

Australian and New Zealand College of Anaesthetists

ACN 055 042 852

and Faculty of Intensive Care



Bulletin

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

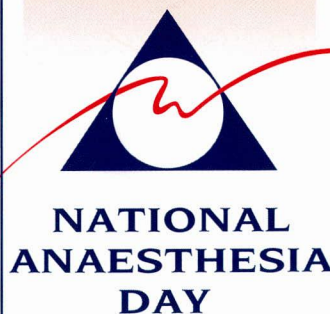
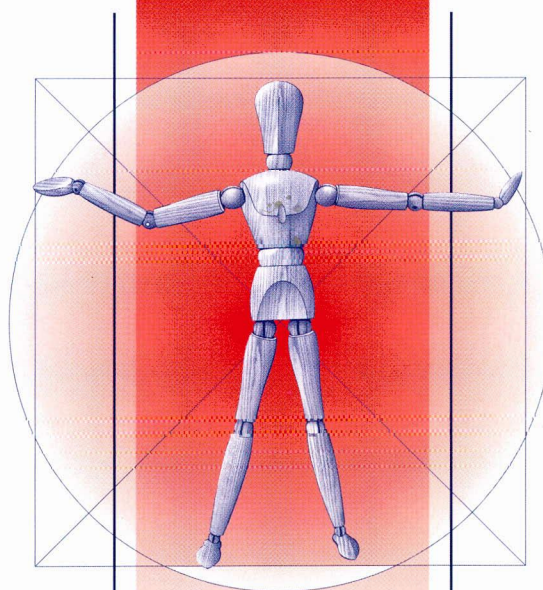
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Pain Relief - a Basic Human Right



**NATIONAL
ANAESTHESIA
DAY**

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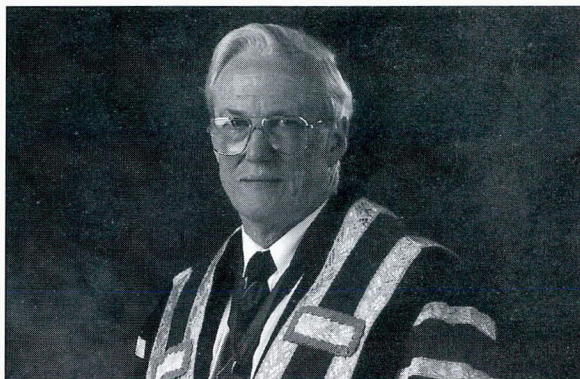
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PRESIDENT'S MESSAGE



Many issues arise between Council meetings which are considered and dealt with by individual officers of the College, by College staff, or by the Executive. The majority of these issues form a large workload for many people, including myself, the Chairman of Executive, Richard Walsh, the Assessor, John Gibbs, the Chairman of the Hospital Accreditation Committee, Ian Rechtman, the Chairman of Examinations, Richard Willis, the Communications Officer, Mike Martyn, the Registrar, Joan Sheales and her staff, together with the Chairmen of Council Committees and Regional Committees, as well as individuals such as our Honorary Solicitor, Michael Gorton, and Media Consultant, Eddie Dean.

A similar workload is borne by the Faculty Board and its staff. Combined with the enormous effort of the Officers and staff of the ASA, NZSA and ANZICS, the image of anaesthesia, intensive care and pain management is growing rapidly, and its sphere of influence is increasing both in Australia, New Zealand, Asia and the Pacific, and world-wide.

Just as the views of the community and politicians about life in general are dynamic, so must we be, taking opportunities as they arise, while standing firm on issues of standards and quality patient care.

To compete within, and take a leadership role in medicine requires much time and effort of the sort which is often poorly rewarded financially, and which can impact on an individual's personal life adversely unless a correct perspective is kept.

Examples of rapid change in the last few years are easy to find - minimally invasive surgery, day surgery, interventional radiology, anaesthesia workstations, acute pain services, the internet, maintenance of standards, simulators, crisis management, media utilisation, health funding, political correctness etc. to name a few.

Anaesthesia, intensive care and pain management are prospering due to the efforts of many people. As the College develops its strategic plan, Fellows are encouraged to seek constructive input whenever they see an opportunity.

Council will refer as many issues as is practicable to Regional Committees and Fellows for comment. However, many of these will have been worked up prior to all input being received and in some cases, decisions will be made without consultation, due to time constraints or confidentiality.

A number of matters currently under consideration by Council are:

- Production of a report on Mortality in Anaesthesia based on the collaboration of State Mortality Committees.
- Privileges in Anaesthesia in non-teaching hospitals
- Paediatric Anaesthesia in Hospitals without paediatric units
- Revision of infection control guidelines
- Future needs for College facilities, both at Headquarters and in the Regions
- Workforce issues in collaboration with the Australian Medical Workforce Advisory Committee and the Medical Training Review Panel.

With regard to up and coming events, I draw your attention to three important ones:

1. *ASM - Christchurch 10-14 May*
2. *Pugh Sesquicentenary Meeting - Launceston 6-8 June*
3. *National Anaesthesia Day - 2 July.*


G.D. PHILLIPS

CAREER MEDICAL OFFICERS IN AUSTRALIA

Recent developments in health have prompted Council to examine the role of Career Medical Officers and develop strategies to best fulfil the College's Mission objectives with respect to these doctors.

A Career Medical Officer (CMO) is a doctor who works in a public institution but who is not a GP or specialist or an accredited specialist College trainee. This post was first introduced by the NSW Department of Health in the early 1980s to retain junior doctors in public hospitals, and has now been implemented by some public institutions in other States. CMOs filled a need in rural and certain metropolitan areas, performing medical duties that GPs and specialists were unable or unwilling to service. They are now employed in many roles (eg. in Accident & Emergency Departments, psychiatric wards, general wards, operating theatres, and community and public health centres) and under various titles (eg. hospital medical officer, senior medical officer, etc.). CMO posts, despite having no formal educational opportunities or a career structure, attracted some young doctors disinclined to pursue GP or specialist training. Recently, they have been joined by some doctors unable to enter training programmes of specialist Colleges or pass specialist examinations.

The number of CMO posts are set to increase in Australia and New Zealand. The AMA and Australian State and Federal governments are giving attention to this grade of doctors, and its support from governments is likely. Recent changes in the Australian Health Insurance Act (ANZCA Bulletin March 1997) will swell the ranks of CMOs. Now, Medicare payment benefits are denied to newly registered graduates who are not in an approved GP or specialist training programmes, and to overseas trained doctors (OTDs) for a period of 10 years. (Certain exceptions are made, eg. a rural locum in an approved placement.) Each year, about 1,200 graduates of Australian medical schools complete their internships and 200 OTDs pass the AMC examination. These newly registered medical practitioners have to compete for about 1,000 available training posts (400 for GPs and 600 for specialists). As a result of the Health Insurance Act changes, the 400 unsuccessful doctors are now unable to practise as private GPs and have to seek salaried employment as non-training doctors, ie. CMOs. If CMO posts become saturated because of their nature,

the backlog of doctors seeking hospital employment will increase. In New Zealand, growth of salaried non-training hospital doctors will present similar situations.

Relevance to ANZCA

CMOs in anaesthesia have already been appointed in some Australian hospitals. With increasing numbers of non-training doctors in public hospitals, anaesthesia departments will come under pressure to accept CMO members. Eventually, since they have no career structure, some CMOs will remain as permanent staff, thus creating an underclass of anaesthetists. Failed or drop-out trainees may also fill CMO posts, and department morale may suffer, especially if salaries are vastly different and are perceived to be unfair by either CMOs or accredited trainees. It is not inconceivable that some hospital administrators, when faced with severe financial shortfalls, may choose to accept a lower standard of care and replace specialists with cheaper CMOs.

The above eventualities jeopardize ANZCA's mission to serve the community by fostering high standards of care, and the College has to act accordingly. ANZCA opposes a two-tier structure of career anaesthetists and the implementation of the CMO grade in Australian and New Zealand hospitals which are adequately staffed by specialists and accredited trainees. However, realistically, the numbers of hospital non-training doctors are likely to increase, and the College needs to adopt proactive policies on CMOs. CMOs will seek educational opportunities, and cash-strapped Universities and TAFE Colleges are likely to respond. The uniformly consistent high standard of specialist training conducted by ANZCA will be compromised by a plethora of patchy postgraduate programmes and qualifications in anaesthesia. We need to take charge of training CMOs to maintain high standards of education in clinical anaesthesia. If we are the body responsible for training CMOs in our departments, we will be in a better position to define the level of training and to coordinate and implement the placement and numbers of training posts, rather than have these imposed on us. Council does not favour certification of CMOs as this will introduce a second tier diploma, (eg. the previous British

DA). Thus the following resolutions were passed by Council after lengthy consideration.

1. ANZCA formally opposes the denial of provider numbers to new Australian doctors by writing to the federal Minister of Health, the AMA and the CPMC.

2. ANZCA formally opposes widespread placement of CMOs in non-rural hospitals, but supports the placement, after appropriate training, in areas of need where there is a shortage of specialist anaesthetists.

3. Accreditation – All CMO posts in anaesthesia in ANZCA training hospitals must be accredited by the College. The number of CMO posts should not compromise high standards of training and clinical service.

4. Education – CMOs in anaesthesia must participate in department continuing education activities. CMOs require clinical teaching and training appropriate to the first two years of FANZCA vocational training.

5. Duties – CMOs are not accredited vocational trainees. Duties must be delineated and appropriate supervision provided.

These resolutions have been referred to the Education Committee.

TEIK OH

LAW REPORT

Michael Gorton, B.Comm, LLB.
Partner, Russell Kennedy, Solicitors
College Honorary Solicitor

PRE-EMPLOYMENT MEDICAL TESTING - GUIDELINES FOR DOCTORS



Doctors and health practitioners are increasingly being called upon by companies to perform pre-employment medicals. Under Federal and State equal opportunity and anti-discrimination laws, these must be performed in a non-discriminatory manner. Both doctors and employers can be liable for a discriminatory medical test.

Many employers routinely use pre-employment medical tests as part of their selection process. These tests can be a useful component of the selection process for jobs that require certain physical or mental capacities.

Physical tests are relevant to jobs involving physical activity. Unless there are unusual circumstances, such as extensive training requirements, it is less likely that sedentary jobs will require a level of physical health that would justify medical testing. Where physical testing is conducted, it is important that all relevant employees are tested and that discrimination factors, such as age, are not used to determine who should be tested and who should not.

Where it is necessary to test for specific skills, it is best to restrict testing to people who meet all the other requirements of the job; that is, short-listed applicants. This is not a legal requirement, but it reduces the likelihood of a complaint based on a request for

information that could be used for a discriminatory purpose.

Pre-employment medical tests should relate exclusively and directly to the genuine and reasonable requirements of the job and not unfairly discriminate against people with disabilities/impairments.

The following checklist will assist doctors and other health practitioners to conduct a non-discriminatory medical test.

