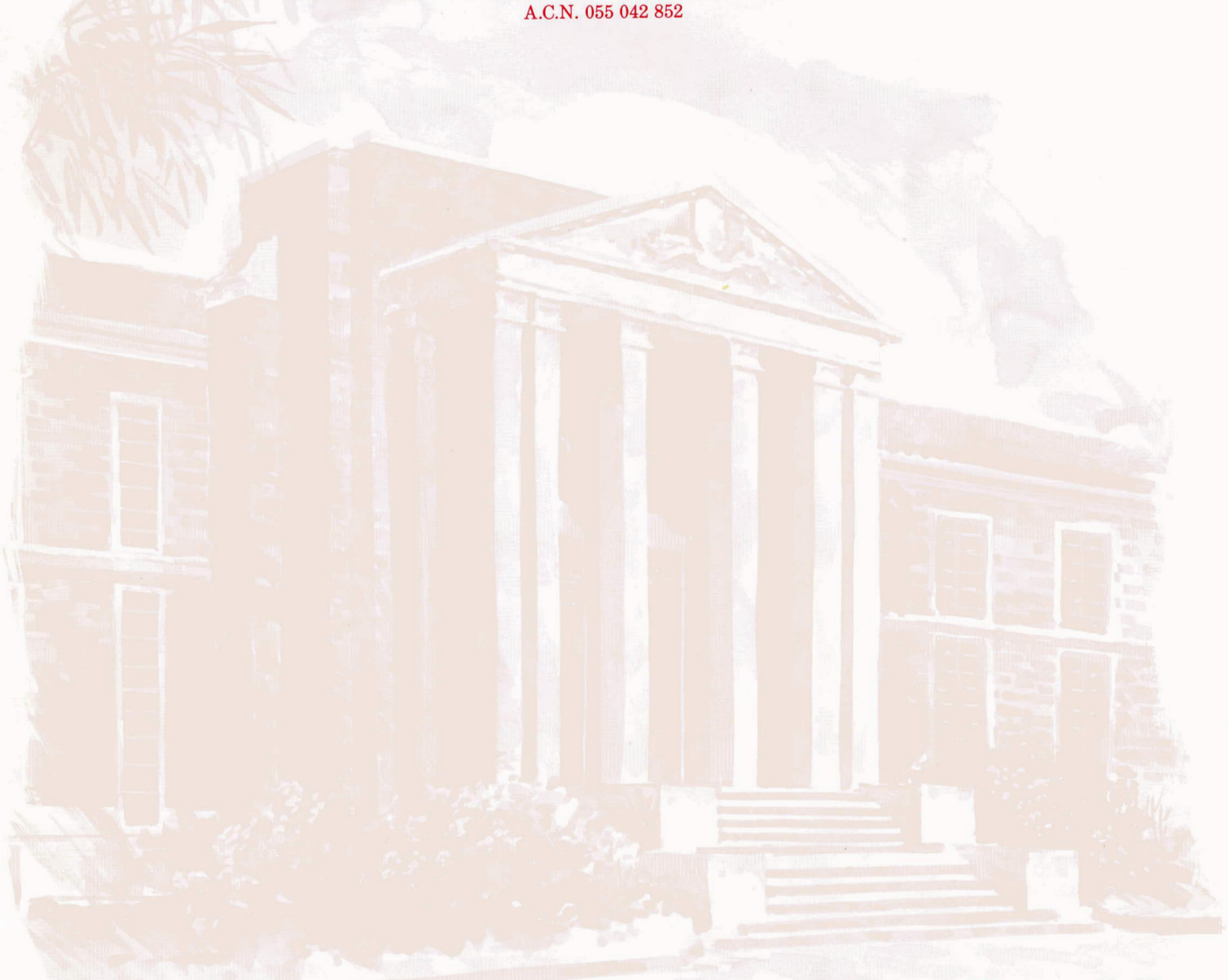
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852



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CONTENTS

EDITORIAL

The Australian and New Zealand College of Anaesthetists *Bulletin* is published four times per year by the Australian and New Zealand College of Anaesthetists, A.C.N. 055 042 852, Spring Street, Melbourne, 3000, Victoria.
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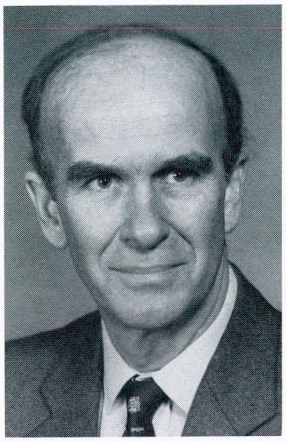
PRESIDENT'S MESSAGE



After a very relaxing break over Christmas and the New Year, with uncharacteristically good weather, I am refreshed and ready to get back to the affairs of the College.

January started quietly with a little correspondence, one teleconference and one trip to Melbourne. The month was highlighted by the New Year and Australia Day Honours which included three Fellows of the College:

Dr W. Mayne Smeeton of New Zealand was created an Officer of the British Empire. Dr Smeeton was the former Research Director for Merck, Sharpe & Dohme.

Dr Nerida M. Dilworth, a former Member of the Board of Faculty of Anaesthetists, Assessor and recently retired Director of Anaesthetics at the Princess Margaret Hospital for Children in Perth, was awarded the Member of the Order of Australia.

Dr Mervyn D. Cobcroft, currently Honorary Secretary of the Queensland Regional Committee and Medical Historian of note, was awarded the Medal of the Order of Australia.

It is an honour for these three Fellows to be recognised in this way and it is also an honour for this new College.

February's activities have included to date our Council Meeting, a week in Singapore involved in the accreditation visit to their teaching Hospitals where we have trainees, the Council Meeting of the Royal Australasian College of Surgeons, the Executive Committee Meeting of the Australian Society of Anaesthetists and a meeting of the Organising Committee for the Annual Scientific Meeting of our College in Launceston in 1994.

Besides routine matters attending to College affairs, there is the correspondence, responses to enquiries from Fellows, Hospitals, other institutions and Government and there are social functions. Family and practice have to be fitted in around all this.

A considerable amount of work of Council is in defence of the specialty and the cost both in time and money is very considerable and perhaps something not appreciated by many Fellows.

The Annual Scientific Meeting in Launceston will be an historic Meeting. It will be our first independent Scientific Meeting and it will be held in the city where, on 7th June 1847, the first anaesthetic was given for a surgical operation in Australia by Dr William Russ Pugh.

Launceston is a small, old and unique city which has many attractions. Where else in Australia could you have a Penny farthing race from Launceston to Hobart. The Tasmanian Regional Committee has appointed an extremely enthusiastic Organising Committee who are working with our Annual Scientific Meeting Officer, Dr Dick Willis.

Fellows will be aware of the unfortunate publicity generated late last year when the National Health and Medical Research Council (NH & MRC) released its 'Report on Deaths Associated with Anaesthesia in Australia 1988-1990'. I issued a Press Release concerning the alarmist nature of the press coverage which unfortunately was not taken up by the media. I have however, written to the Chairman of the NH & MRC expressing the concerns of the College at the unfortunate publicity and the involvement of some of their Council members in this.

The work of the NH & MRC in this area is important and I hope that in the next twelve months there can be agreement on the standardisation of data including a uniform reporting system, a standardisation of clinical data collection and a uniform classification system. When this is in place reports will be meaningful and of significance.

Another area of public debate which the College has been involved in, but not with bad publicity, has been the matter of the provision of health services to rural and other remote areas. This College has co-operated with the Faculty of Rural Medicine of the Royal Australian College of General Practitioners in developing an anaesthetic curriculum for the training programme for General Practitioners who have to work in such areas and provide an anaesthetic service. I must stress that the policy of the Collelge on anaesthetic privileges has not changed:

'Anaesthetics should be administered by fully trained and certified specialists except in areas where specialists are unavailable or in insufficient numbers to provide a complete service.

I must also stress that no qualification in anaesthesia in any form will be given.

General Practitioners who undertake such anaesthetic training would be eligible for anaesthetic privileges in rural and other remote areas but not metropolitan areas or other areas where there is a complete specialty anaesthetic service. There is a full article on this topic later in the *Bulletin* prepared by Associate Professor Neville Davis.

The recent publicity over the decision of the High Court of Australia in Rogers v Whittaker involving informed consent has been a source of concern to Fellows. Legal opinion is that before the full implications are known, the full judgement will need to be considered in depth. However, it is quite clear that our patients must receive an appropriate outline of the risks of anaesthesia.

The National Health and Medical Research Council has a Working Party developing 'General Guidelines for Medical Practitioners on Providing Information to Patients; and the College is represented by Dr Michael Davies. Council at its last Meeting endorsed a final draft of the Working Party and when it is finally approved by the National Health and Medical Research Council it will be made available to Fellows. It is not felt appropriate at this time for the College to prepare specific anaesthetic guidelines on consent in that they could be too prescriptive. There is a potential danger that 'guidelines' could become legal documents in cases of litigation. Further developments are inevitable and the College will follow events closely.

The final matter I wish to raise is that of visas for overseas medical practitioners seeking occupational training in this country. After years of the medical profession pointing out to Government the problems created by the unrestricted access of overseas trained doctors into this country, the Government suddenly produced quite severe restrictions which unfortunately included genuine occupational trainees. This was never contemplated my the medical profession and has created problems for these trainees and for the Hospitals which were trying to help them. The College has a responsibility to assist educationally other countries, particularly our South East Asian and South Pacific neighbours and it is hoped that a proposal being recommended by the Medical Workforce Data Review Committee to the Australian Health Ministers' Advisory Council will resolve the problem.

