

# Australian and New Zealand College of Anaesthetists

ACN 055 042 852

and Faculty of Intensive Care



# Bulletin

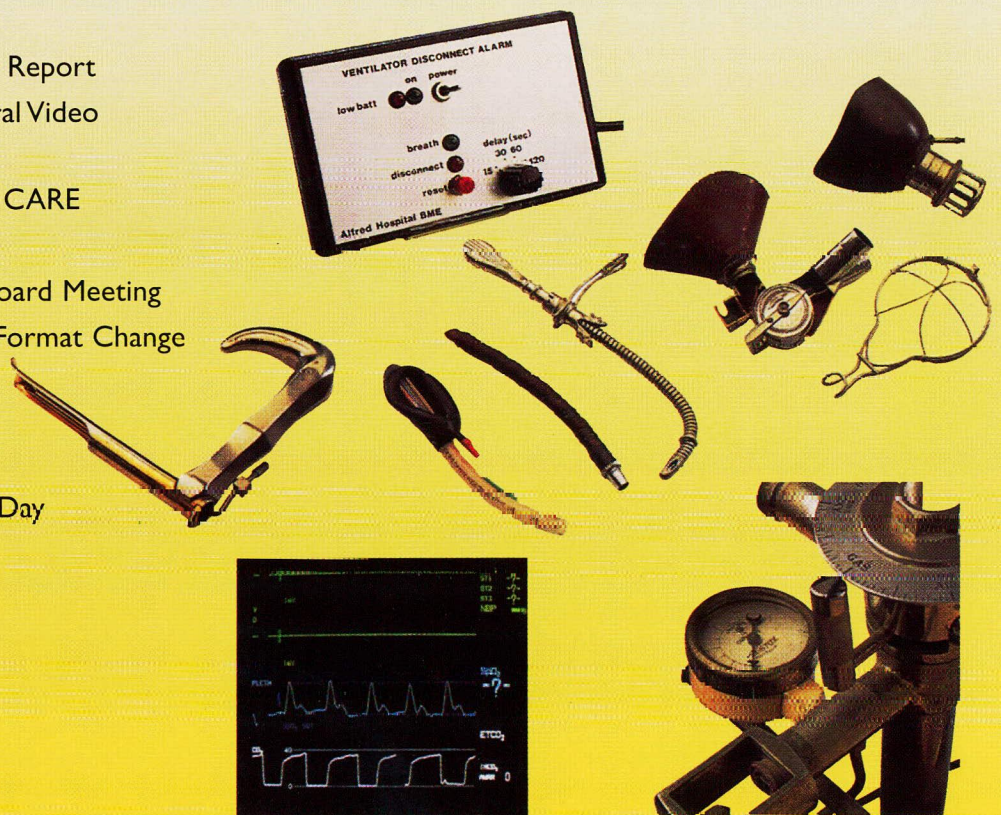
*'To serve the community by fostering safety and quality patient care  
in anaesthesia, intensive care and pain management'*

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- Draft MOPS Programme
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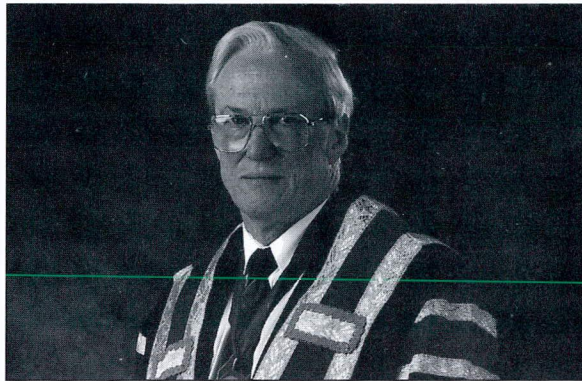
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## PRESIDENT'S MESSAGE



Four issues have occupied my thoughts more than most others over the last few months. The first is Overseas Trained Anaesthetists, the second is the proposed Academy of Medicine (or Medical Colleges) and the third is Anaesthesia Related Mortality. A fourth, the question of extensions to College Headquarters, is addressed by Richard Walsh in this issue of the Bulletin.

### *Overseas Trained Anaesthetists*

During 1995 the College co-operated fully with the Australian Medical Workforce Advisory Committee (AMWAC) in providing and assessing data regarding the anaesthetic workforce in Australia<sup>1</sup>. The Working Party recommended an increase in the number of funded anaesthetic training positions and trainees, and formation of State based working groups to address short term local means to meet any shortfall. Options were to include local incentives to increase the current workload of specialist anaesthetists; use of appropriately qualified and skilled overseas trained anaesthetists, and increased skilling and use of general practitioners, particularly in rural areas.

The College has increased training positions ahead of the target set by AMWAC and reached agreement with RACGP on training requirements of rural general practitioners. The use of local incentives and overseas trained anaesthetists have varied from State to State, sometimes involving ANZCA, sometimes not, and sometimes in opposition to ANZCA.

The Medical Training Review Panel (MTRP) was established by the Commonwealth Minister for Health and Family Services<sup>2</sup>. Its first report, published in August 1997, noted that overseas trained specialists may be required to undertake further training through the relevant Australian Specialist Medical College before they are recognised as a specialist in Australia by the Australian Medical Council (AMC). The report also noted that State and Territory Health Administrators sometimes fill less popular positions with Temporary Resident Doctors employed on a temporary visa and conditional registration.

ANZCA has a role in advising both the AMC and the New Zealand Medical Council on what further training and examination an immigrant specialist requires to achieve equivalence with our own Fellows. If this route is followed successfully, Fellowship of the College is normally awarded. The minimum requirement is one year in a post approved by Council and a pass in the Final Examination. Sometimes more training and a pass in the Primary Examination may also be required, depending on assessment of the specialist's prior training and examinations passed.

Health Authorities in both Australia and New Zealand are often frustrated by this system. What they want is an anaesthetic service and argue that an overseas trained specialist must surely be competent and certainly better than no anaesthetist.

ANZCA's position is quite clear. The quality and safety of anaesthesia in Australia and New Zealand is highly



regarded nationally and internationally. The findings of the Quality in Australian Health Care Study<sup>3</sup>, and the recently released ***Report on Anaesthesia Related Mortality***<sup>4</sup> both support this statement. Work to achieve this began in 1957 when the Faculty of Anaesthetists, RACS was established to train anaesthetists. ANZCA replaced the Faculty in 1992 and continues this role.

But there is a problem. The community is entitled to an anaesthetic service and ANZCA cannot be seen to be an obstacle to this. Accordingly, Council has agreed to re-examine the issue of what training and examinations it should recommend an overseas anaesthetist should undertake to achieve specialist recognition in Australia and New Zealand.

### ***The Academy***

AMWAC collected data from a variety of sources, some not able to be tapped by the Colleges, and proposed Workforce objectives in several specialties.

The Medical Training Review Panel, with involvement of the Colleges and other bodies, examined training opportunities for Hospital Medical Officers (HMOs) in the Colleges, training opportunities in State and Territory Public Hospitals and trainee selection in Australian Medical Colleges. The last two of these have been the subject of external consultancies, which obtain information from the Colleges and other sources, then make their own recommendations to MTRP.

What the MTRP has shown to date and what cannot be challenged by the Colleges, is that in some areas specialists of some disciplines are not providing the service the community wants, when and where it wants it. The trainee selection processes in the Colleges vary and in the words of the MTRP *"Many in the medical community have highlighted the continuing concerns among many HMOs that selection and review processes of some Medical Colleges are not suitably transparent, do not reflect equal employment opportunity principles and are open to improper use."*

I would suggest that if the Committee of Presidents of Medical Colleges (CPMC) had doubts about its effectiveness before all this, its decision to become more effective was not only warranted, but also overdue, hence the decision to form an Academy.

Then came the task of getting all Colleges and Faculties forming CPMC to agree on a proposed Memorandum and Articles of Association to form a body with a new name and a new image while gaining acceptance from the other bodies, which might be affected – the Australian Medical Association, the Societies, the Medical Schools, Ministers, Health Departments etc. An early decision was to include New Zealand in the new body. Complicating the task were various obstacles. The CPMC could not release information until there had been agreement by the Colleges. Leaks necessarily occurred and were fed to the media: *"a body funded by Government"...**"a peak medical body to be played off against the AMA"...**"a body to control the Colleges"* etc.

My view is that the CPMC, with the Presidents backed by Councils elected by Fellows, is the only group that can pursue this matter, and they should be supported by their Fellows. It is not the name of the body, or the words in the Articles, which will determine its future, it is the people who gather with good intentions and who make decisions after debating the best available information to them in Australia and New Zealand. Their decisions will not always be right or please everybody, but it is better for there to be an agreed position by the Combined Colleges when this is demanded, rather than diverse and varied responses or no response at all, because the training and standard setting bodies have not been asked.

### ***Anaesthesia Related Mortality***

It was a great pleasure to see the release of the College Working Party's Report ***Anaesthesia Related Mortality in Australia 1991-1993***, and I congratulate the State Mortality Committee Chairmen on their co-operation in bringing this report to completion, and Brian Horan on editing the Report.

Media coverage has been good and the College has endeavored to ensure an effective message that the



anaesthetic community in Australia not only is reporting relevant deaths to the Coroner, as required by law, but also has voluntarily formed State Committees to analyse such deaths in great detail. Lessons learned can be used to educate trainees and specialists and to make anaesthesia safer for the community. In the process it has been shown that mortality figures in Australia are comparable to the best available, as calculated on the data we have. What we need are better data and that requires a joint approach by Mortality Committees, Government and Coroners as well as a higher reporting rate. The College will endeavor to facilitate this.

Best wishes,



GARRY PHILIPS

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1. Australian Medical Workforce Advisory Committee. The Anaesthetic Workforce in Australia, supply, requirements and projections 1995-2006. AMWAC Report 1996.3, 1996.
2. Medical Training Review Panel, First Report, Commonwealth of Australia 1997.
3. Wilson, R McL, Runciman WB, Gibberd RW et al, The Quality in Australian Health Care Study, Medical Journal of Australia, 1995: 163: 458-471.
4. Working Party on Anaesthetic Mortality. Report on Anaesthesia related Mortality in Australia, 1991-1993 ANZCA 1998.



## ANZCA DONATIONS

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The College acknowledges with thanks the generosity of the following Fellows for their donations to the Foundation.

Dr F A Brough	Victoria
Dr P N S Chang	New South Wales
Prof. T. R. Cramond	Queensland
Dr N M Dilworth	Western Australia
Dr A S Gunatunga	Victoria
Dr M J Hodgson	Tasmania
Dr R A Howard	Queensland
Dr B R Hutchinson	New Zealand
Dr M P Jaimon	New South Wales
Dr J S A Kroek	New South Wales
Dr L L Lau	Hong Kong
Dr K Leslie	Victoria
Dr G Littlejohn	Victoria
Assoc Prof D H McConnel	Queensland
Dr R E Rawstron	New Zealand
Dr I Rechtman	Victoria
Dr I Smith	Victoria
Dr S Sundaraj	New South Wales
Dr S K Swallow	Queensland
Dr S Taylor	New South Wales
Dr J Thirlwell-Jones	New South Wales
Dr Siu-Lun Tsui	Hong Kong
Dr P R Waizer	New South Wales
Dr J W F Wong	Western Australia



## **"IT'S YOUR LABOUR" - EPIDURAL VIDEO**

The need to provide more balanced and appropriate antenatal information regarding epidural analgesia to expectant couples has been a recurring topic of concern for anaesthetists for many years.

ANZCA and ASTRA, in a joint public education venture, have produced a video specifically aimed at assisting antenatal education in this important area.

The completed video has already received considerable acclaim from medical, nursing, patient and media groups. It will be available, free of charge, to be incorporated into antenatal education programmes. This distribution includes not only to major obstetric centres but also those involving individual practitioners. ASTRA representatives are currently taking orders for the video. Copies should be available by May. An accompanying leaflet based on the video is being completed.

Although the concept for such a video had been discussed for several years the joint venture was formally commenced late in 1996. The production team involved Stuart Boyd (then of Astra), Mike Martyn (ANZCA) and R & B Productions (a Sydney based film company).

The script for the video was developed following focus group meetings with anaesthetists, obstetricians and midwives held in Sydney, Melbourne, Brisbane, Adelaide and Perth. This involved a total of more than 100 practitioners and provided a consensual input into the script development. There was also input from couples both antenatal and postnatal.

Filming of the script was carried out in Melbourne and Sydney and involved Jo Bailey (whilst pregnant) as the presenter, Perth anaesthetist Dr Michael Paech, Melbourne obstetrician Dr Miriam O'Connor and Sydney midwife Ms TN Vung. Numerous antenatal and postnatal couples were filmed providing spontaneous questions and comments. Excellent computerised graphics were generated to illustrate the epidural

anatomy. The video was completed following the birth of Jo Bailey's baby just prior to Christmas 1997.

The video, presented in a very personable manner covers how epidurals work, how they are given, the advantages, contraindication, myths, side effects and a realistic appraisal of risks.

The ANZCA President, Professor Garry Phillips, formally launched the video on Thursday 5th February, 1998, at "Ulimaroa" to a gathering of local and interstate anaesthetists, ASTRA personnel and media. A media release, background paper and TV quality video extracts were distributed nationally.

The media response has been impressive to date with the video launch being covered by both Channel 7 and 9 TV news services in Sydney and Melbourne as well as Cable TV news. Several radio interviews included a public talkback session on 3LO in Melbourne with Michael Paech. There have been numerous newspaper articles and a very supportive segment on the Nationwide Channel 9 TODAY Show.

Congratulations are deserved to all the people who have been involved in this important project.

The video is available for viewing by contacting your ASTRA representative or Michael Brooke (Director, Hospital Business Unit) on Sydney (02) 9978-3642. The video will also be on show at the ASTRA booth during the Newcastle ASM. Copies can be ordered by all those involved in antenatal education.

The media release and background paper can be viewed on the ANZCA website.

MIKE MARTYN, COMMUNICATIONS OFFICER



## **LAW REPORT**

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

### **THE DANGERS OF E-MAIL**



Modern offices have been revolutionised by the use of electronic mail systems (e-mail). The speed at which communication can take place and the nature of information that can be transmitted with graphics, tables and graphs means that we can do a lot more, more efficiently.

However, e-mail also has its own culture. It is almost conversational and takes the place of office gossip, jokes and commentary.

With address lists, information can be sent to a wider range of people very easily.

It is for this reason that we must sound a warning about the use of e-mail as a modern form of communication.

Just as you would be careful what information you put in documents, faxes or anything in hard written form, so e-mails should be vetted to ensure that information is not misleading, defamatory or "politically" unwise.

E-mail is a form of communication and it can become a permanent record. There is a risk in taking a

conversational tone in e-mails – they may come back to haunt you. Be careful what you say!

Additionally, e-mails are easily "trashed". Sometimes they do not become a permanent record and it would, therefore, be difficult to prove that particular information or comments were made at any particular time. From a legal point of view, sometimes it is necessary to show that particular information was communicated, or that certain statements were made. Unless e-mails are retained (both e-mails sent and e-mails received), there will be little or no proof that the information or statement was made. If sending e-mails which are of a contractual nature, or contain important information, – either save the information or print a hard copy for filing. This seems to defeat the purpose of the "paper-less office", but is a worthwhile precaution where the documentation or information being sent is important.