Doctors should:-

- Ensure that they are aware of the genuine and reasonable job requirements for the particular job and the capacities required to perform. Employers should supply this information to the doctor.
- Outline to job applicants the nature of the test to be conducted, the capacities or aspects of their health which will be tested and how these relate to the genuine and reasonable requirements of the employment position. Job applicants should also be told that the employer will only be informed about those aspects of the applicant's health which relate to their capacity to perform the genuine and reasonable requirements of the job.
- Only inquire as to and test those aspects of the job applicant's health that are strictly job related and confined to the inherent requirements of the employment. (For instance, it is generally unlawful to ask job applicants whether they have ever made a worker's compensation claim, how many days sick leave they took in the previous year, or questions about health conditions they may have that do not relate to the capacities required to perform the job applied for. Further, rather than requesting applicants to provide information about the nature of any disability they may have, it is preferable to outline to applicants the kinds of duties they would be expected to perform in the position for which they are

applying and then ask them or test whether they have any conditions which will affect their ability to perform those.)

- Be aware that employers are obliged to make reasonable accommodation for persons with disabilities/impairments. Employers may also be obliged to modify the job, where reasonable, to accommodate persons with a disability. This may involve the provision of services or facilities to enable or assist the employee to perform the genuine and reasonable requirements of the employment. Employers are not obliged to provide services or facilities which would impose an unjustifiable hardship on the employer or which it would not be reasonable to provide in all the circumstances.
- Ensure that job applicants with disabilities are tested using any service or facility they routinely use to perform the essential duties of the job. For example, if an applicant uses a hearing aid, wears glasses or takes medication, be sure the aid or glasses are used during the assessment and that an applicant takes their usual medication.
- Ensure that medical tests are not used to screen out applicants with certain past injuries or disabilities or those who have a family history of certain illness or disabilities, as job-related skills are the only relevant factor.
- Only supply job-related health information to the employer. Other irrelevant information that the applicant may disclose in the course of the examination should not be disclosed to the employer. An employer cannot refuse to employ a person with a disability/impairment on the basis of a medical examination that discloses a disability/impairment unrelated to adequate performance of the job.
- Keep all medical records confidential.

The following examples illustrate some of these points -

KIM is hypertensive. He applied for cleaner/labourer positions with the same employer on two separate occasions. Part of the application process was a medical examination. Kim did not pass the medical test because of his hypertension. The employer's doctor conducting the tests did not match Kim's abilities to the level of fitness actually required for the job. The doctor was not aware of

the specific duties involved and just assumed that Kim's fitness would be insufficient to enable him to carry out the required duties.

Kim may lodge a discrimination complaint.

In similar circumstances in *Hurley v. the Electricity Commission of NSW* (1994) EOC 92-624, the NSW Equal Opportunity Tribunal found that the respondent employer discriminated against the complainant on the basis of his impairment in not offering him employment. The complainant was awarded \$40,000 in compensation.

KYLE was refused a job as a security guard on the sole basis of his myopia detected during the course of a medical examination. He was not permitted to wear his contact lenses during the eye test. When wearing these, he has perfect vision.

Kyle could lodge a discrimination complaint. At conciliation, the employer may agree to employ Kyle and to back-date his starting date for the purposes of calculating superannuation and long service leave entitlements to the date he would have been employed had he not been subjected to discrimination.

In similar circumstances in *Flannery v. O'Sullivan* (1993) EOC 92-501, the Queensland Anti-Discrimination Tribunal found that the respondent employer discriminated against the complainant and ordered the respondent to take whatever steps necessary to admit the complainant as a recruit. His starting date for appointment for the purposes of calculating superannuation and long service entitlements was set as the date on which he would have been admitted as a recruit had he not been subjected to the discrimination.

Some other examples of misuse of medical information that could make employers liable for unlawful discrimination include:-

- Using information about an applicant's actual or assumed disability as part of the pre-interview culling process.
- Asking applicants questions at interview or in application forms about past or current injuries,

number of sick days taken in the previous year, or previous worker's compensation claims.

An employer may also be liable under privacy laws if it discloses results of a medical test to others, eg. other employees.

If applicants have been provided with an outline of the inherent job requirements, they may be asked about their ability to perform those requirements. For example, rather than asking, "Have you ever lodged a worker's compensation claim?", an employer could ask, "This job requires heavy lifting/sitting at a computer terminal for long periods of time. Are you able to perform these duties?"

NALYNI applied for a job as a prison officer. She attended an interview and did well in the written examination. She was requested to attend a medical examination. Although she was found to be physically fit to perform the requirements of the job, she was refused employment because she had only recently recovered from Hodgkin's Disease. The employer had a policy of not employing people who had suffered from cancer in the last two years. **The employer's reliance on Nalyni's past illness to exclude her from employment may be unlawful.**

In similar circumstances in *Barry v. State of Victoria* (1994) EOC 92-598, the Victorian Equal Opportunity Board found that the respondent discriminated against the complainant on the basis of his past impairment in not offering him employment. The complainant was awarded \$5,071 for loss of salary.

Medical tests for determining eligibility to join a superannuation fund are not relevant at the pre-employment stage. These tests are more appropriately carried out after the applicant has accepted the offer of the position. Such tests should be used for other purposes and should not affect the person's eligibility for employment.

Any psychological testing should be conducted in accordance with these guidelines and relate specifically to the genuine and reasonable requirements of the job. Care should be taken that the form or content of the testing does not disadvantage persons possessing any of the attributes protected by the Act.

Federal and State legislation prohibits discrimination on the basis of disability/impairment.

Disability/impairment is broadly defined and can include:-

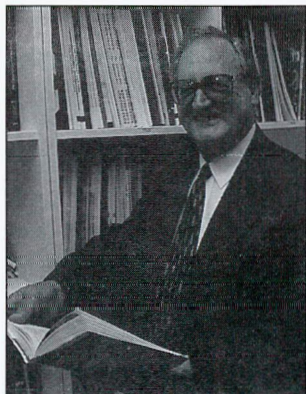
- *total or partial loss of bodily function;*
- *the presence in the body of organisms that may cause disease;*
- *total or partial loss of a part of the body;*
- *malformation or disfigurement of a part of the body;*
- *malfunction of a part of the body including -*
 - *a mental or psychological disease or disorder;*
 - *a condition or disorder that results in a person learning more slowly than people who do not have that condition or disorder.*

[This Report attempts to generally canvass the issues of anti-discrimination law in Australia and New Zealand. It is based on information issued by the Equal Opportunity Commission in Victoria, whose contribution is gratefully acknowledged.

Doctors involved in employment medical testing should obtain information for their own State or Territory from their local Equal Opportunity or Anti-Discrimination body.

Michael Gorton is a Commissioner with the Equal Opportunity Commission of Victoria.]

WORKING WITH THE MEDIA



It is recognised that some participants in National Anaesthesia Day will have access to their own Public Relations personnel. Others will have had previous experience in dealing with the media. These brief notes are supplied by the College Communications Consultant, Business

Essentials Pty Ltd, as a broad guide where expert assistance and/or experience is not readily available.

DEVELOPING NEWS "ANGLES"

On an occasion such as National Anaesthesia Day, the media will need a new "angle" on anaesthesia.

The Fact Sheet being supplied outlines the main parameters of the message for the Day. Hospital departments and other participants will, of course, prefer to concentrate on their particular area(s) of expertise in the field of pain treatment and management.

In advance of the Day, and before preparing any News Release, or media contact, look for such things as:

- recent research or studies which show trends in pain treatment - eg: are more women asking about/choosing epidural analgesia for labour?
- recent introduction of new specialist staff, facilities, equipment or services, in the pain field
- plans for starting a new specialist pain service or facility, or to seek funding for such a project
- **especially**, human interest "angles" - is there a particular recent successful pain treatment which, with patient approval and participation, can be used to "showcase" anaesthetist's work to the media?

- any unusual example or happening, that can demonstrate the skills of an anaesthetist in dealing with the problem, and saving life
- it is possible that a patient from your area has been successfully treated at a Pain Centre, and has returned to a normal lifestyle, and work.

These are examples of the types of stories most likely to catch the eye and ear of the newscaster, and the public.

THINK VISUALLY

Whether it be for television or print think about the ways your story can be illustrated with pictures.

A good still photo in print, or 30-60 seconds of good video on TV news are very strong ways to make an impact on the public mind.

MAKING CONTACT

Many organisations already have their own contact with their local media.

Otherwise, the general rule is to address your information to the Chief of Staff (COS), or the Editor, with a copy to the specialist (health/medical) writer if they exist.

Where available, contact the local newspaper, radio station and television station (in country cities and towns).

1. Mail/Fax a brief advisory note, or make a phone contact or a personal visit (if the media are amenable), seven to ten days in advance, to outline the storyline and your activity planned for National Anaesthesia Day.
2. Local radio talkback programmes are generally a particularly fertile field, and attract considerable audiences.
3. If any of the media want to run a "preview" story, by all means encourage them to publish

information that will attract the public to your "event".

4. Before any contact is made, and any News Release is issued, it is essential to decide **who** is your spokesperson, and stick to that individual throughout.
5. A fundamental of this procedure is that the chosen spokesperson is easily contactable in work hours, and **outside work hours**, for the relevant period. The media often find it necessary to make follow-up checks, or seek additional information in **their** time.

This sometimes can make the difference between a story being correct, or incorrect, when it appears. Media people do like to check facts.

PREPARING A NEWS RELEASE

There are some proven elements which help the preparation and readability of News Releases. They are all directed at achieving maximum clarity of communication, and assisting reporters who are often under time and travel pressures.

Some of the key rules:

- Use A4 paper
- Use the organisation's letterhead, wherever possible

- The heading needs only to be short - it's not necessary to be cute
- Start a new paragraph after each sentence unless a short, directly supportive second sentence is essential
- Double space, and leave wide margins at the sides, top and bottom
- Do not double-side
- As a general rule, two pages are ample
- Date the Release, and always put at the bottom:

Further information: CONTACT NAME, TITLE, AND PHONE NUMBERS FOR BUSINESS AND AFTER HOURS

IT IS ESSENTIAL THAT THE PERSON NAMED IS REACHABLE - ESPECIALLY AFTER HOURS. IF PROFESSIONAL COMMITMENTS OR EMERGENCY CALLS MIGHT INTERVENE, AN ALTERNATIVE CONTACT SHOULD BE NAMED, OR BE ABLE TO FIELD CALLS TO THE PRIMARY SPOKESPERSON'S NUMBERS

EDDIE DEAN
COMMUNICATIONS CONSULTANT

MAJOR PROGRAMME GRANT TO PAIN MANAGEMENT AND RESEARCH CENTRE

At the opening of the Phase II development of the Pain Management and Research Centre of the University of Sydney and Royal North Shore Hospital, on Friday, 7th March 1997, the **Chairman of the Board of MMI**, Mr. John Curtis, announced a \$1.5 million grant for the years 1997-2001. This substantial grant was made as a result of MMI's assessment that the Pain Management and Research Centre (PMRC) was capable of working with MMI to "change the way pain is managed in Australia" with an emphasis on the early rehabilitation of injured workers.

MMI is Australia's largest workers compensation insurer and has recently joined forces with Europe's largest insurer in this field, Allianz: Allianz will use the expertise of MMI to develop workers compensation insurance in the Asian Pacific region. Thus MMI was also attracted to the PMRC's University of Sydney based Diploma and Masters Degree in Pain Management, which will soon be available on a distance learning basis throughout Australia and in the Asian Pacific region.