MICHAEL HODGSON

DEATHS

Dr A.J. Gyngell, Vic Fellow, FFARACS 1988, FANZCA, 1992

Dr I.L.G. Hutchison, NZ Fellow, FFARACS 1961, FANZCA, 1992

Dr G.B. Westmore, Vic Fellow, FFARACS 1974, FANZCA, 1992

HONOURS AND APPOINTMENTS

Dr John Hains, QLD – President Australian Society of Anaesthetists

Associate Professor Garry Phillips, SA – Chair – Professor of Anaesthesia and Intensive Care, Flinders University of South Australia, Flinders Medical Centre

Dr Douglas Jones, HK – Chair of Anaesthetics, University of Queensland, Royal Brisbane Hospital

Dr W. Mayne Smeeton, NZ – OBE, New Year's Honours List

Dr Nerida M. Dilworth, WA – Member of the Order of Australia

Dr Mervyn D. Cobcroft, QLD – Medal of the Order of Australia

WORKING AS A FLYING ANAESTHETIST IN OUTBACK QUEENSLAND

Flying Specialist teams have provided surgical services to the rural community of outback Queensland for more than 30 years.[1] [2] At present there are three flying teams operating in Western Queensland. One surgeon is based in Longreach while the other two teams (one surgical, the other Obstetric and Gynaecology) are based in Roma 500 km west of Brisbane. Each consists of Surgeon, Anaesthetist, and pilot with their own dedicated aircraft.

Details of the Flying Obstetric and Gynaecology (FOG) service covering 24 (now 27) towns scattered over an area of approximately three quarters of Queensland state has been reviewed recently.[3]

The Flying services cover seven regions in Queensland, covering a distance of approximately 150,000 km a year delivering both an elective and emergency service to towns in remote outback areas. All teams are on-call for emergencies every day throughout the year, except for four days each month nominally covered by one of the Flying Surgeons. The anaesthetist's role parallels that of the surgeon however, recruitment has been and remains a major problem.

Rural Anaesthesia represents a unique working environment for the Specialist.[4] Patients' ages range from neonate – 89 years, and weigh between 3-150 kg with each day bringing new and often unexpected challenges. Our six-seater twin engine Beechcraft Baron is usually airborne at 0700 heading towards outback hospitals usually 30-120 minutes flying time from base.

Emergency calls occur once or twice weekly flying out to deliver babies by caesarian, placement of epidural or spinal for forceps, dealing with ruptured ectopics, ruptured viscus, or trauma cases.

The 600 hours of flying a year can be spent constructively catching up on reading of journals, preparing talks or projects and doing necessary administration and correspondence. An opportunity for sleep is also provided when the days have been particularly long.

The airstrips are mostly all weather although some are grass or dirt. At night where electric lighting is unavailable at the aerodrome, reliance is placed on local people to prepare oil-lit beacons at the estimated time of our arrival.

Anaesthetic equipment carried includes: isoflurane vaporiser, laryngeal masks, whitacre pencil point 25G spinal needles. Dinamap and combined portable pulse oximeter-capnometer. Dantrolene, heavy Marcain and Ephedrine are also carried. A hospital staff member usually meets us on arrival to transport us and our payload to the local hospital.

Towns visited have theatre sessions from once a week to once every three months depending on size. The Obstetric patients pose a particular challenge where weights at term are not infrequently over 130 kg (heaviest anaesthetised to date 151 kg). Spinals or epidurals are my preferred option to avoid the risk of a failed intubation.

For many years Anaesthetic services have been provided by medical officers with little practical experience and no anaesthetic qualification with learning being very much 'on the job'. Surprisingly, disasters have been few and far between and many have gone on to become Consultant Anaesthetists in later years.[4] Patients receive a highly personalised service delivered by motivated and dedicated local medical and nursing staff often with the minimum of administrative interference.

What then are the main advantages of coming out as a Specialist and working in these communities for a period of time? Firstly the work is immensely challenging; giving an anaesthetic in situations that are less than ideal can be both exciting and extremely rewarding. There is complete independence as far as how one practices and there is immense scope for the development of what is currently a reasonable service into an excellent one. The role is very much what each individual makes it.

If one just wants to sit back and provide a purely technical anaesthetic service with no other commitment that is possible. However there is scope for much more; the rationalisation of anaesthetic/recovery area equipment, training of staff assisting the anaesthetist, and supervision of medical practitioners in remote areas to whom learning and maintaining anaesthetic related skills are all-important.

The development of anaesthetic services to rural communities cannot be accomplished from the sidelines. Even base hospitals are too far removed from anaesthetic practice in remote areas. One has to be part of it, living and working amongst these communities in their own environment. From there comes understanding of needs and delivery of a truly specialist service not only as good as might be achieved in city practice but possibly better . . .

References:

1. Cummins C.F.A. The Flying Surgeon Service. *Medical Journal of Australia* Aug 24 1961; 341-344.
2. Cummins C.F.A., Biggs W.W., Whiting J.C. The First Half Million Miles. *Medical Journal of Australia* Aug 29, 1964; 348-352.
3. Baker J.W., Buttini M.J. The Flying Obstetric and Gynaecology Service in rural Queensland: its first two years. *Medical Journal of Australia* 1991; **154:** 578-582.
4. Taylor B.L., Biggs W.W. Anaesthesia and the Flying Surgeon Service 25 years on. *British Medical Journal* 1987; **294:** 233-235.

'INFORMED CONSENT' - DOCTOR'S OBLIGATION TO INFORM PATIENTS

Michael Gorton, B. Comm, LLB. College Honorary Solicitor; Partner - Abbott Tout Russell Kennedy

The doctor's legal obligation to fully inform and advise patients in respect of medical procedures has been developed over a number of years by the Courts in Australia and the United Kingdom. Suffice to say that the nature and extent of the doctor's obligation remains complex and unclear.

The National Health and Medical Research Council is presently engaged in the development of a comprehensive booklet providing 'Guidelines for Medical Practitioners on Providing Information to Patients'. Much work and effort has been involved by representatives of the medical and legal professions in the development of those Guidelines, although it is not anticipated that the Guidelines will necessarily comprehensively advise on all situations where doctors will have an obligation to inform patients. Whilst there is some concern that the promulgation of formal guidelines may impose a greater duty on doctors than presently exists at law (since the Guidelines may be adopted by the Courts as a set of "Rules"), the preparation of a comprehensive statement on the matter will, at least, be a useful educational guide to doctors seeking to clarify their position and work their way through the morass of conflicting and technical judicial determinations.

Of some note, the recent decision of the High Court of Australia in **'Rogers v Whittaker'** represents the latest considered view of Australian Courts on this issue. The Australian decision is recognised as an extension of the existing obligations of doctors to inform patients. The High Court decision confirms the existing obligations of doctors to exercise reasonable care and skill in providing advice and treatment to patients. The standard of care and skill required is that of the ordinary skilled person exercising the particular specialist skills involved. The law recognises that a doctor has a duty to warn a patient of a material risk inherent in any proposed procedure or treatment. A risk will be considered material if, **in the circumstances of the particular case, a reasonable person in the position of the patient, if warned of the risk, would be likely to attach significance to it, or if the medical doctor is, or should reasonably be, aware that the particular patient, if warned of the risk, would be likely to attach significance to it.**

Thus, when considering the need to inform a patient of a particular risk, there will be two separate matters that will require consideration:-

(a) would a reasonable person in the position of the patient be likely to attach significance to the risk; and

(b) is the doctor aware, or should the doctor be reasonably aware that the particular patient would be likely to attach significance to that risk.

This new formulation by the High Court places an additional burden on doctors to carefully consider what information is given to patients in relation to particular procedures. Because the particular consequences for doctors can be severe, these are clearly matters which must be properly understood and applied in all cases. It is particularly important for doctors to keep detailed records of all significant discussions with patients where advice has been given.

Certainly, where there is any doubt or confusion, proper advice should be sought.

Employment Contracts

In Victoria, the Employee Relations Act 1992 has introduced the provisions for widespread employment agreements. The system created under the legislation will apply to all Victorian employees covered by a State Award.

All existing State Awards expired on 1st March, 1993. Employees who have not entered into an employment agreement by that date, or become subject to a new Award, will be bound by an individual employment agreement which will be deemed to contain the same terms and conditions as those set out under the expired Award.

New employment agreements may be individual or collective. Employees are entitled to have representatives represent them in negotiating employment agreements.

It is a requirement that all employment agreements (whether collective or individual) must be in writing. Employers are required to give a copy of an employment agreement to any employee as soon as possible upon request.

Employment agreements are required to contain certain minimum terms and conditions:

(a) Four (4) weeks annual leave.
(b) One week's paid sick leave per year.
(c) A minimum of rate of pay equal to the hourly rate as contained in the prior Award.
(d) An entitlement to maternity, paternity or adoption leave.
(e) Standard long-service leave provisions.
(f) Dispute and grievance resolution procedures, particularly in relation to 'stand-down' provisions.

Both employers and employees should be wary of entering into hastily prepared agreements, as there are many pitfalls under the legislation. Each should carefully review their position and determine whether an Employee Agreement is appropriate, or whether reliance on the expired Award will form a sufficient basis for an ongoing employment agreement. However, it is worth noting that Agreements which are overly simplistic may have the potential to generate disagreements or disputes in the future.

The legislation contains provisions requiring employers to keep particular records of employees and the terms of employment. New legislation also regulates the ability of employees to strike or be engaged in industrial action.

It is worth noting that the legislation only applies in respect of Victorians under State Awards. There is, of course, an ongoing process under which many Victorian Unions are seeking to transfer to Federal Awards.

