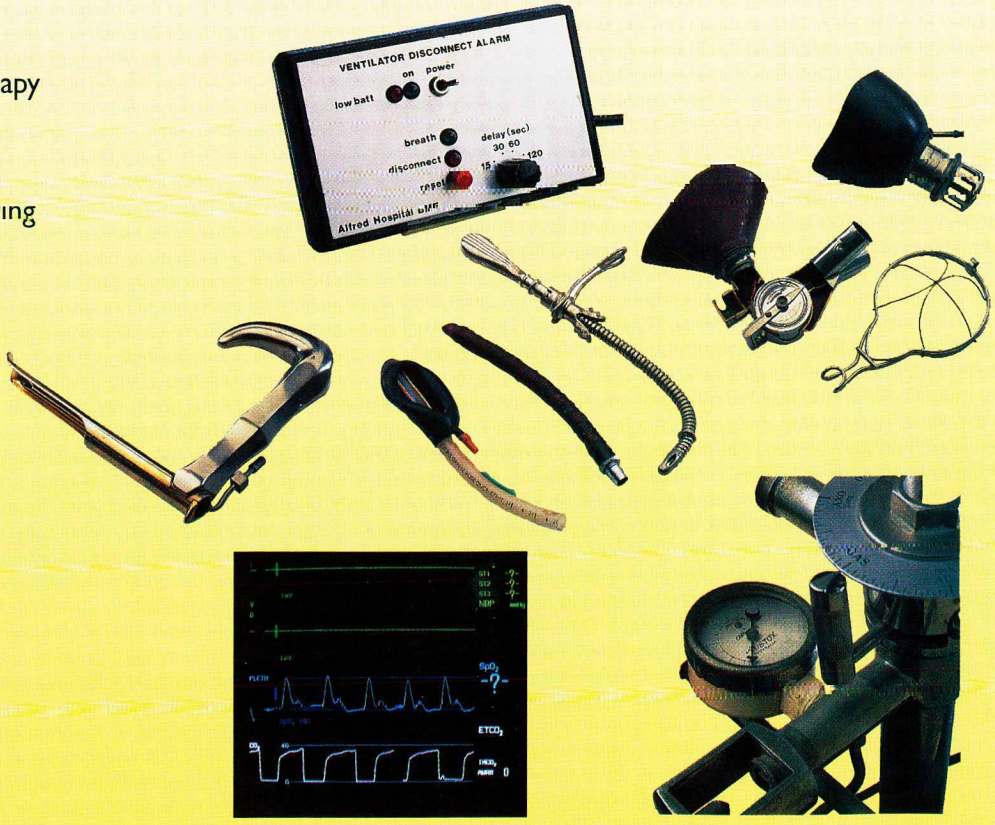
Australian and New Zealand College of Anaesthetists
ACN 055 42 852
and Faculty of Intensive Care

Bulletin

Inside...



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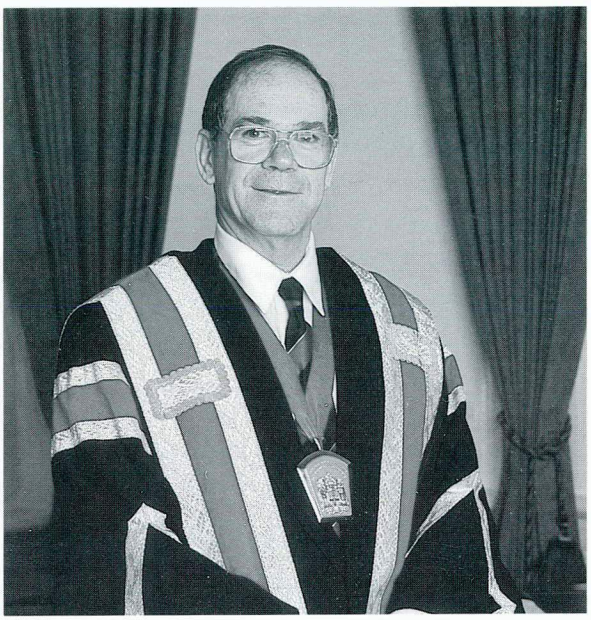
PRESIDENT'S MESSAGE



I am pleased to be able to report that the organisation for the Combined Scientific Meeting in Perth in October is progressing very well. Convenor Leigh Coombs has been very active and Neville Gibbs is organising a Scientific Programme which will be of a very high standard. Hopefully large numbers of you will come to Perth. Those who are connected to the Internet will have seen the Home Page on the CSM put together by Dr Wilson Lim. The ability to spread the word (and the pictures) electronically means that prospective visitors can learn more about Perth and the Meeting than has ever been possible previously.

You will note that the College Council has made a decision to place more emphasis on training in pain management (both acute and chronic pain) and trainees will be encouraged to experience a rotation in pain management during their first four years of training.

I have recently participated in the Australian Medical Workforce Advisory Committee investigating the specialist anaesthesia needs in Australia now and for the next ten years based on the projected workload and expected loss due to retirement. The figures show a significant deficit in the output of anaesthetists and although these figures have not yet been scrutinised by the College Council, it is clear that the College has to address this problem.

Prior to the World Congress, I will be hosting a CIREBA Meeting (Committee of International Reciprocating Examining Boards of Anaesthesia) at Ulimaroa. This meeting which has the President and Vice President of each of the anaesthetic Colleges or Boards of the *"English Speaking World"*, is a forum for exchange of information on many aspects. Organisations change various regulations frequently which sometimes has a bearing on other countries and this meeting helps to overcome this. The College headquarters is a wonderful venue to hold such a meeting.

I am delighted to announce that Professor Garry Phillips has been elected to the position of President Elect to take office following the Annual General Meeting. I extend my warmest congratulations to Garry.

Neville Davis

N.J. DAVIS

HIGHLIGHTS OF THE FEBRUARY 1996 ANZCA COUNCIL MEETING

INTERNAL AFFAIRS

President-Elect

Professor Garry Phillips (SA) has been elected President-Elect to take office following the Annual General Meeting of the College in June.

FINANCE

Council resolved that the registration fee for the Certificate in Pain Management be A$200, in New Zealand NZ$200 + GST, in addition to the annual training fee.

Occupational Visa Applications

As a result of the increase in applications for support for Occupational Visas and the administrative time of the College Assessor and staff in dealing with such applications, it has been necessary to levy an assessment fee for consideration of Visa Applications or extension of same. As from 1 February 1996, a levy of $50 has been struck for such assessment. This requirement has been disseminated to the Chief Executive Officer and the Director of Anaesthesia of all Hospitals accredited for Anaesthesia training in Australia.

ASM Complimentary Registration for newly Graduated Fellows

Council has resolved that as from 1996, complimentary basic registration for the Annual Scientific Meeting be granted to newly graduated Fellows in the year they present to the College Ceremony, subject to such presentation being within the first two years of admission to Fellowship.

This complimentary registration does not include social events.

Registration Fees for Invited Speakers at CME Meetings

Council resolved that:

1. As a guiding principle, all people attending ANZCA involved CME Meetings are responsible for paying the registration fee, travel and accommodation expenses. This includes all Speakers, Organisers and Councillors.
2. That invited Speakers from outside the specialty may be reimbursed expenses.
3. That keynote invited Speakers from the specialty (whether Fellows or non-Fellows) may be paid expenses. These should be limited to four presenters for a major National Meeting and two for a Special Interest Group or Regional Meeting.
4. Special invited guests and Presidents of sister organisations may be offered complimentary registration.
5. That Fellows permanently retired from all medical and related practice be granted an exemption from the ASM and National CME Meeting Registration fees. Such Fellows would be required to pay for the social activities.

6. That Fellows working in a missionary or similar field where income is small be granted a 50% concession from registration fees for the ASM and CME Meetings. Such Fellows would be required to pay for the social activities.

7. That Registered ANZCA Trainees be granted a 25% concession from the Annual Scientific Meeting and Continuing Medical Education Meetings registration fees. Such trainees would be required to pay for the social activities.

CONTINUING EDUCATION AND QUALITY ASSURANCE

Annual Scientific Meeting 1998
Newcastle, New South Wales has been selected as the venue for the 1998 Annual Scientific Meeting of the College and Faculty of Intensive Care.

EDUCATION

Council resolved that the names and Hospitals of all Supervisors of Training in Anaesthesia be published annually in either the *Bulletin* directly or as a flyer to be distributed with the *Bulletin*. The Education Officer has been requested to communicate with all Directors of Anaesthesia in College accredited Hospitals detailing the importance of the post of Supervisor of Training.

Sub-specialty experience in Pain Management
Council approved an amendment to the Statement on Sub-Specialty Experience for Anaesthesia Trainees to include:

"A three month block attachment devoted exclusively to Pain Management is desirable; such an attachment should preferably be to a multi-disciplinary pain service. Where this cannot be achieved, trainees should be involved in the assessment and management of at least one hundred patients with post-operative pain, 25 with chronic non-cancer pain and 25 with cancer pain. At least observation and preferably direct involvement in the range of treatment options in such patients should include: neural blockade techniques including spinal drug administration; spinal cord stimulation; neurosurgical pain relief methods; physical therapy; psychological and other methods of pain relief".

The full Statement is published elsewhere in this *Bulletin*.

Objectives of Training in Anaesthesia
Council supported the establishment of a Task Force for the development of a curriculum in anaesthesia. In addition, Council approved the attendance of two members from the Education Committee to attend a Cochrane Course to clarify the methodology for developing the curriculum.

EXAMINATIONS

External Examiners for Asian Specialty Examinations
In future, where the College is invited to nominate Examiners to participate as External Exainers for other Colleges or Educational institutions, it was resolved that these College representatives be either current or recently retired Examiners.

INTERNAL AFFAIRS

House Committee
The Council established a House Committee to be responsible for the general maintenance and running of Ulimaroa.

Hospital Accreditation Group
The Council approved a change in name in this group to the **Hospital Accreditation Committee.**

College Representation on RACS Council
Whilst Council supports the continuation of cross-representation at ANZCA and RACS Council Meetings, it was agreed that the ANZCA President would identify items of interest to be discussed during attendance of the RACS Council Meeting. It was further agreed that it is not essential for the ANZCA President to attend the entire Meeting of the RACS Council.

ANZCA involvement in the appointment of Trainees and Electoral Advisory Committees
The College has in place indemnity for all Fellows acting on College business provided they act in line with College policy. College policy is that whatever mechanism exists in the Hospital for the appointment of trainees, Fellows making recommendations about such appointments must act in their capacity as members of the Hospital Department and not College representatives.

College Representation on Electoral Bodies
It is the role of College representatives to comment only on the acceptability of the qualifications of applicants for positions and to not comment on the suitability or otherwise for the appointment of such applicants. Should the latter occur, such representatives would have to express such opinion from a personal viewpoint and would not be indemnified by College insurance.

Academic Anaesthesia Enhancement Grant
The Council agreed to change the name of the Academic Anaesthesia Establishment Grant to **Academic Anaesthesia Enhancement Grant**. It was also resolved that the Academic Anaesthesia Enhancement Grant be open to occupants of newly established Chairs in Anaesthesia and/or Intensive Care, and to incumbents of Chairs of Anaesthesia and/or Intensive Care commencing new initiatives.

An advertisement for the Academic Anaesthesia Enhancement Grant of $75,000 appears elsewhere in this *Bulletin.*

Annual Research Grants
Advertisements appear in this *Bulletin* inviting applications from Departments of Anaesthesia and/or Intensive Care, Fellows of the College, Faculty of Intensive Care and registered Part II trainees for Research Awards or support for Projects related to Anaesthesia, Resuscitation, Intensive Care or Pain Management. These Awards will be in the form of a Project Grant or Research Fellowship/Scholarship.

Research Fellowship/Scholarship will be available to the Awardee for one to three years, subject to an annual satisfactory report.

College Relations with Asia Pacific Countries
The Council has accepted strategic plans for assistance in Asia Pacific Countries with the following objectives:

1. To assist Countries in Asia to improve their standards of Anaesthesia and Intensive Care.
2. To assist Countries in Asia to establish local Training and Examination programmes in Anaesthesia and Intensive Care.
3. To promote Continuing Education in Anaesthesia and Intensive Care in Asia.
4. To promote the status of Anaesthesia and Intensive Care in Asia.
5. To enhance the relationship of the College with local Colleges/Academies in Asia.
6. To increase the standing of the College in Asia.