The Phase II development of the PMRC was opened by the **Chancellor of the University of Sydney**, Emeritus Professor Dame Leonie Kramer AC who commented after viewing the work of the Centre, that she was impressed that Pain Management specialists focused very much on the whole patient with an obvious consideration for the impact of the pain on patients' lifestyles. She found this very appropriate from her perspective as a humanist. She also commented that the University of Sydney was proud of the research and teaching achievements of the Pain Management and Research Centre.

The Director of the Centre, Professor Michael Cousins, referred to the "hidden epidemic" of pain in the health care area, which represented a financial cost of over \$15 billion annually in Australia and an even greater cost in human suffering, which is reflected in erosion of lifestyles, disruption of families and the depletion of the Australian workforce, with over 70 million workdays lost each year due to pain. Professor Cousins also referred to the 1996 Norman Cowper Oration of the Federal

Minister for Health, Dr. Michael Wooldridge, where Dr. Wooldridge stated in part:

"The major cost to the Australian community in health care are . . . pain, asthma, diabetes. . ."

"The potential savings to a country in the best practice management is probably about 25%".

Professor Cousins went on to say that this saving would represent \$3.8 billion annually in Australia. Thus it is not surprising that the costs of severe pain exceed the combined costs of AIDS, heart disease and cancer. These enormous costs are rising exponentially in all industrialised countries.

One of the **patients treated in the Centre, Donna Reed**, spoke of her experience before and after treatment in the Centre. Prior to a back injury, Donna was a fit 21 year old athlete who worked as a Gym Instructor. The following is taken in part from her statement at the opening:

"I was so desperate for a cure that I went everywhere, saw everybody, had two operations which were both unsuccessful. The pain was enough to make me faint some days. I lost all muscle and went down to weighing just 36 kilograms. Every day was like living with the drip, drip, drip of water torture. I was so depressed and in complete despair. I was in tears every day for 8 months. I really believe that no matter what lies ahead for me, it will never compare to what I suffered."

Following assessment and initial treatment in the Centre, Donna was entered into the Centre's intensive three week pain management programme (the ADAPT programme). Donna continued:

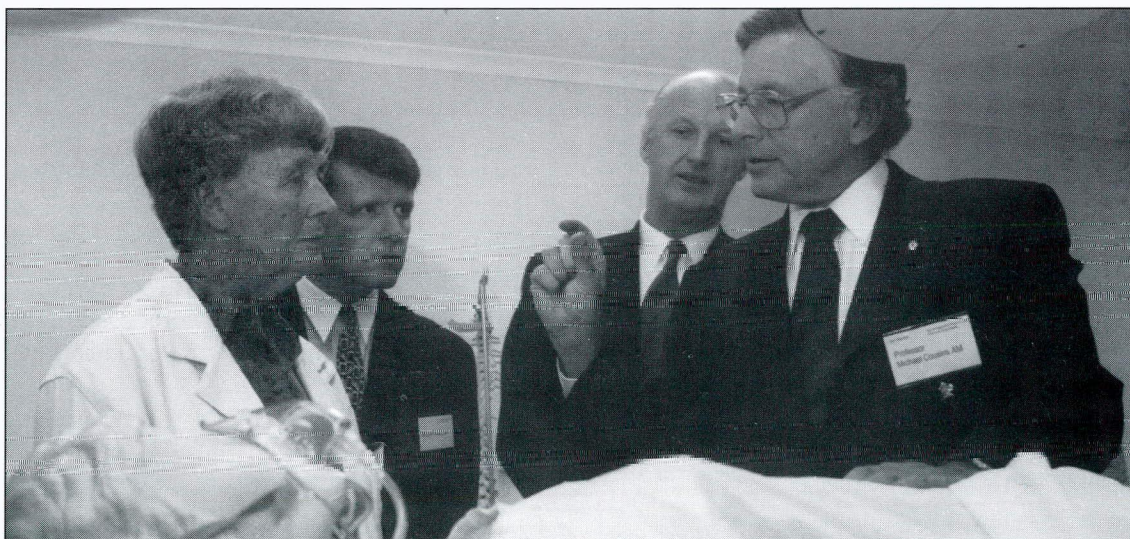
"Now 12 months after treatment in the Centre, I am back living by myself, doing all my chores and . . . also working full time as a fitness instructor!. I am at University, part time too. The programme has shown me what can be achieved and its above and beyond anything I ever thought would be possible. It is a sensible, sustainable programme that works long term."

Donna had benefited from various aspects of the ADAPT programme aimed at individuals with chronic pain which is interfering with ability to work and to lead a normal lifestyle. Each patient receives a treatment plan, developed through consultation with a medical specialist, clinical psychologist, physiotherapist and specialised nurse. ADAPT aims to help individuals understand and come to terms with their pain, to stop seeking more treatment, to use as little medication as possible, to deal with depression and other associated features of the pain and to learn to lead a normal life and return to work. The programme has been very successful in meeting these aims with more than 70% of graduates achieving a successful outcome.

Mr. Curtis commented that Donna was precisely the type of patient that MMI aimed to help . . . "when accidents occur, MMI helps to provide injured people with the support they need to return to work as soon as possible. Unfortunately for around 10% of those injured, chronic pain can prevent them from returning to work and leading a normal life. Each year in New South Wales alone, there are 2,000 back injuries causing permanent disability and over 1,100 cases leading to temporary disability lasting more than six months. The NSW WorkCover Authority estimated that in the 1991 financial year, back pain alone cost \$366 million - 35% of the total payments for work related injuries in that year. Clearly something needs to be done to address the problem."

Mr. Curtis went on to say that the Centre's ADAPT programme was of particular interest to MMI because of the results that were achieved and the large financial savings that could be made if injured workers are treated as early as possible. He concluded by saying "MMI will benefit from access to the knowledge of one of the leading pain management facilities in the world. In turn MMI will provide the Centre with access to our firsthand experience providing Workers Compensation and injury management services for one in five working Australians. We will also work with the Centre to assist with a number of other projects. These include the establishment of similar pain management Centres around Australia and education and training of health professionals."

The Centre was delighted to have the Registrar of ANZCA, Mrs. Joan Sheales present at the opening, which was also attended by the Member for Gladesville Mr. John Watkins MP representing the Deputy Premier and Minister for Health and Aboriginal Affairs, Dr. Andrew Refshauge. Also present were the new Chief Executive Officer of the Northern Sydney Area Health Service Dr. Stephen Christley, the CEO of Royal North Shore Hospital, Dr. Gavin Frost, a number of State and Federal politicians from both sides of politics and senior representatives of the business sector who have supported the Centre.



Prof. Cousins (at right) in Pain Centre operating theatre with an unusual tutorial group comprised of the Chairman of MMI (next to Prof. Cousins), the Member for Gladesville, Mr. John Watkins MP and the Chancellor of the University of Sydney, Emeritus Professor Dame Leonie Kramer, at the Opening of Phase II.

• **ERRATUM** •

**DAY CARE ANAESTHESIA PRACTICE
DOCUMENTATION**

On page 4 of the March 1997 Bulletin an incomplete copy of the Medical History Questionnaire was published. The complete article is reprinted below.

The Executive of the Day Care Anaesthesia Special Interest Group has developed three documents which may be of assistance to Anaesthetists involved in the establishment of Day Surgery Units. These documents are intended only as guidelines which may be modified according to the requirements of individual units.

1. MEDICAL HISTORY QUESTIONNAIRE

This is a modification of the questionnaire originally developed by Dr Ruth Hippisley for the St Vincent's Private Hospital in Sydney. It consists of a double-sided sheet to be filled in by the patient prior to the preanaesthetic consultation. It covers medical history, problems related to anaesthesia, medications and allergies. Vertically arranged "Yes" and "No" columns allow the Anaesthetist to rapidly evaluate the patient's condition and identify those areas which require special attention.

2. PREOPERATIVE INSTRUCTIONS FOR THE PATIENT

This document provides basic information for the patient scheduled for Day Surgery. It covers six important areas on a single-sided sheet. The instructions provided cover fasting requirements, preoperative medication, transport arrangements and postoperative care.

3. POSTOPERATIVE INSTRUCTIONS FOR DAY SURGERY PATIENTS

This is intended to be a guideline form to be used by both Surgeon and Anaesthetist. While it could be argued that more detailed instructions could have been included, the

DAY SURGERY UNIT		
MEDICAL HISTORY		
(To be completed by the PATIENT)		
YES	NO	Are you suffering from, or have you ever had:
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble?
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain?
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure?
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever?
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations?
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath?
<input type="checkbox"/>	<input type="checkbox"/>	Asthma?
<input type="checkbox"/>	<input type="checkbox"/>	Collapsed lung?
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	Thrombosis or clots?
<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding or bruising (or someone in the family with this problem)?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blood transfusion?
<input type="checkbox"/>	<input type="checkbox"/>	Could you have AIDS or be HIV positive?
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion, heartburn or ulcer trouble?
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble?
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or jaundice?
<input type="checkbox"/>	<input type="checkbox"/>	Kidney trouble?
<input type="checkbox"/>	<input type="checkbox"/>	A stroke?
<input type="checkbox"/>	<input type="checkbox"/>	Fits or funny turns?
<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness?
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis of the spine or jaw?
<input type="checkbox"/>	<input type="checkbox"/>	Any other serious illnesses?
<input type="checkbox"/>	<input type="checkbox"/>	If female, are you (or could you be) pregnant?

MEDICAL HISTORY (Continued)		
YES	NO	Do you have:
<input type="checkbox"/>	<input type="checkbox"/>	Dentures, capped teeth or crowns?
<input type="checkbox"/>	<input type="checkbox"/>	Chipped or loose teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses, hearing aids or prostheses?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had an anaesthetic before?
<input type="checkbox"/>	<input type="checkbox"/>	If so, for what operation?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any problems with anaesthetics?
<input type="checkbox"/>	<input type="checkbox"/>	Has any relative had problems with anaesthetics?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a recent cold, 'flu or sore throat?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a cough?

TABLETS, MEDICINES AND INJECTIONS		
YES	NO	Are you taking or have you ever taken:
<input type="checkbox"/>	<input type="checkbox"/>	Drugs for diabetes?
<input type="checkbox"/>	<input type="checkbox"/>	Drugs for heart trouble?
<input type="checkbox"/>	<input type="checkbox"/>	Drugs for high blood pressure?
<input type="checkbox"/>	<input type="checkbox"/>	Drugs for asthma?
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone or similar drugs?
<input type="checkbox"/>	<input type="checkbox"/>	Drugs to stop blood clotting?
<input type="checkbox"/>	<input type="checkbox"/>	Drugs for "nerves" or sleeplessness?
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or other pain-relieving drugs?

HAVE YOU ANY ALLERGIES? Please list:	
DO YOU SMOKE? How many?	DO YOU DRINK ALCOHOL? How much?
LIST THE MEDICATIONS, TABLETS AND INJECTIONS THAT YOU ARE TAKING AT PRESENT:	
WHAT OPERATION ARE YOU HAVING?	

Executive were of the opinion that a simple form was more likely to be understood and acted upon by the patient. The essential information provided includes post anaesthetic instructions, post surgical instructions, postoperative medication orders, contact information in the event of a postoperative complication and follow up arrangements. Because of the wide variety of surgical procedures undertaken at Day Surgery Units it was considered that a simple, non-specific form of this type was more appropriate than one providing more complicated and possibly confusing instruction.