We should all benefit from the greater productivity that electronic mail systems present. However, like any new invention, or any new procedure, we should also be wary as to the traps and pitfalls that may come with it. Just as we are entering the electronic age, this is a timely reminder that e-mail is just another form of communication and all of the usual issues (defamation, filing, contractual documentation, etc.) will apply.

#### **DOCTORS AS EXPERT WITNESSES**

Many doctors will already have experienced the thrill of acting as an expert witness in court or tribunal proceedings. Most doctors will already have been engaged to prepare medical reports in relation to patients, or on a referral basis. These reports are often

undertaken in circumstances where their conclusions will affect the outcome of litigation or legal process. Particularly with the increase in personal injuries litigation, medico-legal reports are an important part of the evidence presented to support or diminish a plaintiff's case.

Where a doctor has examined a patient, or where the doctor has supplied a medical report, he or she may be called to give evidence in relation to his or her observations in the examination, or the comments made in the report.

The doctor is an expert witness, because of the special skills and knowledge of the doctor in relation to the **medical** condition of the patient. Doctors should remember, however, that they are giving expert evidence as to the medical condition of the patient, not the financial condition of the patient, not necessarily the demeanour of the patient, the doctor's views on MediCare or WorkCover, or other political issues!! Information supplied by the doctor should be relevant to the medical issues only.

Accordingly, doctors should ensure that their reports or evidence in court is:

- *accurate;*
- *fair and impartial;*
- *clear, concise and as unambiguous as possible;*
- *within the specialty or medical skill or knowledge of the doctor, or his or her expertise;*
- *relevant to the medical issues involved.*

The doctor is asked to assist the court to provide an objective view of the medical situation in relation to the patient. The doctor may be assisting the court to determine the nature of the injury or ailment of the patient, the nature of the damage which the patient has suffered, the prognosis for recovery, and other relevant matters.

In relation to court and tribunal processes, normally the doctor would be issued with a subpoena, requiring the

doctor to attend at court at a particular time. Arrangements may be made with the solicitors involved to defer the time for attendance, but doctors should remember that a subpoena is an order from the court to attend, and failure to attend could be a contempt of court.

In giving evidence, the party calling the doctor will conduct the "examination in chief". These are the preliminary questions of the doctor to explain the facts and expert opinions of the doctor in relation to the issues at hand. The "opposition" solicitors will also have an opportunity to "cross examine" to challenge the evidence and views of the doctor.

Doctors should therefore remain objective at all times. Doctors should "stick to the facts". The doctors "expert" opinion should be based on factual and objective grounds.

If the doctor cannot remember all that has occurred, he or she is allowed to review their notes or the medical report to assist in recollection.

If the doctor does not understand a question, he or she should ask to have it clarified.

Obviously court processes can be frustrating, time consuming and protracted. The court process may have little regard for the timetable and scheduling of the doctor's practice.

Nonetheless, expert opinion from medical practitioners is an important part of the legal process. Good, clear, credible evidence of a doctor can "make or break" many legal cases.

If a doctor is in doubt as to whether they must answer a subpoena, or concerned about the nature of the evidence which they are to give, the concerns can be discussed with their MDO representative, or their own legal adviser.



# HIGHLIGHTS FROM THE FEBRUARY 1998 COUNCIL MEETING

## ELECTION OF PRESIDENT ELECT

Dr Richard Walsh, New South Wales, was elected President Elect of the College to take office in June 1998.

## COLLEGE AWARD

The ANZCA Medal was awarded to Associate Professor Alan Merry, New Zealand.

## EDUCATION

### *Appointment of Supervisors of Training*

Council resolved that there be no minimum time period for a Supervisor of Training to have held the Diploma of FANZCA.

### *Maximum Recognition of Training at a Single Hospital*

Council resolved that no more than four of the five years of vocational training at one hospital will be recognised towards the Diploma of Fellowship of ANZCA.

### *Manual on Training*

A revised Manual on Training has been referred to the March Executive for approval and promulgation.

### *Trainees Rostered for Non-Anaesthesia Duties*

Council resolved that time spent at Hospitals which roster anaesthesia trainees for duties exclusive of anaesthesia duties will not normally be recognised as approved vocational training.

### *Office of Education*

Council agreed to pursue the implications of the establishment of an Office of Education.

### *Directory of Training*

Following a suggestion from the Medical Education Special Interest Group Executive, Council supported the concept of a Directory of Training being developed and has referred this concept to the Education Committee.

It is envisaged that the Directory will include the number of positions available in the various Departments with the areas of specialised interests and be available particularly for the use of Provisional Fellows.

***Recognition of SHO Posts in United Kingdom***

Council agreed that as from the 1st January 1998 SHO posts in the United Kingdom may be recognised as contributing to ANZCA training in TY1-4 subject to the following:

- a) That the post is in a hospital which is recognised by the RCA and which has specialist registrar posts in anaesthesia;
- b) That the post is held for a minimum of three months and will be recognised by ANZCA for a maximum of 12 months;
- c) That trainees counting time in such a post will not be able to proceed to TY3 until the ANZCA Primary Examination has been passed, unless exempt from the Primary Examination.

***Guidelines for completion of Formal Projects - Effective Date of Implementation***

Council resolved that Formal Projects which are currently in progress should be assessed under the previous guidelines as set out in Policy Document E11 (1992) - Formal Project. All Formal Projects submitted for assessment after the 1st January 1999 must comply with all requirements as set out in Policy Document TE11(1997) - Guidelines for the completion of a Formal Project.

***In-Training Assessment Forms***

Council resolved that all In-Training Assessment Forms be destroyed following the trainees admission to Fellowship.

**INTERNAL AFFAIRS*****Expansion of College Headquarters***

Council agreed to submit a plan to the City of Port Philip seeking approval of the concept for the proposed development at the College Headquarters.

***Memorandum and Articles of Association***

Following consideration of Recommendations of the Constitution Review Sub-Committee to the Memorandum and Articles of Association of the College, Council approved minor amendments relating to removal of discriminatory language, a change in the timing of the financial year and subscription payments which will be submitted to the Australian Securities Commission for approval and distributed to all Fellows for acceptance.

***Amendment to Regulations - Election to Fellowship***

Council resolved to amend the following Regulations to read:



6.3 The Council of the College may elect to Fellowship of the College without Examination:

**6.3.1 (d)**

“duly qualified medical practitioners of at least 25 years standing and not less than 60 years of age, who have made a significant contribution to anaesthesia or related disciplines in Australia or New Zealand”.

**6.3.1 (e)**

“Under exceptional circumstances, Council may elect to Fellowship specialist anaesthetists who have made a significant contribution to College activities.”

***Overseas Trained Doctors – Examination and Training Requirements***

Overseas trained doctors assessed through the Australian Medical Council and Medical Council of New Zealand systems and having to complete the minimum requirements of a pass in the Final Examination and 12 months in a post approved by Council, may now undertake the requirements concurrently rather than sequentially.

**PAIN MANAGEMENT**

***NHMRC Clinical Practice Guidelines on the Management of Acute Pain***

Council endorsed the Final Programme of the NHMRC Clinical Practice Guidelines on the Management of Acute Pain.

**CONTINUING  
EDUCATION AND  
QUALITY ASSURANCE**

***Maintenance of Professional Standards Programme***

Following a Workshop held at the College in November 1997 on the Maintenance of Standards Programme, a revised programme has been drafted and is published in the Bulletin, inviting Fellows' comments.

***Funding to ASM for Asia Pacific Anaesthetists***

Council agreed that the cost of a full registration be offered to two young specialist anaesthetists from the Asia Pacific Region to attend the 1998 Annual Scientific Meeting in Newcastle.

**ADMISSION TO  
FELLOWSHIP BY  
ELECTION**

***Under Regulation 6.2***

Professor Hugo K. Van Aken, Germany  
Professor Simon Gelman, USA

***Under Regulation 6.3.1(e)***

Associate Professor Stephan A. Schug, New Zealand

**EXAMINATIONS**

***Primary Examination - Telephonic advice of results***

Council agreed to adopt a telephone system to permit Candidates to ascertain whether they have been invited to the Vivas. This system is being trialled in an

endeavour to eliminate delays in Candidates making arrangements to attend Vivas.

This system will operate on one identified day only for each Primary Examination and will be reviewed after a period of two years.

### ***Panel of External Examiners***

Following requests to assist examining institutions in South East Asia, and the Pacific, Council agreed to establish a Panel of External Examiners which will comprise recently time-expired Examiners and current Examiners.

In establishing this Panel, Council expressed concern at the workload on current Examiners, and believed this system would provide an opportunity for many recently time-expired Examiners who would be interested in assisting these regions.

## **PROFESSIONAL**

### ***Proposal – Australian and New Zealand Academy of Medicine***

Council considered the draft Memorandum and Articles of Association for the proposed Australian and New Zealand Academy of Medicine to replace the Committee of Presidents of Medical Colleges. Council requested amendments to the name and the objectives of the organisation for reconsideration.

### ***Report on Anaesthesia Related Mortality in Australia 1991-1993***

Council noted the completion of the Report on Anaesthesia Related Mortality in Australia 1991-1993 to be published by the College and distributed to all Fellows and Trainees, Federal Minister and Department of Health and Community Services, State Ministers and Health Departments, Coroners and various associated organisations.

### ***Off-Label Prescribing – Nitric Oxide***

The College has received requests for authorisation for particular Fellows to use Nitric Oxide as an unregistered drug. It is a requirement of the Therapeutic Goods Administration that such authorisation be granted by either the Institution where the drug will be administered or the relevant College.

The Council resolved that the College does not provide support for off-label prescribing as this is the role for the Institutional Ethics Committee in which the individual works.

### ***Tripartite Consultative Committee on Anaesthesia (JCCA)***

Council agreed to a tripartite Consultative Committee with the RACGP and ACRRM on the basis of equal representation of specialists and non-specialist anaesthetists.



***Policy Documents***

Following a review of the following policy documents, they were updated and are published elsewhere in this Bulletin.

***PS7 (formerly P7) – The Pre-anaesthesia Consultation***

***PS8 (formerly P8) – The Assistant for the Anaesthetist***

***TE15 (formerly E15) Guidelines for Trainees and Departments seeking College approval of posts for the Certificate in Pain Management.***

***PS37 Regional Anaesthesia and Allied Health Practitioners***

In 1990, the Faculty of Anaesthetists, RACS made a Statement with regard to Podiatry. Upon review, Council has approved the Policy Document ***“Regional Anaesthesia and Allied Health Practitioners”*** which is published elsewhere in this Bulletin.

## **“ULIMAROA” AND THE NEED TO EXPAND**

As noted in the November 1997 College Bulletin, the Council is considering solutions to increasing inadequacies of current office space and other facilities at the College headquarters in Melbourne. The situation has been brought about by expansion of College activities on behalf of Fellows and Trainees, and by proposed developments that will benefit anaesthesia, intensive care, pain management and related clinical activities.

The Council has considered a number of options, including relocating all or part of our activities to another site, expanding into an adjacent property, or extending the current building. After extensive examination of all options, the most economic and practical solution appears to be the last option. To that end, initial plans have been drawn up, and relevant planning permits lodged. These applications, if approved, will remove a potential obstacle if the extension eventually proceeds. In the meantime, the other options stated above remain open.

The cost of all options, including extending, would be significant. However, preliminary estimates indicate that the cost would be substantially met from existing cash reserves of the College.

Previously published College financial statements and Honorary Treasurer's Reports have shown that cash reserves have increased over the past few years, enabling appropriate fiscal security of the College and provision for future expanding needs such as those under current consideration.

Do we need to expand now? The view of all Councillors, supported by Strategic Planning and other professional advice, is that we do. The College requires significantly increased space for administration, training, examinations, maintenance of professional standards, library and museum facilities, intensive care and pain management activities, and other developments.

The College headquarters provides the infrastructure for what the College does in training specialists, setting standards of clinical care, and maintaining professional standards in Australia, New Zealand, and Asia Pacific areas of influence. A suitable headquarters is essential to achieve the aims of the College, and any decision by the Council to expend funds will only be made after careful and appropriate deliberation.

RICHARD WALSH, PRESIDENT-ELECT



# THE SOUTHERN HEALTH CARE NETWORK SIMULATION CENTRE

## David Gaba Visit



The Southern Health Care Network Simulation Centre at Monash Medical Centre in Melbourne was honoured recently by a visit by David Gaba, M.D. Dr. Gaba is Associate Professor of Anaesthesia at Stanford University, and developer of the Eagle Simulator, the simulator recently acquired by the Centre in Melbourne, as well as the centres in Sydney and Perth. Dr Gaba spent several days in the Department at Monash Medical Centre while in Melbourne in conjunction with an international conference.

The highlight of his visit was an evening at the Centre, at which Dr Gaba gave a presentation on the diverse applications of patient simulation. In particular he made mention of uses for simulators in the following areas: Education, Training, Research, Risk Management and Public Relations. He made a point of the distinction between "Education", the goal of which is to improve knowledge and conceptual understanding, and "Training", the goal of which is to improve the performance of tasks or functions. He provided a variety of examples of usage of simulation to help illustrate this difference.

Simulation provides a range of opportunities to educate in such areas as physiology, pharmacology and physical assessment. Dr Gaba however was more interested in highlighting the role of simulation with regard to its training applications. Training can be targeted at specific groups, and focused on the actual skills, tasks and behaviours required in the particular field. Training activities using simulators can range from very simple to highly complex. Dr Gaba suggested

the following applications: for paramedics, training in airway management, intravenous therapy, and basic and advanced life support; for nursing staff, in-service training on new equipment, new procedures and new drugs or techniques. Novice anaesthesia trainees can train in areas such as air-way management, techniques for induction of anaesthesia, and managing routine abnormalities during anaesthesia. More experienced anaesthetic registrars and anaesthetic consultants can train in advanced airway management, anaesthesia crisis resource management, new techniques or technologies, and preparation for, or "refresher courses" in, anaesthesia subspecialties.

Research applications of simulation include: developing tools for measuring the performance (both technical and behavioural) of clinicians; investigating the decision-making and interaction of clinical teams; investigating the effects of performance-shaping factors, such as fatigue and stress; examining the cognitive and physical ergonomics of medical equipment; and developing new technologies and procedures. Dr Gaba made mention of the expanding role of simulators in pre-procurement product evaluation and for assessing user-interface problems reported during clinical use. Two other areas in which simulators are gaining increasing prominence are Risk Management and Public Relations. There is an increasing perception in some centres in North America that appropriate simulation training may reduce: the frequency of adverse clinical events; the impact of clinical events that do occur; the likelihood of litigation after an event; and a jury's perception that the institution did not take patient safety seriously. Simulator-based activities are highly visual and dynamic, so that ongoing training and research attract considerable media attention, raising the profile of an institution, as well as the profile of Anaesthesia as a specialty.

At the conclusion of his presentation, Dr Gaba was presented with a pair of sketches in honour of his visit, and in recognition of his considerable assistance in the establishment of the Centre at Monash Medical Centre. Dr Gaba in turn presented the Centre with a Certificate of Accreditation, in recognition of compliance with standards approved for simulation training.