The Council is considering plans to implement the foregoing objectives.

PROFESSIONAL

The following Policy Documents were reviewed and promulgated:

P6: Minimum Requirements for the Anaesthesia Record

P22: Statement of Patients' Rights and Responsibilities

P25: Requirement for Multi-disciplinary Pain Management Centres Offering the Certificate in Pain Management

P20: Responsibilities of the Anaesthetist in the Post-operative Period

E15: Guidelines for Trainees and Departments seeking College Approval of Posts for the Certificate in Pain Management.

These documents are published in this *Bulletin.*

AMA CRAFT Group Representative

Dr Mike Hodgson (Tas) has been re-nominated as the CRAFT Group Representative (Anaesthesia) within the Australian Medical Association.

Honours and Appointments

Associate Professor R A Boas, NZ — Fellow Royal College of Anaesthetists by Election

Dr P Brine, WA — Member of the Order of Australia (AM)

Professor G J A Clunie, FRACS — Vice-Dean, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne

Associate Professor N J Davis, WA — Chairman, Committee of Presidents of Medical Colleges

Professor Roberta L Hines, USA — Professor and Chairman, Department of Anesthesiology, Yale University

Dr J A H Williamson, SA — Associate Clinical Professor of Anaesthesia, University of Adelaide

MAINTENANCE OF STANDARDS

A detailed review of the Maintenance of Standards Programme will be published in the next *Bulletin,* once aggregated data from the 1995 Annual Returns have been analysed.

At this stage 1246 participants have enrolled in the programme, and of these 202 have submitted an Annual Return.

Developments during 1995 have included the introduction in Western Australia of a new condition of service agreement for medical staff in teaching hospitals whereby a new top salary scale will only be paid if certification that the applicant has successfully complied with the Maintenance of Standards Programme is provided.

Accordingly, each Fellow, on submission of an Annual Return, will be issued with a standard letter indicating that he/she is participating in Maintenance of Standards Programme.

Submission to the College of evidence of credentialling, i.e. Provision of a copy of current registration or practising certificate from the relevant Medical Board or Council, and evidence of accreditation at an institution of practice, is only required with the fifth Annual Return.

The Faculty of Intensive Care has now introduced its Maintenance of Standards Programme. Those Fellows practising both anaesthesia and intensive care should enrol in both programmes. The data required are so similar, that it will not be difficult to meet the requirements of both programmes by claiming points for the same Maintenance of Standards Programme activities where there is overlap.

GARRY D. PHILLIPS

CLINICAL PHARMACOLOGY AND THE SPECIALTY OF ANAESTHESIA, PAIN MANAGEMENT AND INTENSIVE CARE

Since its inception the Primary Examination of our Faculty, now College, has set a high standard in basic and clinical pharmacology of relevance to the specialty; however, a perusal of the current Guide to Study reveals a very substantial cross section of the entire field of *"Clinical Pharmacology".* Clinical practice as a specialist in Anaesthesia, Pain Management and Intensive Care requires the maintenance of a high level of knowledge of Clinical Pharmacology, which is often associated with involvement in undergraduate and postgraduate education and/or research in this field.

However, despite the above, only a few individuals within our specialty have been appointed within or held joint appointments in, departments of Clinical Pharmacology. This is surprising given our strong commitment to this field and is in sharp contrast for example to Fellows of the College of Physicians, many of whom serve a dual role as Physicians and Clinical Pharmacologists. This has often been a very successful strategy, for example in the field of hypertension where Australia has been a World leader, partly due to the research and teaching contributions of Physicians/Clinical Pharmacologists. There has been a perception that Clinical Pharmacology as a standalone discipline may have made a lesser impact upon the care of patients, despite undoubted contributions to undergraduate/postgraduate teaching and research.

It appears that at least one State Health Department is interested in exploring the relationship of Clinical Pharmacology to appropriate clinical disciplines. The College believes that the model developed by Physician/Clinical Pharmacologists could be extended with benefit to the fields of Anaesthesia, Intensive Care and Pain Management.

Directors of Departments and Senior Academics in our specialty could pursue the provision of funding for joint clinical pharmacology/clinical specialist posts as described above. There appear to be several avenues which include State Health Departments, Universities and pharmaceutical companies.

M.J. COUSINS

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

STATEMENT ON SUB-SPECIALTY EXPERIENCE FOR ANAESTHESIA TRAINEES

Council recognises the importance of sub-specialty training and makes the following statements for the guidance of Fellows and Trainees.

1. Experience in sub-specialty areas of anaesthetic practice is an essential part of the training of an anaesthetic specialist as outlined in ***Objectives of Training in Anaesthesia, Second Edition — 1991.***

2. When training programmes are being inspected, a particular note will be taken of the capacity of that programme to provide a broadly based training in anaesthesia with exposure of all trainees to sub-specialty areas of experience.

3. While the College does not require trainees to obtain specific numbers of cases or to spend a specified time in each area, the following guidelines may be used as an indication of Council's views as to necessary experience during the first four years of approved vocational training.

   3.1 **Neurosurgical Anaesthesia.** A three month block attachment for emergency and elective neurosurgery is desirable. Where this cannot be obtained, trainees should be involved in the management of at least 25 intracranial procedures in both emergency and elective situations.

   3.2 **Thoracic and Cardiac Anaesthesia.** A three month block attachment for emergency and elective thoracic and cardiac surgery is desirable. Where this cannot be obtained, trainees should be involved with the peri-operative management of at least 25 intra-thoracic cases. These should include:
   (a) a minimum of ten cases for bypass cardiac surgery; (b) a minimum of fifteen cases involving the use of double-lumen tubes and management of one-lung anaesthesia.

   3.3 **Paediatric Anaesthesia.** A three month block attachment devoted exclusively to paediatric anaesthesia is desirable. Where this cannot be achieved, trainees should be involved with the management of anaesthesia in at least 100 children aged less than four years and with 200 children aged between four and ten years of age.

   3.4 **Obstetric Analgesia and Anaesthesia.** A three month block attachment devoted exclusively to obstetric analgesia and anaesthesia is desirable. Where this cannot be achieved, trainees should be involved with the management of at least 150 obstetric patients of more than 24 weeks gestation. Experience of the management of Caesarean Section by both general and regional anaesthesia must be included.

   3.5 **Pain Management.** A 3 month block attachment devoted exclusively to pain management is desirable; such an attachment should preferably be to a multidisciplinary pain service. Where this cannot be achieved, trainees should be involved in the assessment and management of at least 100 patients with postoperative pain, 25 with chronic non-cancer pain and 25 with cancer pain. At least observation and preferably direct involvement, in the range of treatment options in such patients should include: neural blockade techniques including spinal drug administration, spinal cord stimulation, neurosurgical pain relief methods, physical therapy, psychological and other methods of pain relief.

4. Council strongly advises trainees to keep a log book of their experience during training. This record should allow identification of the specialty area and any cases of particular interest. Training Departments may be able to assist with computer generated records but primary responsibility should remain with trainees so that they are able to identify areas in which their experience may be deficient.

5. Sub-specialty experience as recommended above should be obtained during the first four years of training. This gives the opportunity for any areas of deficiency to be corrected during the Provisional Fellowship Year.

6. Council recognises that there are other areas of sub-specialty training of importance to the specialist anaesthetist which are not specifically mentioned in this statement. It is considered that the principles used in arriving at the statements above could also be used in planning training at an individual or Departmental level. In all cases, the statement of ***Objectives of Training in Anaesthesia, Second Edition — 1991*** is a valuable resource for planning purposes.

February 1996

National Anaesthesia Day
October 16, 1996

October 16, 1996 marks the 150th anniversary of the first public demonstration of an anaesthetic for a surgical procedure. College Council has accepted a proposal to use this unique date for an ambitious and comprehensive public relations and information programme. This has been designed to focus media and community interest, further public understanding of the role of anaesthetics and to promote the desired image of anaesthesia in line with the strategies and efforts of both the College and the ASA.

The concept of a National Anaesthesia Day was successfully piloted in 1995. This year there is the opportunity to harness the support, imagination and enthusiasm of anaesthetists throughout Australia and New Zealand. College Council has approved the distribution of the proposed programme to Regional Committees, ASA and NZSA in order to further the planning process. Liaison with the ASA and NZSA has commenced. This date fits well with other planned events throughout the year and leads into the ANZCA/ASA Combined Scientific Meeting being held in Perth on October 26-30.

Ideally the National Anaesthesia Day will involve not only the College infrastructure but also anaesthetic departments, group practices and individual anaesthetists. This involvement could be just setting up a simple display in the hospital foyer or be part of the active professional education campaign.

At this stage a logo and poster is being designed that relates to our past but also strongly embodies the desired current professional image of anaesthesia. Suggestions are welcome and more information will be forthcoming.

What could you do to promote anaesthesia on National Anaesthesia Day, October 16, 1996?

MIKE MARTYN
Communications Officer

Death of Fellows

Council noted with regret the death of:

Dr Hilary J K Fisher — Qld Fellow, FFARACS 1977, FANZCA 1992

Dr R C Hallowes — Vic Fellow, FFARACS 1964, FANZCA 1992

Dr Gwenda M Lewis, NZ Fellow, FFARACS 1967, FANZCA 1992

Dr J G Lomaz — NSW Fellow, FFARACS 1961, FANZCA 1992

LABAT LECTURER 1996 – AMERICAN SOCIETY OF REGIONAL ANESTHESIA

The American Society of Regional Anesthesia (ASRA) has announced that the 1996 Labat Award recipient and Labat Lecturer will be Professor Michael Cousins. The title of Professor Cousins' Lecture will be *Neural Blockade and the Integration of Acute, Cancer and Chronic Non-Cancer Pain Management Services,* to be delivered at the Annual ASRA Scientific Meeting, San Diego, March 28-31, 1996.

Previous Labat Lecturers have been:

1977	John J. Bonica, Daniel C. Moore
1978	Sir Robert Macintosh
1979	Torsten Gordh
1980	John Adriani
1981	Robert Hingson
1982	Alon C. Winnie
1983	Peere C. Lund
1984	Philip R. Bromage
1985	J. Alfred Lee
1986	Benjamin G. Covino
1987	Nicholas Greene
1988	D. Bruce Scott
1989	Ronald Melzack, Patrick Wall
1990	P. Prithvi Raj
1991	Bertil Lofstrom
1992	B. Raymond Fink
1993	Sol M. Shnider
1994	Phillip O. Bridenbaugh
1995	Rudolph H. DeJong
1996	Michael J. Cousins

Labat was born in 1876 in Victoria on Mahe, the largest island of the Seychelles group of islands, approximately 1200 miles east of the coast of East Africa. Both of Labat's parents were of French extraction. Labat was a brilliant student during his school years and was fluent both in English and French. In early adult life, he went to Portuguese East Africa to work in the design and construction of machinery for extracting sugar juice from cane. When he returned to Mauritius, he teamed up with the husband of his sister who was involved in pharmacy and eventually he and Labat established a chemist shop. Only 18 months after this new enterprise, Labat registered as a medical student in Montpellier, France.

During his medical student years, Labat initially matriculated in the Faculty of Sciences in 1914, receiving a silver medal for distinction in physics, chemistry and natural sciences. From 1914-1916 he was a student in the Faculty of Medicine at the University of Montpellier and in 1916 transferred to the University of Paris. During his time in Paris from 1918-1919 he was the assistant of Dr Victor Pauchet at Boucicault, Louvre and St. Michel Hospitals. Labat carried out surgical training under Pauchet who was a renowned civil and military surgeon. In 1914, Pauchet and Sourdat published the first edition of a book on regional anaesthesia. By 1921, Labat had become a co-author of the text and was described by Pauchet as 'having played the greatest role in the turnaround of this book'. Pauchet's text was published in its Third Edition in 1921 just as Labat left for the United States to take up a position at the Mayo Clinic. This resulted from a visit by Charles Mayo to Pauchet in Paris in 1920, where Mayo was most impressed by the methods of regional anesthesia employed by Dr Pauchet and his able assistant, Gaston Labat.