DAVID GIBB
CHAIRMAN,
DAY CARE ANAESTHESIA SIG

Please turn to page 16 for examples of "Instruction for Patients Undergoing Day Surgery" and "Postoperative Instructions for Day Surgery Patients"

Scheduling of Day Only Patients On Mixed Lists

It is essential that Operating Theatre staff give due consideration to the scheduling of day patients when they are combined with inpatients on "mixed" operating lists. Day patients should be placed first on the list unless there are special reasons for the inpatient to have priority (eg. Diabetes mellitus). Where inpatients are given priority, surgeons should provide notice of at least one week, so that the Day Surgery staff can appropriately modify the admission and discharge arrangements for the day patient.¹

All patients should have a standard preoperative assessment for their anaesthesia, which preferably should be carried out prior to the day of admission. Facilities which ensure patient privacy during interview are essential.

On the day of surgery, patients should arrive at least one hour prior to the scheduled operation time to allow preoperative preparation. Delays should be avoided as long preoperative waiting times may accentuate anxiety in day patients, many of whom will be unpremedicated.² It is therefore appropriate that day surgery patients are scheduled first on the operating list to cater for the special preoperative issues, anaesthesia, recovery and discharge requirements.

REFERENCES:

1. Chung F. Recovery pattern and home-readiness after ambulatory surgery. *Anesth Analg* 1995; 80: 896-902.
2. GE Rudkin, AK Bacon, B Burrow, MH Chapman, M Claxton, B Donovan, D Gibb, LS Weber. Review of efficiencies and patient satisfaction in Australian and New Zealand Day Surgery Units: a pilot study. *Anaesthesia and Intensive Care* 1996; 24: 74-78.

INSTRUCTIONS FOR PATIENTS UNDERGOING DAY SURGERY

1) FASTING INSTRUCTIONS

- I) No solid food to be taken on the day of surgery, unless authorised by the anaesthetist. If your operation is late in the day, your anaesthetist may permit you to have a light breakfast.
- II) Up until 3 hours prior to your operation you may take a cup (200ml) of clear fluid per hour (eg. water, fruit juice, black tea or black coffee).
- III) Nothing further should be taken by mouth in the 3 hours prior to the scheduled time of your operation apart from medications and water specified below.

2) MEDICATION INSTRUCTIONS

You should take your usual morning medications (tablets, capsules, etc) with a sip of water before leaving home on the day of your operation, **with the exception of:**

3) TRANSPORT INSTRUCTIONS

YOU MUST NOT DRIVE HOME AFTER YOUR OPERATION. You should make arrangements for a responsible person to accompany you home after your operation. If the patient is a small child who will be driven home following surgery, it is recommended that a second adult be present in the vehicle to supervise the child. **(If you live more than an hours drive from the hospital, the advisability of having your operation as a Day Only patient should be discussed with your surgeon).**

4) POSTOPERATIVE CARE

You should also arrange for a responsible person to stay with you overnight, following your operation, to assist you should a complication arise.

5) IMPORTANT POSTOPERATIVE INSTRUCTIONS

Although you may feel that you have fully recovered from a general anaesthetic or from intravenous sedation after 3 or 4 hours, your ability to think normally or to carry out simple tasks may in fact be impaired for a much longer period. For your own safety, therefore, you must avoid,

- I) Driving a motor car or using machinery
- II) Exposure to hazards (eg. heights, hot stoves, chemicals)
- III) Signing legal documents or making important decisions until the following morning.

Alcohol and sedative drugs will greatly prolong your recovery and should be avoided for at least 24 hours after surgery.

6) FURTHER INFORMATION

Following surgery you will be issued with,

- I) Postoperative instructions
- II) A list of medications (if required)
- III) An emergency contact number
- IV) A follow up appointment.

DAY SURGERY UNIT

POSTOPERATIVE INSTRUCTIONS FOR DAY SURGERY PATIENTS

POST ANAESTHETIC INSTRUCTIONS

Although patients who have received a general anaesthetic or intravenous sedation may appear quite normal after 3-4 hours, sensitive tests have shown that the effects of the drugs administered may last for a much longer period. For your own safety, therefore, you are advised not to drive a motor vehicle or operate dangerous machinery until the morning after your operation. You should also avoid potentially hazardous situations (eg. heights, hot stoves) for a similar period. In addition you are advised not to take alcohol or sedative drugs for 24 hours as these may further delay your recovery.

Where the surgery has been carried out under a local anaesthesia without intravenous sedation, full recovery can be expected within 4 hours.

POST SURGICAL INSTRUCTIONS:

POSTOPERATIVE MEDICATION:

EMERGENCY TELEPHONE NUMBER:

It is most unlikely that you will suffer a postoperative complication, but if this does occur, please ring the following number immediately.

PHONE NUMBER:

FOLLOW UP APPOINTMENT:

PLACE :
DATE :
TIME :

ADMISSION TO FELLOWSHIP BY EXAMINATION

Richard Donald ALLEN, Vic
 Hung Kiat Terence BEH, Vic
 Jennifer Jean BRUCE, WA
 Tak Vai CHAN, Hong Kong
 Jennifer Marie FABLING, NZ
 Mark Andrew FEATHERSTON, NZ
 Matthew Frederick HOSKIN, WA
 Gregory Charles Bevan LLOYD, NSW
 William Charles MACAULAY, NZ

Rex Rowan MARTIN, Vic
 Andrew Derrick McKEE, Vic
 Norhayati Binte Muhammed NOR, Malaysia
 Mark Campbell REDDY, NZ
 Brian Thomas SPAIN, Vic
 Sharon Louise TIVEY, USA
 Leonie Maria WATTERSON, NSW
 Duncan Howard WILLIAMS, NZ
 Paul Alfred WILSON, NZ

Honours and Appointments

Professor Michael Cousins, NZ – Councillor, National Health & Medical Research Council
 Professor David Glass, USA – President, The American Board of Anesthesiology
 Dr John Paull, Vic – President, Asian Oceanic Society of Regional Anaesthesia
 Dr Richard Walsh, NSW – Association of Anaesthetists of Great Britain and Ireland – Pesk Certificate of Honour
 Dr Gregory Wotherspoon, NSW – Association of Anaesthetists of Great Britain and Ireland – Pesk Certificate of Honour

Death of Fellow

Dr Judith Nella Nicholas, NSW
 – FFARACS 1956, FANZCA 1992

ANAESTHESIA PATIENT SIMULATOR AT MONASH MEDICAL CENTRE

Managing critical events is one of the most challenging and important tasks required of an anaesthetist. As anaesthesia training has progressed, it has become apparent that there exists a need for more formal attempts at crisis management training. As part of this evolution, over a ten-year period, a group at Stanford University in California, has developed a model that combines medical expertise with technology from the aviation simulation industry.

Today, as a result, we have available a Simulated Anaesthesia Mannequin, that can produce, in a realistic environment, a much-feared crisis, without risking patient safety. This technology also allows the analysis, through debriefing, of individual responses and practical skills during such events.

The Anaesthetic Department at Monash Medical Centre in Melbourne is pleased to announce the arrival of a realistic Anaesthesia Simulator to their hospital. The CAE Patient Simulator was installed on March 17 and - along with a similar model received by Royal North Shore in Sydney - represents the first such device in Australia.

The project has been funded as part of a joint venture by the Southern Health Care Network and the Victorian State Government and will be housed in a state-of-the-art research centre at the Monash Medical Centre, Moorabbin campus. The State Health Minister presided over the official launch of the simulator at a Rural GP Anaesthetists' Conference at the Melbourne Convention Centre, on April 4.

The CAE Patient Simulator is based on technology developed by Dr. David Gaba at Stanford University. The simulator includes an adult-size mannequin that features realistic physiology and response to intravenous fluid and pharmacological agents. It has a voice, arm movement, ventilation with gas exchange, twitch response, heart and breath sounds, pulses and blood pressure, and can respond realistically to a wide variety of predefined events.

The mannequin responses are computer controlled by a simulator instructor from behind a one-way glass window in the Control Room, adjacent to the mocked-up "Operating Theatre". Both the mannequin and the computer are linked to a standard anaesthesia delivery system and its monitors, through which changes in the mannequin are reflected.

Brendan Flanagan, FANZCA, Medical Director of the project, and Jennifer Machen, Project Development Officer, head the Monash team. Dr Flanagan, a staff anaesthetist at Monash, spent two and half years working with Dr Gaba in his laboratory at Stanford, and close links now exist with the Stanford group. It was there that the concept of "Anaesthesia Crisis Resource Management" (ACRM) was developed (which was, in fact, what lead Gaba to develop the simulator). The concept was subsequently used to initiate a curriculum for anaesthetists, irrespective of their level of experience. The training course was designed to close gaps in the "traditional" training of anaesthetists concerning several aspects of decision-making and crisis management, in the recognition that these issues were not systematically addressed at any stage during an anaesthetist's career.

The principal purpose of the centre at Moorabbin will be to use lifelike simulation of adverse perioperative events to enable Fellows of the College and anaesthetic registrars to practise crisis management. Real nurses and surgeons (and/or actors) will participate in the events. The curriculum will closely follow that of Gaba's ACRM course.

Likewise, the centre at Moorabbin is modelled on the Simulation Centre for Crisis Management in Health Care at Stanford University, of which Dr Flanagan was the first manager. The main Simulation Room will replicate a completely equipped operating theatre, but will also be able to be reconfigured to resemble an intensive care unit, or accident & emergency bay (to enable training for personnel in these domains).

Each simulation session will be videotaped and followed by a debriefing session, a critical part of simulator-based training. The centre's sophisticated audiovisual system is computer-driven and time-coded, enabling scenario events to be "marked" on the tape as they occur. This facilitates rapid search of the tape and retrieval of multiple views of "key" events that can be viewed simultaneously in synchrony - a feature that greatly enhances the smooth conduct of the session.

During each debriefing, participants will view the videotapes and critique their own performance, with the assistance of a specially trained ACRM instructor. The instructor will attempt to link the participant's actions to the concepts of anaesthesia decision-making and the principles of effective crisis management. The goal is an interactive, constructive, nonjudgemental critique of options and alternatives.

The debriefing room will also be the site of didactic and group exercise portions of ACRM training courses.

Research overseas suggests that the ACRM course provides an opportunity to develop a new cognitive framework for thinking about one's practice, including how to prevent crises and better manage critical situations.

While the overwhelming priority of the centre will relate to Anaesthesia, there is potential for the simulator to be utilised in an Intensive Care or Accident & Emergency

setting. Some time will be made available for the ongoing education and training of rural GP anaesthetists, as well as paramedic training and medical student education.

It is intended that, as an extension of the educational and training possibilities, the centre will also provide ongoing research opportunities. In particular, the centre will participate in collaborative research involving groups at Stanford, Harvard and the University of Toronto. Hopefully, as other simulator centres emerge throughout Australasia, similar joint research efforts will be established here. There should also be scope for industry device and pharmaceutical research projects.

The centre at Monash Medical Centre looks forward to the integration and cooperation of simulation centres across Australasia to provide access to this technology for all Fellows of the College.