## ADMISSION TO FELLOWSHIP

### DECEMBER 1997 - FEBRUARY 1998

Brett Tasman	ANDERSON	NSW	Scott Matthew	LOCKLEY	NSW
Mark Clement	ANDERSON	VIC	Donald Ross	MACKENZIE	NZ
Gregory Steven	AUSTIN	NSW	Evangelyn	MALKOUTZIS	VIC
Nicholas George	BALIS	VIC	Timothy James	McCULLOCH	NSW
Stephen John	BIGNELL	QLD	Robert John	McDOUGALL	VIC
Bernard Francis	BRETT	QLD	Nicolas Laurence	McKEVITT	QLD
Philip William Harkness	BROWNE	TAS	Brian	McKINNEY	QLD
Stephen John	BRUCE	QLD	Anthony Sandanasamy	MICHAEL	Mal.
Robyn Majella	CAMPBELL	SA	Alistair James	NORTON	SA
Ming Kit	CHAN	NSW	Gajinder Singh	OBEROI	SA
Simon Kin Cheong	CHAN	HKG	Arthur Julian	PENBERTHY	VIC
Ai Yu	CHENG	HKG	Ann Louise	ROTHER	VIC
Susan Jeanette	CLARK	QLD	Peter Francis	SEAL	VIC
Philip John	CORKE	NSW	Catriona Melody Pauling	SHAW	WA
Andrew John	DAVIDSON	VIC	Susan Dawn	SHERLOCK	VIC
David William	ELLIOTT	NSW	Mark Fairbridge	SINCLAIR	SA
Andrew William	FOCK	VIC	Gurdial	SINGH	NSW
Scott Comber	FORTEY	NSW	Marcus Welby	SKINNER	WA
Richard Anthony	FRENCH	NZ	John Gardner	SPEIRS	SA
Robert Frank	GRACE	NSW	Mark Gordon	STEWART	NSW
Michael David	GRUBB	TAS	Antony Hugh Lawrence	STEWART	NSW
Peter Robert Charles	HAMMER	NSW	Malcolm Victor	STUART	NZ
Emad Samir Said Abdel-Shahed	HANNA	VIC	Paul	TALBUTT	QLD
Colin Constantinos	IATROU	VIC	Chin How	TAN	HKG
Kishor	KANJI	NZ	Robert John	TURNER	NSW
David Patrick	KIBBLEWHITE	QLD	Arthur	VARTIS	NSW
Colin Paul	KING	NZ	Anica	VASIC	NSW
Kitman	LAM	QLD	Stephen Anthony	WATTS	WA
Kit-hung, Anne	LEUNG	HKG	Shelagh Mary	WINSHIP	UK
Joseph Paul	LEW	VIC			

### **CERTIFICATION IN PAIN MANAGEMENT**

Dr Michael Howard Basler, South Australia, was awarded  
the Certificate in Pain Management.



# EA ROVENSTINE MEMORIAL LECTURE “PAIN: THE PAST, PRESENT AND FUTURE OF ANAESTHESIOLOGY”

## AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Delivered by Professor Michael Cousins, AM October 1997

EA Rovenstine was “senior registrar” to Ralph Waters at a time when the Nuffield Chair of Anaesthesia in the United Kingdom was being developed. Rovenstine was one of the most revered figures in the history of American anaesthesiology and in 1962 the American Society of Anesthesiologists decided to devote its most prestigious heponomous lecture to his memory. The Citation in the 1997 Scientific Programme reads as follows:

“This lectureship honors Emery Andrew Rovenstine, M.D., distinguished anesthesiologist, Chair of the Department of Anesthesiology, New York University Medical Center and Director of Anesthesia, Bellevue Hospital, a founder and past president of the American Board of Anesthesiology, past president of the ASA and recipient of the Society’s 1957 Distinguished Service Award. Because of his stimulating influence, anaesthesiology developed in stature. Because of his devotion to education, students with ability followed in his footsteps. Because of his pursuit of knowledge through research, an era of science in anaesthesiology developed. Because of these efforts, anaesthesia is safer. A third and fourth generation of anesthesiologists benefiting from the stimulating influences of this great physician are participating in the 1997 Annual Meeting.”

In the introduction to his lecture, Professor Cousins paid tribute to the extraordinary foresight of Rovenstine who identified pain management as being a crucial part of the specialist practice of anaesthesiology and exhorted anaesthesiologists to examine the role of the specialty of pain management outside the operating theatre. He was the author of a number of papers which pursued this theme in 1948 in the company of Professor EM Papper. Professor Cousins also quoted from the PhD thesis of

Professor Papper which was awarded at age 72 and was entitled “Anaesthesiology, Pain and Suffering in the Romantic Era”. In this 1990 thesis, Professor Papper put the case that the writings of the poets in the early to middle 1800’s played a crucial part in preparing the way for an environment that would be accepting of the relief of pain during surgery and in childbirth. This theme was developed to put the case the society is currently less than prepared to accept the relief of chronic long term pain as being a major priority; indeed the current situation for chronic pain can be likened to that which existed at the time of introduction of pain relief for childbirth in 1847. A substantial portion of Professor Cousins’ Lecture was devoted to providing the anaesthesiologist with an insight into the very large body of new knowledge about mechanisms and treatment of severe pain. He concluded with a recommendation that anaesthesiology should regard pain management as being the major frontier of basic research and a major opportunity for the speciality to contribute to the broader field of medicine.

The list of previous Rovenstine Memorial Lecturers makes interesting reading as shown below. Many of the names are familiar to anaesthetists and include the early pioneer of administration of intravenous fluids during surgery (Francis D Moore) the pioneer respiratory physiologist (Julius H Comroe), the pre-eminent cardiac physiologist (Eugene Braunwald), the “Father” of many academic anaesthesia departments in the USA, (E M Papper) the Nobel prize winner, Julius Axelrod, pre-eminent anaesthetists from the United Kingdom (William W Mushin, Harry Churchill Davidson, John Nunn). It is interesting to note that the Rovenstine Lecture has been given only five times by an individual outside the USA in its 34 Year history between 1962 and 1996.



## **HONOURS, APPOINTMENTS AND AWARDS**

*Dr T. C. K. (Kester) Brown, Victoria, Member of the Order of Australia; and  
Honorary Member, The German Society of Anaesthesiologists and Intensive  
Care Medicine*

Dr Alan Merry, New Zealand, Honorary Clinical Associate Professor of  
Anaesthesia, University of Auckland

Professor John Gibbs, New Zealand, Elected Life Member, New Zealand Society  
of Anaesthetists

Dr J. Ronald Lo, Tasmania, Elected Fellow, Royal College of Anaesthetists

Dr Neville Gibbs, Western Australia - Doctor of Medicine, University of  
Western Australia

Dr Michael Davies, Victoria - Doctor of Medicine, University of Melbourne

Dr Richard Walsh, New South Wales - Corresponding Member, The German  
Society of Anaesthesiologists and Intensive Care Medicine

## REPRESENTATIVES FOR THE 1998 YOUNGER FELLOWS' CONFERENCE TO BE HELD IN NELSON BAY, NEWCASTLE

Dr Chris Butler, Queensland  
Dr Frank Daday, Queensland  
Dr Jenny Elson, Western Australia  
Dr Anthony Fitzpatrick, New South Wales  
Dr Judith Lynch, New South Wales  
Dr Leonnie Watterson, New South Wales  
Dr Barbara Trytko, New South Wales  
Dr Andrew Michael, South Australia  
Dr Alistair Norton, South Australia  
Dr Philip Cornish, New Zealand  
Dr Murray Harty, New Zealand  
Dr Paul Goggin, Victoria  
Dr Robert McDougall, Victoria  
Dr Colin Chilvers, Tasmania  
Dr Theresa HUI Wan-Chun, Hong Kong

*Councillor-in-Residence: Professor John Gibbs*  
*Board Member-In-Residence: Dr Neil Matthews*  
*Convenor: Dr Peter Saul*

## DEATH OF FELLOWS

Council noted with regret the death of the following Fellows:

Dr Pamela A. K. Edwards, Queensland, FANZCA 1995.  
Dr Sankarakurup Gopinathan Nair, New Zealand, FFARACS 1984, FANZCA 1992

## OBITUARY

### DR PAMELA ANNE KERR EDWARDS MB BS FANZCA 1963-1997

Pamela Edwards was born in Brisbane on July 11<sup>th</sup> 1963 to Patrick Edwards, a psychiatrist, and Beverley Edwards, a medical officer in child psychiatry.

She attended Somerville House school in Brisbane, where she was Dux of the school and graduated from the University of Queensland in 1986 with first class honours.

Pam's anaesthetic training was based at the Royal Brisbane Hospital. She passed the Final examination in

1994 and was awarded the Cecil Gray prize which was presented to her at the 1995 Annual Scientific Meeting in Townsville.

Her Provisional Fellowship year was completed at the Royal Women's Hospital Brisbane.

Pam excelled in all areas of her life. She was keen sportswoman, a devoted animal lover, enjoyed her food and wine, travelled extensively and was a very loyal friend. For the last three years she had a very successful private practice in Brisbane. She will be sadly missed by her family and her many friends.

ELIZABETH BOGE



# MAINTENANCE OF PROFESSIONAL STANDARDS

## REVISED PROGRAMME

The introduction of the College Maintenance of Standards programme in 1995 included plans for a review of the programme. This review has recently started with a workshop (attended by Councilors and Regional and Faculty Education Officers) and deliberations by Council and the CE and QA Committee. Recommendations from these discussions are now incorporated in a proposed new programme, called Maintenance of Professional Standards (MOPS).

The principal objective of the College MOPS programme is now stated, i.e. "to foster continuing scholarship in order to maintain a high standard of clinical practice". Thus the principal role is educational, and the MOPS programme monitors and validates continuous medical education (CME), quality assurance (QA), and other self-improvement educational activities. There is some evidence to suggest that participation in CME and QA activities is associated with improved clinical performance. Nonetheless, while clinical competence is presumed, it cannot be taken for granted. It must thus be clear that the MOPS programme is not intended as an attestation of clinical competence. In order to certify clinical competence, all levels of competence must be reliably assessed. These include knowledge, theoretical practical "know-how", "hands-on" procedural skills, and actual performance over time. Personal qualities such as clinical judgement, humanistic values, and communication skills must also be judged, and of course, misconduct, drug addiction and "mental impairment" must be excluded. The MOPS programme cannot do all these, and to acknowledge it as a credential of "competence" would be erroneous and misleading.

The key elements of the new programme are:

- The programme places emphasis on CME and QA while recognizing the important contributions from other areas in enhancing clinical standards.
- There is flexibility and diversity in crediting educational activities to meet the varied needs of individual participants. More activities are credited, including those relating to multi-media and self-initiated learning.
- Attention is given to feedback and self-analysis by peer comparison, and to recording outcome of each activity, so as to assess and enhance the educational value of activities. Deficient areas can be self-targeted for improvement.
- A prepared diary or logbook is used to record activities. This facilitates annual returns and self-reviews of one's activities.
- The programme is not points-driven, although a basic level of CME and QA activities is required every year.

There is no incentive to creatively accumulate points, as any useful analysis involves self-comparison with peers.

- Activities of other Colleges and specialties are recognized, if they are relevant to one's particular practice of anaesthesia and related disciplines.

Enrolment is open to Fellows and all anaesthetists in Australia and New Zealand. Participation is not compulsory, although the programme encourages and facilitates colleagues to participate, whatever the nature of their practice. The 5-year cycle remains, but there is now no minimum total of 500 points to chalk up at the end of the cycle. Nonetheless, participants need to expand some effort *consistently*; hence the requirement to attain modest minimum points *every year* for QA and CME activities.

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

This new MOPS programme will start on 1 January 1999. Those already enrolled under the present programme will continue with their 5-year cycle, but with using the new programme from that date. For example, if you enrolled in 1996, you will start the fourth year of your 5-year cycle on 1 January 1999 under the new programme. New registrants enrolling before 30 June this year will start under the current programme and enter their second MOPS year and the new programme on 1 January 1999. Registrants after 30 June 1998 will start their 5-year cycle on 1 January 1999. The present programme and its requirements will cease to apply from 1 January 1999. Participants will be deemed to have satisfactorily completed their MOPS for every year (before 1999) that they have submitted an annual return. From next year, each participant will be issued every year with a statement of participation. At the completion of a 5-year cycle, participants will be awarded a *Maintenance of Professional Standards Certificate*.

Please direct enquiries and comments to me. As there is a lot of documentation to prepare for printing, please do so before the end of June.

TEIK OH, QA/MOPS OFFICER



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# MAINTENANCE OF PROFESSIONAL STANDARDS

## OBJECTIVE OF THE MOPS PROGRAMME

The major objective of the Maintenance of Professional Standards (MOPS) Programme is to foster continuing scholarship in order to maintain a high standard of clinical practice.

## PROGRAMME STRUCTURE

Participation is voluntary and open to all Fellows and all anaesthetists in Australia and New Zealand. The programme has a 5-year cycle and requires participants to self-maintain a MOPS *Portfolio of Activities*, which is a log-book record of involvement in specified educational activities in anaesthesia and related disciplines.

Points are credited according to activities undertaken. Participants must obtain at least 50 points for Continuing Medical Education (CME) activities and 25 points for Quality Assurance (QA) activities every year. There is no requirement to accumulate points over a 5-year cycle.

Successive 5-year cycles will start from the first day of January and July each year; a participant's cycle will begin on the next starting date after receipt of the enrolment application. At the beginning of a new MOPS year, each participant must declare his/her intended clinical commitments, on which his/her individual Programme will be based for that year. All participants are required to submit return forms at the end of each MOPS year. This can be done using a prescribed form or computer file.

Feed back on the MOPS Programme will be undertaken to enable participants to compare their activities with those of their peers. Information on each participant will be made known only to that respective person so that confidentiality will be maintained.

Upon acceptance into the MOPS Programme, and at the beginning of a new MOPS year, each participant will be issued with a statement of participation. Evidence of accreditation at an institution or practice and medical registration with a Medical Board or Council, must be submitted with the last (fifth) annual return form. Upon successful completion of a 5-year cycle, participants will be awarded a *Maintenance of Professional Standards Certificate*.

## RANDOM REVIEW

Random reviews will be undertaken on up to 5% of participants to verify the accuracy of their returns and the relevance of activities claimed in individual Programmes. Documentation related to MOPS activities - such as meeting programmes, agendas, timetables, reports, invitations and publications - for the current and previous year's activities should be kept on file with the MOPS Portfolio. A participant who has successfully completed a random review will not be liable for another review for the remainder of the cycle.



**CONFIDENTIALITY**

All data and individual records gathered through participation in the programme are held in strict confidence. The College MOPS Programme has been declared under the Commonwealth Insurance (Quality Assurance Confidentiality) Amendment Act 1992 to ensure protection of collected information. New Zealand participants are required to give consent for the College to approach third parties when necessary, for data to verify compliance with the MOPS Programme.

**KEY ELEMENTS OF THE PROGRAMME**

- The programme places emphasis on CME and QA while recognizing the important contributions from other areas in enhancing clinical standards.
- There is flexibility and diversity in crediting educational activities to meet the varied needs of individual participants. More activities are credited, including those relating to multi-media and self-initiated learning.
- Attention is given to feedback and self-analysis by peer comparison, and to recording outcome of each activity, so as to assess and enhance the educational value of activities. Deficient areas can be self-targeted for improvement.
- A prescribed diary or log-book is used to record activities. This facilitates annual returns and self-reviews of one's activities.
- The programme is not points-driven, although a basic level of CME and QA activities is required every year. There is no incentive to creatively accumulate points, as any useful analysis involves self-comparison with peers.
- Activities of other Colleges and specialties are recognized, if relevant to one's particular practice of anaesthesia and related disciplines.