ITEMS OF INTEREST FROM THE FEBRUARY 1993 COUNCIL MEETING

WELCOME

The President welcomed Dr Ron Trubuhovich, Chairman of the Section of Intensive Care, Dr John Hains, President of the Australian Society of Anaesthetists and Dr Hugh Clarkson, President of the New Zealand Society of Anaesthetists to the Meeting.

EDUCATION

Recognition of Provisional Fellowship Year Posts

1. That from the commencement of the 1994 Hospital Year, Provisional Fellowship Year posts will be recognised on the same basis as other training posts (College Policy Document E1 "Guidelines for Hospitals seeking College Approval of Training Posts in Anaesthesia"). They will form part of the complement of training posts and will normally be reviewed as part of the College's review of training schemes.
2. That each Provisional Fellowship Year position must have a Job Description which has been approved by the Assessor.
3. That trainees must seek prospective approval from the Assessor to commence the Provisional Fellowship Year. The application must include the Job Description and should indicate whether or not the post has changed in any respect from that previously accepted for a Provisional Fellow.
4. That approval for Provisional Fellowship Year posts outside of Australasia, Singapore, Malaysia and Hong Kong must be given on an individual basis for each Provisional Fellow. The Assessor will require a Job Description and an indication that the requirements of College Policy Document E13 "Guidelines for the Provisional Fellowship Year" will be met.
5. That the Assessor may approve individual Provisional Fellowship Year job descriptions outside the above categories on a 'one-off' basis.

Specialty Training

Council accepted the principle that appropriate subspecialty experience be a mandatory requirement for training in Anaesthesia.

Selection of Committees for Intensive Care Appointments

Council agreed that the College representatives on Selection Committees for appointments in Intensive Care should be Fellows endorsed in Intensive Care.

UK Graduates and Intensive Care Specialist Registration

Council resolved that medical graduates who have obtained their United Kingdom postgraduate qualification in Anaesthesia and have completed their Higher Specialist Training, and then spent two years as a Senior Registrar in one or more of the recognised training posts in intensive therapy in the United Kingdom, be eligible for College support for recognition as a specialist in Intensive Care in Australasia.

EXAMINATIONS

Final Examination (Anaesthesia)

The following changes in the format of the vivas for the Final Examination (Anaesthesia) will take effect from September 1993.

The MCQ paper will remain the same.

The long essay paper will be replaced by a short answer paper of 15 questions with a time allowed of 2.5 hours.

The vivas will be similar to the current system but there will be nine in number, each of 19 minutes duration. The long clinical examination will be replaced by three encounters, each of 19 minutes duration; two will be observed assessments of patients and one will be an oral encounter, testing knowledge and understanding of clinical investigations. The clinical specifically tests a candidate's ability as an anaesthetist, to assess a patient and determine the presence of disease processes.

100 marks will be allocated for the whole examination. 25 for the MCQ, 15 for the SAQ, 15 for the clinical and 45 for the anaesthetic vivas.

CONTINUING EDUCATION AND QUALITY ASSURANCE

Publication of ASC Abstracts

1. Council agreed that selected abstracts of papers presented at the 1993 Annual Scientific Congress be published in 'Anaesthesia and Intensive Care'.
2. That selected abstracts of papers presented at ANZCA ASMs from 1994 be published in 'Anaesthesia and Intensive Care'.
3. That selection of abstracts of papers to be published in 'Anaesthesia & Intensive Care' be determined by a Committee including:
   - 3.1 the ANZCA ASM Officer
   - 3.2 the Chief Editor of 'Anaesthesia & Intensive Care' (or nominee);
   - 3.3 the relevant ASM 'Scientific Programme Convener.
4. That criteria for publication of selected abstracts will be:
   - 4.1 the paper is of an original scientific nature and has not been published or accepted for publication in whole or in part by any journal;
   - 4.2 the abstract is self-contained, appropriately formatted and does not exceed 300 words in length;
   - 4.3 the paper is not a review, discussion or general interest document (an exclusion notice to this effect will appear in the Journal);
   - 4.4 the abstract follows the accepted format of a full scientific paper (but in a much abbreviated form), including relevant results, conclusions, one or two references and one small figure suitable for photo-reduction;
   - 4.5 the abstract is accompanied by a statement signed by all authors explaining that:
     - 4.5.1 the authors intend the work to be considered for publication in 'Anaesthesia & Intensive Care';
     - 4.5.2 all authors have each contributed significantly to the paper;
     - 4.5.3 the authors assign copyright of the abstract of the paper to 'Anaesthesia & Intensive Care';
     - 4.5.4 the work has received appropriate human or animal ethics approval;
     - 4.5.5 the authors note that the Journal will not supply proofs to authors nor enter into correspondence prior to publication.

Special Interest Group – Education
That an Education Special Interest Group be formed which would bring together those within the College who have a particular interest in educational issues relevant to anaesthesia and intensive care; and who would make a significant on-going contribution to the educational ethos without necessarily being involved in College Education Committees.

Launceston 1994 – Annual Scientific Meeting
Dr Carl C. Hug jnr. has accepted the invitation as a Foundation Visitor. Dr Hug will deliver the Ellis Gillespie Lecture at this Meeting.

Preparations are well under way for the first independent Annual Scientific Meeting of the College to be held in Launceston from 30th April to 5th May 1994.

INTERNAL AFFAIRS

Meeting of Councillors with Regional Committee Chairmen and Secretaries
Regulation 3.23 was amended to read:

At the Annual Scientific Meeting of the College, the Chairman and Secretary of each Regional Committee shall meet with members of the Council of the College.

ANZCA Foundation
The Australian Taxation Office has approved the Trust Deed relating to the ANZCA Foundation which has now been established. The Foundation provides taxation concessions for any funds paid to the Foundation.

Melbourne Headquarters
Council agreed to the appointment of a Consultant to assist in seeking an appropriate College Headquarters in Melbourne.

PROFESSIONAL

Policy Documents
The following Policy Documents were reviewed and promulgated:

P3 Major Regional Anaesthesia
P14Guidelines for the Conduct of Epidural Analgesia in Obstetrics
E9 Quality Assurance

Copies of these documents are published in this *Bulletin.*

Council also supported the development of a statement of Standards of Cardio-Pulmonary By-pass Practice.

Standards Australia
The College/ASA Liaison Committee is reviewing anaesthetic representation on the various Standards Committees.

Council agreed to fund the attendance of one representative to the International Standards Meeting in March/April in Toronto.

PROCEDURAL TRAINING FOR RURAL GENERAL PRACTITIONERS

Many Fellows and Trainees will be aware that there has been recent concern at the provision of health care services to rural and other remote areas and that over the past twelve months curricula have been developed for the training of rural general practitioners, in surgical, obstetric and anaesthetic skills. These curricula have been developed by the Faculty of Rural Medicine of the Royal Australian College of General Practitioners with the co-operation of the specialist Colleges.

The policy of the Australian and New Zealand College of Anaesthetists is quite clear:

> ***"That anaesthetics should be administered by fully trained and certified specialists except in areas where specialists are unavailable or in insufficient numbers to provide a complete service."***

The geography of Australia however is such that rural general practitioners are required to provide some anaesthetic service in rural and remote areas.

Representatives of our College aided the Faculty of Rural Medicine in the preparation of the anaesthetic curriculum. This curriculum is designed for rural trainees who elect to major in anaesthesia studies in the Rural Training Programme.

The anaesthetic training will consist of twelve month (three months of this year can be intensive care or accident and emergency). There will be formal assessment during the programme as well as at its completion and the assessment panel will include a Fellow of this College. Finally, there will be a programme of continuing education which will be mandatory.

The following is the criteria for the selection of Trainees into the Faculty of Rural Medicine Programme:

1. ***Completion of two years of the Rural Training Programme which may include a three month term of anaesthesia, emergency medicine or intensive care.***
2. ***Successful completion of the EMST Course or a secure position with a future course.***
3. ***Demonstration of relevant knowledge, skills and experience including a similar experience as an RMO term in anaesthesia.***
4. ***Demonstration of commitment to rural general practice including experience of at least one term in rural general practice.***

Concern by some Fellows is not surprising as it may seem unusual that our College is to be involved in training and assessment of general practitioners but with certification by the Faculty of Rural Medicine, Royal Australian College of General Practitioners. The reality is that there are rural areas which require general practitioners to give anaesthetics – surely it is time we had some standard for training of these doctors. The concern of many will be the obvious one – what if these general practitioners set up in opposition to our Fellows in large towns or in the small western area.

The Faculty of Rural Medicine representatives have stated quite clearly they would not support such action and if there were any such occurrences, understand all support of the Australian and New Zealand College of Anaesthetists would be withdrawn.

A Joint Consultative Committee is to be set up between our College and the College of General Practitioners with representation from other interested parties. This Committee will have an important role in monitoring the outcome of this rural practice venture.