For more information about the Southern Health Care Network Anaesthesia Simulation Centre, please contact Brendan Flanagan or Jennifer Machen at:

Department of Anaesthesia,
 Monash Medical Centre,
 Clayton Road,
 Clayton 3168
 Ph: (03) 9550 1111
 Fax: (03) 9550 3290
 Email: flanab@ozemail.com.au

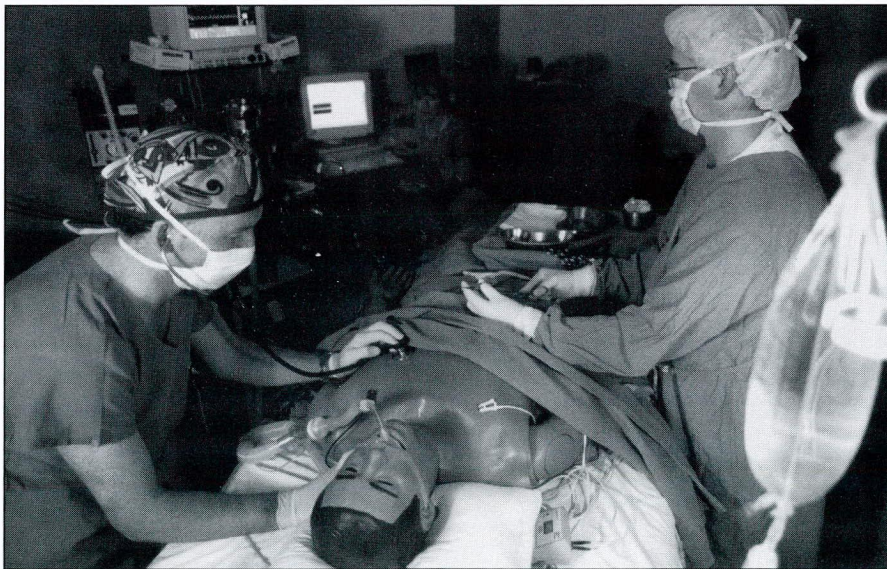


PHOTO COURTESY OF "HERALD WEEKLY TIMES"

Dr Brendan Flanagan (left) with Dr Craig Noonan and Ms Jennifer Machen.

LETTER TO THE EDITOR

ULIMAROA

Dear Joan,

While reading a book on Douglas Mawson about the Australasian Antarctic Expedition from 1911-1914, I came across an interesting reference to Ulimaroa. The book is called *The Home of the Blizzard*, published by Wakefield Press. This is a 1996 reprint and on Page 348 it mentions that the developments in wireless communication allowed the team returning from the First Australian Antarctic expedition to have wireless communication with the ship. This was from McQuarrie Island to the ship. The ship was called the SS Ulimaroa.

It gives an indication of the communication problems that existed with the small weak radios that were available then. On the next night the comment is made that they could communicate

with Sydney, the Australian SS Ulimaroa and HMS Drake. They heard that a wireless station was working in Melbourne but could not communicate with it and one was to be established in Hobart about a month after this communication. The date for this would have been 13 February 1914.

It does seem curious that through the name Ulimaroa, Anaesthetists should be linked with Douglas Mawson and his survival epic in Antarctica and on McQuarrie Island.

FORBES BENNETT
Hastings, NZ

REGIONAL COMMITTEES ANNUAL REPORTS 1996-1997

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Dr. Kate Leslie

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Assistant Education Officer:

Dr. Beth Ashwood

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Dr. Mark Radnor

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Dr. Peter Brown

CME Officer:

Dr. Peter McCall

Assistant CME Officer:

Dr. Bill Hurley

Formal Project Officer:

Dr. Kate Leslie

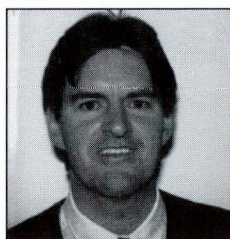
Paramedical Personnel:

Dr. Mark Buckland

Councillors:

Dr. Ian Rechtman

Dr. Rod Westhorpe



Dr. Phil Ragg



Dr. Kate Leslie

VICTORIA

1. CONSULTATIVE COUNCIL ON ANAESTHETIC MORTALITY AND MORBIDITY

During 1996 the Council met on 10 occasions and to date has reviewed 108 reports with a further 10 to be completed.

During the year the sixth report covering the years 1989 to 1992 was published as well as two information bulletins. The Council is grateful to the Victorian Regional Committee for facilitating the distribution of these bulletins which highlight concerns which need to be promulgated more quickly than is possible with the main reports.

A highlight of 1996 was the development of a dedicated anaesthetic data base system which will be able to provide a rapid response on any requests for information or for teaching. Data for the years 1993-1995 have been retrospectively entered and this will facilitate early publication of the next report within four months' time.

Presentations have been made at the ANZCA/ASA meeting in Perth and at several meetings in Melbourne teaching hospitals. The Chairman also provides lectures in country hospitals on crisis management, based on the experience and perspectives of the Council.

It was disappointing that the NH&MRC decided not to continue to support a national report on Anaesthetic Mortality. However we are fortunate that the ANZCA has decided to provide support for this and a recent meeting of State Chairmen of Councils under the chairmanship of the President of the College reached agreement about the format of the report which will cover the years 1991-1993. It is expected that this report will be available by the end of the year.

Discussions are also being held in order to get a uniform method of reporting of all deaths within 24 hours of surgery by both anaesthetists and surgeons and for providing guidelines for forensic pathologists as to the sequence of events prior to death. These discussions are being chaired by Professor Stephen Corder and involve representatives of the Colleges of Pathologists, Anaesthetists and Surgeons.

Victorian surgeons are now negotiating with the Department of Human Services to set up a Consultative Council on Perioperative Mortality. While it is important that the Victorian Consultative Council works in close co-operation with such a Council, as we already do with the Obstetric and Perinatal Councils, it is equally important that the Anaesthetic Council also retains its independence and continues to review in depth problems related to anaesthesia and pain management in the immediate peri-

Victoria (*continued*)

operative period. This will be an important issue in 1997 when the Minister appoints the new Council for the next three years.

2. PARAMEDICAL PERSONNEL

The pilot course for the Associate Diploma in Health (anaesthesia and operating theatre technicians) run by Barton TAFE was completed successfully by the majority of students enrolled. All involved were very pleased with the standard achieved by candidates. The Barton TAFE are indebted to those Fellows who provided lectures, tutorials and exam assistance during the course. It is now planned to run the course on a regular basis. Fellows and other members of the anaesthetic community remain actively involved in the education of other Allied Health groups.

3. CONTINUING EDUCATION

Continuing Medical Education continues to assume an important role for the Victorian Regional Committee. Several quality speakers presented papers and visited hospitals during 1996. An interesting variety of topics are currently in preparation for 1997.

The Combined ANZCA/ASA Meeting held August 1996 on "Issues in Obstetric Anaesthesia" once again proved to be a very successful meeting.

Topics covered in 1996/1997 include:

February 1996

Mivacurium: A Review.

- Dr Geoff Beemer

June 1996

Preparation of Scientific Papers.

- Professor Teik Oh

November 1996

Does Regional Anaesthesia Provide Real Advantage to the High Risk Patient ?

- Professor Pierre Coriat

February 1997

Understanding the Circle Breathing Circuit

Using an Educational Computer Simulation.

- Dr Julian Goldman

Most of these topics have been videotaped and are available for loan from the ANZCA Library.

This year's Combined ANZCA/ASA CME topic is "Anaesthesia and the Circulation" to be held on Saturday 16th August at the Hotel Sofitel. The International Guest will be Dr Michael Pinsky, Department of Anesthesiology and Critical Care Medicine, University Hospital, Pittsburgh, USA.

In order to co-ordinate the CME activities of the College, ASA, Departments of Anaesthesia, Drug Companies and Trade, a Victorian Register of Meetings has been introduced.

Victoria (*continued*)

An updated Register of Meetings will be forwarded to Victorian Fellows on a regular basis. This measure is intended to enable forward planning, avoid clashes of dates and increase attendance at meetings.

4. EDUCATION

Registrars' Scientific Meeting - Melbourne 1997

The Registrars' Scientific Meeting will be held on Saturday 19th July 1997. A Prize donated by Anaequip (Vic.) Pty Ltd will be presented to the best paper at the conclusion of the meeting. This meeting offers a high standard of interesting information and discussion, however, the success is dependent on the presentation of sufficient material covering a broad range of topics. To that end, all registrars are encouraged to present, and or, attend this meeting, as are Fellows.

Primary Fulltime Course

The next Primary Course will be held from Monday 26th May to Friday 6th June 1997. The final primary course for the year will be held 10th - 21st November 1997.

Part II Fulltime Course

Dr Garry Donnan has resigned as Part II Course Organiser and Dr Kate Leslie will undertake this position. Dr Donnan is very grateful for the contributions from so many Victorian Fellows.

The next Part II Course will be held from Monday 14th - Friday 18th July. This is the final Part II Course for 1997.

5. FORMAL PROJECTS

During 1996/1997, fourteen (14) projects were submitted for assessment and all were approved. Many projects were presented at national scientific meetings in anaesthesia and intensive care, or at the 1996 Annual Registrars' Scientific Meeting. The minority were approved as a result of publication, or in the form of a dissertation on a series of cases.

Formal Projects approved were:

Intravenous Fluids in Gynaecological Laparoscopy.	
Does it Ameliorate Postoperative Nausea and Vomiting (PONV)?	- Dr J. Lew
The Difficult Airway	- Dr D. Lindholm
Respiratory Arrest in Two Children Following Postoperative Flushing of Suxamethonium from the Deadspace of Intravenous Cannulae.	- Dr A. Davidson
An Audit of a Trainee's Caseload.	- Dr C. McKenzie
Continuous Measurement of Arterial of Endtidal Carbon Dioxide During Cardiac Surgery.	- Dr M. Higgs
Hyperreflexia: considerations for the anaesthetist.	- Dr A. Leaver
Anaesthetic related recovery room complications: 10 years on.	- Dr D. Vote

Victoria (*continued*)

- A Descriptive Survey of Ropivacaine in Regional Anaesthesia for Cataract Surgery - Dr D. Bain
- Preliminary Observations on the Acidic Nature of Intravenous Fluids. - Dr D. Story
- The Apparent Volume of Distribution of Phosphate in Hypophosphataemic Critically Ill Patients. - Dr C. French
- Anaesthetic Machine & Breathing System Contamination and the Efficacy of Bacterial/Viral Filters. - Dr I. Hogarth
- Spinal Epidural Abscess - Case Report associated with Obstetric Epidural Catheterisation and Review of Literature. - Dr B. Spain
- Quality of Recovery After General Anaesthesia: Development of an Index Score. - Dr T. Beh
- Anaesthesia for Bilateral Sequential Lung Transplantation: Experience of 64 Cases. - Dr A. Silvers

RACS Road Trauma Committee

Dr Beth Ashwood was nominated to represent the Victorian Regional Committee on this Committee following Dr Garry Donnan's resignation.

At the first meeting the pros and cons of "Bull Bars" with respect to safety for pedestrians and drivers was discussed at length. A representative of the Ford Motor Company was present and he informed the Committee of safety design improvements in the Ford Bull Bar as fitted to utilities. The majority of bull bars, however, impose a threat of severe injury to a pedestrian in a collision and impair other safety features of modern vehicles such as crumple zones and air bags which may not function properly and cause injury to drivers and passengers. This does not appear to be common knowledge.