**EXPLANATION OF ACTIVITIES****1. CONTINUING MEDICAL EDUCATION**

Participation in Continuing Medical Education (CME) activities is mandatory. A wide range of educational activities relevant to anaesthesia and related disciplines can be credited. The minimum requirement is for 50 points each year.

***1.1 Major Continuing Medical Education Meetings***

These are scientific meetings, workshops, and seminars conducted by an official professional organization. Seminars are generally small group meetings directed at a topic. Workshops are generally interactive small group activities with clear educational objectives that consider the needs of participants. Only international, national, or regional activities, including those of other medical colleges, can be credited under codes 111 and 112. Points can be claimed for sessions (3 points/hour) or whole day attendances (20 points/day). Sessions attended at meetings of other specialties must have relevance to anaesthesia and related disciplines.

*Examples:*

College ASM, Australian Society of Anaesthetists' NSC, American Society of Anesthesiologists' Annual Meeting, Regional ANZCA/ASA Continuing Education meetings, ANZICS annual meeting, and annual scientific meetings of other colleges.

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Meeting programmes, registration receipts, invitations, or publications.

**1.2 Local Continuing Medical Education Meetings**

These are formal Hospital, Department, or Practice Group CME Meetings. Meetings must be held on a regular basis with a focus on patient care. Local CME meetings may occasionally engage in QA activities, when points may then be claimed for local QA activities (code 231, 3 points/hour), but not for both.

*Examples:*

Hospital Grand Rounds

Department educational meetings and seminars

Industry-sponsored scientific/dinner meetings

Private/rural practice group educational meetings (e.g. monthly practice CME meetings, including reports of major meetings by those who attended)

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Meeting notices, agendas, and minutes, records or attendance sheets.

**1.3 Remote Group Learning**

These are long distance group learning activities, which must be in real-time and interactive, with specific topics. Activities organized by the College and Regional Committees, the ASA, the NZSA, and ANZICS are automatically accredited for 3 points/hour.

*Examples:*

Tele-conferencing,

Video conferencing,

Internet conferencing.

*Approval from MOPS Office:*

Yes, if not an ANZCA, Faculty, ASA, NZSA, or ANZICS activity.

*Documentation Required (examples).*

Meeting notices, programmes, agendas, registration receipts, minutes or reports.

**1.4 Self Directed Learning Activities**

These are self assessment and self initiated educational activities. Apart from submitted HELP self assessment modules (20 points/issue), the activities are



credited with 1 point/hour, with each code 142, 143, and 144 limited to a maximum of 10 points in each year.

*Examples:*

Completing HELP and other self assessment programmes (code 141),  
Reading journals and books (code 142),  
Listening and watching educational audio and video tapes (code 143),  
Using computer learning programmes and internet databases (code 144).

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Diary entries and completed programmes where available.

**1.5 Learning Projects**

Participants may pursue projects in areas of interest, in a structured and systematic manner. The projects should be learner-initiated and planned, and must have educational objectives. Except for EMST and ATLS courses, approval from the QA/MOPS Officer must be sought in advance. Points credited range from 25-100 per project, according to a category rating (1 to 4) which will be allocated by the QA/MOPS Officer, based on educational value and time spent.

*Examples:*

EMST or ATLS courses (category rating 4, with a credit of 100 points) - other resuscitation/trauma courses need prior approval,  
Formal courses of study relevant to the practice of anaesthesia and related disciplines,  
Courses to learn a new technique such as trans-oesophageal echocardiography,  
Producing teaching videos or computer educational material.

*Approval from MOPS Office:*

Yes, before undertaking project, except for officially registered EMST or ATLS courses.

*Documentation Required (examples):*

Course registration, programmes, enrolment acknowledgements, or completed educational material.

**1.6 Continuing Medical Education Committee Work**

Points can be claimed for work in planning CME activities in formal committees of hospitals or professional organizations. Time claimed is limited to the time dealing with CME matters on the agenda. One point/hour can be claimed, to a maximum of 10 points in a year.

*Examples:*

Member of Hospital CME Committee,  
Department CME convenor,  
Member of College CE and QA Committee.  
Member of a regional or professional education committee.

## 2. QUALITY ASSURANCE

*Approval from MOPS Office: No.*

*Documentation Required (examples):*

Meeting notices, agendas, minutes, or reports.

Quality Assurance (QA) can be defined as "an organized process that assesses and evaluates health services to improve practice or quality of care." The MOPS Programme requires participation in QA relevant to one's clinical practice. This is consistent with an evolving requirement on health care professions to demonstrate QA and improvement in practice. It provides participants with the opportunity to study, analyse, and audit selected aspects of their clinical performance with the aim to improve their practice.

The minimum requirement is for 25 points every year. This can be achieved from points compiled from participating in QA meetings (codes 221 and 231), QA planning (code 251), and short hospital attachments (code 521), or from a single activity such as a clinical audit project (codes 211 and 212), a practice peer review (code 411), or a one-week hospital attachment (code 511).

### **2.1 Clinical Audit Projects**

These are audits of clinical practice and must involve design and planning, collection of data, analysis of data, and assessment of changes resulting from interventions (to "close the loop"). Selection of projects should depend on relevance to practice, specific questions to address, and the feasibility of acquiring useful findings. The aim is to review clinical performance and derive interventions to improve areas of deficiency, and later on, evaluate the results of the interventions. The principal investigator may claim 30 points, and an active participant 25 points per project. Clinical audit projects are not necessarily restricted to the following examples.

*Examples:*

Criteria-based audit: This is a project that evaluates performance according to predetermined criteria, which are usually reported outcomes of peer groups. In areas without published criteria, new criteria can be established by original study or a consensus of peers. A criteria-based audit is usually based retrospectively, but can be a prospective study. Examples include the incidences of perioperative mortality, postoperative nausea and vomiting, and headaches following dural taps. Other examples include audits on aspects of organization which affect patient care, such as utilization of operating rooms and cancellations of elective surgery due to inadequate preoperative assessment.

Clinical indicators: These are predetermined criteria, and collecting data on clinical indicators is a form of criteria-based audit. The *College Clinical Indicators for Anaesthesia* present criteria for anaesthesia performance, based on perioperative data. A review of such clinical indicators data from a department or group is a clinical audit project.



Clinical guidelines or protocols: These are recommended methods of clinical practice that contribute to good care. A clinical audit project could, for example, check for the existence of clinical guidelines, compliance with guidelines, whether guidelines are regularly reviewed, and propose recommendations for improvement.

Critical reviews: These are structured analyses of patient care in areas where clinical guidelines may not be available or are inappropriate. A clinical audit project could, for example, review whether pre-operative assessment procedures are adequate, whether pre-admission anaesthetic clinics reduce unexpected adverse events, and the suitability of general anaesthesia for some day-surgery procedures. Recommendations and outcome from implementing changes are highly desirable.

Critical incidents: These are voluntary reports by staff on events that led to, or could have led to, an adverse outcome in patients or staff members. A critical incident monitoring project must analyze the incidence, causes, contributing and mitigating factors, and outcome of critical incidents, and should recommend strategies for improvement. An evaluation of results from implementing changes is highly desirable.

Patient Surveys: These are satisfaction surveys of patients treated by a department or practice group. A clinical audit project could measure specific issues relevant to anaesthesia, such as satisfaction with communication, anxiety alleviation, informed consent, pain management, and the anaesthesia procedure received. Issues such as confidentiality, and patient anonymity and fear of reduced care consequent to critical comments, should be addressed.

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Documentation must be available to show that planning, implementation, and analysis of results were undertaken for a clinical audit. Recommendations for improvements and follow-up reviews are highly desirable. A reasonably substantial formal report or publication in a journal would suffice.

## **2.2 Major Quality Assurance Meetings**

These are meetings, workshops, and seminars conducted by an official professional organization to specifically foster QA. Only international, national, or regional activities, including those of other medical colleges are credited under code 221 (20 points/day or 3 points/hour). Some College or specialty scientific meetings may have a session devoted to QA; participants may claim time in the session as QA activities, but cannot concurrently claim that time under CME (e.g. to claim for a QA session plus that whole day of CME). Approval by the QA/MOPS Officer is not required.

*Examples:*

Meetings, sessions, workshops, or seminars on critical incidents monitoring, clinical indicators, clinical audits, and maintenance of professional standards.

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Meeting programmes, registration receipts, invitations, or publications.

**2.3 Local Quality Assurance Meetings**

These are properly constituted Hospital, Department, or private/rural practice group formal QA Meetings. Dedicated QA meetings must be held on a regular basis, and must be devoted to QA with a focus on patient care. The objective is to evaluate performance. There must be a high degree of interaction and discussion, and areas of improvement should be examined. Follow-up of outcome from changes made is highly desirable. Participants should be restricted to peers. Points may be claimed as code 231, 3 points/hour. Case discussions in regular department meetings are normally credited as CME activities, but occasional department meetings may be claimed as QA activities under this code if the above qualifiers apply.

*Examples:*

Peer reviews such as mortality and morbidity meetings and reviews of patient care from randomly chosen patient records.

Regular reviews or reports on outcome audits, clinical audits, clinical indicators, clinical guidelines, critical incidents, and patient satisfaction surveys.

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Meeting notices, agendas, minutes, records or attendance sheets.

**2.4 Hospital Accreditation Reviews**

College appointed inspectors who undertake hospital accreditation reviews may claim 30 points/day under code 241.

*Documentation Required (examples):*

Correspondence of appointment, timetables of inspections, or review reports.

**2.5 Quality Assurance Committee Work**

Points may be claimed for work in planning QA policies and activities in formal committees of hospitals or professional organizations. Time claimed is limited to the time dealing with QA matters on the agenda. One point/hour can be claimed, to a maximum of 10 points in a year.

*Examples:*

Member of Hospital QA Committee,

Member of a regional or professional committee which occasionally addresses clinical QA.



### 3. TRAINING, TEACHING AND RESEARCH

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Meeting notices, agendas, minutes, or reports.

Credit points from training, teaching and research activities are not mandatory requirements of the MOPS Programme, but these activities contribute significantly to continuing scholarship. Participants, as medical professionals, should uphold a commitment to these activities.

#### **3.1 Teaching**

Credit at 5 points/hour may be obtained from set formal teaching periods outside clinical duties in the operating room, pain clinic or ICU.

*Examples:*

Teaching of health professionals, including undergraduates, vocational trainees, nurses, allied health staff and anaesthetic assistants,

Teaching examination and viva techniques for ANZCA/Faculty examinations.

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Time tables, rosters, course programmes, evaluations of teachers, or institution reports.

#### **3.2 Examinations**

Examiners participating in ANZCA and Faculty oral and/or clinical examinations may claim 30 points/day. Examiners who prepare questions and mark papers for ANZCA and Faculty examinations, and participants who prepare questions for HELP self assessment modules may claim 2 points/hour. Participation in other examinations requires accreditation by the QA/MOPS Officer.

*Examples:*

FANZCA Primary and Final Examinations,

FFICANZCA Final Examinations,

HELP modules

*Approval from MOPS Office:*

Yes, except for College and Faculty examinations and HELP modules.

*Documentation Required (examples):*

Examination time tables, letters of appointment, and HELP questions.

#### **3.3 Publications and Reviews of Manuscripts and Grants**

All authors of publications may claim points. Abstracts in meeting proceedings cannot be credited. Higher points are credited to theses and publications in indexed journals. Points can be claimed for reviewing manuscripts, theses, and research grants. Theses require a category rating (1 to 3) from the QA/MOPS

Officer. In general, points credited for this academic category do not reflect the considerable time and scholarship put into the work.

*Examples:*

Papers (code 331, 20 points/paper in indexed journals, and code 332, 5 points/non indexed journal paper),

Books (code 333, 50 points/book, and code 334, 10 points/chapter),

Professional guidelines, policies and protocols (code 335, 5 points/item),

MD, PhD, MPhil, MSc theses (code 336, 50-150 points according to category rating 1 - 3),

Reviews of manuscripts and research grants (code 337, 5 points/item),

Examination of a thesis (code 338, 20 point/thesis).

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Reprints of papers, copies of protocols, policies, books, chapters, and theses, and invitations to review manuscripts and theses.

### **3.4 Presentations**

Only presentations at major meetings in 1.1 and 2.2 may claim points.

*Examples:*

Oral presenter (code 341, 20 points/presentation),

Chairman (moderator) of a session (code 342, 5 points/session),

Poster presenter (code 343, 5 points/poster).

*Approval from MOPS Office:* No.

*Documentation Required (examples):*

Invitations, acceptance notices, meeting programs, abstract books and proceedings, and reprints of papers.

### **3.5 Teaching and Research Committee Work**

Credit may be claimed for committee work in teaching and research activities. These must be formal committees of hospitals or official organizations. Activities claimed are limited to the time dealing specifically with teaching or research on the agenda. One point/hour can be claimed, up to a maximum of 10 points a year.

*Examples:*

Institution teaching programme committees,

Supervisor of Training; work in planning teaching,

Institution research committee,

Institution ethics committee.

*Approval from MOPS Office:* No.



*Documentation Required (examples):*  
Meeting agendas, minutes, or reports.

#### 4. PRACTICE PEER REVIEW

This is a one-day, review of a participant's practice, on-site at the practice, by a peer nominated by the Regional Committee and endorsed by the QA/MOPS Officer. For rural participants who work at the same institution, up to three participants can be reviewed by the peer on that day. Points can be claimed for both CME and QA (code 411, 25 and 75 points respectively) for each practice review. This activity allows a participant to fulfill the mandatory QA requirements for the year. It also provides an opportunity for participants to gain specific information about their practices that will assist them to maintain the best possible standards of care. Participants need to register with the MOPS office and pay a fee determined by the College. A written report is required from the reviewer who will be entitled to claim 30 points for QA and an additional 20 points for QA if there is more than one participant reviewed at the same time (code 412).

*Example:*

A review will include -  
a review of practice setting, case mix, profile, and records,  
evidence of compliance with College guidelines, policies and protocols,  
evidence of participation in CME and QA activities,  
observation of clinical skills where appropriate,  
observation of the participant interacting with patients and staff.

*Approval by MOPS Office:*

Yes, in advance.

*Documentation Required (examples):*

Confirmation by the MOPS Office.

#### 5. HOSPITAL ATTACHMENT

This is a period of attachment at a hospital accredited for FANZCA training, where a participant can observe and engage in hands-on clinical practice. It provides participants an opportunity to update their knowledge and clinical skills. This category excludes services provided infrequently at an accredited hospital, by an anaesthetist who is based at another hospital.

##### **5.1 One Week Hospital Attachment**

Credit is given for an attachment period of at least five days. An organized programme is essential, and the five days must be consecutive. Points are given for both CME and QA (code 511, 50 points each). This activity allows a participant to fulfill the mandatory CME and QA requirements for the year. Approval from the QA/MOPS Officer must be sought in advance.