NEVILLE J. DAVIS
Assessor

ADMISSION TO FELLOWSHIP BY EXAMINATION
ENDORSED IN ANAESTHETICS

John Andrew Akers, WA
Mark Richard John Allen, Qld
Kwan Seng Ang, NSW
Andrew Stephen Armstrong, NSW
Kin Wah Au Yeung, Hong Kong
Warren Grant Beckett, Tas
Andrew Belessis, NSW
David Alan Bollinger, NSW
Gregory Mark Bond, Qld
David Howard Francis Buckley, Vic
Mary Suma Cardosa, KL
Jonathan Seton Christie, Qld
Philip Bruce Cornish, NZ
Thomas Andrew Edgley, Vic
Louis Peter George, NSW
Megan Nancy Gray, NSW
Phillippa Noeline Hall, Qld
Rajesh Parsotam Haridas, NZ
Gregory Bruce Henderson, Vic
Michael Anthony Henderson, NSW
Peter Robert Hicks, NZ
Edward William Hughes, NZ
Ian Richard Jenkins, WA
Christine Maree Jorm, NSW
Anne Siu-Sing Kwan, HK
Choon Ye Lee, Malaysia
John Lioufas, Vic
David William James Mecklem, Qld
Roderick John McRae, Vic
Gregory Edward Moloney, Qld
Brendan James Nunn, Vic
Warwick Dean Ngan Kee, NZ
Susan Maree Pingel, SA
David Mickle Scott, NSW
Hugh Libert Seaton, NSW
Paul Francis Soding, Vic
Jeneen Kay Thatcher, Qld
Albert Garth Thomas, Qld
Bruce Donald Todd, Qld
Simon Richard Tomlinson, NZ
Margaret Benson Walker, SA
Suellen Monica Walker, Vic
Donna Joy Westbrook, NSW
Robert John Young, SA

FELLOWSHIP DIPLOMA ENDORSED IN INTENSIVE CARE

Grant Frederick Eruiini-Bennett, NSW
Hing Yu So, Hong Kong

ADMISSION TO FELLOWSHIP UNDER REGULATION 6.3.15

Paul Leslie Gordon Ferris, NSW
Vincent Chi Hang Ho, Hong Kong
Philip Neil King, Qld
Patrick Desmond Lynch, NSW
Peter John Maddern, WA
Thean Cheong Tan, Malaysia

ADMISSION TO FELLOWSHIP BY ELECTION UNDER REGULATION 6.2

Pierre Foex, UK
Michael F. Roizen, USA

THE DONOR FAMILY - THE NEGLECTED SUFFERERS?

Roy Knudson, National Education Officer, Australian Kidney Foundation

My personal experience with donation occurred eight years ago. During the ensuing years I have established two goals, the first being that – for the general public, transplant education does not belong in the Intensive Care waiting room; and secondly – you should never take a journey without fully understanding the destination. Based on my own experience, I would like to pose the question 'Are Donor Families the Neglected Sufferers?''

My personal involvement in organ donation began with the loss of my two young boys who were four and seven years of age, one with the option of organ donation and one without. I have experienced a numbing shock of running to a level crossing to see our seven-year-old son with a severe head injury. Our four-year-old son and 16-year-old neighbour were further along the railroad tracks covered by blankets. My wife and I sat for several hours in the Intensive Care waiting room as the doctor periodically reported the progress of our son on a life support machine. The doctor's next visit was to announce the brain-death of our son.

Then began the difficult process of communication and education as I asked 'What do you mean, brain-dead?' After explaining, the doctor left us to be consoled by our family, friends and Minister.

The doctor was then confronted with the dilemma posed by organ donation. Does he approach this totally traumatised family about the donation of their son's organs?

It is important to stop at this point and compare the options that we, as sufferers, are faced with. If the doctor's answer was 'No' then the second set of brain-death tests would have been performed and the respirator turned off. My wife and I would have left the hospital to put our lives back together with no further contact with the medical profession. Or should he offer us the option of organ donation?

The doctor's decision was to give us the right to make our own choice. After he broached the delicate question, we began our transplant education. Would it affect the funeral? How would the organs be removed? What could be used? Was it against any teachings in the Bible? Would there be any cost to us?

During our transplate education, the doctor asked if we had ever discussed the subject of organ donation as a family. This triggered within my wife memory of a discussion that she and our son had had a year earlier. They had watched a new program featuring a three-and-a-half-year-old girl who was a liver recipient. After the segment ended our son enquired – 'Mum, what really happened to that little girl?' My wife explained transplantation and our son related a lesson he had just learned in Sunday School – that God promises us a new body when we get to Heaven. He then shocked my wife with the request to help people like that little girl should he ever die. My wife acknowledged the comment and then, as we often do with young children, gave the congenial pat on the head. Parents do not wish to consider the mortality of their children.

I hesitate to even begin to try to describe the avalanche of emotions that one is flooded with on the sudden death of a loved one. It is like being set adrift in a black ocean. The struggle between the sheer shock of the loss and denial is like being caught in 'no mans land' during a battle. I can only empathise with those families who have not known the wishes of their deceased loved ones previous to being confronted with the request for organ donation.

Once aware of my son's wishes, any doubts or reservations I may have had were eliminated. Having eased the burden of the decision, the next step was to say 'Goodbye' to my brain-dead son, who for all intents and purposes looked asleep. Emotionally my heart said 'No' this could not be happening, but intellectually I needed to focus on the facts of brain-death. Bearing in mind that my other son and neighbour had been killed, my son's decision to donate his organs was our only glimmer of light. That glimmer of light extended to five other families through our son's corneas, heart and kidneys.

Transplantation is wrought with emotional pitfalls. We could have been distressed by the fact that the specific organ our son wished to donate was not removed. A suitable recipient for the liver could not be found. The second instance came through a newspaper article that stated an 11-year-old who had received our son's heart died later that night. This news could have been devastating, particularly after our having allowed his body to be flown to the recipient's hospital to assist the heart removal. One could easily have fallen into an emotional pit of despair and said 'Why did we submit ourselves to this?' On the positive side, we were interviewed on radio three months after the accident. Shortly after, a recipient broke his anonymity to say 'thank you' from his wife and three children – his new kidney had given all of them a new lease of life. I can only imagine how traumatised I might have been at a later date on realising that the doctor had not offered us the option of organ donation. Our other son could have been a corneal donor, if only someone had informed us.

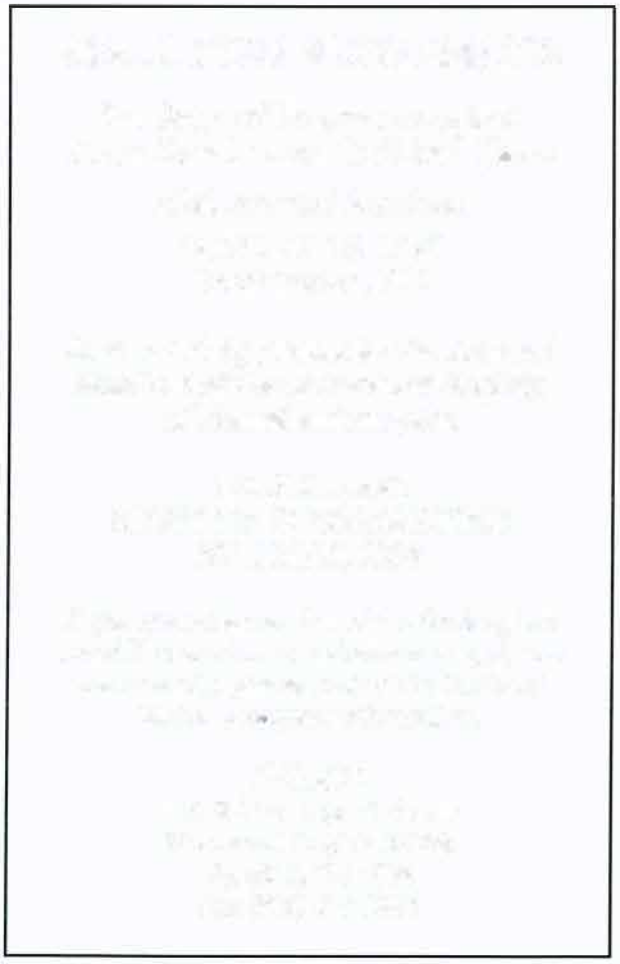
We plan for our death by the making of a Will and provide for the financial security of our loved ones by having insurance. I equate the discussion of organ donation with grief insurance. After eight years of suffering the loss of one child with donation and one without, I appreciate more than

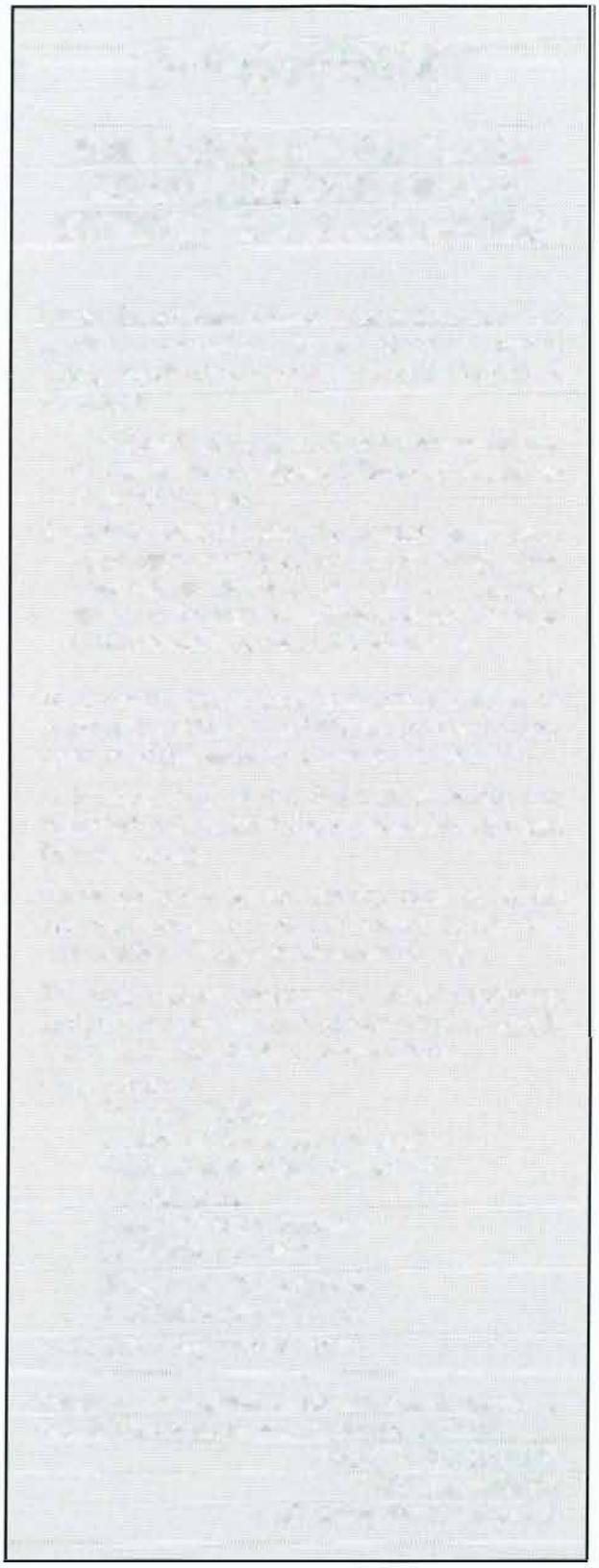
ever the decision made by the medical staff to give us the option of organ donation. Organ donation has been a positive influence on the grieving process for both my wife and myself. Our marriage is strong and we are in the process of rebuilding our lives.