The second meeting focused on the dangers of Motorcycle riding and measures to reduce deaths and injuries from accidents involving motorcycles. The chance of death or injury whilst riding a motorcycle is many fold greater per km travelled compared with driving a car.

Increases in third party insurance premiums were discussed for cyclists. This would not be popular with cyclists and may be something of a deterrent.

6. TREASURER'S FINANCE REPORT

The accounts of the VRC remain in good stead. This year a NEC computer projector (\$10,000) and accompanying Macintosh laptop computer (\$3,845) have been purchased following requests by many Victorian Fellows. These purchases were made with funds accumulated over the last three years. This equipment will improve the quality of presentations at our courses and CME meetings. While predominantly intended for VRC use, they are available to other groups within the College.

The VRC Secretary's computer has been upgraded. As a result the Secretary can now be contacted by email at victoria@anzca.edu.au.

Victoria (*continued*)

7. VICTORIAN MEDICAL POSTGRADUATE FOUNDATION INC.

The VMPF continues to conduct the Computer Matching Service for residents, interns and nurses. It is also investigating the future training of career medical officers.

The VMPF Journal "Access" is available in the College Library, the latest issue is January 1997, Vol 22, No.1.

8. SAFETY

There have been recent discussions at Committee Meetings on the issue of latex allergy. This topic was raised originally at the last Regional Chairmen and Secretaries' meeting in Perth with Council. Dr Helen Kolawole has thoroughly researched this topic and published an article in the College Bulletin. The Committee agreed to host an evening CME Meeting on this issue later this year.

9. SOCIAL

In November 1996 members of the Victorian Regional Committee and other invited guests hosted a dinner at Arrigo Harry's Bar to entertain our overseas guest CME speaker Professor Pierre Coriat.

10. LIBRARY

The Librarian, Miss Shanti Nadaraja has advised that the College Library is open 9am - 5pm Monday to Friday, however it will remain open later every Wednesday until 8pm.

11. RURAL ACTIVITIES

Victorian Rural activity has been somewhat subdued this year, with increasing realisation, both on a state and national basis, that local issues are at present more important to the provision of specialist anaesthetic services to rural and provincial areas than efforts by the College or College Fellows. Despite that, it seems likely that a new registrar position will be created at the Goulburn Valley Hospital next year.

Rural representation on the Victorian Committee is likely to be at a much lower level for the foreseeable future with the change in Committee meeting times. Plans for a teleconference link up may improve this arrangement.

Efforts have been made to encourage the view that the quality of anaesthetic practice, even given by non College Fellows, should be at least in part the responsibility of our College. As such, College Fellows have been active in speaking at Rural General Practitioners' Meetings, and have attended the launching of the Australian College of Remote and Rural Medicine at the Gold Coast in March.

Victoria (*continued*)

12. OTHER ACTIVITIES

Dr Garry Donnan has recently resigned from the Victorian Regional Committee after contributing to various activities spanning over nine years. The Committee is very grateful for Garry's support and contribution.

The Victorian Regional Committee Office contact details are as follows:

Telephone: 03) 9510 6441
Fax: 03) 9510 2108
Email: victoria@anzca.edu.au

Philip Ragg, *Chairman*

Office Bearers and Regional Committee Members:**Chairman:**

Dr Jennifer Parslow

Vice Chairman:

Dr. Peter Moran

Honorary Secretary:

Dr. Ranald Pascoe

Honorary Treasurer:

Dr. Lyndall Patterson

Regional Education Officer:

Dr. Kerry Brandis

CME Convenor:

Dr. James Bradley

Co-opted Council Representative:

Dr. Diana Khursandi

Formal Projects Officer:

Dr. Mark Gibbs

Committee Members:

Dr. Robert Whiting

Dr. Geoff Gordon

Dr. Rob Edwards

Co-opted ASA Chairman:

Dr. Don Logan

QUEENSLAND

The last year has seen the number of Fellows of the College in Queensland increase to over 300 which has resulted in an increase in the number of the members of the Regional Committee from 10 to 11 members at the last election in June 1996. This factor along with a number of resignations from the Regional Committee in 1996 has seen many new faces onto the Committee.

The Committee would like to thank the retiring members - Dr Ted McArdle, Dr Jim O'Callagan, Dr John Murray, and Dr Bart McKenzie for their contributions to the work of the College over the years they spent on the Committee.

CME Activities

As well as many one day meetings held throughout the year, organised by the ANZCA-ASA Combined Continuing Education Committee, the highlight of the year was the weekend meeting at the Sanctuary Cove Resort. The main theme for the meeting was electronic record keeping which generated a lot of audience comment and participation. Another highlight of the meeting was the personal presentation at the Saturday night dinner of Dr John Taske's amazing story of survival as part of the tragic Mt Everest expedition of early 1996. All who attended felt spellbound at the amazing pictures of the expedition as well as hearing the amazing story of survival and tragedy of the different expedition members.

Trainee News and Education

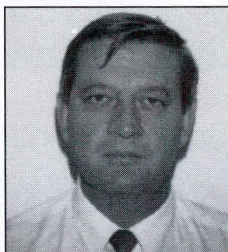
Over the past three years Queensland has increased the trainee numbers from 58 in 1995 to 70 in 1996. One pleasing aspect of this increase is that many of these new positions have been created in non-metropolitan hospitals with there now being 27 training positions in either Provincial City hospitals or smaller hospitals in the outer suburban areas around Brisbane. It is hoped that having trainees rotate through Provincial Centres will encourage the trainees to see the advantages of working in these centres as specialist anaesthetists in their working years to come.

Workforce issues are high on the agenda of the work of the Queensland Regional Committee with the number of Specialist Anaesthetist vacancies having decreased considerably over the past year due mainly to the migration of specialist anaesthetists from overseas and interstate. A summit on the topic of Medical Specialist Workforce for Queensland will be held in April with representatives from the State and Commonwealth Health Departments and the various Medical Specialist Colleges.

Although it is appreciated that in keeping with the AMWAC Report the number of trainees for Queensland may still need to be increased further, a decision was made not to increase the number of trainees in 1997 in view of the lack of funding for paediatric anaesthetic positions to ensure that all trainees are able to obtain paediatric experience in their first four years of experience.



Dr. Jenny Parslow



Dr. Ranald Pascoe

Queensland (continued)

Negotiations are ongoing with the Queensland Health Department and it is hoped that the situation can be resolved before trainee positions are advertised for 1998.

The past two years have seen Queensland conduct a Part I Short Course in May. Although this course has only a short history it is enjoying considerable popularity with over 30 trainees enrolled for 1997, with trainees coming from as far away as Hong Kong, New Zealand and ACT as well as local trainees. Dr Kerry Brandis who had already enjoyed an excellent Part I teaching reputation from his work at the Gold Coast Hospital has taken over the role of Regional Education Officer along with the task of organising this year's Short Course.

There is as well a popular Long course conducted for the Part I trainees. For many years the Part I Long Course had been very competently looked after by Dr Frances Ware from the Royal Children's Hospital with assistance from Dr Jim Bradley and Dr Mark Gibbs for the Pharmacology. However this year owing to Dr Ware accepting an overseas appointment, it was necessary to organise other arrangements for this Long Course and the Committee has been delighted to have Dr Liz Boge, a newly qualified Fellow, agree to take over the organisation of the course.

REPRESENTATIVES ON EXTERNAL COMMITTEES:**Dr Jennifer Parslow**

Chair, Theatre Utilisation Working Party: for the Clinical Advisory Committee within the Elective Surgery Project, Queensland Health.

Advisory Panel to Health Rights Commission

Committee of Queensland Medical Colleges

Medical Workforce Specialist Working Party

Queensland Health Theatre Utilisation Steering Committee

State Health Department's Committee (Statewide Management Systems for Elective Surgery)

Ministerial Task Force on Elective Surgery

Staff Panel of Peers, Senior Staff Specialist Status, Queensland Health

Visiting Panel of Peers, Senior Visiting Specialist status, Queensland Health

Dr Peter Moran

Editorial Committee Representative "Australasian Anaesthesia"

Postgraduate Diploma in Anaesthetic Nursing, Queensland University of Technology

ANZCA/RACS Building Committee

Dr Robert Whiting

ANZCA/RACS Building Committee

Dr Bart McKenzie

Medical Workforce Specialist Working Party

Queensland (continued)

Dr Mark Gibbs

Queensland Committee to Investigate Perioperative Deaths

Dr Geoff Gordon

Emergency Services Specialist Advisory Panel

Dr Diana Khursandi

Post-Graduate Medical Education Committee, The University of
Queensland

Dr Alison Holloway

Chairman,
ANZCA Sub-Committee on Anaesthetic Technician Training Committee

Dr Julia Byatte

Anaesthetic Technician Training Committee

Dr Ian Stephens

Maternal Morbidity and Morality Sub-Committee of Queensland Council
on Obstetric and Paediatric Morbidity and Mortality

Dr Ranald Pascoe

Red Cross Blood Transfusion Service

Dr Ken McLeod, Toowoomba Base Hospital

Queensland Council for Rural Medicine, Rural Specialist Steering Group

Dr Chris Anstey, Nambour General Hospital

RACS Queensland Trauma/Road Trauma Committee

Dr Liz Boge

Physiology and Pharmacology Long Course Lecture Series Co-ordinator

Dr Rhonda Boyle

Primary Practice Viva Sessions Co-ordinator

Office Bearers :

Chairman:

Dr. A.R. Laver

Deputy Chairman:

Dr. A. Rainbird

Hon. Secretary/Treasurer:

Dr. P.M. Franklin (until Jun 96)

Dr. A. Pearce (from Jul 96)

Committee Members:

Dr. N. Maycock

Dr. D. Bullen

Dr. J.D. Richards

Dr. T.J. Semple

Dr. R. Sorby-Adams

Dr. M. Wiese

Regional Education Officer (Ana)

Dr. P.C. Woodhouse

Regional Education Officer (IC)

Dr. J.A. Myburgh

Younger Fellows Representative:

Dr. N.F. Maycock (until Jun 96)

Dr. M.A. Fox (from Jul 96)

Dr. L. McEwin (from Aug 96)

Ex Officio

Member of Council:

Professor G.D. Phillips

Dr. R.J. Willis

ASA Representative:

Dr. J.D. Richards (until Sept 96)

Dr. G. Newcombe (from Oct 96)

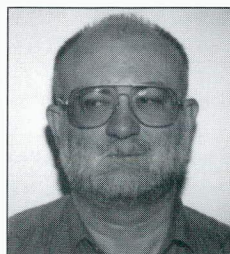
SOUTH AUSTRALIA

MEETINGS

The Annual General Meeting of the South Australian Regional Committee was held on Wednesday, 11th December 1996, at Clavary Hospital.