Labat's classic work 'Regional Anaesthesia: Its Technique and Clinical Application' was first published in 1922, however, much of the work for the text took place during barely a one year appointment at the Mayo Clinic as a Visiting Lecturer in Regional Anesthesia. More than 50 of the original illustrations prepared during that year are still on hand in the Mayo Clinic archives. In the 1992 publication of the text, there were 315 original illustrations. The quality of the text depended very greatly on the superior illustrations which established the work as superior to any previous text on this subject.

Labat subsequently took up an appointment at the Bellevue Hospital in New York City in 1921 and the second edition of his text was published in 1928. By 1930 over 10,000 copies of his text had been printed, a most extraordinary achievement for such a specialised text.

In 1923, Labat established the 'original' American Society of Regional Anesthesia. His colleagues in the initial society wished to name it the 'Labat Society' but he resisted this suggestion. Only four of the members of the original society were anesthetists, the majority of the initial members being neurosurgeons.

Labat is acknowledged as having made a major contribution to the development of regional anesthesia and many of the descriptions of block techniques in his text remain the basis of our practice today. It is thus fitting that ASRA has acknowledged Labat by naming its most prestigious award and lecture in his memory.

Note: A biography of Louis Gaston Labat can be found in *Regional Anesthesia* Vol. 17, 249-262, 1992.

ADMISSION TO FELLOWSHIP BY EXAMINATION

Bruce Alfred AGER, NSW
David Stanley BARKER, NSW
Christopher Milne BOLTON, VIC
William James BUCHANAN, NZ
Ross Michael CALCROFT, NSW
Tsz-yeung CHAN, Hong Kong
Colin Ross CHILVERS, TAS
Ka Peng, David CHUA, Hong Kong
Jerome Garth Lineham COCKINGS, SA
Ian Robert COX, NSW
Joseph Quinto CUDIS, VIC
Stephanie Joy DAVIES, WA
Gregory Bryan DOWNEY, NSW
Wendy Jane FALLOON, TAS
John Leslie GIBSON, NSW
Clement Wak Hiong GOH, New Zealand
Melissa Jane GOLDBERG, VIC
Peter Douglas GOOD, NSW
Stuart Russell GREEN, QLD
Wallace George GRIMMETT, NSW
Stephen Nicholas HOCKING, WA
Winnie HONG, NSW
Mark Rupert HURLEY, VIC
Suchitra Anandhi KANAGASUNDARAM, New Zealand
Carole Therese LAMOND, NSW
Graham Frank LIBRERI, VIC
Roddy LIN, NSW
Stephen John LLEWELLYN, NSW
John Anthony LOADSMAN, NSW
Paul Anthony MacDONALD, NSW
Glen Robert MARTIN, QLD
Paul Thomas McALEER, SA
Robert Brian McCROSSIN, QLD
Fiona Kate MERRITT, VIC
William Harry MILES, QLD
John Patrick MONAGLE, VIC
Vernon MOO, QLD
Guy Richard ORLAY, QLD
Andrew David PAIX, SA
Clifford John PEADY, SA
Owen Jonathon PERKS, SA
Jennifer Lorraine PROWSE, NSW
Anthony Peter RICHARDS, New Zealand
Megan Sue ROBERTSON, VIC
Lorraine Mary ROBINSON, SA
Colin Forbes ROYSE, VIC
Kevin William RUSSELL, NSW
Arne SCHIMMELFEDER, NSW
Claudia SCHNEIDER, NZ
Martyn Robert SEAY, NZ
Oliver Conrad Yeatman SHAW, NSW
Michael Francis SOLLY, VIC
Edward Richard STACHOWSKI, NSW
Tracey Maree TAY, NSW
Andrew Donald James WATTS, WA
Timujin Alexander Wuteh WONG, TAS
Patrick Wai Yin WONG, New Zealand

LAW REPORT

Michael Gorton, LL.B., BComm.
Partner, Russell Kennedy
College Honorary Solicitor

PROFESSIONAL INDEMNITY REVIEW REPORT

The final Report of the Professional Indemnity Review has been released. At this stage, only executive summary recommendations are available, and the full Report is expected to be printed and available during March 1996. Many recommendations are made relating to compensation when adverse events occur. This, of course, differs from "negligent" events, which may be the responsibility of health care providers.

Among the major recommendations of the Report are:

- *Changes recommended for the structure and contractual arrangements for medical defence organisations*
- *A requirement that professional indemnity should be compulsory for all health care professionals*
- *Some improvement to the common law tort system in relation to plaintiffs seeking compensation for injury sustained as a result of medical negligence*
- *A rejection of a total "no fault" system for medical mis-adventure at this stage*
- *Support for particular contingency fee arrangements for lawyers representing plaintiffs seeking redress for alleged medical negligence*
- *Support for continuing research and incident monitoring schemes to detect errors in professional practice and recommendation of alternative procedures*
- *Further investigation and research in relation to the long hours worked in some medical institutions by health care providers and their effect on standards and treatment*
- *Clarification of the law of vicarious liability to ensure that negligence risks are only covered once (not, as at present, by both the doctor and the hospital or other institution).*

The recommendations of the PIR Report have been the subject of much review in the media. Some criticisms have been made in relation to the information upon which some of the recommendations appear to have been based.

Following the PIR Report, the Victorian Parliament has also begun a review of "legal liability of health service providers", under the auspices of its Law Reform Committee. A discussion paper has issued from the Committee, seeking submissions on:

1. Increasing costs of professional indemnity insurance and its effect on access to medical services.
2. Ensuring medical services provided are of a high standard, and redress where those standards are not maintained.
3. Reduction of any disincentives where the provision of health services by fear of inappropriate liability.
4. Use of structured settlements to maximise benefits of an injured person to financial compensation.
5. Alternatives to the current common law tort system.

The medical colleges are currently preparing a submission in relation to this parliamentary inquiry. Much of the work already undertaken in relation to the PIR Project will be of use in framing the profession's response to this discussion paper.

Must I ensure that a patient actually goes to see a Specialist or other Consultant to whom the patient is referred?

A recent case has dealt with the obligations of a doctor in relation to the obligation to ensure that the patient actually attends any Specialist or other Consultant to whom the patient is referred. The case of **Kalokerinos v. Burnett** (NSW Court of Appeal, unreported, 30 January, 1996) has been widely reported, but much media comment appears to have been misguided.

In this case, a doctor practising in a small country town was consulted by a patient complaining of heavy vaginal bleeding. The doctor referred her to a specialist, noting an appointment for her with the specialist at a future date. The appointment was not kept by the patient, nor cancelled.

It was later determined that, if the patient's cancer had been detected in the course of the specialist's examination, it could have been treated by hysterectomy, and the patient may not have suffered from the consequences of radiation therapy which arose.

The Court of Appeal has concluded that the doctor was negligent, with some contributory negligence of about 20% by the patient. The case has been regarded in the media as standing for the principle that doctors must make their patients go to see specialists or consultants to whom they are referred. In other words, it is suggested that doctors must make sure that patients attend future appointments.

In fact, this is not the principle of the decision in this case. The shortcomings for which the doctor was ultimately held responsible was not explaining adequately to the patient the consequences of not attending the future appointment. This is more like a position of failing to provide sufficient information (informed consent), rather than some new obligation on doctors to check that patients meet their appointments.

The Court accepted the evidence of the patient that, had she been adequately told of the consequences of not attending the specialist's appointment, she would have kept the appointment and ultimately avoided the health consequences, which subsequently occurred. The finding of contributory negligence of about 20% relates to the obligations the patient also bore as a consequence of choosing not to attend the future appointment.

Must I attend every crisis to which I am called?

In another recent case – **Woods v. Lowns and Procopis** (NSW Court of Appeal, unreported, 5 February, 1996) – there is support for the proposition that, where a doctor is aware of the consequences that may follow from non-attendance, the doctor has an obligation to attend a medical crisis to which he or she is called.

In this case, the particular "patient" was a diagnosed epileptic, who had begun to fit. The patient's mother sent the patient's sister to go and get a doctor. The sister ran to the doctor's surgery, approximately 300 metres away. The sister explained to the doctor that her brother was having a fit, and that a doctor was needed. It was alleged that the doctor suggested that they get an ambulance. On being told that an ambulance was coming, the doctor decided not to attend.

In the case the doctor disputed the description of the circumstances in which he was allegedly called to the medical crisis.

The Court of Appeal, by a majority, found the relevant doctor was negligent in failing to attend the scene, despite the fact that the epileptic was not, in fact, a patient of his. It was conceded by the doctor that, if the circumstances were as suggested (which he disputed), he would have attended the medical emergency, and that he would have had an obligation to do so, and that it would have been misconduct under the relevant legislation for him to fail to attend.

In a strong dissenting judgement, Mahony J A, recently appointed the new President of the Court of Appeal, suggested that there is no such duty of an unqualified nature upon doctors to attend the scene of a medical emergency. Mahony stated:

> *". . . the suggested obligation is not one, the nature and extent of which is simple, nor is it without qualifications and exceptions. As I have said, an experienced general practitioner would immediately suggest the qualifications and exceptions to which any such principle should be subject. The doctor must be a relevant doctor; it is not clear that, e.g., an ophthalmologist or a psychiatrist would be obliged to go to a fitting child. There must be qualifications upon when a doctor, general practitioner, may be expected to go. The time of night, the doctor's judgement as to the requirements of the stated illness, the appropriateness of treatment at home or in a surgery are some of the matters which would qualify any absolute statement of such an obligation. An experienced doctor may properly conclude that the stated condition was properly accommodated by, e.g., ambulance officers or other para medics, or require the hospital, rather than him. And there would, no doubt, be qualifications arising from the nature of the patient and the doctor's previous experience of his complaints.*
>
> *Matters of this kind indicate that, if an obligation is to be imposed upon a doctor, it cannot be imposed in absolute terms, or without qualifications and exceptions. And those qualifications and exceptions will go not merely to matters which would be, e.g., matters of excuse from the application of the general principle, but matters qualifying and limiting the nature and extent of the obligation itself. An obligation of this kind is, in my opinion, not one appropriate to be imposed by judicial fiat".*

In both of the above cases, there is the possibility of further appeal.

PURCHASER PROVIDER AGREEMENTS

Most specialists will now have received proposed agreements from health insurers offering contracts for the provision of medical services to the health insurer. This is part of the new package of health insurance and medical funding arrangements initiated by the Federal Government.

There are many political and policy issues to be considered before a specialist agrees to deal with the health insurer, or wishes to participate in the new government imposed system. The political policy issues are for others to comment upon.

Interestingly, anecdotal evidence suggests that only a very small number of specialists (perhaps less than 5%) have agreed to enter into such contracts. It is also suggested that the fees offered by the medical insurers have ranged from a mere 2% above the relevant scheduled fees to up to 150% and 200% above the scheduled fees.

Opponents of the purchaser provider agreements system have suggested:

1. System amounts to price regulation, which should be opposed by doctors.
2. The quality of health care will suffer, which is not in the interests of the health care system.
3. The patient effectively loses their choice of doctor.

There are many competing arguments about the value of this system or otherwise.

However, the purpose of this article is to remind specialists, who may be considering entering into a purchaser provider agreement, that it is nonetheless a legal contract, with various terms and conditions that will require, at the very least, a legal explanation, and, at the worst, a complete review and renegotiation.

Advice has recently been obtained from Queens Counsel in relation to some of the draft agreements proposed by the more notable health insurers. In summary, that advice notes:

1. No contract will interfere with the duty of care a doctor owes to a patient. Whether or not an agreement is entered into, the relationship between the doctor and the patient is maintained, and all relevant legal liabilities and obligations continue, including the necessity to obtain informed consent, provide service at the requisite level of skills and care, etc.
2. The draft contracts reviewed by Queens Counsel do not expressly interfere in the relationship between the patient and a doctor. However, it was suggested that additional provisions be included in such agreements, to place the matter beyond doubt, so as to avoid any suggestion that the health insurance company may be able to dictate either the nature of the treatment, the level of the treatment, the frequency of the treatment, or the location where the treatment is undertaken.
3. The agreements provide for different ways in which fees are payable to the doctor. These require careful review in each case. In most cases, the calculation of fees is based on the Commonwealth Medical Benefits Schedule. Some agreements permit the specialist to seek a co-payment from the patient, which would be in addition to the amount provided by the health insurer.
4. Agreements differ as to whether they provide a mechanism for review in the event of dispute or disagreement. These provisions must be reviewed in each case, and legal advice should be sought.
5. Some agreements provide a requirement for the specialist to use their best endeavours to ensure that the relevant contracted hospital enters into discussions with the health insurer in respect of fee arrangements. Queens Counsel suggests that clauses of this nature place an unnecessary burden on the specialist.
6. Some contracts also impose a condition which may compel the doctor to reveal information, potentially in breach of patient confidentiality. Information as to the nature and extent of treatment may well infringe on these requirements. Again, some modification of agreements may be required in order to protect the specialists from any breach of their duty to the patient or otherwise at law.