The receiving department's Chairman should nominate a senior specialist to be the participant's preceptor. This preceptor is required to provide a written report on the participant's attachment period for the MOPS office, and may claim 20 points for QA (code 512).

*Example:*

Application to the MOPS office should include a programme agreed to by the Chairman of the receiving department.

The preceptor's report should verify fulfillment of the programme by the participant.

*Approval by MOPS Office:*

Yes, in advance.

*Documentation Required (examples):*

Confirmation by the MOPS Office and the report by the preceptor.

**5.2 Short Hospital Attachments**

These are attachment periods of less than five days at a hospital accredited for FANZCA training. Each attachment must last at least one day. A confirmatory note of attendance signed by the receiving department Chairman is required (to be kept by the participant), but a preceptor, written report, or prior approval by the MOPS office is not necessary. Participants may claim code 521, 15 points for CME plus 5 points for QA/day. Five non consecutive short attachment days cannot be claimed in lieu of code 511 above.

*Example:*

Self-arranged visits with the Chairman of the receiving department. Each short attachment should have a learning objective, e.g. to "brush-up" on neuroanaesthesia.

*Approval by MOPS Office:* No.

*Documentation Required (examples):*

Confirmation of attendance by the receiving department Chairman.

**6. SIMULATOR COURSES**

Simulator-based training and education can be credited if the course is approved and completed at an accredited simulator centre. Approval from the MOPS office must be sought in advance for other simulator sessions undertaken. Half day courses are credited with code 611, 15 points each for CME and QA. Full day courses are credited with code 612, 25 points each for CME and QA. Tutors for simulator courses may claim points under Teaching (code 311, 5 points/hour).

*Example:*

Courses in any simulator centre approved by the MOPS office.



*Approval by MOPS Office:*

Yes, if not an approved course.

*Documentation Required (examples):*

Registration receipts, course programmes or reports.

## **7. OTHER ACTIVITIES**

Other activities considered suitable for MOPS require a detailed submission to the MOPS office for evaluation. Points if credited under code 700, will depend on the educational value of the particular activity. Approval from the QA/MOPS Officer should preferably be sought in advance.

*Examples:*

Teaching in a foreign country as a member of an official Australasian delegation, Sabbatical leave in a local or overseas institution.

*Approval by MOPS Office:*

Yes, preferably in advance.

*Documentation Required (examples):*

Letters of invitation, attendance notes, etc.

## MOPS PROGRAMME (Con'd)

## CREDIT POINTS ALLOCATION – QUICK REFERENCE

### 1. CONTINUING MEDICAL EDUCATION

Minimum requirement of 50 points every year

#### 1.1 Major CME Meetings

*Participant* – anaesthesia, pain, and  
intensive care meetings

*Participant* – other specialties' meetings

*Presenter / Chairman, see 3.4*

#### Code

111

*20 points/day or  
3 points/hour*

112

*10 points/day or  
3 points/hour*

#### 1.2 Local CME Meetings

*Participant*

#### Code

121

*3 points/hour*

#### 1.3 Remote Group Learning

*Participants*

#### Code

131

*3 points/hour*

#### 1.4 Self Directed Learning Activities

*Self assessment (HELP) modules, if submitted*

*Reading journals and books; unmarked HELP modules*

*Audio and video tapes*

*Computer assisted learning (Internet searches etc)*

#### Code

141

*20 points/issue*

142

*1 point/hour*

143

*1 point/hour*

144

*1 point/hour*

Codes 142, 143, and 144 - maximum limit of 10 points each in a year

#### 1.5 Learning Projects.

*Per project according to category rating 1 - 4*

*EMST or ATLS courses - category rating 4*

#### Code

151

*25-100 points  
100 points*

#### 1.6 CME Committee Work

*Participant*

#### Code

161

*1 point/hour,  
maximum 10 points*

### 2. QUALITY ASSURANCE ACTIVITIES

Minimum requirement of 25 points every year

#### 2.1 Clinical Audits

*Principal co-ordinator of a group project*

*Active participants in a group project*

#### Code

211

*Points per project  
30 points*

212

*25 points*

#### 2.2 Major QA Meetings

*Participant*

*Presenter / Chairman see 3.4*

#### Code

221

*20 points/day or  
3 points/hour*

#### 2.3 Local QA Meetings

*Participant*

#### Code

231

*3 points/hour*

#### 2.4 Hospital Accreditation Reviews

*Inspector*

#### Code

241

*30 points/day*

#### 2.5 QA Committee Work

*Participant*

#### Code

251

*1 point/hour,  
maximum 10 points*



<b>3. TRAINING, TEACHING, AND RESEARCH</b>		
<b>3.1 Teaching</b>	<b>Code</b>	
<i>Participant</i>	311	5 points / hour
<b>3.2 Examinations</b>	<b>Code</b>	
<i>Participant in a full examination</i>	321	30 points / day
<i>Participant in preparing questions or marking papers</i>	322	2 points / hour
<b>3.3 Publications, Reviews of Manuscripts &amp; Grants</b>	<b>Code</b>	
<i>Journals, per paper - refereed journals</i>	331	25 points
<i>- non refereed journals</i>	332	5 points
<i>Books, per book</i>	333	50 points
<i>Book chapters, per chapter</i>	334	10 points
<i>Professional guidelines, policies and protocols</i>	335	5 points per item
<i>Theses: category rating 1 - 3</i>	336	50-150 per thesis
<i>Reviews of papers, books, and research grants</i>	337	5 points per review
<i>Examination of a thesis</i>	338	20 points
<b>3.4 Presentations (only at approved major meetings)</b>	<b>Code</b>	
<i>Oral presenter</i>	341	20 points per paper
<i>Chairman</i>	342	5 points per session
<i>Poster presenter</i>	343	5 points per poster
<b>3.5 Teaching and Research Committee Work</b>	<b>Code</b>	
<i>Participant</i>	351	1 point / hour, maximum 10 points
<b>4. PRACTICE PEER REVIEW</b>	<b>Code</b>	
<i>Participant</i>	411	75 points for QA & 25 points for CME
<i>Reviewer, reviewing one participant only</i>	412	30 points QA
<i>Reviewer, reviewing 2-3 participants at same time</i>	412	50 points QA
<b>5. HOSPITAL ATTACHMENT</b>		
<b>5.1 One Week Attachment</b>	<b>Code</b>	
<i>Participant</i>	511	50 points for QA & 50 points for CME
<i>Preceptor</i>	512	20 points for QA
<b>5.2 Short Attachments</b>	<b>Code</b>	
<i>Participant</i>	521	Per day 5 points for QA & 15 points for CME
<b>6. SIMULATOR COURSES</b>	<b>Code</b>	
<i>Half day College approved course</i>	611	15 points for QA & 15 points for CME
<i>Full day College approved course</i>	612	25 points for QA 25 points for CME
<i>Tutors see 3.1, code 311</i>		
<b>7. OTHER ACTIVITIES</b>		
	700	varying
Points if credited, will depend on the educational value of the particular activity. Approval from the QA/MOPS Officer should be sought, preferably in advance.		

## EQUIVALENT POINTS FOR THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS MAINTENANCE OF PROFESSIONAL STANDARDS PROGRAMME

Some participants in the ANZCA MOPS Programme who practise some intensive care, may also be enrolled in the RACP MOPS Programme. To facilitate returns for both Programmes, equivalent points credited by the RACP for the same activities outlined in the ANZCA Programme are listed below. FRACP participants whose practice includes anaesthesia and/or pain management should consult the RACP if claiming RACP points for non-intensive care activities. Participants should always confirm claims with the RACP.

ANZCA Codes and Points	RACP Activities and Points
<b>1.1 Major CME Meetings</b>	<i>Accredited Meetings or Workshops</i>
111 20 points/day or 3 points/hour	If Meeting, 0.5 points/hour, max 100 points/5 year cycle.
112 10 points/day or 3 points/hour	If Workshop, 2 points/hour, max 50 points/workshop.
<b>1.2 Local CME Meetings</b>	<i>Practice-Related CME</i> , 0.5 points/hour,
121 3 points/hour	max 250 points/5 year cycle.
<b>1.3 Remote Group Learning</b>	No RACP equivalent. Possible claim under Accredited
131 3 points/hour	Workshop, 2 points/hour, max 50 points/workshop.
<b>1.4 Self Directed Learning</b>	<i>Self Assessment</i> : only for RACP recognized modules
141 20 points/HELP module	(ASAP, PSAP, MKSAP) 2 points/hour, max 50 points.
142 1 point/hour	<i>Practice-Related CME</i> , 0.5 points/hour,
143 1 point/hour	max 250 points/5 year cycle for 142-144.
144 1 point/hour	
<b>1.5 Learning Projects</b>	<i>Learning Projects</i> , 2 points/hour, max 50
151 25-100 points/project	points/project.
<b>1.6 CME Committee Work</b>	No RACP equivalent. Some activities may possibly be
161 1 point/hour	claimed under <i>Practice-Related CME</i> , 0.5 points/hour,
	max 250 points/5 year cycle.
<b>2.1 Clinical Audits</b>	<i>Active Quality Assurance</i> : 2 points/ hour,
211 30 points/project	max 50 points/project for 211 and 212.
212 25 points/project	
<b>2.2 Major QA Meetings</b>	<i>Accredited Meetings or Workshops</i>
221 20 points/day or 3 points/hour	If Meeting, 0.5 points/hour, max 100 points/5 year cycle.
	If Workshop, 2 points/hour, max 50 points/workshop.
<b>2.3 Local QA Meetings</b>	<i>Practice-Related CME</i> , 0.5 points/hour,
231 3 points/hour	max 250 points/5 year cycle. If "active role", may
	claim Active Quality Assurance, 2 points/hour.
<b>2.4 Hospital Accreditation</b>	<i>Active Quality Assurance</i> , 2 points/hour.
30 points/day	
<b>2.5 QA Committee Work</b>	<i>Passive Quality Assurance</i> , 0.5 points/hour.
251 1 point/hour	If Chair, claim <i>Active Quality Assurance</i> , 2 points/hour.



<b>3.1</b>	<b>Teaching</b>	<i>Teaching</i> , 1 point/hour.
311	5 points/hour	
<b>3.2</b>	<b>Examinations</b>	If RACP approves, <i>Teaching</i> , 1 point/hour for Final FFICANZCA examinations.
321	30 points/day	
<b>3.3</b>	<b>Publications</b>	<i>Publications</i> , 5 points/publication for 331- 336.
331	20 points/paper	
332	5 points/paper	
333	50 points/book	
334	10 points/chapter	
335	5 points/item	
336	50-150 points/thesis	
337	5 points/review	<i>Practice-Related CME</i> , 0.5 points/hour,
338	20 points/thesis	max 250 points/5 year cycle for 337 and 338.
<b>3.4</b>	<b>Presentations</b>	<i>Presentations</i> , 3 points/presentation for 341.
341	20 points/presentation	
342	5 points/chair	No RACP equivalent. May be claimed under <i>Accredited Meeting or Workshop</i> .
343	5 points/poster	No RACP equivalent.
<b>3.5</b>	<b>Teaching/Research Committee</b>	No RACP equivalent. Membership of research grant review and ethics committees may claim under <i>Practice- Related CME</i> , 0.5 points/hour, max 250 points/5 year cycle.
351	1 point/hour	
<b>4</b>	<b>Practice Peer Review</b>	No RACP equivalent for an anaesthesia practice review. An intensive care practice review requires registration with RACP. Such a RACP credited <i>Practice Quality Review</i> will also be recognized for the ANZCA Programme for points under 411, for participants who practise mainly in intensive care.
411	75 points for QA plus 25 points for CME	
412	30 or 50 points for QA	No RACP equivalent.
<b>5.1</b>	<b>1-Week Hospital Attachment</b>	<i>Learning Projects</i> , 2 points/hour, max 50 points/project for intensive care.
511	50 points for QA plus 50 points for CME	
512	20 points for QA	No RACP equivalent.
<b>5.2</b>	<b>Short Hospital Attachments</b>	<i>Learning Projects</i> , 2 points/hour, max 50 points/project for intensive care.
521	5 points for QA/day plus 15 points for CME/day	
<b>6</b>	<b>Simulator Courses</b>	No RACP equivalent
<b>7</b>	<b>Other Activities</b>	Check with RACP or the RACP manual

These equivalent points allocation are intended only as a guide to facilitate returns of participants in both ANZCA and RACP MOPS programmes. Automatic endorsements by the RACP cannot be assumed. Please check with the RACP or their programme manual.

# MEDICAL EDUCATION SPECIAL INTEREST GROUP

## ANNUAL REPORT

During the current year the Medical Education Special Interest Group made significant contributions to the ASM in Christchurch, by holding a successful one day satellite meeting on May 9, facilitating a simulation experience for around 90 ASM registrants and by co-ordinating a trial of Problem Based Learning Groups. A Business Meeting in Christchurch was cancelled.

The composition of the Executive Committee of the SIG has changed during the year. Dr David Griffiths (Tasmanian Representative) resigned, he has moved to Queensland. His contribution was much appreciated and we wish him well in his new post. I have resigned as the NZ representative (replaced by Dr Vaughan Laurenson) and as Chairman (replaced by Dr Bob Wong), in order to spend a year in the USA.

### **1. Simulation In Anaesthesia - State of the Art May 9, 1997**

This was the first meeting to be convened by this SIG and was attended by 61 registrants and 12 Industry delegates. During the day the many facets of this new and evolving area were covered. The overseas guest speaker, Assoc. Prof. Michael Good, University of Florida, provided a great contribution to the meeting. His expenses were covered entirely by METI, one of the two commercial simulator manufacturers. A total of eight speakers helped to create an excellent review of the issues. Seven companies contributed to the trade display and this was pleasing considering the fact that they re-located to the Convention Centre the next day. The meeting was held in Noah's Hotel.

### **2. Simulation Experiences**

We provided a 15-20 minute simulation experience, with a de-briefing session of the same duration. There was a surcharge of A\$50 for ASM registrants (whereas it was included in the Simulation Meeting registration fee) and the schedule was completely booked out at 90 registrants. The simulations were a real team effort, requiring support from the trade, from Fellows and considerable administrative input. METI brought a simulator and a director, from Florida; we brought Brain Robinson and Peter Larssen from Wellington to run the simulator and Drager provided two anaesthesia machines and personnel. We were troubled by mechanical problems, which

were stressful for the team rather than insurmountable. In hindsight it was obviously a mistake for METI to bring a machine directly from the production line without it being "run-in". A team of 26 Fellows attended an early morning training session and then helped by providing the clinical supervision and de-briefing for the simulations.

### **3. Problem Based Learning**

This was organised by Geoff Cutfield; and by all accounts was very successful and a credit to Geoff and the team of facilitators. Three groups each with 10-12 discussants were held before afternoon tea, and then repeated after the break so that around 70 registrants were able to take part. These sessions were dependent upon the availability of Peter Klineberg, David Sage, Tim Pavy, Alan McKenzie, and Peter Hicks as facilitators and their effort was greatly appreciated.

The SIG Executive Committee has yet to review the feedback questionnaires. My view is that the vast majority of the comments are positive and therefore PBL sessions warrant inclusion in the programme of further Annual Scientific Meetings. It is of note that the CECANZ meeting and the ASA meeting in 1997 chose to include PBL.