Continuing Education Meetings – The South Australian Regional Committee thanks the Combined CME Committee for organising the following meetings throughout 1996/early 1997:

1. **8th May 1996** – at Calvary Hospital – Presentation by Dr Richard Yeend, Consultant Cardiologist, Royal Adelaide Hospital – “Interventional Cardiology - Recent Advances and Implications for Anaesthetic Practice”.
2. **3rd July 1996** – at Calvary Hospital – Presentations by Professor Guy Maddern, R P Jepsen Professor of Surgery, The Queen Elizabeth Hospital and Dr Tony Purser, Specialist Anaesthetist – “Laparoscopic Surgery - Surgical Advances, Anaesthesia and Analgesia”.
3. **7th August 1996** – at Calvary Hospital - Presentation by Dr Geoff Mullins, Director, Department of Anaesthesia, Princess Margaret Hospital for Children, Perth – “Latex Allergy and Anaesthesia”.
4. **9th October 1996** – Annual Pain Dinner at the Donald Bradman Room, Adelaide Oval – Presentations by Dr Pam Macintyre, Director, Acute Pain Service, Royal Adelaide Hospital, Dr Tony Russell, Specialist Anaesthetist, and Dr Scott Simmons, Director, O&G Anaesthesia, Women’s and Children’s Hospital – “Acute Pain Management - Can we improve on current practice?”
5. **31st October 1996** – at Calvary Hospital – Presentation by Professor Bruce Cullen, Professor and Chief of Service, Department of Anesthesiology, Harborview Medical Centre, Seattle, USA – “Occupational Hazards for Anesthesiologists”.
6. **11th December 1996** – at Calvary Hospital – Registrars’ Scientific Presentations – Drs R Harris, B Singh, A Czuchwicki, M Gould and D Wilkinson participated.
7. **5th February 1997** – at Calvary Hospital – “Adelaide Paediatric Anaesthetic Forum” – Dr Johan van der Walt, Director of Paediatric Anaesthesia, Women’s and Children’s Hospital moderated.
8. **5th March 1997** – at Calvary Hospital – Presentations by Dr Peter Newland and Dr Henry Newland – “Current Trends in Eye Blocks - An Anaesthetic and Surgical Perspective”.



Dr. Tony Laver

South Australia (continued)

MATTERS OF CONCERN TO SOUTH AUSTRALIAN FELLOWS

1. Inspection of Adelaide Training Hospitals

Registrar concerns regarding adequacy of training and supervision at a major Adelaide teaching hospital were relayed to College Council via the Supervisor of Training and Regional Committee. A commendably rapid response by the College resulted in an inspection which highlighted many problems resulting from a severe consultant staff shortage. Improvements in remuneration and an aggressive recruiting campaign saw these problems largely resolved.

Ongoing staff losses across the city continued to stress the ability of Departments to provide service and teaching. A further inspection of the entire Adelaide Training Scheme in November 1996 highlighted problems including inadequate staffing levels, insufficient block teaching and inadequate level 2 teaching. All hospitals are actively involved in the necessary modifications to training in Adelaide.

The effectiveness of the College and Regional Committee in maintaining training standards was felt to be confirmed by these events.

2. National Anaesthesia Day

National Anaesthesia Day 1996 was felt to be a success, largely as a result of the improved communication beforehand. The ongoing duplication of ASA and ANZCA Public Relations exercises e.g. Patient Information Booklets, continues to cause concern.

3. Anaesthesia Machines for Country Hospitals

A bulk purchase of Anaesthesia machines by the SA Health Commission has resulted in the enforced provision of complex integrated Anaesthesia machines to country hospitals. Questions about the maintenance of these machines and the adequate training of General Practitioners have not been answered. Concerns have been expressed that the Regional Committee, as the body concerned with maintenance of standards and training, was not consulted in any way.

CORRESPONDENCE AND MAJOR DISCUSSIONS

1. Policy Documents: ongoing review of all draft documents.
2. Mortality Sub Committee: ongoing active role.
3. ASM Adelaide 1999: preliminary planning and appointment of convenors.
4. Credentialling of Practitioners in Country Hospitals: clarification of actual role of College in the credentialling of members of other speciality colleges e.g. RACGP.
5. Burnell Jose Visiting Professorship 1998: preliminary planning.

South Australia (continued)

6. Anaesthesia in Myanmar: Possibility of College role in teaching and examination visits.

Regional Training Committee:

Chairman - Regional Education Officer:	Dr. P.C. Woodhouse
Co-ordinator of Training:	Dr. N.F. Maycock
Organiser - CME:	Dr. M. Gabriel (until Dec 96) Dr. T. Semple (from Jan 97)
Course Organiser - Primary:	Dr. A. Pearce
Course Organiser - Final Fellowship:	Dr. C.J. Acott

Office Bearers :

Chairman:

Dr. Simon Fraser

Secretary:

Dr. Michael Lorimer

Treasurer:

Dr. Ruth Matters

Regional Education Officer:

Dr. Margaret Walker

CME Officer:

Dr. John Hickman

Co-opted Council Member:

Dr. Mike Martyn

Co-opted Faculty of Intensive Care Member:

Dr. George Merridew

TASMANIA

- A combined ANZCA/ASA Meeting was held at Grindewald on the weekend of the 2nd and 3rd November 1996. Invited speakers were Professors Bruce Cullen and Duncan Blake.
- A State Committee has been established with the ASA to co-ordinate CME activities.
- We look forward to welcoming a large number of Fellows at the Pugh Sesquicentenary Meeting in Launceston on the June long weekend, and to the ASA Meeting in Hobart in October.
- Reporting of anaesthetic mortality from Tasmania to the NSW Special Committee Investigating Death under Anaesthesia is haphazard. Efforts are being made to improve this situation.
- Anaesthetic manpower in Tasmania remains suboptimal.

Michael Lorimer, *Secretary*



Dr. Simon Fraser



Dr. Michael Lorimer

Office Bearers :**Chairman:**

Dr. E. Loughman

Vice-Chairman:

Dr. M.R. Crawford

Honorary Secretary:

Dr. M.A. Joseph

Honorary Treasurer:

Dr. M.R.R. Jones

Other Members:

Dr. J. Beckett-Wood

Prof. D.B. Gibb

Dr. R.K. Kerridge

A/Prof. P.L. Klineberg

Dr. F.X. Moloney

Dr. A.W. Quail

Dr. C.J. Sparks

Co-opted Member:

Dr. B.F. Horan

Ex-Officio:

Prof. M.J. Cousins, AM

A/Prof. G.E. Knoblanche

Dr. R.J. Walsh

Education Officer:

Dr. R.K. Kerridge

Formal Project Officer:

A/Prof. P.L. Klineberg

Supervisors of Training:

Part I Course - Dr. P. Kam

Part II Course - Dr. M.J. Bookallil

NEW SOUTH WALES

Following the election for membership of the Committee in April last year, the new Committee formed in June was unchanged, with the exception of the new College Councillor, Associate Professor Greg Knoblanche re-joining the Committee. However, after more than ten years service as the Committee's secretary, Helen Cody left the College. We are pleased to have Ms Janice Taylor now staffing the office in Harrington St, near Circular Quay.

Practice Matters

Work continued this year with the Department of Health on developing hospitalisation guidelines for small children, with the Committee advising on age limits for children requiring treatment where subspecialty services are not available, as well as advising on credentialling processes where a 'customised' approach to service delivery is relevant. The Department is expected to issue revised guidelines soon.

The Committee was recently informed that the Health Care Complaints Commission is expanding its panel of peer and expert reviewers to assist it in receiving appropriate advice when considering how to deal with complaints. Fellows may contact the office for further information. The Commissioner has been advised of the Committee's nominees, as was the NSW Medical Board when a similar approach was made several years ago.

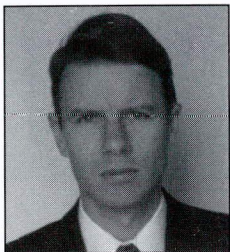
Throughout the year community attention continued to fall on medical indemnity matters. The 'Tito Report' was discussed, one of the medical defence organisations promoted substantial change to aspects of the present litigation system, and the NSW Attorney General embarked on a review commencing with a public meeting in Sydney in December. Developments in such a substantial matter will not occur rapidly, and Fellows are encouraged to participate in the debate, and communicate their views to the Committee.

The Committee's Chairman and Honorary Secretary have met representatives from other Colleges and the Department of Health for discussions on the application of published evidence in the development of practice guidelines (an approach to health care becoming known as evidence based practice). Fellows will already be familiar with practice guidelines on cardiopulmonary resuscitation (Australian Resuscitation Council, American Heart Association), and pain management (NHMRC). Practice guidelines offer benefits to patients and anaesthetists, and guideline development is likely to be enhanced by the involvement of clinicians. Fellows interested in this area are invited to offer the Committee suggestions as to how best to proceed. Background material is available from the NHMRC in 'Guidelines for the development and implementation of clinical practice guidelines'.

Training and Education

The Committee undertook reviews of hospital anaesthesia services in several locations during the year, including Nepean, Liverpool, Newcastle, Woden Valley, Bankstown, and Shellharbour, with increases in training positions in several regions.

Two successful meetings were conducted by the combined ANZCA/ASA Continuing Education Committee; Anaesthesia Controversies and Complications, in July, and Pre-operative drugs and Anaesthetics, in November. Further meetings are planned for the coming September and November.

E. Loughman, *Chairman*

Dr. Ed Loughman



Dr. Michele Joseph

Regional Committee:

Chairman:

Dr. Hugh Speirs

Deputy Chairman:

Dr. Leigh Coombs

Secretary:

Dr. Geoff Mullins

Regional Education Officer:

Dr. Grant Turner

Treasurer:

Dr. Mike Hellings

Continuing Education Officer :

Dr. Leigh Coombs

Faculty Education Officer:

Dr. Steve Edlin

Councillor:

Dr. Moira Westmore

Other Members:

Dr. Terry McAuliffe

Dr. Phil Smith

Dr. Wilson Lim

Dr. Craig Sim

Special Interest Representatives:

Acute Pain: Dr. Grant Turner

Rural Anaesthesia: Dr. Graham Dale

Cardiac, Vascular & Perfusion:

Dr. Ken Williams

Neuroanaesthesia:

Dr. Wally Thompson

Research: Dr. Neville Gibbs

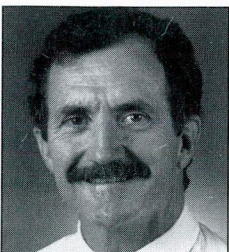
Medical Education: Dr. Robert Wong

Day Care Anaesthesia:

Dr. Brent Donovan



Dr. Hugh Speirs



Dr. Geoff Mullins

WESTERN AUSTRALIA

Continuing Education

During the year, in addition to the Annual Autumn and Winter Scientific Meetings, meetings were arranged on Infusion Anaesthesia (Speaker: Dr. G. Kenny), Sevoflurane (Speaker: Dr. Suellen Walker) and Ropivacaine.

A meeting on factual risk management was organised as a combined meeting of ANZCA/ASA/MDA Western Australia.

Country Visits

During the year there were two ANZCA organised meetings to rural areas; Albany (May) and Broome (October). These meetings are directed to GP Anaesthetists, Assistants to Anaesthetists and Nurses and cover topics of general anaesthetic interest and acute pain management.

Regional Education

The Part 1 Tutorial programme was organised by Dr. Nedra Vandendriesen and Dr. R. Wong. The Part 2 Tutorial programme is organised by Dr. W. Weightman. All trainees continue to have adequate sub-specialty exposure. High pass rates were achieved in both Part 1 and Part 2 examinations. The Cecil Gray Prize for May 1996 was awarded to Dr. Cyrus Edibam.