Obviously these agreements will radically change the contractual arrangements for specialists, and may impact adversely on the relationship between doctor and patient. The agreements should not be signed lightly, and legal advice should be sought.

It remains up to the doctor, and his or her representative bodies, to otherwise determine whether, as a matter of policy, the agreements should be considered.

I'M ALLERGIC TO YOU!

The term "allergy" is widely misused by medical practitioners, nurses, patients and the media. When a patient claims to be allergic to morphine (because it makes her vomit) this information is plastered all over the notes, bright stickers cry the news to all, she might even wear a red hat to theatre to mark her as special, even though she is not allergic to morphine at all!

An allergic reaction is an immunologically mediated response to a drug with systematic effects ranging from rash to full anaphylaxis.

An adverse drug reaction may include allergic reactions but encompasses the unwanted effects of a drug such as nausea and vomiting from opioids or prolonged apnoea from pseudocholinesterase deficiency. In some cases the anaesthetist may choose to use this drug if indicated.

How can we improve a situation which apart from being annoying has the potential for medico-legal implications. If, for example, I prescribe morphine despite it having caused nausea in the past because I believe it to be the best option, will the nurse administer it if "allergic to morphine" stickers are all over the notes?

The answer lies in more accurate documentation of the reaction and a process of education. We are able individually to educate patients, we can attempt to inform nurses in the institutions in which we work.

The medication chart should be the first port of call. We suggest that you discuss this matter at your next Department meeting. What about proposing that the medication chart be altered as in the example below?

At least the reactions are adverse and not all allergic, a description informs as to the severity of the reaction and there is room for comment. This is one way to begin educating nursing staff and improve this situation.

Patients may be advised to get a Medic Alert bracelet. The details inscribed are on the authorisation of the patient's doctor – usually her general practitioner. These doctors may tick the allergy box and staff at Medic Alert are not qualified or authorised to alter this information. If you advise a patient to get a bracelet, fill the form in yourself to enable the information to be correct. The education process must also include the GP's authorising these bracelets. We will communicate with the Medic Alert organisations in an attempt to improve their forms, and with the Royal Australian College of General Practitioners and any further suggestions will be enthusiastically received.

We welcome feedback regarding this problem and encourage your active participation in making documentation more accurate.

MOIRA WESTMORE and STEUART HENDERSON
Pharmaceutical, Safety and
Technical Officers (Aust and NZ)

ADVERSE DRUG REACTIONS

DRUG ALERT LABEL ENTER DETAILS ☞	Date of Reaction	DRUG	DETAILS OF REACTION	SIGNATURE

AUSTRALIA AND NEW ZEALAND HYPERBARIC MEDICINE GROUP

STATEMENT ON THE USE OF HYPERBARIC OXYGEN THERAPY AT SITES OTHER THAN PUBLIC HOSPITALS

1. PRE-AMBLE

Periodically, and usually for indications not generally accepted by hyperbaric medical practitioners, enthusiasm is generated in the community for the use of Hyperbaric Oxygen Therapy (HBOT) in locations other than mainstream hospital or Naval facilities. The compression of patients for therapeutic purposes in such out of hospital locations exploits the current situation by which the administration of oxygen is not governed by the Therapeutic Goods Administration Acts currently in force in the Commonwealth and New Zealand. It is the opinion of the Australia and New Zealand Hyperbaric Medicine Group (ANZHMG) that the practice of HBOT requires regulation to maintain the current standards of safety and appropriate use in the best interests of the community.

This statement outlines the provision of the ANZHMG with regard to these matters for the consideration of the various Health Administrations in Australia and New Zealand.

2. DEFINITIONS

ANZHMG: The professional body of the trained practitioners of Hyperbaric Medicine in Australia and New Zealand and is at present a sub-committee of the South Pacific Underwater Medicine Society (SPUMS). All presently operating hospital-based and military facilities for the practice of HBOT are represented by this group.

Hyperbaric Oxygen Therapy: The administration of oxygen for therapeutic purposes at pressures greater than one atmosphere. This requires the application of pressure to the body and simultaneous administration of oxygen for breathing. This is carried out in a vessel designed for the purpose called variously a compression chamber, recompression chamber or decompression chamber. Such chambers may be designed for single occupancy or multiple occupancy and have an atmosphere of either air or 100% oxygen. When the atmosphere is air, the patient is required to breathe oxygen (or sometimes other gas mixtures) through a mask or via a hood. Many chambers are designed to operate at a range of pressures as required for the treatment of a variety of conditions.

HBOT is at present carried out in a number of facilities around Australia and New Zealand. Most are officially called 'Hyperbaric Medicine Unit', 'Hyperbaric Therapy Unit' or similar and they provide a 24-hour service, commonly in association with the intensive care or emergency medicine departments of major hospitals.

3. CURRENT SITUATION

Currently there are eight facilities operating in tertiary hospitals around Australia and New Zealand and three operated by the Navies of the two countries. One civilian facility is located in each State of Australia and one in the Northern Territory, while the NZ Navy operates a facility in Auckland and a civilian facility is located in Christchurch. While there are some geographical gaps in coverage, for the most part each State has elected to concentrate resources in these single facilities. Smaller hospitals have chosen not to enter the field both because of the extensive specialist back-up required and the probable under-utilisation of an expensive resource. However, technical advances are beginning to lower the capital cost of at least the smaller, monoplace chambers.

4. POSITION STATEMENT

Physician Requirements:

It is the opinion of the ANZHMG that HBOT must be prescribed by a physician with appropriate training in Hyperbaric Medicine. There are two appropriate courses operating in Australia at present, being those at the Royal Adelaide Hospital and at the Submarine and Underwater Medicine Unit at HMAS Penguin in Sydney, which satisfy a minimum level of theoretical instruction. At present practical experience is obtained by an informal process through the various facilities. There are many equivalent theoretical courses and training fellowships internationally.

At present the local qualification in the field is the Diploma of Diving and Hyperbaric Medicine (DipDHM) which is administered by SPUMS. The minimum requirements are successful completion of one of the courses noted above, six months supervised training in a registered hyperbaric facility and presentation of a written thesis (accepted by appointed referees) for publication in the South Pacific Underwater Medicine Society Journal.

It may be that for management of specific recognised indications in facilities expressly built for that purpose, a modified curriculum would be appropriate theoretical training. This area is controversial and there are no current plans for the definition of such criteria.

Physicians prescribing this treatment are medically accountable for the safety of the patient and staff involved in the treatment. This requires both a knowledge of the indications, contraindications, side-effects and complications of therapy and the provision of an environment where there is immediate availability of emergency medical skills and equipment sufficient to treat any problems that may reasonably be anticipated. In the field of HBOT, this most definitely includes advanced life-support facilities.

It is important to bear in mind that the staff in such facilities are subject to risk directly as a consequence of compression themselves when acting as medical attendants in multi-place chambers and indirectly by the proximity and operation of equipment requiring the use of high pressure gas supplies.

Chamber Requirements:
All chambers operated for the purpose of HBOT must comply with appropriate technical and Worksafe standards. These are currently under extensive review to improve their relevance to hospital practice and the new Australian standard entitled "Guidelines for Clinical Multiplace Hyperbaric Facilities" is now in its second draft. The current standard is AS2299 - 1992 "Occupational Diving".

The ANZHMG feels that hyperbaric facilities should adhere to the guidelines in this document and make extensive reference to international standards and guidelines until the revised local document is published. The most relevant international standards are Z2751 - 1993 Hyperbaric Facilities (Canadian) and two reports from the safety committee of the Undersea and Hyperbaric Medical Society (UHMS) - Monoplace Hyperbaric Chamber Safety Guidelines and Guidelines for Clinical Multiplace Hyperbaric Facilities. The UHMS is the largest international body representing the practice of hyperbaric medicine to which the great majority of local practitioners belong.

Chamber Operator Requirements:
Any person charged with the responsibility of operating a vessel for the purpose of HBOT must have had appropriate recognised training in the field. The minimum requirements for such operators in Australia and New Zealand are currently under review by the Hyperbaric Technicians and Nurses Association (HTNA) but may be chamber-specific and less comprehensive than those currently derived from the commercial diving industry. These standards are however currently required for all operators in the facilities previously mentioned in this document.

Chamber Attendant Requirements:
In any operation which requires a medical attendant present with the patient(s) in the chamber, such attendants must have appropriate training in the field and be medically fit for compression. The HTNA is about to publish a national curriculum of minimum requirements for such training. Courses are currently offered in a number of the hospital-based facilities around Australia, primarily for the provision of sufficient attendants for those facilities. At present all such attendants are either registered nurses, medical practitioners or Navy trained medics who have satisfied such requirements.

Indications:
The ANZHMG believes that treatment should be limited to accepted indications for HBOT and for the proper investigation of potential new indications, ideally through the initiation of appropriate randomised controlled trials after sufficient anecdotal and case-descriptive evidence has been documented to justify such studies. Prior approval by an appropriate Ethics Committee is mandatory.

Exceptions:
The only currently acceptable exceptions to the above principles, in the view of the ANZHMG, are the on-site commercial chambers required for the safe execution of diving and tunnelling operations. Such chambers are operated by technicians with extended training and for specific purposes. They are viewed not primarily as therapeutic vessels but as integral to safe diving operations and for the purposes of on-surface safe decompression schedules. They are regulated by a comprehensive set of standards and legal requirements which are also under review at the present time. In practice, such chambers often maintain a close liaison with their local HBOT units.

5. CONCLUSIONS
The ANZHMG accepts that many currently proposed out of hospital facilities will not easily be able to comply with all the above principles. We feel, however, these represent the minimum requirements for the safe and rational use of HBOT. Facilities not meeting the above principles cannot be endorsed by the ANZHMG as being appropriate for the administration of this potentially harmful therapy.

The ANZHMG would be glad to assist in the development of further hyperbaric facilities in the region where there is a desire to establish such safe and appropriate use of hyperbaric oxygen.

6. ADDENDUM – THE TREATMENT OF SPORTS INJURIES WITH HBOT

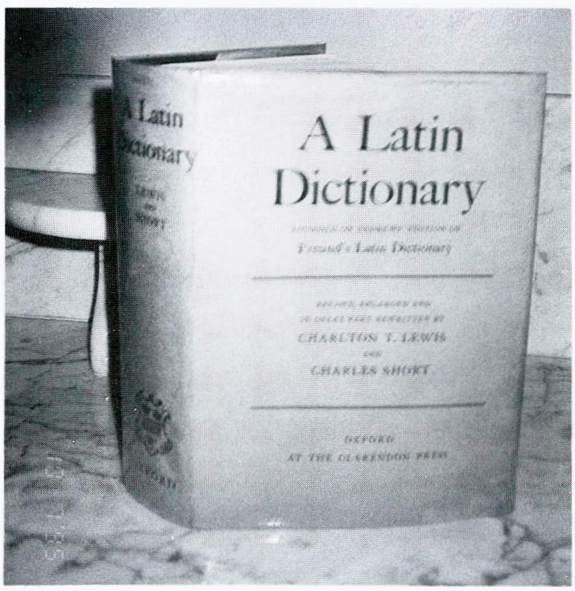
The ANZHMG supports the investigation of this potential indication for HBOT. It should be stressed that, at this time, treatment of such conditions with this therapy remains unproven. People presenting for HBOT with sports-related injuries should be made aware of this, be under the care of appropriately trained medical staff and ideally be willing to participate in controlled trials to assess the efficacy of such treatment. At present, the only facilities in a position to do this are the hospital-based facilities in cooperation with those trained in Sports Medicine or related medical practice.