### **4. Other activities**

4.1 Hyperbaric Medicine. Dr Chris Acott has been working on a suggested syllabus and a draft document will be forwarded to the Education Officer in due course.

4.2 Directory of Provisional Fellowship Posts. An initiative to develop a directory with the intention of providing fourth year trainees with information to help them choose a PFY post was supported by Council and referred to the Education Committee for development.

In completing this report I wish Bob Wong well as Chairman and I thank the SIG Executive Committee for their hard work. I wish to thank the members of the CE and QA Committee for their help and support while I have chaired this SIG and I also thank the College Staff, particularly Helen Morris, for the tremendous assistance I have received.

SANDY GARDEN, Immediate Past Chairman,  
Medical Education SIG

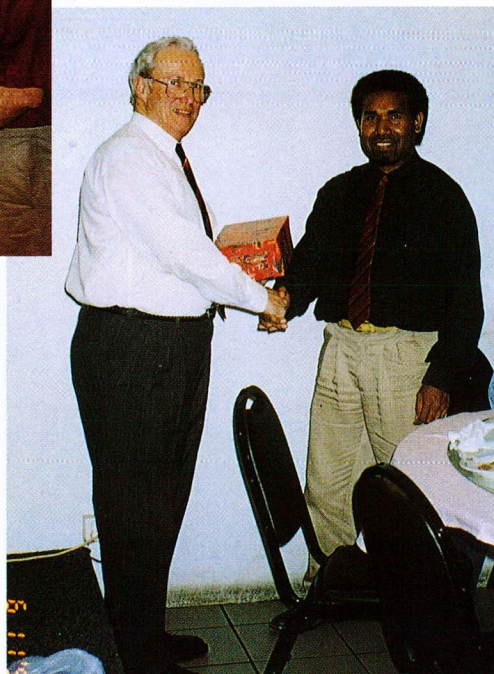




Dr Mike Martyn, College (Communications Officer), Mr Michael Brooke, (Director – Hospital Business Unit, Astra Australia), Dr Michael Paech, WA, Professor Garry Phillips (President), Mr Brad Christensen (R&B Productions) at the launch of *“It’s Your Labour”*.



Dr Sue Clarke, inaugural winner of the Tess Cramond Prize with Professor Cramond, Dr Jenny Parslow, Chairman Queensland Regional Committee, Dr Alison Holloway, Chairman Queensland Section ASA, and Professor Douglas Jones.

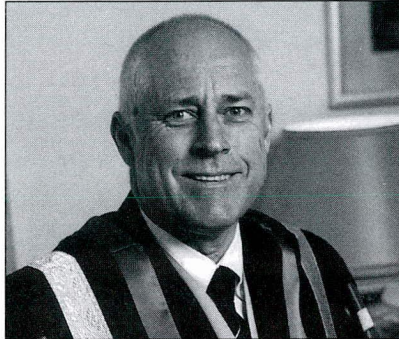


President, Prof. Garry Phillips, presenting prize to best candidate M. Med II University of Papua New Guinea 1997 in Port Moresby Dr Kaeni Aigiomea from Solomon Islands.



## FACULTY OF INTENSIVE CARE

# DEAN'S MESSAGE



In this issue of the Bulletin, the President-elect, Dr Richard Walsh, outlines College deliberations or solutions to the current inadequacies of office space and other facilities at Ulimaroa. Like the College, the Faculty is in a phase of rapid growth and development and has outgrown its accommodation. Although there are a number of options, it is likely that the College will decide to extend the current building. The Faculty's requirements are recognised as a high priority and the Board has projected its long term space requirements for inclusion in any proposed redevelopment. Sharing of many facilities will continue including the new technologies. The discussions to this point are exciting and Fellows can be assured that the future of the Faculty is being catered for.

The College is currently undertaking the first planned review of its Maintenance of Standards Programme. A draft document incorporating significant changes is published in this issue of the Bulletin. The revised programme would remain voluntary with similar entry requirements. It differs, overall, however in being less points-driven and recognises a wider range of activities. It clearly states its aim as educational and now requires minimum annual points for quality assurance and continuing medical education activities. Importantly the revised programme would incorporate a feedback mechanism to allow Fellows to compare their practice with those of their peers. The Board has reviewed the draft and is likely to closely follow these changes when reviewing the Faculty Programme. Specific modifications relating to intensive care will be included. The Board invites comments from its Fellows

on the proposed changes and would welcome any other suggestions.

The Faculty is indebted to Professor Don Harrison, Dr Phil Byth and Ms Kate D'Este for compiling a report to the Board of a survey of Fellows (by examination) up to and including the Final Examination in 1995. Overall, the report finds that the Faculty's training and examination programme is achieving its goals and that most respondents to the survey are gainfully employed in intensive care. The report does uncover some perceived deficiencies in the training programme, supervision and assessment processes. The Board will take the results of the survey on board as it reviews each aspect of the programme.

Arrangements for National Intensive Care Day are progressing well. An imaginative poster has been designed and leaflet drafted. The level of interest from the Societies, Units and politicians has been encouraging. Specific examples and suggestions on how to contribute will be circulated to Units that have expressed interest in being involved.

The Newcastle Annual Scientific Meeting is drawing closer. The Organising Committee has constructed a stimulating and innovative programme and I would encourage as many Fellows as possible to attend. I look forward to meeting you there.

*Alan Duncan*  
A.W. DUNCAN, Dean



# NATIONAL INTENSIVE CARE DAY WEDNESDAY 1ST JULY 1998

In deciding that National Anaesthesia Day for 1998 should be devoted to intensive care, the College Council is providing intensive care teams with a great opportunity to really present themselves to the community. It is now up to us to make the most of this opportunity. Faculty efforts will be backed by College resources and a specific budget, and the College has placed the efforts of Eddie Dean, College Communications Consultant, at our disposal.

Progress to date includes the distribution of a letter-questionnaire to individual ICUs, to ANZICS and the nursing organisations; letters to the Federal and State Health Ministers from the President and the Dean; and completion of the design of the NICD poster and leaflet. The questionnaire particularly demonstrated a notable enthusiasm for this special day on the part of nursing staff in ICUs. You should be thinking hard as to how you are going to organise the Day and present yourselves to the public.

So how are you going to organise your activities for this day? By now each Unit should have involved its hospital's public relations consultants for their expertise in matters of dealing with the public. We cannot provide the conventional type of Open Day in an ICU because of considerations for the privacy of those patients occupying the Unit on the day (and because there may well be a grieving group in the environment of the Unit). Nonetheless many of you will have high profile VIP ex-patients who may be willing to contribute to the "people stories" or "success stories" associated with your Unit. Probably the biggest key to success will be media involvement for the Day, whether it is from your local newspaper or local television (the Communications Committee will be dealing with the national profiles). Conventional displays either in the Unit waiting areas or in the hospital foyer are an

obvious way of communication, but this day needs to get to more than just the Hospital or Unit visitors ie. media attention is vital. Do not be shy about offering interviews by a suitable spokesperson who will of course be emphasising the team approach for intensive care and the special people working there.

We can now supply the public with factual data of studies from the ANZICS database to back up any claims made for the high level of performance in ICUs in Australasia, whether these units are metropolitan, rural or private. We can emphasise the high survival rate we achieve (and that "He's in intensive care" is not a death sentence). We can also emphasise how providing intensive care in the post-operative period supplements and can make possible many of those anaesthetics and operations which hitherto just could not be undertaken without follow-on supportive care afterwards.

Perhaps something we should consider is that this day also provides an opportunity to have people consider their own position on being an organ donor, and getting themselves signed up. People often ask us "But just what do you do in intensive care?" So let's tell the world.

R.V. TRUBHOVICH,  
Communications Officer  
Faculty of Intensive Care

## Recognition of the specialty of Intensive Care by Medical Council of New Zealand

The following is an extract from the Newsletter of the Medical Council of New Zealand:

### **“NEW VOCATIONAL BRANCHES**

The Education Committee is reviewing existing branches, and receiving applications from new branches, for recognition for the purposes of vocational registration, including re-certification programmes and MOPS (Maintenance of Professional Standards)..

At the December 1997 Council meeting, a new branch – Intensive Care – was recognised in principle. Existing vocational groups, Occupational

Medicine, Diagnostic Radiology and General Practice, were endorsed as branches. The Education Committee expects to consider further applications at its first meeting in 1998 in early March.

However, the Medical Practitioners (Vocational Registration) Order made on 17 June 1996 will have to be amended before Council can receive applications from individual doctors for vocational registration in new branches not named in the 1996 Order. This stage may not be reached until towards the end of the first half of 1998 as it requires Ministerial approval, then action by the Governor-General.”



## **ITEMS OF INTEREST FROM THE FEBRUARY 1998 BOARD MEETING**

### **HONOURS AND APPOINTMENTS**

The Board noted the appointment of Dr J. Ronald Lo as Elected Fellow of the Royal College of Anaesthetists, and Dr Richard Walsh as President-elect of the Council.

### **EDUCATION AND TRAINING**

#### ***Accreditation of Training***

The Board conducted a workshop to consider and compile information and views gathered over the past few years during its review of accreditation, with particular reference to the accreditation and classification of units and training posts. This issue has been discussed at length and Regional Committees consulted.

The Board agreed in-principle to the following:

- The Faculty will continue to inspect and accredit Intensive Care Units as a means of defining standards for training. However the number of training posts accredited within a Unit will be unrestricted.
- Approval of core intensive care training is dependent upon (a) trainees being registered with the Faculty of Intensive Care at the time training is undertaken, (b) trainees being registered with the RACP and undertaking advanced training in intensive care and (c) a trainee undertaking their Provisional Fellowship Year with in-training assessments for that period of training.
- Units will be classified or re-classified by duration of core training ie. 24 months, 12 months, 6 months.
- The core period of intensive care training can not be undertaken before the third year of approved vocational training.

The Board will now consider amendments to its Policy Documents and Administrative Instructions and revise them with a view to implementing these initiatives in the near future.

#### ***Suggested Reading List***

A list of suggested texts and reference books relating to intensive care was approved and will be circulated to Supervisors and Trainees.

#### ***Formal Project***

The Board amended the Administrative Instructions to include the requirement for trainees commencing training from 1997 to complete a formal project, as per the Board resolution of June, 1996.

***The Australian Donor Awareness Programme for Transplantation (ADAPT)***

The Board considered a proposal from ADAPT for trainees to attend training courses designed to educate professionals in grief and bereavement knowledge and the management of brain dead patients and their families. The Board endorsed the course but agreed it should not be a mandatory requirement of training.

***Availability of Paediatric Anaesthesia Training***

The Board acknowledged difficulties experienced by trainees undertaking the endorsement in Paediatric Intensive Care, in gaining the minimum requirement for six months in paediatric anaesthesia training. The Board resolved to amend Administrative Instruction 1.4.1.5 (b) to require twelve months of clinical anaesthesia training, in any combination of adult or paediatric anaesthesia.

***Registration of Trainees following 12 months of general hospital appointments***

In line with College policy, the Board resolved to amend its Administrative Instructions to allow trainees to register on completion of 12 months general hospital appointments. However trainees are still required to complete 24 months of such appointments prior to commencing approved vocational training.

**PROFESSIONAL**

***Overseas Trained Doctors***

A document detailing the process of assessment of Overseas Trained Doctors was approved by the Board. Finalising the New Zealand document awaits the forthcoming gazetting of intensive care medicine as an independent specialty there.

***High Dependency Units***

A draft document on the role of trainees in High Dependency Units and minimum standards is under consideration.

***Australian Medical Workforce Advisory Committee***

The Faculty continues to be involved in the review of the intensive care workforce currently being undertaken by AMWAC. There is an obvious workforce shortage but the recent increase in examination candidates is more encouraging.

***Survey of Fellows admitted by Examination***

The Board received a report of a survey conducted by Professor G.A. Harrison, Dr P. Byth and Ms K. D'Este of Fellows covering their views on intensive care practice and training.



**CONTINUING  
EDUCATION**

***Increase in Occupational Training Visa Fee***

In line with College policy, the Board resolved that the fee for processing an application for support of an Occupational Training Visa be increased to \$75.00.

***Maintenance of Standards Programme***

The Board agreed to review its MOS Programme in line with changes being undertaken by ANZCA.

***Welfare of Anaesthetists Group***

The Board agreed that the issues being explored by this Group are also of relevance to intensivists, and support Faculty involvement. The aim of the Group is to promote the professional and personal wellbeing of anaesthetists, intensivists and their families.

**INTERNAL AFFAIRS**

***Election of Dean-elect***

The Board elected A.W. Duncan as Dean-elect.

***Hospital Accreditation Committee***

The Board resolved to introduce a sub-committee to consider matters relating to Accreditation of Units, composed of the Dean, the Education Officer and members of the accreditation team of inspected Units.

***Communications***

A review and higher profile for the Faculty Website was noted by Board members as a priority. A poster and leaflet were reviewed and approved for National Intensive Care Day on 1st July 1998. It was noted that participating Units will be forwarded information kits in preparation for the Day.

**YOUNGER FELLOWS CONFERENCE**

**APRIL 30th – MAY 2nd 1998  
WESTBURY'S MARINA RESORT**

*The following have been nominated as representatives of the Faculty to attend this Conference:*

***Dr Dorothy Breen, New South Wales***

***Dr John Green, Victoria***

***Dr Carl Scott, Queensland***

***Dr Rob Young, South Australia***

***Dr Janet Liang, New Zealand***

**ADMISSION TO FELLOWSHIP  
BY EXAMINATION**

**Koo Chi Kwan, HK  
Richard Creighton Leonard, WA  
Dianne Patricia Stephens, NT  
Shane Christopher Townsend, QLD  
Balasubramanian Venkatesh, QLD  
Hui Yi Florence Yap, HK**

**DEATH**

The Board noted with regret the death of a Fellow of the Faculty;  
Dr Catherine Geraldine Mary Flynn, Ireland



# **AMENDMENTS TO** **ADMINISTRATIVE INSTRUCTIONS**

At its February meeting the Board of Faculty resolved to amend Administrative Instruction 1 as follows:

***Trainees may register following 12 months of general hospital appointments***

- 1.1.1 As from the commencement of the 1998 Hospital year, a trainee may register with the Faculty on completion of 12 months of whole time rotating clinical duties in a hospital (general hospital appointments) after graduating from a medical school.
- 1.1.2 Approved training cannot commence until at least 24 months of general hospital appointments have been completed after graduation from a medical school. The date of graduation is taken as that on which there is formal certification of University studies and the candidate becomes eligible for award of the graduating degree.

General hospital appointments may include no more than six months spent

in any combination of anaesthesia, intensive care and/or pain management.

***The mandatory requirement for six months training in paediatric anaesthesia was removed and the requirement revised as follows:***

- 1.4.1.5 (b) Twelve months of clinical anaesthesia, not necessarily continuous, in any combination of paediatric and adult anaesthesia.

***Formal Project***

- 1.4.7 That trainees commencing approved vocational training on or after the beginning of the 1997 Hospital Year must complete a Formal Project as a prerequisite for awarding the Diploma FFICANZCA, in accordance with the guidelines outlined in the JSAC-IC document 'Formal Project Requirements'.

That Administrative Instruction 1.4.7 and 1.4.8 be renumbered accordingly.