Positive steps are being taken in several areas to meet the extended requirements of being a donor family. Donor Family studies are being conducted, specific Donor Information booklets are being prepared, intensivists are allowing families to observe the test for apnoea, viewing is being offered after removal of organs, specific church services of Thanksgiving are being organised, Community Awareness campaigns are ongoing and Education Programs are being developed for Secondary Schools.

As technology develops and awareness expands, so understanding deepens. With understanding, society will possess the emotional preparation to deal with the options that organ donation offers.

'Are Donor Families the Neglected Sufferers?' – or are they offered that positive ending to what could have been a totally negative experience?





1992 College Council

Back Row: *Dr I. Rechtman, Assoc. Prof. P.D. Livingstone, Prof. J.M. Gibbs, Drs R.S. Henderson, R.J. Willis, D.H. McConnel, D.R. Kerr, Mrs Joan Sheales (Registrar).* ***Front Row:*** *Drs R.G. Walsh, M.J. Davies (Vice-President), M.J. Hodgson (President), Assoc. Prof. N.J. Davis, Prof. G.D. Phillips.* ***Absent:*** *Mr R.L. Atkinson and Mr J.McK. Watts.*

Professor Robert Porter (left) (Dean, Faculty of Medicine, Monash University), with Dr Peter Lowe (Chairman, Victorian Chairs of Anaesthesia Appeal Advisory Committee) at the recent handover of a cheque in line with the agreement that the Appeal contribute $1.25 million for the establishment of the Foundation Chair of Anaesthesia in Victoria at Monash University, Clayton.

Victorian Chairs of Anaesthesia Appeal Patron, Sir George Lush and Lady Lush with Professor Colin Goodchild, Professor of Anaesthesia, Monash University, at a reception held at the College.

EDUCATION AND STANDARDS SUB-COMMITTEE POLICY ON RECERTIFICATION

Adopted by the Committee of Presidents of Medical Colleges on 26th November, 1992

Introduction

There is no debate about the need for medical practitioners in all branches of professional practice to update continually their knowledge and skills if they are to maintain a high standard of performance. Knowledge acquired by the time of graduation from medical school or obtaining a postgraduate diploma indicating competence to commence specialist practice rapidly becomes either obsolete or incomplete. One of the obligations we all accepted on entering medical practice was to participate in some form of Continuing Medical Education to maintain professional competence.

There is also no question that there is increasing pressure from outside the medical profession to impose forms of regulation of professional practice. One of the requirements implicit in such proposed regulation is the demonstration of maintenance of professional competence. There is a progressive reluctance on the part of community and government bodies to accept assurance from within the professions that its members are maintaining appropriate standards, and it is anticipated that the professions will be required to demonstrate that they have processes in place which will ensure continuing competence for clinical practice.

The combination of the conviction that Continuing Medical Education is an essential requirement for competent practice and the expectation by a variety of government bodies that the professions demonstrate maintenance of competence has led to a move among a variety of medical professional groups including organisations in Australia and overseas to institute time-limited certificates and/or recertification procedures. A variety of different processes or requirements has been used or proposed, and their extent reveals that it is not a simple matter to institute a system which will ensure competent practice and provides the correct forms of incentives for all practitioners.

Requirements for Recertification

The recent meta-analysis by Beaudry has provided support for the belief that Continuing Medical Education (CME) leads to improvement in knowledge and performance by medical practitioners.[1] However, it throws no light on the central question of whether compelling everyone to take part (mandatory CME) is better overall than the voluntary participation of a smaller proportion. For this reason, systems for recertification based solely on mandatory participation in a limited range of CME activities are at best incomplete, and may have negative effects by their concentration on imposing minimum standards over a limited area of practice rather than encouraging overall improvement in standards in the profession.

The requirements in relation to maintenance of standards vary depending on the nature and patterns of practice. Although the ultimate method of assessing clinical competence would be a prolonged analysis of actual performance, limited methodology is available to allow this, and its expense would be overwhelming. Several specialty boards in the USA have instituted a time-limited certificate with a requirement for recertification based on passing a written examination. Such a system emphasises maintenance of factual knowledge, but, despite some attempts to test problem solving skills, is not able to test the skills and attitudes required for good clinical performance, and is even further removed from testing whether actual performance is competent.

It is recommended that approaches to recertification preserve the concept of the individual practitioner having the right to choose from a number of options those best suited to his/her requirements for maintaining and improving his/her knowledge and performance.

Other Issues to be Considered

The questions of remedial activity or punitive actions for those who fail to meet the requirements of recertification have to be addressed. Should a College Diploma be withdrawn? Is it legal to do so? What implications does this have with the State Specialist Recognition Advisory Committees and medical benefits rebates? All these issues must be resolved, although the RACOG has already given them considerable attention and has withdrawn the FRACOG from a number of its members. An incentive to meet recertification guidelines may be that failure to do so may lead to higher insurance premiums (or possibly no insurance) and/or that hospitals may refuse to re-credential unrecertified Fellows.

Recommendation

The tide favouring a form of recertification of medical practitioners is becoming stronger, and it would be wise for all Colleges to develop some form of recertification. Evidence and philosophy does not support a rigid system based solely on minimum participation in mandatory CME. A flexible approach tailored to individual needs based on self assessment programs, participation in quality assurance and peer review programs, and forms of continuing education appropriate to the geography and type of practice of the individual doctor should be devised. It should provide the incentives for continuous improvement rather than emphasise the detection of those who have failed to meet a minimum standard. There will be an essential requirement for Colleges to provide a range of educational materials and opportunities. Participation in hospital-based quality assurance and peer review activities and credentialling processes should be used in Colleges in combination with participation in their own programs. Systems of recertification based on re-examination would probably add little to the methods described above, would be expensive and cumbersome to mount and would encounter considerable professional resistance. They are not recommended at this time.

Reference

1. Beaudry J.S. "The Effectiveness of Continuing Medical Education: Quantiative Synthesis." *The Journal of Continuing Education* 1989; **9:** 285-307.

THE GEOFFREY KAYE MUSEUM OF ANAESTHETIC HISTORY

Rod Westhorpe

The museum is slowly but surely undergoing a transformation which, it is hoped, will make it accessible, interesting and educational for Fellows, Trainees and interested visitors.

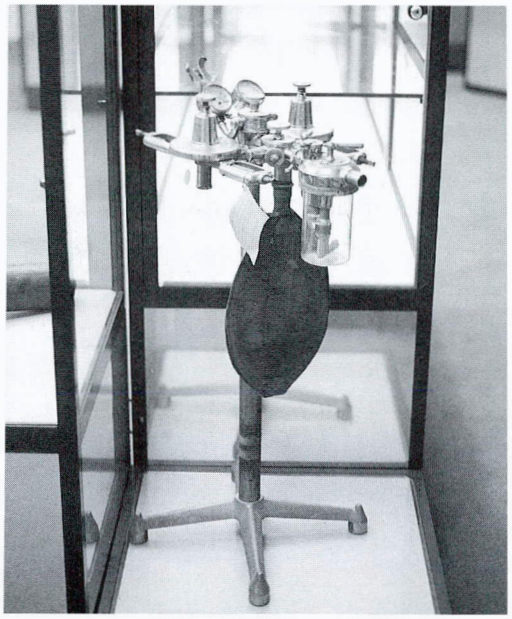
The College Council has been highly supportive of the re-establishment of the museum, their commitment being amply illustrated by the purchase of high quality display cases. Although it is likely that the College of Surgeons' attic is but a temporary home, it is envisaged that a full display will soon be ready for exhibition.

The collection is a very extensive one, perhaps the largest in the world and only a small fraction will be able to be displayed at any one time. Thus displays will be rotated from time to time highlighting different aspects of the development of our specialty. At the same time considerable effort is being put into the development of a computer-based cataloguing system in collaboration with Curators of other collections, notably the Charles King Collection in London. I am indebted to Dr John Reeves for his efforts in this area.