DR MICHAEL BENNETT
Secretary, ANZHMG
October 1995

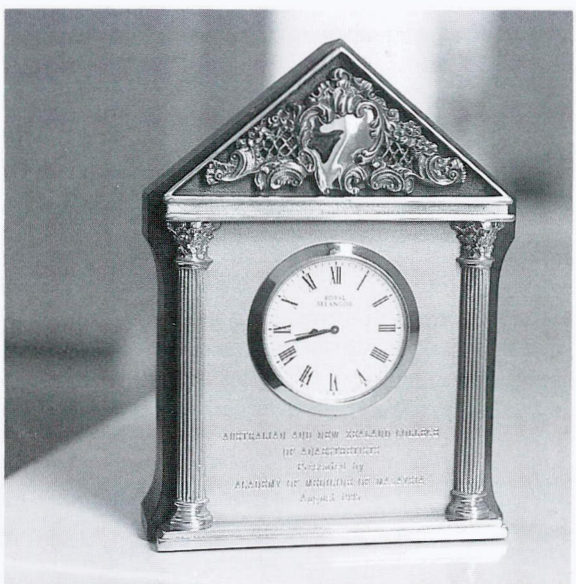
GIFTS TO ULIMAROA

Pair of diamond cut crystal vases presented by Dr Neville Davis.

Lithograph 'Yarra from Below Princes Bridge, 1853' by E. Thomas was presented by Dr Michael Davies.



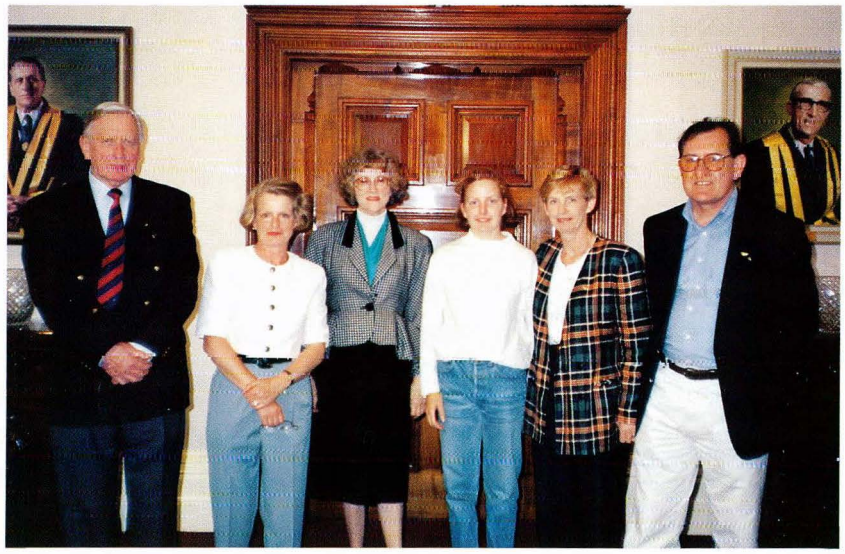
1st Edition of Oxford Latin Dictionary presented by Dr Brian Horan.



Pewter clock presented by the Academy of Medicine of Malaysia.

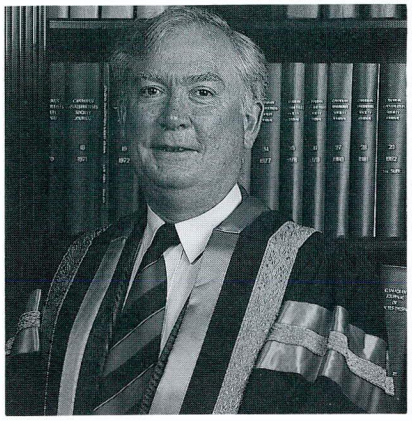
VISITORS TO ULIMAROA

Dr Michael Davies with Dr Dennis T. Mangano (USA).



Ulimaroa was built by the Wathin family in 1890. The above descendants of that family were delighted to visit Ulimaroa recently.

DEAN'S MESSAGE



Although the Faculty has been a hive of activity since it was established, there are three areas of activity I am finding particularly interesting.

The first relates to the joint training process with the Royal Australasian College of Physicians. The inaugural meeting of the Joint Specialist Advisory Committee in Intensive Care (JSAC-IC) took place on February 21 1996. The Committee structure is as follows:

Four FICANZCA members:
Dean, Geoff Clarke (elected Chairman)
Censor, Alan Duncan
Chairman of Examinations, Richard Lee
Education Officer, Felicity Hawker

Four nominated by the RACP:
Two physician members of ANZICS, Ray Raper and Heather Low
One member from the Australian College of Paediatrics, Jonathan Gillis
One member from the RACP, Robin Mortimer.

ANZICS member:
FRACP, FFICANZCA or both, ANZICS President, David Tuxen.

The atmosphere in this Committee could not have been more positive. Differences were defined, areas where we are already drawing together were identified and steps taken to get the whole process in operation.

Already there are physician trainees expressing interest in presenting for the FICANZCA Fellowship Examination, and the first of these will undoubtedly sit in 1996.

The second area relates to the Intensive Care Medical Liaison Committee of ANZICS-FICANZCA-RACP. This Committee deals with a broad range of issues affecting intensivists and the practice of intensive care. It is involved in interactions with government and other bodies. This Committee, chaired by the President of ANZICS, is functioning well.

The third area relates to our involvement with Asia. To date this has been meagre. I certainly hope it will grow. The Faculty has expertise in training and accreditation in intensive care and we will be happy to share that expertise. Currently Professor Oh is chairing a group from Council exploring College relations with Asia Pacific countries with respect to anaesthesia and intensive care. The Board fully supports Professor Oh's initiatives.

In conclusion I would like to say that I am very happy with the way in which the Board and the Regional Committees are functioning. Intensive care is still small enough to be able to establish useful lines of communication and to keep them open. Let us do this.

GEOFFREY M. CLARKE

ITEMS OF INTEREST FROM THE FEBRUARY 1996 BOARD MEETING

EDUCATION

In-Training Assessment

The Board reviewed Policy Document IC-11 on in-training assessment to expand the requirements and responsibilities for trainees undergoing in-training assessment. The revised document is printed elsewhere in the Faculty section of the *Bulletin*. An addendum to the assessment form was also approved, with provision for an undertaking from non-Faculty, non-RACP-IC trainees authorising the assessment. It is anticipated that the document and the forms will shortly be circulated to Supervisors of Training, Regional Education Officers and Trainees for information.

Manual on Training

In line with the review of the College document 'Manual on Training', the Board undertook to produce a separate document for the Faculty in due course.

Accreditation of Training Programmes in Intensive Care

A review of the Faculty's policy regarding accreditation of training was discussed, including concepts such as the possibility of accrediting trainees' programmes as opposed to posts, and limited rotations to units not approved for core training, subject to those units offering valuable training experience. The Board reaffirmed its policy that core training can only be undertaken in units approved for core training, and that the minimum period of core training remain at six months. It was noted that training in units not approved for core training but offering valuable specialised training could be undertaken during the elective period of training.

Certificate of Training for Overseas Personnel

Guidelines for issuing a 'Certificate of Training' to overseas personnel are currently under consideration. It is envisaged that such a Certificate would be offered to overseas doctors occupying an approved post for a minimum period of twelve months.

Formal Project

The Board is considering the requirement for trainees to undertake a Formal Project during training. The matter will be further discussed by the Joint Specialist Advisory Committee in Intensive Care.

TRAINING AND EXAMINATIONS

Guidelines for Examiners

The Board reviewed a set of Guidelines for Appointment and Training of Examiners, and approved Guidelines for Observers at the Fellowship Examination.

Annual Training Fees

The Board noted the recent amendment by Council to the requirements for annual training fees, and as a result, Fellows who have achieved the FANZCA will now be required to pay the annual training fee, if undertaking intensive care training. The fees apply from 1996.

PROFESSIONAL

Joint Specialist Advisory Committee — Intensive Care

Following ratification of a proposal for Conjoint Training and Certification in Intensive Care by both the Council of ANZCA and the Council of the RACP, it is now possible for RACP-IC trainees to exercise the option of being exempt from the ANZCA Primary Examination. The inaugural meeting of the Joint Specialist Advisory Committee in Intensive Care was held recently, attended by representatives of the Faculty of Intensive Care, the Royal Australasian College of Physicians and the Australian and New Zealand Intensive Care Society.

The Board noted the election of Dr Geoff Clarke as Chairman of this Committee. The Committee is currently identifying issues of commonality, such as accreditation of posts or programmes, accreditation of units and in-training assessment. Development of a proposal for certification in paediatric intensive care is also under consideration. The question of training fees for conjoint trainees was discussed and it was agreed that the matter of fees was an issue to be decided by the Faculty and RACP individually.

Occupational Training Visas

The Board resolved that a fee of $50 will apply to the processing of occupational training visas, as from 1 February 1996.

Policy Documents

The draft Statement of Patients' Rights and Responsibilities continues to be reviewed by the Board.

The following documents have been reviewed and approved by the Board:

IC-10 "Minimum Standards for Transport of the Critically Ill"
This is a conjoint document with the Australasian College for Emergency Medicine and was previously published as College Policy Document P23 (1992).

IC-11 "In-Training Assessment of Trainees in Intensive Care".

The Board approved the promulgation of the following new Policy Document:

IC-12 "Examination Candidates Suffering from Illness, Accident or Disability".

These documents are published elsewhere in the *Bulletin*.

Criteria for Recognition as a Specialist in Intensive Care

The Board ratified these criteria which have been considered and approved by the Joint Specialist Advisory Committee and the Intensive Care Medical Liaison Committee.

Clinical Indicators

The Board noted the draft Clinical Indicators published by the ACHS Care Evaluation Programme in January 1996. Representatives of the Faculty continue to be involved with a Working Party with the Australian and New Zealand Intensive Care Society.

CONTINUING EDUCATION

Combined Scientific Meeting — Perth 1996

The Faculty component of the Combined Scientific Meeting for Sunday 27 October was noted. Session topics include Neurotrauma with speakers including Dr Wally Thompson, Dr Bill McAulliffe and Dr Steve Lewis, the Neurosurgical Research Fellow at the Royal Adelaide Hospital. Dr Lewis is completing a PhD on Monitoring in Neurotrauma. Other sessions include Septic Shock, Medicolegal Aspects of Anaesthesia and Intensive Care Management, and Poisoning.

Annual Scientific Meeting — Christchurch 1997

Dr Keith Walley, currently on sabbatical leave at The University of Michigan, has accepted the invitation to be the Faculty's Foundation Visitor for 1997.

Registration for New Fellows

The Board noted the Council's recent policy of complimentary Basic Registration to the ASM being offered for that ASM to newly admitted Fellows by Examination who present at the College Ceremony within two years of admission to Fellowship.

Maintenance of Standards Programme

The Board has resolved that a maintenance of standards programme is to be available to Faculty Fellows in 1996, and has a draft, very closely based on the ANZCA programme, which will now be developed and promulgated shortly.

The proposed programme is voluntary but highly recommended and will offer a certificate of participation in the maintenance of standards programme to be issued after five years involvement, based on annual returns detailing a minimum of 30% involvement in clinical intensive care practice and the requirement for evidence of current registration and accreditation at an institution of practice.

The Board noted it would be desirable to have a programme consistent with that used by the RACP, however agreed that the allocation of points would be in line with the ANZCA system, in view of the large number of Fellows participating in both an ANZCA and Faculty programmes.

INTERNAL AFFAIRS

Election of Dean-elect

Dr Geoff Clarke was elected to the office of Dean-elect, and will therefore continue in the office of Dean for a further year from June 1996.

THE G.A. (DON) HARRISON MEDAL

has been awarded to

Ho, Kwok Ming, Hong Kong

for his outstanding performance in the 1995 Fellowship Examination

SOUTH AUSTRALIA TO IMPLEMENT SPANISH MODEL OF ORGAN DONATION

In May 1995 a Parliamentary Select Committee of the South Australian House of Assembly released an interim report on Organs for Transplantation. The report highlighted the downward trend in Australia in the organ donation rate, which now falls far short of the demand for organs to be transplanted.

	1989	1990	1991	1992	1993	1994	6Y average
SA	13	19	10	14	16	16	14
Qld	13	13	15	22	14	12	15
NSW/ACT	15	13	12	11	12	12	12
Vic	15	10	10	9	12	6	10
Tas	4	4	4	8	13	13	8
NT	13	6	13	0	18	6	9
WA	11	7	14	8	11	9	10
Australia	14	12	12	12	13	10	12

Source: National Organ Donor Registry (Herbert & Disney)

In considering the experience of organ donation in various other countries, the Committee concluded that South Australia should implement a system based on the experience of the Spanish network of transplant coordinators. Introduction of that system has seen a significant increase of organ donor rates in Spain from 14 to 25 per million population.

