive care training. Units may be approved as follows:

8.1.1 The core component of intensive care training must be undertaken in Units approved by the Board for core training for 24, 12 or 6 months. These Units are classified as C24, C12 or C6 respectively. Not more than one period of training in a Unit classified as C6 will be permitted during core intensive care training, without prior approval of the Censor.

8.1.2 Notwithstanding the requirement for core intensive care training to be undertaken in periods of six months or more, periods of three months will be permitted in units classified as S3 as part of a rotation from a C24 unit. This rotation must be part of a program for specific clinical experience.

9. Other posts approved for training

9.1 Posts for the anaesthesia component of intensive care training must be in hospitals approved for training by the Australian and New Zealand College of Anaesthetists.

9.2 Posts for the medical component of intensive care training must be in hospitals with programs approved for training by the Royal Australasian College of Physicians. This post must not be in an intensive care unit.

9.3 Posts in surgery related to intensive care must be in hospitals with training posts approved for training by the Royal Australasian College of Surgeons.

9.4 Posts in Emergency Medicine must be in hospitals with training posts approved for training by the Australasian College for Emergency Medicine.

9.5 Notwithstanding the above Administrative Instructions, in exceptional circumstances the Censor may approve other training.

All enquiries, applications and communications must be addressed to the Executive Officer, Faculty of Intensive Care, ANZCA, 'Ulmaroa' 630 St Kilda Road, Melbourne, Victoria, 3004, Australia.

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

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,*
PS-38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 99, pg 93*

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

POLICY DOCUMENTS

E = Educational P = Professional T = Technical EX = Examinations

PS = Professional Standards TE = Training and Examinations PM = Pain Medicine

- E1 (1996) Guidelines for Hospitals seeking College Approval of Posts for the First Four Year of Vocational Training in Anaesthesia
Bulletin Nov 96, pg 64
- E3 (1994) The Supervision of Trainees in Anaesthesia *Bulletin Nov 92, pg 41*
- TE4 (1997) Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
- E6 (1995) The Duties of an Anaesthetist *Bulletin Nov 95, pg 70*
- E7 (1994) Secretarial Services to Departments of Anaesthesia *Bulletin Nov 94, pg 43*
- TE9 (1993) 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 98, pg 83*
- EX1 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 96, pg 70*
- T1 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites *Bulletin Nov 95, pg 52*
- T3 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities *Bulletin Nov 95, pg 56*
- T4 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT) *Bulletin Nov 94, pg 59*
- T5 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries *Bulletin Nov 95, pg 65*
- T6 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites *Bulletin Nov 95, pg 61*
- P1 (1997) Essential Training for Rural General Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin May 97, pg 81*
- P2 (1996) Privileges in Anaesthesia *Bulletin Nov 96, pg 72*
- PS3 (1998) Major Regional Anaesthesia and Analgesia *Bulletin Nov 98, pg 85*
- P4 (1995) Guidelines for the Care of Patients Recovering from Anaesthesia *Bulletin Aug 95, pg 64*
- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
- PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
- PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 98, pg 75*
- P9 (1996) Sedation for Diagnostic and Surgical Procedures *Bulletin Nov 96, pg 73*
- P10 (1994) The Handover of Responsibility During an Anaesthetic *Bulletin Nov 94, pg 44*
- P11 (1991) Management of Cardiopulmonary Bypass *Bulletin May 91, pg 43*
- PS12 (1996) Statement on Smoking as Related to the Perioperative Period *Bulletin Nov 97, pg 78*
- P13 (1992) Protocol for The Use of Autologous Blood *Bulletin Aug 92, pg 49*
- PS14 (1998) Guidelines for the Conduct of Major Regional Analgesia in Obstetrics *Bulletin Nov 98, pg 81*
- P15 (1995) Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Aug 95, pg 62*
- P16 (1994) The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 94, pg 45*
- PS17 (1997) Endoscopy of the Airways *Bulletin Nov 97, pg 80*
- P18 (1995) Monitoring During Anaesthesia *Bulletin Nov 95, pg 68*
- P19 (1995) Monitored Care by an Anaesthetist *Bulletin Nov 95, pg 60*
- P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 96, pg 52*
- P21 (1996) Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
- P22 (1996) Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
- P24 (1997) Sedation for Endoscopy *Bulletin May 97, pg 78*
- P26 (1994) Guidelines on Providing Information about Anaesthesia *Bulletin Aug 94, pg 61*
- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion *Bulletin Nov 94, pg 46*
- P28 (1995) Policy on Infection Control in Anaesthesia *Bulletin Mar 95, pg 38*
- PS29 (1997) Anaesthesia Care of Children in Healthcare Facilities without Dedicated Paediatric Facilities *Bulletin Nov 97, pg82*
- PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg84*
- PS36 (1997) Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg93*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 98, pg 79*
- PS38 (1999) Statement Relating to the Relief of Pain and Suffering and End of Life Decisions *Bulletin June 99, pg 93*
- PM1 (1999) Guidelines for Trainees and Departments seeking College Approval of Posts for Training in Pain Medicine *Bulletin Mar 99, pg73*