## NEWCASTLE ASM 1998

### **FACULTY FOUNDATION VISITOR**

#### **DR GORDON DOIG**

The Faculty Board seeks in its Foundation Visitor some of the following characteristics:

- high level communication skills with large audiences and small groups
- prominence in a specialty area and with good academic record combined with
- a sense of humour

Dr Doig meets all these requirements without being an intensivist! In fact, he began his professional life as a veterinarian and then epidemiologist. He then saw the light and undertook a two year Critical Care Research Fellowship with Dr William Sibbald. Promotion followed: he is currently Assistant Professor of Critical Care Medicine at the University of Western Ontario. Comparing his experience in epidemiology and biostatistics with his new home in a critical care medicine division gives him insights into the design and analysis of clinical trials and evidence based discussion making not usually found in clinical intensivists. His major research interests include clinical trials design, research transfer, the use of evidence based guidelines to improve the efficiency of care delivery and the application of medical informatics in continuous quality improvement. Dr Doig has been an invited speaker and workshop leader at the Brussels Symposium on Intensive Care on a number of occasions.

Gordon will also be visiting centres in Victoria and Queensland. He is keen to meet and work with Australasian intensivists as well as taking in a game of Rugby and playing tennis with anyone he can beat.

### **INVITED OVERSEAS SPEAKER**

#### **JOHN McCLENAHAN**

John McClenahan is a Fellow at the King's Fund Management College, London, UK, where he has been since 1985. He joined the College after 15 years with Arthur Andersen & Co (now Andersen Consulting). He has worked at all levels of the health service from front line service delivery teams to regional and national levels.

Two abiding interests are working with doctors to improve the management of their own practice and their organisations' services, both operationally and strategically; and enabling them to make more effective use of information management and technology. John and a colleague have facilitated a number of management training programmes for intensive care teams and consultants in association with the British Intensive Care Society. A particular interest is bringing together the 'softer' process aspects of personal and team management, and the 'harder' subjects of information and finance to the most productive effect.

Over the past year he has been working with a health region on understanding the relevance and application of Evidence Based Practice to changing clinical work. It is still far from straightforward to make the connection between sound research-based evidence of efficacy, organisational energy to support its use, and personal commitment by individual clinicians and clinical teams to changing day to day practice accordingly. Partial solutions are emerging which should help the longer term changes needed to make EBP a widespread reality rather than an aspiration.



# FACULTY OF INTENSIVE CARE GENERAL FELLOWSHIP EXAMINATION CHANGES TO EXAM FORMAT 1999

As alluded to in the report of the last Board Meeting, there will be major changes to the oral part of the Exam commencing in April/May 1999. Candidates, tutors and Supervisors of Training should be aware of these changes. They will be detailed not only in the Bulletin, but also at the Faculty Scientific Meeting, the Tuta Course and the Adelaide Course. The Exam Committee will be prepared to answer any questions from interested parties.

The changes consist of:

- 1) The Investigations Section will be incorporated into an Objective Structured Clinical Examination (OSCE). OSCE means different things to different people. For us, OSCE will take the form of ten to twelve "stations" that each candidate will visit in rotation. Ten minutes will be allocated for each station and there will be two minutes in between each station. Investigations, as previously encountered in the Exam, will be the main focus of the stations but there will also be stations for performance of procedures (CPR, ICC insertion, CVC insertion etc), principles of equipment and role plays (common ethical or management problems in ICU). Therefore the candidate in turn may encounter at one station three CXRs on which to provide written comments and answer several questions, at the next he/she may be asked to demonstrate a common ICU procedure on a manikin and in the next he/she may be asked to counsel a volunteer whose relative is dying or who is complaining about mistreatment.
- 2) The Clinical Section (Medical Cases) will be split into two parts "cold" cases (non-acute) and "ICU" cases each of 30 minutes duration. There will be

separate pairs of examiners for each part. The nature of this section will be otherwise unchanged in terms of questions, types of patients and setting.

- 3) The Cross-Table Vivas will be structured. Each candidate will encounter six tables. There will be one examiner per table and the candidate will spend twelve minutes at each table. Each candidate will be presented with the same subject or scenario and opening questions at the same table. The candidate will be given one minutes to read the scenario or opening question before joining the examiner at the table for questioning. The coverage of this section will be the same as in previous years.
- 4) To ensure that each candidate gets as close as possible to the same exam, it will be important from time to time that groups of candidates be quarantined from other groups. This means that candidates may be expected to present early to the exam site and wait with other candidates with books, refreshment, etc.

It is obvious that implementation of these changes will vary depending on the numbers of candidates presenting and as the Exam develops further changes will occur.

All parties are encouraged to discuss these format changes freely so that no candidate is disadvantaged.

Richard Lee  
Chairman, Fellowship Examination Committee



## **EXCERPTS THERAPEUTIC DEVICE BULLETIN 12/97**

*Reprinted with approval Therapeutic Goods Administration*

### **Safety Alert – Thermal Blankets**

TGA has received a number of reports, both from overseas and from within Australia, concerning incidents with metallised foil thermal blankets, commonly used in emergency situations to minimise loss of body warmth from an injured patient.

Some of these blankets consist of a thin, tough plastic film to which has been applied a layer of metal, to act as a heat retainer.

### **US FDA introduces Latex Labeling requirements**

In response to reports of allergic reactions to some medical devices, the United States Food and Drug Administration (FDA) is requiring that the labeling of all medical devices which contain natural rubber latex be amended to include a statement on the label which states, "Caution: **This Product Contains Natural Rubber Latex Which May Cause Allergic Reactions**". Medical device packaging that contains latex will be required to carry a similar statement on the label. Products and packaging containing dry natural rubber will have to be identified as containing dry natural rubber.

The new requirements, published on 30 September 1997 in the Federal Register as a Final Regulation, will enable people who are allergic to latex to easily identify medical devices that contain latex.

Over the past decade, FDA has received more than 1,700 reports of severe allergic reactions, including 16 deaths, related to medical devices containing latex. The deaths were caused by a reaction to latex cuffs used on the tip of barium enema catheters which have been recalled from the market. The product supplied currently includes a silicone cuff.

Allergic reactions have been reported to a wide range of medical devices that contain latex including latex surgical gloves, adhesive bandages, intravenous catheters, and anaesthesia equipment. FDA sponsored an international conference on latex sensitivity in 1992 to determine the cause and extent of the problem and explore ways to address it.

While the risk of an allergic reaction to latex for the general public is estimated to be less than 1 percent – health care workers and patients with conditions involving multiple surgical procedures are at greater risk due to frequent exposure.

FDA is also requiring that all 'hypoallergenic' claims on medical devices be removed because of the potential to mislead people sensitive to latex. Such claims are currently found on many medical devices that contain reduced levels of latex protein. However, these products may still cause allergic reactions in people who are latex sensitive. While manufacturers may not use the term 'hypoallergenic' the labelling may include a claim for reduced incidence of sensitivity.

Manufacturers have one year - until September 30, 1998 to comply with the new law. The regulation does not apply to latex containing medical devices that do not come in contact with people.

### **Safety Alert - Physio-control Lifepak 500 Automatic External Defibrillator**

Physio-Control has issued a reminder for users of the LifePak 500

Automatic External Defibrillator. The software in the LifePak 500 performs an automatic selftest every night. In doing this it switches on automatically, performs the self test and then switches off. If at the time of the test, the device detects a cardiac like signal such as from an ECG simulator it will remain on and in monitoring mode until the device is either switched off or the internal battery depletes.

This may lead to unexpected flat batteries. In such cases Lithium batteries will require replacement while sealed Lead-acid batteries require recharging. In the event the defibrillator is required for an emergency, flat batteries may lead to an unexpected delay in delivery of therapy.

Although the chances of this occurring are minimal, users should ensure that cardiac simulators or similar sources of cardiac signals are not left connected to the defibrillator when not in use. For further enquires please contact Acute Care Systems on 02 9878 6222. DIR 10476

### **Pacemakers, AICD's and Mobile Phones**

TGA continues to review findings of clinical and laboratory research, both within Australia and overseas, which has indicated a potential for temporary interaction or interference between mobile phones and the operation of pacemakers and implantable defibrillators.

The findings have indicated that interference may be caused by

1. The radio signal transmitted from the phone if the phone is held close to the implanted device (ie within about 150mm), or if direct contact is made between the phone antenna and the user's skin. Interference may occur when the phone is in standby mode, or in use, but not when the phone is switched off.
2. Some phones incorporate a magnet, either to activate the phone when opened for use or as a part of the loudspeaker in the phone. This magnet, if strong enough, and if held close to the implanted device, can activate the 'magnet' mode of the pacemaker or defibrillator. This may cause the pacemaker to pace at a fixed rate. It will revert to normal operation when the magnet is removed.

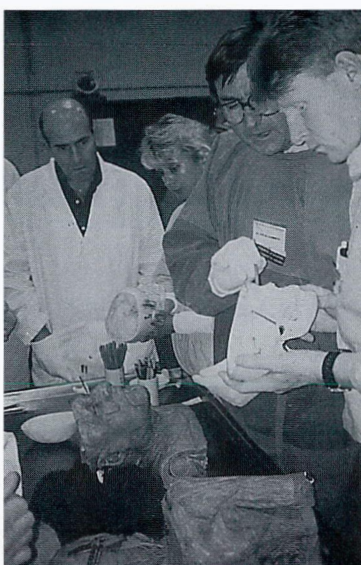
It is important to note that, based on testing to date, any effect resulting from interaction between a mobile phone and an implanted device is temporary. Simply moving the phone away from the implanted device will return it to its correct state of operation.

The potential for a mobile phone to interfere with a pacemaker or implantable defibrillator can be minimised by maintaining a separation of at least 150mm between the mobile phone and implanted device.

This can be achieved by

1. Not keeping the phone in a pocket over the site of an implant
2. Using the ear which is furthest away from the site of the implant when operating the phone.





## ANATOMY WORKSHOP

Each year the NSWACE Committee holds an anatomy workshop for fellows who wish to improve their knowledge of anatomy relevant to regional anaesthesia. The idea for this workshop came from Dr. John McGuinness, an anaesthetist at St. Vincent's Hospital in Sydney, with a special interest in nerve blocks of the head and neck. It has now been running very successfully for eight years, thanks to Dr. McGuinness and his enthusiastic team. The workshop is held on a Saturday in November at the Anatomy Department in the classic buildings of the Sydney University Medical School. All the demonstrators are practising anaesthetists with an interest in regional anaesthesia. The specimens have been dissected for exclusive use in the workshop by Peter Mills from the anatomy school. Peter has been of invaluable assistance and has worked in consultation with several of the participating anaesthetists to modify standard dissections making them relevant to specific nerve blocks. The workshop covers local anaesthetic techniques for the head and neck, upper limb, lower limb, inguinal region, thorax and eye. There are also work stations which review the anatomy of the great vessels of the neck, the vertebral column and the larynx. Numbers are limited so that small groups rotate through each station to allow maximum hands-on participation.

It is a rewarding experience to go back to the dissection rooms with the benefit of clinical experience and an appreciation of the fundamental importance of anatomy to regional anaesthesia. This workshop provides CME relevant to most anaesthetic practices and many fellows return after a few years to review specific areas of interest.

NSWACE committee would like to acknowledge the generous contribution of the anaesthetists who participate as demonstrators and Peter Mills without all of whom this valuable part of our CME programme would not be possible.

Information about the workshop is available from the office address shown below and the dates for 1998 will be advertised in this Bulletin as well as by mailout. Spaces fill quickly so watch out for the advertisement and don't miss out on an enjoyable and informative day.

MS. JAN TAYLOR  
NEW SOUTH WALES REGIONAL COMMITTEE, ANZCA  
Level 4, Quay West, 111 Harrington Street, Sydney, Tel: 02 9247 7712

# POLICY DOCUMENTS

*Review TE15 (1998)*

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

## GUIDELINES FOR TRAINEES AND DEPARTMENTS SEEKING COLLEGE APPROVAL OF POSTS FOR THE CERTIFICATE IN PAIN MANAGEMENT

### 1. INTRODUCTION

- 1.1 The College offers a **Certificate in Pain Management** on the basis of one year of experience in a Multidisciplinary Pain Management Centre fulfilling the requirements set out below and approved for training by College Council.
- 1.2 Training for the Certificate will be available to anaesthetists whose training is at least equivalent to that of a Provisional Fellow.
- 1.3 Multidisciplinary Pain Management Centres recognised by the College for training purposes will be reviewed in respect of that recognition on a three yearly basis.
- 1.4 The number of posts approved within a Multidisciplinary Pain Management Centre will be specified. Additional posts will not be recognised without the prior approval of the College Council on the recommendation of the Pain Management Committee.
- 1.5 An application for recognition of post(s) will require the submission or resubmission of data as outlined in College Policy Document P25 *Requirements for Multidisciplinary Pain Management Centres Offering the Certificate in Pain Management*, and the Pain Management Centre questionnaire. An inspection of the Centre may be part of the recognition process.

### 2. THE TRAINEE

- 2.1 Will ordinarily be a Provisional Fellow or Fellow of the Australian and New Zealand College of Anaesthetists. Holders of other professional qualifications who have equivalent training to Fellows of this College may be accepted as trainees by College Council on the advice of the Pain Management Committee.
- 2.2 Must be registered prospectively for the Certificate in Pain Management and must pay all appropriate fees.
- 2.3 Must work for a full year in a post approved for the Certificate in Pain Management. In the case of a Provisional Fellow, normal training and administrative requirements must be met (see College Policy Document E13 – *Guidelines for the Provisional Fellowship Year*). Part time training may be approved upon application to the Assessor.
- 2.4 Must be allocated exclusively to the Pain Management training programme for not less than 70% of normal working hours. The programme will have a balance of work in the areas of acute pain, chronic non-cancer pain and cancer pain management.
- 2.5 Out of hours duties should include Pain Management.



**3. ASSESSMENT**

3.1 Quarterly in-training assessments will be made by the Medical Director in conjunction with candidates and with College policy. A final report (10% of assessment) will be made by the Medical Director in association with all senior staff of the Approved Unit. The reports should confirm candidates' satisfactory performance with regard to:

1. applied knowledge
2. history taking and physical examination
3. patient and staff interactions
4. development of appropriate skills in communication with patients
5. technical skills
6. other attributes appropriate for multidisciplinary pain management

**Corrective Action by Directors at the Time of Quarterly Reports**

Inadequacies in any area(s) of the quarterly reports should be discussed in detail with the candidate; where appropriate, other senior staff of the unit should participate in this discussion. A corrective plan should be developed by the candidate and director, and agreed upon. At the next quarterly report, the director should document whether or not the candidate has satisfactorily corrected the previously identified inadequacies. In the event that residual problems remain, a further plan must be developed and agreed upon.

3.2 Submission by the trainee of a Pain Certificate Log Book (40% of assessment). The Log Book will include information on: diagnoses and treatment plans for each patient managed; multidisciplinary case discussions attended; diagnostic and therapeutic nerve block and other procedures performed.