In September 1995 the South Australian Minister for Health (Dr Michael Armitage) sponsored a national conference entitled "Improving Australia's organ procurement — how the Spanish model can show us the way". Dr Rafael Matesanz, the Director of Organisacion Nationale Transplante, was invited to participate in the meeting. The meeting was attended by local intensivists, nephrologists, transplant co-ordinators, transplant surgeons and senior nursing staff. Interstate visitors included Dr Paula Boddington (ethicist), Dr Phil Byth (past President ANZICS), and Dr Jeremy Chapman (Director of Renal Medicine at Westmead Hospital) — Dr Chapman had visited Spain and examined their system of organ donor procurement.

Dr Matesanz described the Spanish National Transplant Organization (ONT) which was established in 1989 to overcome obstacles in organ donation. The virtual doubling of the national organ donation rate in Spain following the creation of the ONT was achieved by implementing a network of trained health professionals who are able to identify potential organ donors within the hospital, keeping records of all potential donors and cerebral deaths to find out when and how donors are lost and define when and where effort is needed to address these problems. It was apparent that an "opting in" approach similar to ours is used in Spain, and formal consent is sought for organ donation. However, it was not obvious as to what methods of coercion are employed by the Spaniards when organ donation is refused by families.

The key issues of the Spanish model are:

- Professionalisation of all features of organ donation. Training courses are provided for all staff.
- Centralisation and authoritative organisation with decentralised action and responsibility.
- Active medical management.
- Data collection, analysis and distribution.

The transplant coordinating network has three levels; national, regional and local.

The National Transplant Organisation (ONT) is open 24 hours, 7 days a week and staffed by nurses and doctors. It is attached to the Department of Health and responsible for policy development and overview of the system.

The function of this office is to:

a) Identify and overcome obstacles related to organ donation.
b) Develop and implement policy.
c) Provide training to staff.
d) Maintain the national organ waiting lists.
e) Arrange transport of transplant teams and organs.
f) Communicate with the mass media.
g) Liaise with the general public.
h) Collect, analyse and distribute data.
i) Promote organ donation.

Each hospital has a transplant coordinating team with a nominated leader/coordinator. The number within the team will depend upon the size of the hospital and whether or not transplants are performed. These teams consist of a doctor and nurses, who constantly evaluate their work to improve the donor rates. The doctors come from the specialties of Intensive Care 40%, Nephrology 40% and Surgery 20%. They are young and are responsible to the Medical Director and not the head of the Transplant Team. They continue in the remainder of their

time to perform their normal clinical duties. The appointment as a coordinator is a temporary one (2-4 years). Their main aim is organ procurement. These Medical Transplant Coordinators are closely monitored for signs of 'burn out'. Should the organ donor rate decline, the Medical Transplant Coordinator is replaced.

All Transplant Coordinators undertake an intensive 4 day training course, which covers donor identification, diagnosis of brain death, clinical management of donor and counselling skills needed to approach families to obtain consent.

The responsibilities of the Medical Transplant Coordinator include:

1. Organ donor identification. This includes the daily revision of patient admissions, follow up of patients with a Glasgow score < 7, daily visits to the Intensive Care Unit and Radiology.
2. Initiate family discussion with the relatives of a potential donor, document reason for refusal if applicable.
3. Maintenance of data related to the above.
4. Education programmes.
5. Relations with the media.
6. Administrative tasks.
7. Continual review and monitoring of performance.

Since the September meeting, one of the senior Transplant Coordinators from The Queen Elizabeth Hospital has visited Spain to examine their model, and the South Australian Health Commission have just advertised for a Director of a new South Australian Organ Donation Agency which will develop the policy and operational procedures to increase the rate of organ donation and procurement in South Australia.

South Australia will be a pilot state for the introduction of the Spanish system, with a view to possible nationwide application, and Faculty members will note with interest the efforts of the SA Minister for Health to improve our falling organ donor rate.

P.D. THOMAS
February 1996

Admission to Fellowship by Examination

Michael Bernard ANDERSON, SA
David Andrew COOK, QLD
Mark David LANDY, QLD
Megan Sue ROBERTSON, VIC
Kin Wah AU YEUNG, SA
Christopher John JOYCE, QLD
Andrew Gordon PUDDY, SA
Rex Anthony SMITH, NZ

Admission to Fellowship by Election

Peter Denholm CRONE, NZ

Review IC-10 (1996)

FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
and
AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE
A.C.N. 009 090 715

MINIMUM STANDARDS FOR TRANSPORT OF THE CRITICALLY ILL

INTRODUCTION

Safe transport of the critically ill requires accurate assessment and stabilisation of the patient before transport. There should be appropriate planning of transport and optimum utilisation of communications. Safe transport requires the deployment of appropriately trained staff with essential equipment, and effective liaison between referring, transporting and receiving staff.

An important principle is that transport of the critically ill patient should aim to maintain or improve the patient's clinical status. Management during transport must at least equal management at the point of referral.

1. ADMINISTRATIVE GUIDELINES

Administrative guidelines should cover all aspects of transport of the critically ill. These may include guidelines for such matters as insurance, budgeting and personnel. Staff safety and protection are the responsibility of the employing authority.

1.1 Initiation and Response

Medical transport services using road ambulance, fixed and rotary wing aircraft must be coordinated for prompt, rapid, efficient and safe transport of critically ill patients on a 24 hour basis.

Initiation of patient transport should be simple, with clear guidelines and communication channels. Ideally, the referring doctor should have to make only one telephone call to initiate retrieval.

In all situations requiring transport of the critically ill, rapid response of the transport system and minimal delays are paramount. In emergency interhospital transports, dispatch of the medical transport team to the referring hospital should not be delayed pending the identification of a receiving hospital.

1.2 Coordination and Communication

Coordination of transport services for the critically ill should be centralised to ensure optimum utilisation of resources. Designated individuals need to be available immediately for consultation and planning.

Reliable communication must be available at all times between the transport team and the referring and receiving hospitals and ambulance services. In noisy environments, communication between staff and patients may require special facilities.

1.3 Responsibility

The chain of responsibility must be clear throughout the transfer. Responsibility for patient care during transport must be vested in an appropriately qualified medical practitioner. Formal handover from referring doctor to retrieval doctor and from the latter to the hospital doctor is essential.

1.4 Documentation

The clinical record should briefly summarise the patient's clinical status before, during and after transport, relevant medical conditions, environmental factors and therapy given.

1.5 Audit and Quality Improvement

Organisations involved in medical transport should have an effective medical advisory committee which can audit performance and make recommendations for appropriate clinical management of patients. Incident monitoring and crisis management protocols are recommended.

There should be a process to regularly review records made during transport, to assess the level of care provided. There should also be a process to investigate delays in transport and any specific incidents. Both of these are essential for quality improvement.

A means of patient follow-up after transport should be available as feedback to the clinical staff involved and to assist in evaluating the performance of the organisation overall. There should be opportunities for peer review within the organisation.

2. CATEGORIES OF TRANSPORT

Transport of critically ill patients is necessary in three sets of circumstances, namely, prehospital transport, interhospital transport and intrahospital transport.

2.1 *Prehospital Transport* refers to:

Transport of a critically ill patient from an accident or illness location to hospital. Standards for prehospital transport where determined by ambulance and emergency services are not covered by this policy document.

2.2 *Interhospital Transport* may be:

2.2.1 Emergency Interhospital Transport:

For acute life-threatening illnesses emergency interhospital transport may be needed due to either lack of diagnostic facilities or lack of staff or facilities for safe and effective therapy in the referring hospital.

2.2.2 Semi-elective Interhospital Transport:

For transport of the critically ill patient with major organ failure requiring organ support, either to a tertiary referral centre, or to and from a tertiary centre for special investigations.

2.3 *Intrahospital Transport* may be required for diagnostic or therapeutic reasons.

3. STAFFING

Personnel engaging in transport of critically ill patients should be selected for the transport role, be trained in the various aspects of patient transport and be regularly involved in this activity. Ability to communicate effectively, and to function as part of a team is essential. Staff must be briefed on emergency procedures such as vehicle evacuation.

3.1 Prehospital Transport

Staff will usually be Ambulance Service personnel. Crew with specialised advanced life support skills should be deployed appropriately. In some circumstances, medical officers and/or nurses may be deployed to provide prehospital treatment and transport.

3.2 Interhospital Transport

Interhospital transport of critically ill patients requiring major organ support must be performed and supervised by experienced medical practitioners. Experienced ambulance personnel, or nurses or technical staff should accompany, assist and advise the medical practitioner. On extended journeys, sufficient staff should be carried to allow maintenance of high standards of patient care, and to allow for staff rest periods.

Where it would be immediately lifesaving, the transport of expert medical assistance eg. neurosurgeons, to the referring hospital should be considered.

Specifically trained personnel are required for the transport of neonates, infants and young children.

3.3 Intrahospital Transport

Appropriately trained medical and nursing or technical staff should accompany critically ill patients requiring intrahospital transport.

4. TRANSPORT

Mode of transport used will depend partly on clinical requirements and partly on vehicle availability and conditions.

4.1 **Choice** of transport vehicle will be influenced by:

- nature of illness
- urgency of intervention
- location of patient
- distances involved
- road transport times and road conditions
- weather conditions for airborne transport
- aircraft landing facilities
- range and speed of vehicle

4.2 Transport Vehicle Requirements

Vehicles should be appropriate to the task in terms of design and equipment. Regular inspection and servicing of vehicles is required. Particular requirements relate to:

- safety
- adequate space, with room for an attendant at the head and side
- adequate power and gases for life support systems
- adequate suction
- easy access for embarkation and disembarkation
- adequate lighting and internal climate control
- restraints for stretcher and equipment
- acceptable noise and vibration levels
- adequate speed and response times
- good communication systems, both internal and external
- auditory patient monitoring alarms routed through attendants' headsets where noise is unavoidable, in addition to usual alarms
- appropriate seating and restraints for staff
- impaired gravity drip of fluids

In general, medical fittings to aircraft, and bulky items carried need to have approval of the aviation authorities.

4.3 **Airborne** transport creates special problems, including:
- reduced oxygen partial pressure
- the need for pressurisation to sea level when clinically indicated
- expansion of air filled cavities
- limb swelling beneath plaster casts
- worsening of air embolism or decompression sickness
- danger from agitated patients
- space, lighting and facilities for interventions
- noise
- extremes of temperature
- extremes of humidity
- acceleration, deceleration and turbulence
- vibration
- electromagnetic interference between avionics and monitoring devices
- danger from loose, mobile equipment.

With all modes of transport, stabilisation of vital signs, provision of a secure airway and IV access, securing of all catheters and provision of appropriate monitoring before departure is fundamental to safe transport.

5. EQUIPMENT

Equipment carried should be appropriate for each transport. The duration of transport and the patient's diagnosis and severity of illness should be taken into account. In choosing equipment, attention must be given to size, weight, battery life, gas consumption and durability, as well as to suitability for operation under conditions of transport. Equipment should be adequately restrained, and continuously available to the operator. Electrical and gas supply fittings of all equipment must be compatible with those of the transport vehicle. Specialised equipment is required for neonatal and paediatric transport. Equipment that should be considered includes:

5.1 *Respiratory Support Equipment*
- Airways
- Oxygen, masks, nebuliser
- Self-inflating hand-ventilating assembly, with PEEP valve available
- Suction equipment of appropriate standard
- Portable ventilator with disconnect and high pressure alarms
- Intubation set
- Cricothyroidotomy set
- Pleural drainage equipment
- Oxygen supply in excess of that estimated from the maximum transport time.