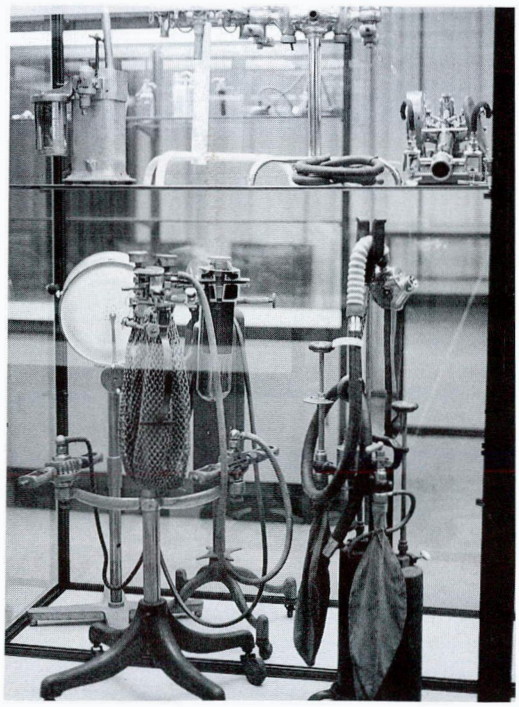
Most of you will be familiar with the covers and cover notes appearing in the journal *Anaesthesia and Intensive Care* over the last three to four years. All of the specimens appearing on the covers have come from the museum. This has served to promote the rekindled interest in the museum both within Australia and overseas. The result has been a marked increase in the number of donations and the museum has recently acquired a new (unused) Ombredanne ether inhaler through the efforts of Dr Michael Goerig in Germany. We will also shortly receive a donation of an anaesthetic machine from Holland.

It is important to stress that the museum is anxious to preserve not only "ancient" anaesthetic equipment, but any apparatus important in the progress of anaesthesia, no matter how recently it was introduced or used. Please contact the Honorary Curator before disposing of any apparatus likely to be of interest!

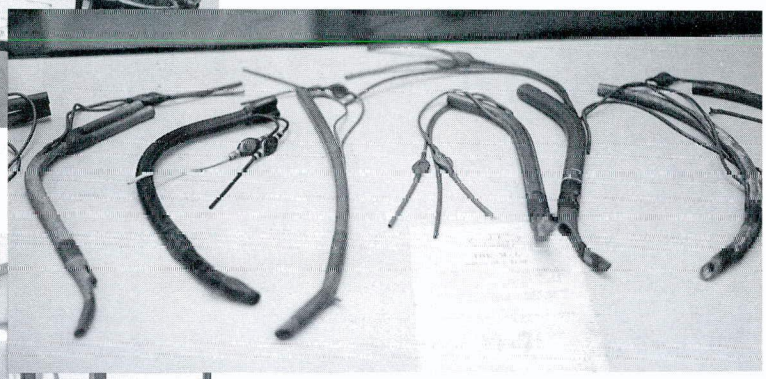
Fellows are invited to look at the collection at any time and I am usually available at the College on Thursday mornings and at other times by arrangement. Trainees may wish to avail themselves of the opportunity to undertake a project in the museum and anyone wishing to assist in cataloguing or preparation of exhibits will be welcomed with open arms. My contact telephone number is (03) 345 5235 or after hours (03) 817 5102.

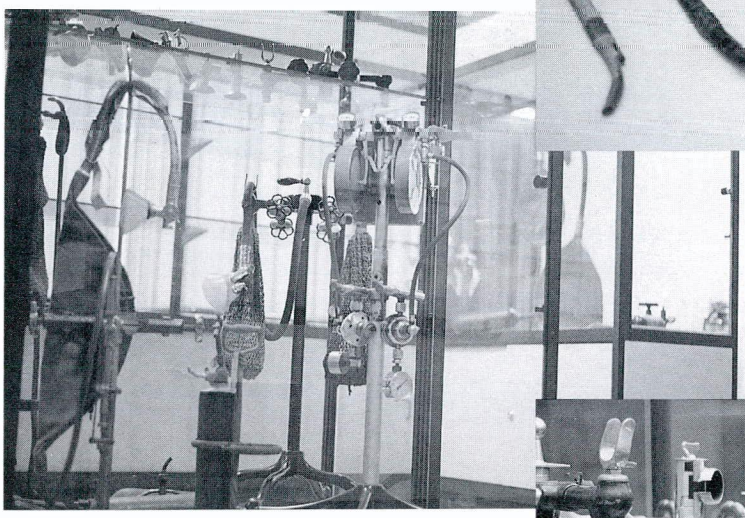


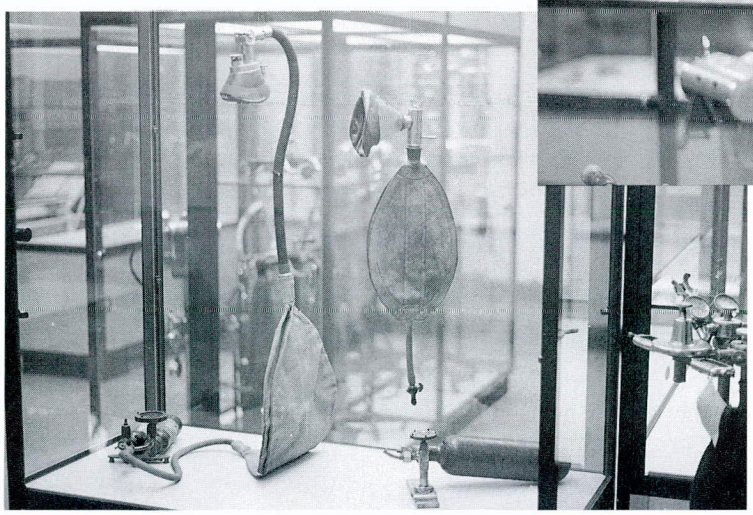
Heidbrink nitrous oxide/oxygen machine, 1928.



Early nitrous oxide/oxygen apparatus including a McKesson and a rare S.S. White machine.

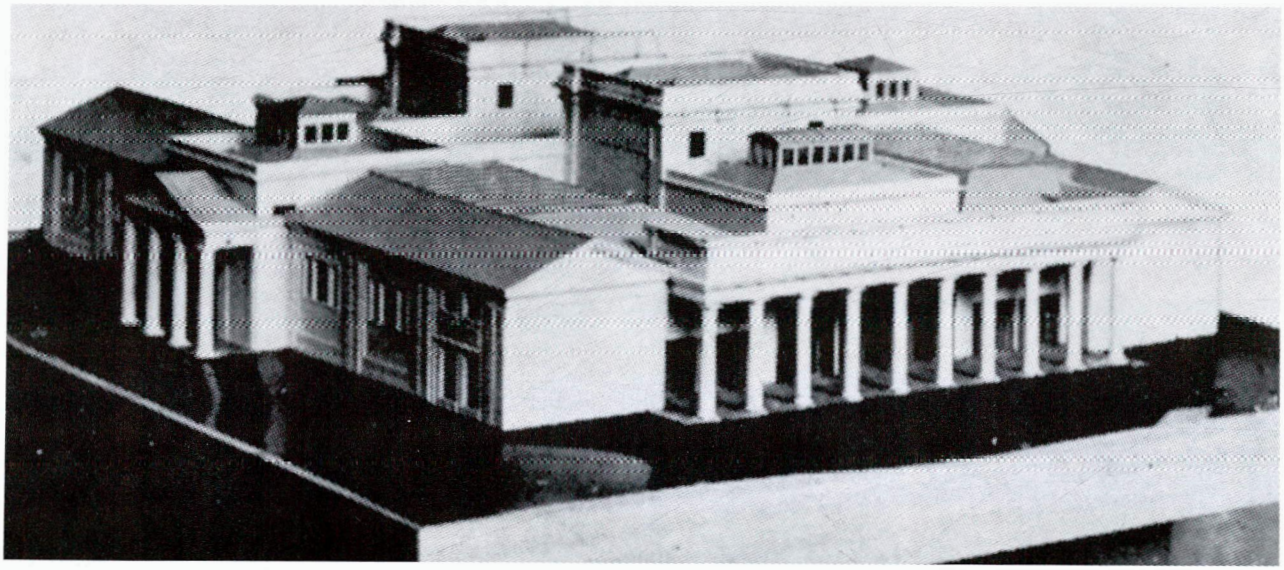






FOR THE RECORD
THE OLD MODEL SCHOOL - PART 2

(Continuing a story which began in the Bulletin of November 1991)



● *A model of the Model School. The perspective is from a position above the intersection of Nicholson St and Victoria Parade, and shows the handsome northern facade of the building. The forward corner of the model would occupy about the same position as the rear of the present Great Hall.*

(Reproduced from L. Burchell, ***Victorian Schools. A Study in Colonial Government Architecture.*** *1837-1900 MUP 1980)*

". . . The National Model Schools on Eastern Hill are now complete and will open today."

Thus the Melbourne *Morning Herald* of 18 September 1854. 'Eastern Hill' was the name then applied to the area around the top end of Spring St, and the report referred to the opening of the first significant public building to occupy what is now the College of Surgeons Gardens.

Note the use of the plural – 'schools'. There were, in fact, three – for boys, girls and infants. In 1854 there were 79 boys and 49 girls in attendance – kept apart by a high fence.

They were also kept away from the grey eminences of the Board of Education, who used the building as their administration centre. They came and went via the Albert St entrance – which was in roughly the same position as the portico of the current building.

The school facade faced north-west toward Victoria Street. Much of the surrounding area to the north and east was still paddocks and bush. The site of Parliament house was still 'a stump-dotted paddock'. Melbourne was less than 20 years old, and the gold rush was on. Law and order and public services were under pressure.

'Dens of iniquity' were reputed to flourish. One such may have been 'a ramshackle house of entertainment called the Salle de Valentino', located on the Spring St/Bourke St corner.

Having such a neighbour does not appear, however, to have significantly distracted the 'Old Model' from its earnest pursuit of education and virtue. According to one devoted 'Old Modellier', it was 'a school in which teachers, scholars and building (were) all of 'model' status; in which all the machinery for the good work (was) concentrated in one central edifice – Board Room and offices for the administrators, basement storerooms whence supplies

of imported requisites, from pencils to books and ink-powders, should radiate out to National Schools . . . in all quarters of the Colony; spacious class rooms for the model scholars, and a 'Normal College' where the model teachers could be trained by a specially imported resident master and mistress . . .'.