3.3 Documentation in the Log Book will include confirmation by quarterly signature of the Medical Director and Supervisor of Training of cases logged, and final confirmation of:

1. direct involvement in the management of 300 patients with chronic non-cancer and cancer pain (min 50)
  2. direct involvement in the management of 200 patients with acute pain (post-operative, post-trauma, acute exacerbations of cancer, acute presentations of medical conditions, etc.) It is expected that the majority of cases in this category would be post-operative or post-trauma.
  3. performance of at least 200 varied pain relief procedures
  4. participation in a least 40 multidisciplinary case conferences
  5. evidence of interdisciplinary involvement including direct contact with the patient's general practitioner
  6. approximately 10% of each group of patients (acute, cancer, chronic non-cancer) should be logged with respect to multiple visits.
  7. wherever possible, candidates should use pain terms and diagnoses from the IASP taxonomy (2nd ed).
- 3.4 Submission of a typed 'Treatise' (50% of assessment) describing and discussing:
1. one patient with acute pain
  2. one patient with cancer pain
  3. two patients with chronic non cancer pain, one of which must be a case where no procedure by the anaesthetist is appropriate, and thus involvement of other disciplines is required

The discussion section in two of the above cases must be expanded to the level of a 'mini-review' with appropriate referencing. Cases and mini-reviews should be presented in the same format and to the same standard as for the journal *Anaesthesia and Intensive Care*. In evaluating the literature for cases and mini-reviews, candidates should consult the levels of evidence table in the NHMRC *Clinical Practice Guidelines: The management of acute pain*, and determine which level of evidence is appropriate for each reference quoted.

Emphasis should be directed to the multidimensional aspects of pain and the interdisciplinary approach to its diagnosis and treatment. Wherever possible, candidates should use pain terms and diagnoses from the IASP taxonomy. The length of the 'Treatise' should not exceed: 1,500 words for each case and 5,000 for each mini review with associated cases, including references, illustration etc. It should be double spaced on A4 pages, using 12-point type.

- 3.5 The Assessment will be reviewed by three Pain Certificate assessors appointed by College Council on the recommendation of the Pain Management Committee. Following receipt of all assessments by the College, Pain Certificate assessors will confer through the mechanism of a formal College meeting or teleconference in order to reach a joint recommendation for referral to the Pain Management Committee. The Pain Management Committee will forward its recommendations to College Council for approval. In the event the Pain Certificate

assessors are unable to make a recommendation, further assessment may be obtained on the advice of the Pain Management Committee.

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

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

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

Promulgated: 1996  
Date of Current Document: Feb 1998

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*Review PS 7 (1998)***AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS**

ACN 055 042 852

**THE PRE-ANAESTHESIA CONSULTATION****1. INTRODUCTION**

Consultation by an anaesthetist is essential for the medical assessment of a patient prior to anaesthesia in order to ensure that the patient is in an optimal state of health, the anaesthesia management can be planned, and the patient can be appropriately informed of the anaesthesia and related procedures.

Fellows of the Australian and New Zealand College of Anaesthetists are trained in the skills required for the pre-anaesthesia consultation.

**2. GENERAL PRINCIPLES**

- 2.1 The processes involved in delivering safe and effective pre-anaesthesia consultations will vary with the type of practice and environment in which the anaesthetist works.
- 2.2 A pre-anaesthesia consultation must be performed by the anaesthetist who is to administer the anaesthetic even if an assessment has already been performed previously by some other person.
- 2.3 The use of written or computer-generated questionnaires, screening assessments by appropriately trained nurses and pre-admission clinics may be used so long as the requirement of 2.2 is followed.
- 2.4 The consultation must take place at an appropriate time prior to anaesthesia and surgery in order to allow for adequate consideration of all factors. Appropriate physical facilities for private consultation must be available.

2.5 The difficulties inherent in adequately assessing patients admitted on the day of surgery must be recognised by hospital staff. Admission times, list planning and session times must accommodate the extra time required for pre-anaesthesia consultations.

2.6 In some circumstances, early consultation will not be possible (e.g. emergency surgery) but the consultation must not be modified except when the overall welfare of the patient is at risk.

**3. GUIDELINES**

The pre-anaesthesia consultation should include:

- 3.1 Identification of and introduction of the anaesthetist to the patient.
- 3.2 A concise medical history (possibly assisted by a questionnaire) and clinical examination of the patient. This assessment should include a review of any current medications, the results of any relevant investigations and arrangement for any further investigatory or therapeutic measures which are considered necessary.
- 3.3 Consultation with colleagues in other disciplines if required.
- 3.4 A general discussion with the patient (or guardian) of those details of the anaesthetic management which are of significance to the patient. This would usually include such matters as discussion of the anaesthetic procedure, potential complications and risks,

- an opportunity for questions and provision of educational material. This may be in the form of written pamphlets, video recordings or audiotapes.
- 3.5 Obtaining of informed consent for anaesthesia and related procedures.
  - 3.6 The ordering of medications if considered necessary.
  - 3.7 A written summary of the assessment, including those risks and potential complications discussed with the patient, which becomes part of the medical record of the patient.

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

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

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

Promulgated: 1984  
Reviewed: 1989, 1992  
Date of current document: Feb 1998

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## *Review PS 8 (1998)*

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS  
ACN 055 042 852

# THE ASSISTANT FOR THE ANAESTHETIST

The presence of a trained assistant during the conduct of anaesthesia is a major contributory factor to safe patient management. The assistant must have undertaken appropriate training in order to provide effective support to the anaesthetist. The guidelines that follow are therefore stated in general terms to establish both the practical and educational responsibilities of a competent assistant to the anaesthetist.

## 1. PRINCIPLES

- 1.1 The presence of a trained assistant for the anaesthetist is essential for the safe and efficient conduct of anaesthesia.
- 1.2 This requires:
  - 1.2.1 The presence of an assistant during preparation for and induction of anaesthesia. The assistant must remain under the immediate direction of the anaesthetist until instructed that this level of assistance is no longer required.
  - 1.2.2 The presence of an assistant at short notice if required during the maintenance of anaesthesia.
  - 1.2.3 The presence of an assistant at the conclusion of anaesthesia.
- 1.3 These principles apply wherever anaesthesia or sedation is administered by an anaesthetist.
- 1.4 Institutions in which anaesthetics are given must provide a service which ensures the

availability and maintenance of anaesthesia equipment in accordance with College policy documents on recommended minimum facilities for safe anaesthetic practice. The relevant College Policy Documents are:

- T1 Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites
- T2 Protocol for Checking the Anaesthetic Machine
- T3 Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Units
- T4 Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro Convulsive Therapy (ECT)
- T5 Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries
- T6 Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites

- 1.5 Staff employed for the above purposes must be trained as defined below for this role.

## 2. DEPLOYMENT OF ASSISTANTS

- 2.1 The deployment of assistants in accordance with 1.2, should be specified by management protocols.
- 2.2 The nature and workload of the anaesthesia service will determine the number and status of assistants.

- 2.3 The duties of an assistant should be specified in an appropriate job description.
- 2.4 Whilst assisting the anaesthetist, the assistant is wholly and exclusively responsible to that anaesthetist.
- 2.5 The assistant is an essential member of the staff establishment in all locations where anaesthetists are required to administer anaesthesia or sedation.
- 2.6 There must be appropriate staffing establishment and rosters for assistants.
- 2.7 Where a number of assistants are employed, an appropriately trained senior member of a hospital's group of anaesthesia assistants should be designated as being the supervisor.

### 3. EDUCATIONAL REQUIREMENTS FOR ASSISTANTS

An adequately trained assistant to the anaesthetist must have attended and completed a training course which has as a minimum the following criteria:

- 3.1 Eligibility
  - 3.1.1 Those without previous health sector experience must have the Higher School Certificate or its equivalent.
  - 3.1.2 Those with nursing experience must hold a certificate as an Enrolled Nurse or a Registered Nurse, or their equivalents.
  - 3.1.3 Registered Nurses and Enrolled Nurses must be in current clinical employment or have been so employed within one year of acceptance into a training course.
- 3.2 Course of Instruction
 

The course should be developed and administered by an appropriate Institute of learning. A distance learning course is appropriate when conditions demand this.

At a minimum the course will include:

- 3.2.1 A course of lectures that will be provided either full-time or part-time. There will be continuous employment as a trainee anaesthetic assistant during any part-time components of the course.
- 3.2.2 A course of lectures of at least 150 hours in accordance with a curriculum into which anaesthetists have input and in which a significant amount of the lecture material must be prepared and delivered by anaesthetists.
- 3.2.3 Practical instruction supervised by trained anaesthetists which should be documented in a log book as a record describing the type of instruction received and competencies demonstrated.
- 3.2.4 Completion of assignments appropriate to the curriculum which are suitable for presentation to trainees and supervisors.
- 3.2.5 Successful completion of internal assessments and designated examinations.
- 3.3 Duration of the Course
  - 3.3.1 For those without previous hospital experience, three years full-time employment comprising study and work as a trainee anaesthesia assistant.
  - 3.3.2 For those with Enrolled Nurse qualifications, or similar hospital experience, two years full-time employment comprising study and work as a trainee anaesthesia assistant.
  - 3.3.3 For those with Registered Nurse qualifications, one year full-time employment comprising study and work as a trainee anaesthesia assistant.



- 3.3.4 The course should not exceed three years.
- 3.3.5 Study may be undertaken in part-time courses or in full-time blocks.

#### 4. FURTHER EDUCATIONAL ACTIVITIES

The anaesthesia assistant will maintain and upgrade his or her knowledge and skills with regular continuing education activities.

- 5. The Addendum outlines an appropriate syllabus.

### ADDENDUM

#### RECOMMENDED CONTENT OF TRAINING COURSES FOR THE ASSISTANT TO THE ANAESTHETIST

##### Basic Sciences

Instruction will include appropriate elements of:

- Physics
- Chemistry
- Pharmacology
- Anatomy
- Physiology
- Clinical Measurement
- Microbiology

as these apply to the practice of anaesthesia.

##### Anaesthesia

In the following areas, in depth understanding of the various topics is necessary. This must be reinforced by appropriate practical experience obtained while providing assistance to anaesthetists.

##### Anaesthetic Equipment

This will include the care, use and servicing of equipment in normal use.

- Anaesthesia machines and ventilators
- Monitoring equipment
- Airways devices including fiberoptic instruments

Intravascular devices

Cleaning and sterilisation of equipment

Infection control issues for staff, equipment and patients

Pollution prevention

##### Safety

Electrical safety

Gas cylinders and pipelines

Hazards in anaesthetising locations

Patient safety

Staff safety

**Anaesthesia Techniques** and requirements in all areas of perioperative practice in both theoretical and practical terms.

**Invasive Techniques applicable to anaesthesia** including insertion of intravenous, central venous and pulmonary artery catheters and arterial lines as well as their ongoing management. Other techniques such as intercostal tube drainage, red cell salvage and endoscopy of the airways.

**Local Anaesthesia** including all commonly used techniques for regional blockade.

**All Drugs, Fluids and Other Therapeutic Substances** administered during anaesthesia.

**Emergency Care** including provision and care of necessary equipment

Crisis Management including appropriate algorithms.

Cardiopulmonary resuscitation

Airway management

Cardiac defibrillation and cardioversion

Blood transfusion

**Postoperative Pain** including management and equipment required.

##### Management

Rostering

Budgetary matters

Anaesthesia standards and protocols

Incident monitoring

Workplace, Occupational Health & Safety Regulations

Interfaces with other healthcare workers

Legal responsibilities

Interpersonal relationships

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

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

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

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*Reviewed: October 1993*

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## Review PS 37 (1998)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS  
ACN 055 042 852

# REGIONAL ANAESTHESIA AND ALLIED HEALTH PRACTITIONERS

1. The College acknowledges that local anaesthetic agents may be administered to patients by allied health practitioners to perform procedures for which they are legally qualified. Such health practitioners may include Dentists, certain Registered Nurses and Podiatrists.
2. Health practitioners who may administer local anaesthetic agents must be appropriately trained in the use of local anaesthetic agents and relevant regional anaesthesia techniques. This training should be approved by specialist anaesthetists who hold Fellowship of ANZCA or equivalent.
3. The course of instruction should include the detailed pharmacology of the drugs used with emphasis on the complications due to the drugs or injections. Training and certified competence in cardiopulmonary resuscitation is essential.
4. Patients undergoing procedures performed by allied health practitioners should not be denied the benefits of general anaesthesia when clearly indicated.
5. Arrangements must be made for the continuing medical management of such patients if required.

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

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

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Promulgated: 1998

Revised:

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# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

## POLICY DOCUMENTS

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

PS = Professional Standards TE = Training and Examinations

- E1 (1996) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
- E3 (1994) The Supervision of Trainees in Anaesthesia *Bulletin Nov 92, pg 41*
- TE4 (1997) Duties of Regional Education Officers in Anaesthesia *Bulletin Nov 97, pg 88*
- TE5 (1997) Supervisors of Training in Anaesthesia *Bulletin Nov 97, pg 89*
- E6 (1995) The Duties of an Anaesthetist *Bulletin Nov 95, pg 70*
- E7 (1994) Secretarial Services to Departments of Anaesthesia *Bulletin Nov 94, pg 43*
- E9 (1993) Quality Assurance *Bulletin Mar 93, p38*
- TE11 (1997) Guidelines for the Completion of a Formal Project *Bulletin Nov 97, pg 91*
- E13 (1996) Guidelines for the Provisional Fellowship Year *Bulletin Nov 96, pg 66*
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, p62*
- TE15 (1998) Guidelines for Trainees and Departments seeking College Approval of Posts for the Certificate in Pain Management *Bulletin Mar 98, pg 70*
- 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 General Rural Practitioners in Australia Proposing to Administer Anaesthesia *Bulletin May 97, pg 81*
- P2 (1996) Privileges in Anaesthesia *Bulletin Nov 96, pg 72*
- P3 (1993) Major Regional Anaesthesia *Bulletin Mar 93, pg 36*
- P4 (1995) Guidelines for the Care of Patients Recovering from Anaesthesia *Bulletin Aug 95, pg 64*
- P5 (1991) Statement on Principles for the Care of Patients who are given Drugs Specifically to produce Coma *Bulletin Aug 91, pg 50*
- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
- PS7 (1998) The Pre-Anaesthesia Consultation *Bulletin Mar 98, pg 73*
- PS8 (1998) The Assistant for the Anaesthetist *Bulletin Mar 98, pg 76*
- P9 (1996) Sedation for Diagnostic and Surgical Procedures *Bulletin Nov 96, pg 73*
- P10 (1994) The Handover of Responsibility During an Anaesthetic *Bulletin Nov 94, pg 44*
- P11 (1991) Management of Cardiopulmonary Bypass *Bulletin May 91, pg 43*
- PS12 (1996) Statement on Smoking as Related to the Perioperative Period *Bulletin Nov 97, pg 78*
- P13 (1992) Protocol for The Use of Autologous Blood *Bulletin Aug 92, pg 49*
- P14 (1993) Guidelines for the Conduct of Epidural Analgesia in Obstetrics *Bulletin Mar 93, pg 37*
- 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*
- P25 (1996) Requirements for Multidisciplinary Pain Management Centres Offering the Certificate in Pain Management *Bulletin Mar 96, pg 54*
- 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, pg 82*
- PS31 (1997) Protocol for Checking the Anaesthetic Machine *Bulletin Nov 97, pg 84*
- PS36 (1997) Sedation for Regional Anaesthesia for Ophthalmic Surgery *Bulletin Nov 97, pg 93*
- PS37 (1998) Regional Anaesthesia and Allied Health Practitioners *Bulletin Mar 98, pg 79*