5.2 *Circulatory Support Equipment*
- Monitor/defibrillator/external pacer combined unit
- Pulse oximeter
- Aneroid sphygmomanometer (not mercury-containing)
- Vascular cannulae, peripheral and central
- IV fluids and pressure infusion set
- Infusion pumps
- Arterial cannulae
- Arterial monitoring device
- Syringes, needles
- Pacemaker equipment
- Pneumatic anti-shock garment
- Pericardiocentesis equipment

5.3 *Other Equipment*
- Nasogastric tube and bag
- Urinary catheter and bag
- Nasal decongestant spray
- Instruments, sutures, dressing, antiseptic lotions, gloves
- Thermal insulation and temperature monitor
- Splints and equipment for spinal immobilisation
- Neonatal/paediatric/obstetric transport equipment

5.4 *Pharmacological Agents*

Pharmacological agents necessary to manage:
- Cardiac arrest
- Hypotension
- Hypertension
- Cardiac dysrhythmias
- Pulmonary oedema
- Anaphylaxis
- Bronchospasm
- Hypoglycaemia
- Hyperglycaemia
- Raised intracranial pressure
- Uterine activity/atony
- Adrenal dysfunction
- Narcotic depression
- Convulsion
- Agitation
- Pain
- Emesis
- Electrolyte abnormalities

and to provide sedation and neuromuscular paralysis. For special situations, other agents may include antibiotics, thrombolytics, antivenoms, etc.

6. MONITORING

Monitoring of certain fundamental variables should be carried out.

Some or all of these basic recommendations will need to be exceeded routinely depending on the physical status of the patient. Occasionally some of the recommended methods of monitoring may be impractical or inappropriate.

The described monitoring methods may fail to detect unfavourable clinical developments and their use does not guarantee any specific patient outcome.

6.1 **Personnel**

Clinical monitoring is the basis of intensive patient care during transport. This should be supplemented by appropriate devices.

6.2 **Patient Monitoring**

6.2.1 *Circulation*
The circulation must be monitored at frequent and clinically appropriate intervals by detection of the arterial pulse and measurement of the arterial blood pressure.

6.2.2 *Ventilation*
Ventilatory function should be assessed at frequent and clinically appropriate intervals.

6.2.3 *Oxygenation*
The patient's oxygenation should be assessed at frequent and clinically appropriate intervals by observation, and by pulse oximetry as appropriate.

6.2.4 *Temperature*

6.3 **Equipment**

6.3.1 *Pulse Oximeter*
A pulse oximeter should be used for every critically ill patient during transport.

6.3.2 *Alarms for Breathing System Disconnection or Ventilator Failure*
When an automatic ventilator is in use, a device capable of warning promptly of a breathing system disconnection or ventilator failure should be in continuous operation.

6.3.3 *Alarms for Breathing System High Pressure*
When an automatic ventilator is in use, a device capable of warning promptly of high pressure in the breathing system should be in continuous operation.

6.3.4 *Electrocardiograph*
Equipment to monitor and continually display the electrocardiograph should be used for every critically ill patient during transport.

6.3.5 *Other Equipment*
When clinically indicated, equipment to measure other physiological variables, such as a capnograph, should be available.

6.3.6 *Equipment Alarms*
Equipment should incorporate audible and visual alarms.

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IC-11 (1995)
Review 1996

FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

IN-TRAINING ASSESSMENT OF TRAINEES IN INTENSIVE CARE

1. INTRODUCTION

1.1 In-training assessment is an essential part of the training of specialists in Intensive Care. It allows information concerning important but non-examinable attributes to form part of the Faculty's assessment processes.

1.2 In-training assessment of trainees will have two components.

1.2.1 Assessment by training departments.

1.2.2 Certification from the Censor stating satisfactory in-training assessment prior to awarding Fellowship.

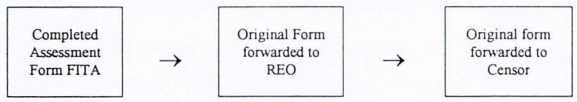
2. IN-TRAINING ASSESSMENT PROCEDURE

2.1 Assessments will be carried out for all registered Faculty trainees at six monthly intervals or in the case of a shorter attachment, at the conclusion of that attachment. However, trainees should be advised of any problems relating to their performance at the earliest opportunity to allow remedial action to be taken. Assessments should be undertaken by the Supervisor of Training in collaboration with other specialists in the Department with whom the trainee has worked during the assessment period. Staff should record a performance level for each attribute on Form *FITA*. They must have personal knowledge of the trainee. If there is a doubt about any particular attribute, it is appropriate to use the 'insufficient knowledge to comment' category.

2.2 During non-intensive care training, assessments should be completed by the Head of the relevant Department, in collaboration with other specialists with whom the trainee has worked within the Department.

2.3 The Supervisor of Training must formally discuss the assessment with the trainee. It is normally appropriate for a third person to be present at the interview. The trainee will be given the opportunity to provide information or an explanation in respect of an unsatisfactory assessment or any adverse comment. This is to be recorded on Form *FITA*. The trainee and supervisor must then sign two copies of Form *FITA*. One copy is retained by the trainee.

2.4 Form *FITA* should be sent by the Supervisor of Training to the Regional Education Officer, care of the Regional Committee Secretariat. The original (for registered trainees) must be forwarded to the Censor and a copy retained by the Regional Committee Secretariat.



Original and copy signed. Copy retained by trainee.

Copy of *FITA* of all Registrars retained by Regional Committee Secretariat.

Original *FITA* of registered trainees to Censor via Faculty Administrative Officer.

3. RESPONSIBILITIES OF THE REGIONAL EDUCATION OFFICER

3.1 To ensure in-training assessment forms are circulated to registered trainees and Supervisors of Training bi-annually at six monthly intervals, at the commencement of each assessment period.

3.2 To ensure assessments are completed and returned to the Regional Committee Secretariat and the original forwarded to the Censor at the Central Office, at the end of each assessment period.

3.3 In the event of an unsatisfactory assessment, the Regional Education Officer should contact the trainee and Supervisor in an attempt to assess and understand the reasons behind the unsatisfactory report, and to offer appropriate advice to both Supervisor and trainee.

3.4 To notify the Faculty Administrative Officer of trainee movements between regions.

4. RESPONSIBILITIES OF THE CENSOR

To keep copies of Form *FITA* in each trainee's central record file.

4.1 Annually and prior to awarding Fellowship, the Censor will review all assessments made in respect of each trainee.

4.2 Following the review of assessments, the Censor will inform the Board of any unsatisfactory assessment where it is considered that a trainee should **not** be awarded Fellowship. The Censor will then inform these trainees that they will not be awarded Fellowship until they have satisfactorily completed further specified training.

5. REQUIREMENTS AND RESPONSIBILITIES FOR TRAINEES UNDERGOING IN-TRAINING ASSESSMENT

5.1 Trainees should ensure that assessments are conducted according to the procedure laid down in item 2 of this document. A minimum of four six-monthly assessments covering the period of core intensive care training is required for all trainees.

5.2 A satisfactory assessment in at least three out of the four six-monthly assessments covering the minimum period of core intensive care training including the final assessment of this two year period is essential for the awarding of Fellowship.

5.3 Penalties will be applied if the overall in-training assessment is unsatisfactory. The penalty for two unsatisfactory assessments during the two year core intensive care training or an unsatisfactory assessment in the final six months, is to add an additional six months to core intensive care training. The penalty for more than two unsatisfactory assessments during core intensive care training is to add an additional 12 months to core intensive care training. Assessment during penalty time must be satisfactory before Fellowship can be awarded.

6. APPEALS PROCEDURE

In the case of an unsatisfactory assessment, the trainee may appeal to the Censor. If the matter is not resolved to the satisfaction of the trainee it will be referred to the Board of Faculty. The decision of the Board of Faculty is subject to appeal according to the Appeal Procedure of the College.

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 Faculty 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: 1995
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POLICY DOCUMENTS INDEX

E = educational. P = professional. T = technical. EX = examinations. IC = Intensive Care.

ANZCA POLICY DOCUMENTS

Review P6 (1996)

MINIMUM REQUIREMENTS FOR THE ANAESTHESIA RECORD

INTRODUCTION

The anaesthesia record is an essential part of the patient's medical record. The record should chart all aspects of the anaesthesia management, including the pre and post-operative management of relevance to the anaesthetist. The record should follow a logical sequence. It must include prompts to show essential information regarding the anaesthetic technique and drugs used, sufficient space to allow the anaesthetist to make more detailed comments when necessary, and a chart for graphically recording data and attaching appropriate automated records if available.

The anaesthesia record provides information which may be helpful to all staff involved in the care of the patient and is of great use to subsequent anaesthetists (both specialist and trainee). It may also be of medico-legal importance and can be used for quality assurance and research purposes. The record must be signed by the anaesthetist.

THE FOLLOWING INFORMATION SHOULD NORMALLY FORM PART OF THE ANAESTHESIA RECORD:

1. Basic Information

1.1 The name of the patient, hospital, record number, age, gender and weight.

1.2 The dates of the pre-operative consultation and the anaesthesia.

1.3 The name(s) of the anaesthetist(s).

1.4 In the case of trainees, the name of the supervisor and the level of supervision as defined in College Policy Document E3 *'The Supervision of Trainees in Anaesthesia'.*

1.5 The name of the surgeon or other proceduralist.

1.6 The procedure(s) planned to be performed and actually performed.

2. Information Prior to Anaesthesia

2.1 Documentation of pre-anaesthesia assessment of the patient, including the category of patient as defined for example by the American Society of Anesthesiologists. (College Policy Document P7 *'The Pre-Anaesthetic Consultation'*).

2.2 Summary of general medical status by relevant systems and diseases.

2.3 Concurrent therapy and any known drug or other sensitivities.

2.4 The history of previous anaesthesia and relevant surgery.

2.5 Assessment of the airway, dental condition and risk of gastric reflux.

2.6 Results of relevant laboratory data and other investigations.

2.7 The pre-medicant drugs, time given, route of administration and a description of any unusual response (if not recorded elsewhere).

2.8 Documentation of discussion with the patient or guardian on the anaesthesia plan, possible therapies and possible outcomes (if not recorded elsewhere). See College Policy Document P26 *'Guidelines on Providing Information about Anaesthesia'.*

3. Anaesthesia Information

3.1 **Medication:** The details of administration of all drugs including any used by the surgeon, and a description of any unusual response.

3.2 **Technique:** The full details of the anaesthetic technique used, whether general, regional or sedation with monitored anaesthesia care, and a description of any problems encountered.

3.3 **Time:** The time of significant anaesthetic and operative events, observations and interventions including administration of drugs.

3.4 **Airway:** The size and type of any artificial airway used, a description of any airway problems encountered and the method of their solution.

3.5 **Fluid Therapy and Vascular Access:**

3.5.1 **Intravenous infusion:** Details of intravenous solutions including the site, type of cannula and the nature and volume of fluids infused.

3.5.2 Details of central venous and arterial access.

3.6 **Blood loss:** An estimate of blood and fluid loss.

3.7 **Position:** The position of the patient during the procedure.

3.8 **Monitoring:** The monitoring methods used and regular documentation of relevant information obtained. Information provided as a monitor print-out must have correct patient identification. See College Policy Document P18 *'Monitoring During Anaesthesia'.*

3.9 **Other Interventions.**

4. Post-Anaesthesia Information (if not recorded elsewhere)

4.1 Respiratory, cardio-vascular and neurological status and any other relevant information.

4.2 Incidents arising during this period and their management. Refer College Policy Document P4 *'Guidelines for the Care of Patients Recovering from Anaesthesia'.*

4.3 Plan for pain management, fluid therapy and oxygen therapy for first 24 hours, especially for guidance of Recovery Room Staff.

4.4 Space for documenting/recording outcome data, including Clinical Indicators, audit and quality assurance information.

4.5 Space for documenting the post-anaesthesia visit.

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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E15 (1996)

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

1. INTRODUCTION

1.1 The College will offer 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 an annual 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 Advisory 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 Advisory 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'*).

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 A report (30% of assessment) from the Medical Director in association with all senior staff of the Approved Unit. The report will be based upon continuous in-training assessment with regard to: knowledge; appropriate abilities in history taking and physical examination; patient and staff interactions; technical skills; other attributes appropriate for multidisciplinary pain management. Particular emphasis will be placed on progress in those areas during the year.

3.2 Submission by the trainee of a Pain Certificate Log Book (20% 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 the Medical Director's signature of: direct involvement in the management of 300 patients with chronic non-cancer and cancer pain and 200 patients with acute pain (eg. post-operative/trauma, etc.); performance of at least 200 pain relief procedures; participation in at least 40 multidisciplinary case conferences.