The first master was Arthur Davitt, from Dublin. He often spent all of his Saturday mornings 'instructing teachers who came (by foot) from the suburbs'. However, his demise was followed by closure of the teacher training facility until 1870.

The longest-serving of the masters (1863-1886) was 'Paddy' Whyte – described as a 'man of religious and educational broadmindedness', and as being to the Model School what Arnold was to Rugby.

Whyte instituted a system mollifying the alleged 'god lessness' of state secular education – allowing representatives of all denominations to instruct their adherents once a week.

He also developed the secondary side of the school. Since 1856 it had 'provided for the advanced studies of its older students by . . . classes in Greek and Latin classics, a modern language, mathematics and history – all to Matriculation standard'. It is claimed that the school achieved, during Whyte's time, 'high scholastic honours with Civil Service and Matriculation classes.'

This represented the State's first venture into secondary education in Victoria. It was the first cautious challenge to a strong consensus that secondary education was a middle class preserve – hence something for which users could afford to pay full cost – hence a field for private enterprise alone.

The Model School provided a ladder of opportunity for talent. Its old students included Sir George Turner – Premier of Victoria 1894-1901 and Federal Treasurer thereafter; William Thwaites – the designer of Melbourne's underground sewage system; Sir Bertram Mackennal – sculptor; Mary Hannay Foott – author of 'Where the Pelican Builds & Other Poems'; Nellie Stewart – singer and actress; Sir Frank Gavan Duffy – future Chief Justice on the High Court of Australia; William John Schutt – an Essendon footballer and a judge of the Supreme Court; and Jack Conway – who organised the first Australian cricket team to tour England.

Then there was Frank Tate – the future charismatic Director of State Education – who spent much of his distinguished career on the site – as pupil, trainee teacher, lecturer, and Principal of the Training College.

If the site had a ghost, it would likely prove to be Tate – and rather a genial presence. Though he might be rather annoyed that the Old Model School is no more.

● *Frank Tate, CMG, ISO, MA, Chevalier of the Legion of Honour (1863-1939)*

(Courtesy Education History Service, Ministry of Education & Training)

(■ To be continued with some more on the teacher training; the 'continuation school' of the early twentieth century; the RACS men who were students there; and the obtaining of the site by RACS)

COLIN SMITH
ANZCA Archivist

Sources:

Articles by A.H. Ramsay, W.F. Kemp, J.A. Allan, G.F. Langley, J. Elden and R. Apple in *The Echo* (Quarterly Magazine of the Melbourne High School Old Boys' Association), 18 September 1954.

J.A. Allan *The Old Model School. Its History and Romance 1852-1904* MUP, 1934.

The Education History Service of the Ministry of Education and Training.

Mr J. Elden, Historian of the Melbourne Continuation School.

HIGHLIGHTS OF RACS COUNCIL MEETING HELD ON FEBRUARY 18-19, 1993

AWARDS, ELECTIONS AND HONOURS

Mr Robert Fyfe Zacharin, AO
Professor John Miles Little, AM
Professor William Henry McCarthy, AM
Professor Frederick Oscar Stephens, AM
Mr Rory Clevedon Willis, AM
Mr Brian Leslie Cornish, OAM
Mr Michael Harry Moreny, OAM

Sir Hugh Devine Medal – Mr Bernard McC. O'Brien, AC, CMG

The Advance Australia Foundation Award for Achievements in Medicine for 1993 – Mr Bernard McC. O'Brien, AC, CMG

Prince Henry's Hospital Medal for distinguished contributions to Plastic Surgery – Sir Benjamin Rank.

RACS Award for Excellence in Surgery – Liver Transplant Service in Queensland.

CENSOR-IN-CHIEF

RACS Training and Examinations in Hong Kong
Council resolved the Final Fellowship Examination of the College not be conducted outside Australia and New Zealand.

Council reaffirmed its commitment that when requested, it would assist countries in the Asia-Pacific region in matters related to education, training, examinations and continuing education of surgeons.

In response to specific representations from Hong Kong, the RACS will collaborate in the further development of training programs and exit examinations in Hong Kong.

PROFESSIONAL AFFAIRS

Guidelines for Surgeons Acting as College Spokesmen on Accreditation and Appointment Committees

Credentials Committees and Professional Responsibility
Council approved the above two documents for promulgation as appropriate. Copies are available from the Secretary on request.

Skills Laboratory
Council discussed a report by G J Clunie on Skills Laboratories and B C Milroy on Laser Skill Laboratories and in consultation with the College Laser Subcommittee, the authors of the reports are to investigate the further use of Skills Laboratories in surgical training and workshops.

Endosurgery Group
A provisional constitution for an Endosurgical Group of the College was before Council and was approved for distribution for comment by Fellows with an invitation to Fellows to become foundation members of the group.

INTERNAL

Elections
Council elected the following Office Bearers and other Officers to take office in June 1993.

President:	D E Theile
Vice-President:	J P Royle
Censor-in-Chief:	B J Dooley
Honorary Treasurer:	C U McRae
Chairman of the Court of Examiners:	E H Bates
Chairman of the Board of Examiners:	D H Gray

Amendments to Articles of Association
Council approved amendments to the Articles of Association for submission to the Annual General Meeting of the College in June 1993 for approval, thence to the Corporate Affairs Commission for adoption.

An agenda for the Annual General Meeting, together with the proposed amended Articles of Association and an explanatory statement have been posted to all RACS Fellows.

Amendments to the Regulations
Council approved amendments to the Regulations flowing from amendments to the Articles of Association and as a result of other organisational and procedural changes.

RACS Research Ethics Committee
Council established a RACS Research Ethics Committee to consider ethical issues associated with the use of animals in EMST Courses and in research.

POLICY DOCUMENTS

Review P3(1993)

MAJOR REGIONAL ANAESTHESIA

1. GENERAL PRINCIPLES

1.1 Major Regional Anaesthesia is an anaesthetic technique which can produce significant physiological changes or local anaesthetic toxicity and which may cause patient morbidity or mortality (e.g. epidural or spinal blockage, plexus blockade, intravenous regional blockade).

1.2 Major regional anaesthesia should be undertaken only by medical practitioners with adequate experience in the technique or by those in a supervised training programme. Such persons must understand the relevant anatomy, physiology, pharmacology and complications of the particular block. They must be able to recognise and promptly treat any complications of the block.

1.3 The Australian and New Zealand College of Anaesthetists does not approve of one person assuming the dual responsibility of both the operator and the anaesthetist for any forms of major regional anaesthesia.

1.4 Management of major regional anaesthesia should include secure intravenous access, patient monitoring in accordance with Policy Document P18 "Monitoring During Anaesthesia" and appropriate sedation.

1.5 The anaesthetist should be in attendance throughout the procedure, or until the block is successful, the condition of the patient is stable and the potential for acute toxicity of the local anaesthetic has passed.

1.6 To ensure that standards of patient care are satisfactory, equipment and staffing of the area in which the patient is being managed should satisfy the requirements of the following Australian and New Zealand College of Anaesthetists Policy Documents:

T1 "Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites"

T6 "Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites"

P2 "Privileges in Anaesthesia"

P4 "Guidelines for the Care of Patients Recovering from Anaesthesia"

P9 "The Use of Sedation for Diagnostic and Minor Surgical Procedures".

2. SPECIFIC PRINCIPLES FOR POSTOPERATIVE EPIDURAL ANALGESIA MANAGEMENT

The placement of an epidural catheter and the administration of the initial dose of local anaesthetic or opioid is the responsibility of the anaesthetist performing the procedure.

2.1 Should the anaesthetist delegate the further administration of epidural analgesia to another person it is the responsibility of the anaesthetist to hand over properly the patient's management to that person and to satisfy himself or herself of the competence of that person to manage the epidural analgesia and carry out the administration procedures. Adequate medical records documenting the time, dose and subsequent effects must be kept.

2.2 Competency should be established by:

2.2.1 A form of accreditation which certifies that the person who will be performing the epidural administration has carried out a sufficient number of similar administrations satisfactorily under supervision,

and

2.2.2 Enquiry of the person to establish familiarity with and knowledge of the procedure and subsequent management, including the management of complications.

2.3 No person should be required to carry out any such procedure if uncertain of their competence to do so.

2.4 All patients must have secure intravenous access throughout the duration of the epidural analgesia.

February 1993

Review P14(1993)

GUIDELINES FOR THE CONDUCT OF EPIDURAL ANALGESIA IN OBSTETRICS

PREAMBLE

Epidural analgesia is a safe and effective method of pain relief in labour, provided appropriate precautions are taken as follows:

1. Epidural puncture and/or cannulation of the epidural space should be carried out only by persons with adequate training and experience in the technique.

2. Such persons must be:

   2.1 Readily available to supervise the management of the epidural.

   2.2 Competent to deal with the occasional life-threatening and other complications which may arise from the injection of agents into the epidural or sub-arachnoid space.

3. An appropriately trained person must be present to assist the anaesthetist whilst performing the epidural block.

4. Once epidural analgesia has been established, and the response of the patient to the agent or agents has been assessed by the anaesthetist, further doses to maintain analgesia may be administered by other suitably trained medical or nursing staff, provided that:

   4.1 The dose has been prescribed by the anaesthetist.

   4.2 The anaesthetist delegating the "top-up" procedure is satisfied that the person who will carry out the task is competent to do so and competent to appropriately monitor the patient and her fetus;

   4.3 The person carrying out these tasks is satisfied that he or she is competent to do so;

   4.4 Appropriate equipment and skilled staff are readily available to treat complications and any adverse reactions; and

   4.5 Written instructions and management guidelines are provided.

5. All patients undergoing epidural analgesia must be nursed in an area appropriately equipped with staff able to:

   5.1 Monitor both the patient and fetus;

   5.2 Detect the extent of the block and any adverse effects; and

   5.3 Judge the necessity for top-up doses.

6. A record must be made of the procedure, the clinical and other observations and the instructions delegated to other staff.