3.4 Submission of a typed "Treatise" (50% of assessment) describing and discussing one patient with acute pain, two with chronic

non-cancer pain and one with cancer pain. The format of the presentation of each case should be similar to that for Case Reports in the Journal *Anaesthesia and Intensive Care*. The discussion section in two cases must be expanded to the level of a "mini-review" with appropriate referencing. Emphasis should be directed to the multidimensional aspect of pain and the interdisciplinary approach to its diagnosis and treatment. The length of the "Treatise" should not exceed 60 typed double-spaced A4 pages, including references, illustrations, etc.

3.5 The Assessment will be reviewed by three Assessors appointed by College Council on the recommendation of the Pain Management Advisory Committee. The Assessors will jointly recommend to College Council, after formal deliberation, whether or not the Certificate in Pain Management should be awarded. In the event the Assessors are unable to make a recommendation, further assessment may be obtained on the advice of the Pain Management Advisory Committee.

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Review P20 (1996)

RESPONSIBILITIES OF THE ANAESTHETIST IN THE POST-OPERATIVE PERIOD

1. The anaesthetist has major responsibility for the management of the patient recovering from anaesthesia. During this time, responsibility is shared with the surgeon or other consultant for consultative advice with respect to:

   1.1 monitoring (including clinical observations)

   1.2 pain relief

   1.3 fluid therapy

   1.4 respiratory therapy

2. The anaesthetist has responsibility for ensuring that the patient recovers safely from anaesthesia in an area appropriately equipped and staffed for that purpose (see College Policy Document P4 *'Guidelines for the Care of Patients Recovering from Anaesthesia'*).

   This responsibility includes:

   2.1 A formal handover of responsibility to recovery area staff with appropriate briefing as to management protocols. Such a handover of care should only occur when the anaesthetist considers that the patient is safe to leave, particularly with regard to cardio-respiratory stability.

   2.2 Availability to deal with any unexpected problems or ensuring that another nominated anaesthetist or other consultant is available and has necessary information about the patient.

   2.3 Ensuring that the patient remains in the recovery facility until safe for discharge to a ward. Where transfer to an intensive care unit or high dependency unit is necessary, responsibility for care remains with the anaesthetist until this transfer is complete.

   2.4 Ensuring that there will be adequate post-operative care of the patient after discharge from the recovery area.

3. When a patient is to be discharged from medical care on the same day that an anaesthetic has been administered, the anaesthetist must ensure that the patient and his/her caregivers understand the principles of post-anaesthesia care (see College Policy Document P15 *'Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery'*).

4. The anaesthetist has a responsibility to:

   4.1 Ensure that any adverse effects which may be related to anaesthesia are recognised, managed and documented appropriately.

   4.2 Audit outcomes of his/her anaesthesia care and include these in quality assurance or peer review processes.

   4.3 Ensure that patients and/or caregivers are aware of any matters relevant to the conduct of anaesthesia particularly when these may impact on future health care.

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Review P22 (1996)

STATEMENT ON PATIENTS' RIGHTS AND RESPONSIBILITIES

The Australian and New Zealand College of Anaesthetists aims to develop and maintain the highest standards of practice, teaching and research in anaesthesia and other associated areas of practice.

Proper medical management occurs in a partnership between patients and their medical practitioners. The College promotes the concept that patients have both rights and responsibilities which include, but are not limited to, the following:

1. Patients have the right to:

1.1 be treated with skill, consideration and dignity regardless of their age, gender, race, religion, disabilities, health and legal status

1.2 know the identity and professional status of all attending medical and other staff and to refuse the presence of other people during treatment

1.3 be informed, with a clear and understandable explanation, of proposed peri-anaesthesia care and procedures including their alternatives and known side effects and risks. Risk should be explained in terms of matters which would be significant to a 'reasonable' person in a similar situation. See College Policy Document P26 *'Guidelines on Providing Information About Anaesthesia'*

1.4 refuse the proposed treatment without prejudice to alternative anaesthesia management strategies provided that the implications of the changes are understood by all involved

1.5 be provided anaesthesia by an anaesthetist after giving written consent (unless this is precluded by the patient's state at the time)

1.6 request a second opinion regarding proposed management without prejudice to any aspect of future treatment

1.7 know of any proposal to be involved in teaching or research activities, and to understand that non-involvement will not prejudice treatment

1.8 know that all aspects of care will remain confidential and that information about that care will only be released to others with their prior knowledge and consent

1.9 know the broad financial implications of therapy

1.10 the presence and support of next of kin, partner and/or friend whenever this is practicable

1.11 expect decisions to be made on their behalf and in their best interests after discussion (when possible) with next of kin, partner or medical agent, should they be unable to communicate their own decisions

1.12 be informed of any matters which may affect anaesthesia management in the future.

2. Patients have a responsibility to:

2.1 inform staff caring for them of all relevant medical history including the possibility of infectious diseases

2.2 comply with the agreed treatment plan or inform staff of their intention not to comply

2.3 consider participation in approved teaching and research activities which may offer no obvious or immediate personal benefit, but which may improve the care of other patients in the future

2.4 consider their ability to meet their financial obligations in relation to care and therapy.

RELATED POLICY DOCUMENT

P26 *Guidelines on Providing Information About Anaesthesia*

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.

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Review P25 (1996)

REQUIREMENTS FOR MULTIDISCIPLINARY PAIN MANAGEMENT CENTRES OFFERING THE CERTIFICATE IN PAIN MANAGEMENT

1. INTRODUCTION

These guidelines establish the minimum standards for Multidisciplinary Pain Management Centres seeking approval to offer training for the **Certificate in Pain Management** of the Australian and New Zealand College of Anaesthetists.

2. ADMINISTRATIVE STRUCTURE AND STAFFING

2.1 The Centre should be recognised by the Hospital Management for funding purposes.

2.2 All staff in the Centre should be accredited by the Hospital for the duties and procedures they perform.

2.3 The Centre should have a Medical Director with a minimum number of five sessions.

2.4 The following medical disciplines form a part of required staffing.

2.4.1 **Anaesthesia:** it is mandatory to have a minimum of eight clinical input sessions weekly by specialist staff.

2.4.2 **Psychiatry, Rheumatology/Rehabilitation Medicine:** regular specialist clinical input sessions are highly desirable.

2.4.3 **Other medical disciplines such as neurosurgery, orthopaedic surgery and general practice:** regular specialist clinical input sessions should be encouraged.

2.4.4 **Nursing staff:** it is mandatory to have senior registered nursing staff exclusively attached for a minimum of 10 sessions weekly.

2.4.5 **Paramedical staff:**

2.4.5.1 **Clinical Psychologist:** with mandatory clinical input of five sessions weekly.

2.4.5.2 **A Physiotherapist:** with mandatory clinical input of five sessions weekly.

2.4.5.3 **Occupational Therapy:** regular clinical input sessions are highly desirable.

2.4.5.4 **Social Work:** regular clinical input sessions are highly desirable.

2.5 The Unit must have a minimum of one officially scheduled interdisciplinary meeting each week.

2.6 The Unit should offer a range of expertise in the following areas:

1. Review of prior medical records
2. History taking and physical examination relevant to pain management
3. Psychological assessment and treatment
4. Referral for external medical consultation
5. Medical management
6. Physical therapy
7. Pain relief procedures
8. Vocational assessment and counselling
9. Other appropriate services, eg:
   - Cognitive behavioural programmes
   - Relaxation techniques
   - biofeedback
   - work hardening/exercise physiology

2.7 Regularly scheduled education sessions are essential.

2.8 Involvement in undergraduate and graduate medical, nursing and paramedical education is highly desirable with students present in the Centre. For anaesthesia, both approved vocational trainees (preferably in blocks of three months) and other Provisional Fellows are desirable.

2.9 Regularly scheduled Quality Improvement/Peer Review Activities are essential.

2.10 An active research programme related to pain management is essential.

2.11 A comprehensive record system is essential. Computerised data review system for diagnosis/treatment is highly desirable.

2.12 Documentation of treatment protocols and procedures for patients together with a statement of their rights and responsibilities is essential.

2.13 At least one full-time equivalent secretary is essential.

3. PHYSICAL FACILITIES

3.1 Appropriate consulting and examination rooms are essential.

3.2 Procedure rooms with adequate equipment and staffing are essential. Staffing will include nurses, technicians and radiographers as required.

3.2.1 Anaesthesia and resuscitation equipment must comply with College guidelines. See College Policy Document T1 *'Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites'.*

3.2.2 Recovery facilities and procedures must comply with College guidelines. See College Policy Document P4 *'Guidelines for the Care of Patients Recovering from Anaesthesia'.*

3.3 Suitable office space for permanent staff and trainees is essential. See College Policy Document E1 *'Guidelines for Hospitals seeking College Approval of Training Posts in Anaesthesia'.*

3.4 Access to in-patient beds.

3.4.1 Access to in-patient beds when necessary is mandatory.

3.4.2 In-patient beds designated to the Multidisciplinary Pain Management Centre are highly desirable.

4. CLINICAL WORKLOAD AND STANDARDS

4.1 Numbers of new patients per annum:

4.1.1 **Acute perioperative:** a minimum of 200 patients per annum per trainee.

4.1.2 **Chronic non-cancer pain and cancer pain:** a minimum of 300 patients per annum per trainee.

4.2 **Out-patient consultant half-day sessions:** There should be a minimum of five per week.

4.3 **Formal interdisciplinary case conferences:** (to draw up treatment plan in discussion among a number of health professionals who have seen the patient in consultation) must be held at least once weekly. Preferably three to five per week will be held.

4.4 **Procedural sessions:** A minimum of five pain relief procedural sessions (eg: diagnostic and therapeutic nerve blocks, etc.) per week.

4.5 **In-patient rounds:** There must be a minimum of six rounds per week.

4.6 **Therapeutic interventions:** Nerve blocks and similar interventions should total approximately 1000 per annum.

4.7 **Audit and clinical review sessions:** These must be held regularly with proper documentation of results.

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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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

POLICY DOCUMENTS

E = educational. P = professional. T = technical. EX = examinations. IC = Intensive Care.

E1 (1991) Guidelines for Hospitals seeking Faculty Approval of Training Posts in Anaesthesia *Bulletin Mar 91, pg 40*
E3 (1994) The Supervision of Trainees in Anaesthesia *Bulletin Nov 92, pg 41*
E4 (1992) Duties of Regional Education Officers *Bulletin Nov 92, pg 44*
E5 (1992) Supervisors of Training in Anaesthesia and Intensive Care *Bulletin Nov 92, pg 45*
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, pg 38*
E11 (1992) Formal Project *Bulletin Nov 92, pg 46*
E13 (1991) Guidelines for the Provisional Fellowship Year *Bulletin Nov 91, pg 38*
E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, pg 62*
E15 (1996) Guidelines for Trainees and Departments seeking College Approval of Posts for the Certificate in Pain Management *Bulletin Mar 96, pg 50*
EX1 (1991) Guidelines for Examiners with Respect to Candidates Suffering Illness (or Accident) at the Time of Examination *Bulletin Mar 91, pg 43*
T1 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites *Bulletin Nov 95, pg 52*
T2 (1990) Protocol for Checking an Anaesthetic Machine before Use *Under review*
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 (1991) Essential Training for General Practitioners Proposing to Administer Anaesthetics *Bulletin Mar 91, pg 44*
P2 (1991) Privileges in Anaesthesia Faculty Policy *Bulletin Mar 91, pg 45*
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*
P7 (1992) The Pre-Anaesthetic Consultation *Bulletin Nov 92, pg 47*
P8 (1993) Minimum Assistance Required for the Safe Conduct of Anaesthesia *Bulletin Nov 93, pg 33*
P9 (1991) Sedation for Diagnostic and Minor Surgical Procedures *Bulletin Mar 91, pg 45*
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*
P12 (1991) Statement on Smoking *Bulletin Nov 91, pg 37*
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 (1992) Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery Aug 95, pg 62
P16 (1994) The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 94, pg 45*
P17 (1992) Endoscopy of the Airways
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 (1992) Sedation for Dental Procedures *Bulletin Mar 92, pg 37*
P22 (1996) Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
P23 (1992) Minimum Standards for Transport of the Critically Ill *Bulletin Mar 92, pg 40*
P24 (1992) Sedation for Endoscopy *Bulletin May 92, pg 45*
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*