7. All patients receiving epidural analgesia must have an intravenous infusion inserted before the institution of the block and the infusion must be left in situ for the duration of the block.

8. Satisfactory and safe epidural analgesia can be produced by continuous or patient-controlled epidural infusion of local anaesthetic alone, opioid alone or local anaesthetic-opioid mixtures. The same principles of management should apply when epidural analgesia is administered by these methods.

9. At all times the ultimate responsibility for the management of epidural analgesia remains that of the anaesthetist who performs the procedure or a delegated specialist anaesthetist.

10. All patients having epidural analgesia in labour must be admitted under the direct care and supervision of a registered medical practitioner.

February 1993

Review E9(1993)

QUALITY ASSURANCE
Guidelines for Departments of Anaesthesia and/or Intensive Care

1. INTRODUCTION

1.1 Quality Assurance is that process which assesses and evaluates overall performances in the delivery of health care.

1.2 Quality Assurance Programmes aim to ensure that high standards of clinical practice are maintained by individuals, Departments and Hospitals or Institutions through regular assessment. The results of such assessments should be reported to appropriate Departmental meetings for evaluation and action as necessary.

1.3 All Departments of Anaesthesia and/or Intensive Care should participate in Quality Assurance Programmes. Smaller Departments should make arrangements with other nearby Departments to enable participation in such programmes.

1.4 All Departments of Anaesthesia and/or Intensive Care should appoint a Quality Assurance Co-ordinator, who will be responsible for the implementation and supervision of the Quality Assurance Programmes in each Department.

1.5 Quality Assurance Programmes are recommended to be developed to ensure that standards of clinical care are consistent with other accepted standards including relevant Educational, Professional and Technical Policy Documents issued by the College.

1.6 Where institutions do not have formally structured Departments of Anaesthesia and/or Intensive Care, these Guidelines on Quality Assurance refer to those Anaesthesia and/or Intensive Care Services as if they are Departments.

2. AIMS OF QUALITY ASSURANCE PROGRAMMES

Quality Assurance Programmes should be designed to provide effective mechanisms to:

2.1 Monitor and evaluate the quality and appropriateness of patient care.

2.2 Monitor and evaluate the clinical performance of Department staff.

2.3 Identify and implement changes where improvements are desirable and to monitor any changes made, including the safe implementation of new methods of treatment and management.

3. MECHANISMS OF QUALITY ASSURANCE

3.1 Quality Assurance Programmes should be designed for selected topics in order to collect data, review the results, determine action to be taken and then assess the consequences of resultant action.

3.2 Every Quality Assurance Programme should be fully planned and defined appropriately before undertaking the study.

4. TOPICS FOR QUALITY ASSURANCE REVIEW

Quality Assurance Programmes in Anaesthesia and/or Intensive Care are recommended to be instituted at appropriate time intervals on some or all of the following:

4.1 The performance of the Department and Anaesthesia service as a whole, including:

4.1.1 The staff and staffing:

4.1.1.1 numbers and qualifications, including senior, junior, nursing, technical and secretarial staff

4.1.1.2 appointment criteria and procedures, and allocation of duties and levels of supervision

4.1.1.3 workload and conditions for work.

4.1.2 The physical facilities:

4.1.2.1 equipment, including compliance with standards, maintenance and replacement

4.1.2.2 the working space for all clinical and non-clinical activities.

4.1.3 The economics of administering the Department, including:

4.1.3.1 budgets

4.1.3.2 expenditure

4.1.3.3 cost effectiveness.

4.1.4 The teaching programmes of the Department.

4.1.5 The research activities of the Department.

4.2 The patient management activities of the anaesthesia staff, including:

4.2.1 Preoperative assessment and investigation.

4.2.2 Conduct of anaesthesia, including:

4.2.2.1 criteria for patient selection (e.g. for day stay management, for particular procedures)

4.2.2.2 criteria for technique selection (e.g. methods and agents used)

4.2.2.3 monitoring selection and use

4.2.2.4 record keeping

4.2.2.5 assistance for the anaesthetist.

4.2.3 Post-anaesthesia management, including:

4.2.3.1 admission and discharge criteria from the Recovery Area

4.2.3.2 criteria for admission to the Intensive Care Unit

4.2.3.3 postoperative pain management

4.2.3.4 postoperative follow-up in general terms.

4.2.4 Patient outcome as assessed by agreed clinical indicators, including critical incidents, morbidity and mortality (4.2.1 to 4.2.3).

4.2.5 Staff outcome as assessed by factors including health, morale, safety, organisation and involvement in education and research.

4.3 The patient management activities of the Intensive Care staff, including:

4.3.1 Criteria for admission to the Intensive Care Unit, including severity of illness and diagnostic groups, and monitoring of patients refused admission.

4.3.2 Patient assessment and investigation on admission.

4.3.3 Patient management during Intensive Care stay, including:

4.3.3.1 diagnostic methods utilised (e.g. clinical, laboratory, imaging).

4.3.3.2 selection criteria for specific therapies (e.g. methods and agents used).

4.3.3.3 monitoring selection and use.

4.3.3.4 record keeping.

4.3.4 Post-discharge follow-up in general terms.

4.3.5 Patient outcome as assessed by severity of illness scoring, agreed clinical indicators, including critical incidents, morbidity and mortality (4.3.1 to 4.3.3).

4.3.6 Staff outcome as assessed by factors including health, morale, safety, organisation and involvement in education and research.

4.4. The individual performance of Anaesthesia and/or Intensive Care staff, including in the following activities:

4.4.1 All patient management activities.

4.4.2 Continuing education and teaching.

4.4.3 Participation in quality assurance activities.

4.4.4 Health, morale and safety.

4.4.5 Research.

5. AUDIT OF QUALITY ASSURANCE PROGRAMMES

Quality Assurance Programmes undertaken, including their validity, should be reviewed extensively by every Department from time to time. Such programmes should be consistent with the size and capabilities of the Department and the Department should ensure that remedial steps are taken whenever problems are identified and that continued review should follow.

6. QUALITY ASSURANCE COORDINATOR

6.1 The Quality Assurance Co-ordinator should normally be appointed by the Department for a period of two years with eligibility for re-appointment, and should have appropriate allocation of time, secretarial and other support to satisfactorily perform the duties required.

6.2 The Quality Assurance Co-ordinator should generally be responsible for ensuring that:

6.2.1 The above College recommendations are implemented as seen reasonable for the size of the Department.

6.2.2 Continuing education and clinical research are encouraged.

February 1993

POLICY DOCUMENTS

E = educational. P = professional. T = technical. EX = examinations.

E1 (1991)	Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Anaesthesia
E2 (1990)	Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Intensive Care
E3 (1989)	The Supervision of Trainees in Anaesthesia
E4 (1992)	Duties of Regional Education Officers
E5 (1992)	Supervisors of Training in Anaesthesia and Intensive Care
E6 (1990)	The Duties of an Anaesthetist
E7 (1989)	Secretarial Services to Departments of Anaesthesia and/or Intensive Care
E8 (1991)	The Duties of an Intensive Care Specialist in Hospital with Approved Training Posts
E9 (1993)	Quality Assurance
E10 (1990)	The Supervision of Vocational Trainees in Intensive Care
E11 (1992)	Formal Project
E13 (1991)	Guidelines for the Provisional Fellowship Year
EX1 (1991)	Guidelines for Examiners with Respect to Candidates Suffering Illness (or Accident) at the Time of Examination
T1 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites
T2 (1990)	Protocol for Checking an Anaesthetic Machine Before Use
T3 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Units
T4 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT)
T5 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries
T6 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites
P1 (1991)	Essential Training for General Practitioners Proposing to Administer Anaesthetics
P2 (1991)	Privileges in Anaesthesia Faculty Policy
P3 (1993)	Major Regional Anaesthesia
P4 (1989)	Guidelines for the Care of Patients Recovering from Anaesthesia
P5 (1991)	Statement on Principles for the Care of Patients who are given Drugs Specifically to produce Coma
P6 (1990)	Minimum Requirements for the Anaesthetic Record
P7 (1992)	The Pre-Anaesthetic Consultation
P8 (1989)	Minimum Assistance Required for the Safe Conduct of Anaesthesia
P9 (1991)	Sedation for Diagnostic and Minor Surgical Procedures
P10 (1991)	Minimum Standards for Intensive Care Units
P11 (1991)	Management of Cardiopulmonary Bypass
P12 (1991)	Statement on Smoking
P13 (1992)	Protocol for The Use of Autologous Blood
P14 (1993)	Guidelines for the Conduct of Epidural Analgesia in Obstetrics
P15 (1992)	Guidelines for the Care of Patients Recovering from Anaesthesia Related to Day Surgery
P16 (1988)	Continuous Intravenous Analgesic Infusions
P17 (1992)	Endoscopy of the Airways
P18 (1990)	Monitoring During Anaesthesia
P19 (1990)	Monitored Care by an Anaesthetist
P20 (1990)	Responsibilities of Anaesthetists in the Post-Operative Period
P21 (1992)	Sedation for Dental Procedures
P22 (1990)	Statement on Patients' Rights and Responsibilities
P23 (1992)	Minimum Standards for Transport of the Critically Ill
P24 (1992)	Sedation for Endoscopy

February 1993