Nerida Dilworth Prize

This prize for the best registrar presentation at a WA CME Meeting was won by Dr. Andrew Miller.

The Dr. John Boyd Craig Research Award was awarded for the second time to Dr. Stephanie Davies.

1996 CSM (ANZCA, Faculty of Intensive Care, ASA)

This meeting was convened by Dr. Leigh Coombs and was held at the Hyatt Hotel, Perth on 26-30 October 1996. It was preceded by the Younger Fellows Conference, convened by Dr. Dennis Hayward and held at the Monastery, New Norcia. Both meetings were judged an outstanding success.

Other Matters

Rural Anaesthetic Practice. In addition to organising continuing education for rural GP anaesthetists the Committee continues to have representation on the Western Australian State-Wide Anaesthetic Reference Group.

ANZCA/ASA Combined Activities

From January 1997 there has been a formal combined ANZCA/ASA CME Committee, jointly chaired by Dr. Leigh Coombs and Dr. Chris Johnson. The

Western Australian (*continued*)

ANZCA and ASA Regional Committees continue to meet together at least three times per year.

National Anaesthesia Day

This was a successful collaboration between ANZCA and ASA with the purpose to raise the profile of Anaesthesia in the wider community. Assistance was also provided by the Anaesthesia Trade Industry. Displays were arranged in Teaching Hospitals as well as major shopping centres and plans are in progress for this to be repeated in July.

Geoff Mullins, *Secretary*

Office Bearers :

Chairman:

Dr. Ray Cook

Honorary Secretary:

Dr. Nick Melhuish

Regional Education Officer:

Dr. Nick Gemmel-Smith

AUSTRALIAN CAPITAL TERRITORY

The past year has seen some major changes in anaesthetic practice in the ACT.

Education

With the recognition of more registrar posts by the College, also the training requirements of registrars of the Faculty and other Colleges, plus medical student teaching, it is now the norm to have one or two trainees for a list. Maintenance of practical skills by the specialist will increasingly rely on their private practice component – a diminishing resource, especially in the public hospital.

CME

The annual Art of Anaesthesia meeting in September was again successful. Discussion is a major component of these meetings – owing as much to the variety of excellent presentations as to the intimate venue.

This September's meeting is a single theme education meeting, and, because of expected greater numbers (being combined with NSW and nurses), is at a larger venue.

Euthanasia

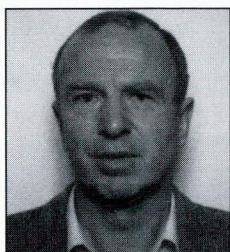
The successful Andrews Bill also had considerable impact in the ACT where a pro euthanasia Bill was in the process of introduction. The possibility of prosecution for passive euthanasia (ie. the withdrawal or withholding of treatment) has been in the local press. Of greater concern is the indication of intent to withhold life-saving treatment eg. CPR, blood transfusion – this is currently being discussed.

Informed Consent

A thick document, apparently with little medical input, just surfaced. Fortunately, a limited circulation for medical review has been achieved. Watch this space.

ACCC

With a virtually all VMO workforce, in the ACT this will mean negotiation of all contracts individually. All current contracts recognise a teaching and education component – a concession of major importance, that one hopes will continue.



Dr. Ray Cook

Ray Cook, *Chairman*

Office Bearers :

Chairman:

Dr Alan Merry

Deputy Chairman:

Dr Forbes Bennett

Honorary Secretary:

Dr Malcolm Futter

Honorary Treasurer:

Dr Sharon King

Education Officer:

Dr Hugh Spencer

Other members:

Dr Peter Cooke

Dr David Jones

Dr Jack Havill

Dr Alan McKenzie

Ex-Officio:

Professor John Gibbs

Dr Steuart Henderson

Dr Vaughan Laurenson

(Medical Director, CECANZ)

Dr Ron Trubuhovich

(Faculty of Intensive Care)

Dr Rob Burrell

(Younger Fellows' Representative)

NEW ZEALAND

Since Jack Havill's report last year, the rapid changes in the structure, administration and regulation of the health service in NZ have continued.

Members of the New Zealand Regional Committee have been very active on a number of fronts, and ongoing interaction with Government agencies, regulatory bodies, Parliamentary select committees and other such groups have simply become the norm. In dealing with matters of New Zealand national interest we have greatly appreciated the support from Melbourne of Garry Phillips, Richard Walsh, Joan Sheales and the Council in general.

Brian Horan crossed the Tasman to assist with hospital inspections and that too was much appreciated.

Committee

Malcolm Futter is now Assistant Assessor for New Zealand.

Activities over the last 12 months have involved all members of the committee and have included:

1. Registration of Overseas Doctors

This has been a major exercise involving the setting up of a programme of interviews and assessment satisfactory to both the New Zealand Medical Council and ANZCA.

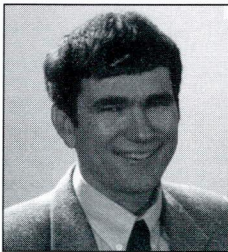
2. NZ Perioperative Deaths Survey

Leona Wilson has chaired a working party which includes anaesthetists, surgeons, gynaecologists and a member of the Ministry of Health, to establish a New Zealand programme similar to Britain's (Confidential Enquiry into Perioperative Deaths). This will utilise the provisions in the new Medical Practitioners' Act for confidential audit. Leona has shown strong leadership in getting this important initiative off the ground.

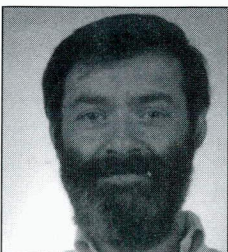
3. Medical Manslaughter

Under the co-chairmanship of Ross Blair (RACS) and myself the New Zealand Medical Law Reform Group continues to advance the cause of the Crimes Amendment Bill (no 5) which (if passed) will establish a more reasonable threshold for manslaughter prosecutions in this country. (Please see the Medical Journal of Australia, 7th April, Vol. 166, no. 7 pp 342-343 for a discussion of the issues). We are presently fully involved in preparing submissions to the Justice and Law Reform Parliamentary Select Committee Hearing on this Bill and ANZCA, like other Colleges, will be backing up the NZ Medical Law Reform Group in this matter with an important submission of its own. The Faculty will, I believe, do the same.

In the long term, I believe this to be the most important issue before our committee. If this Bill fails to become law, anaesthetists in New Zealand



Dr. Alan Merry



Dr. Malcolm Futter

New Zealand (*continued*)

will continue to face very worrying times. At present police are investigating deaths associated with anaesthesia and the problem will not improve without the clear signal that a change in the law will give.

4. Other aspects of medical accountability

The NZ Regional Committee has continued to supply the Medical Council and the Accident Rehabilitation & Compensation Insurance Corporation with the names of appropriate anaesthetists to serve in various roles related to medical accountability. In particular, Leona Wilson and Forbes Bennett are now members of the Medical Practitioners' Disciplinary Tribunal and I am sure they will approach this difficult and important role in a careful and balanced way; and contribute to effective and just accountability under the new Medical Practitioners' Act.

5. Training

The activities of the various bodies associated with the "unbundling" process for post-graduate training continue to occupy the NZ Regional Committee. The only clear point is that the process has produced too little money for the purpose. We have met Sir Frank Holmes from the Committee Advising on Professional Education and continue to liaise with the Clinical Training Agency.

6. Council of Medical Colleges

This continues to be an important forum through which the Chair of our committee can liaise with other Colleges in New Zealand.

7. Combined Newsletter

This amalgamation of the three local Newsletters (NZSA, ANZCA and Anaesthesia Aotearoa) has been a great success. Congratulations to the three editors, Graham Sharpe, Lorna Berwick and Michael Harrison.

8. Faculty of Intensive Care

Under Ron Trubuhovich's guidance the Faculty continues to consolidate its position in New Zealand and Intensive Care should soon achieve recognition as a Vocational Specialty in its own right. The two regional committees continue to work together closely and collaboratively.

9. Courses

Primary Courses were held in Christchurch and Waikato and the Final Course was held in Auckland. We are grateful to the staff of these Departments for running these successful courses.

10. Continuing Medical Education and Conferences

The ISRA meeting in Auckland was an extremely well attended and highly successful international event - so much so that it was a finalist in the

New Zealand (*continued*)

Conference/Convention Tourist Awards. The Aotea Centre proved an excellent venue, the international speakers were of the highest standard, and the local contributions were of an equally good quality. All in all, a major landmark for NZ anaesthesia - congratulations to Convenor David Sage and the Organising Committee.

An ARGONZ meeting was held in Wellington in July, and the quality of the catering was surpassed only by the quality of the papers.

An enormous effort by Sharon King's team from Christchurch will come to fruition in May, with the 1997 ASM. I am very confident that this will be a great success and look forward to meeting many old friends at this meeting.

Peter Cooke is well under way with what promises to be an excellent Single Theme Meeting in Tauranga from 10-12 October 1997.

Two very useful national teleconference have been held under the auspices of CECANZ ; June 20 on Medico-legal and ethical problems and September 5 on Quality Assurance

11. Trans-Tasman recognition

A matter of concern to the NZ Regional Committee has been the change in regulations related to Health Insurance Act Provider numbers in Australia (see Bulletin 1997, Vol. 16, 1 pp 6-9). It seems absurd that Fellows of an Australian and New Zealand College are now unable to obtain a provider number (i.e. are severely restricted in their ability to work in Australia) even if they are graduates of a NZ Medical School.

12. Regional Committee Secretariat

I would like to record my personal thanks to Lorna Berwick for her enormous, cheerful and expert contribution to the running of the NZ Regional Committee. The College is very well and very loyally served in its Wellington office. I would like to welcome Alisha Jewett, who has now joined the Wellington office on a part-time basis and did a sterling job while Lorna was on annual leave.

Alan Merry, *Chairman*

OPENING OF SYDNEY MEDICAL SIMULATION CENTRE

The Sydney Medical Simulation Centre (SMSC) was opened by The Hon. Dr. Andrew Refshauge, Deputy Premier and Minister for Health and Minister of Aboriginal Affairs, NSW Government, on Friday 21st March 1997. The Opening of the Centre was the culmination of over three years work by the SMSC team to produce an "artificial heart/lung simulator" or in other words a totally realistic simulation of cardiopulmonary bypass during open heart surgery. The simulator has, as its name suggests, an artificial heart and a circulation that responds realistically to the many challenges that occur during open heart surgery. Thus the artificial "patient" has venous and arterial lines connected to a standard cardiopulmonary bypass machine. There are also the usual range of cardiovascular and other monitors connected to the patient. The "blood" going into and coming from the patient changes from red to blue in situations where this would occur clinically. Drugs can be administered and physiologic responses occur precisely as they do in the clinical setting.

ANZCA Fellows Dr. Richard Morris, Dr. Stewart Montano and Dr. Andrew Pybus developed the simulator that they have nicknamed "Cedric", in conjunction with a design engineer Mr. John Begg. Drs. Montano and Pybus are VMO perfusionist/anaesthetists at Royal North Shore Hospital and Dr. Richard Morris has been appointed as Director of the SMSC. Dr. Morris previously held the position of Director of the Division of Critical Care at St. George Hospital, Sydney.

A second major component of the Simulation Centre is the anaesthesia/life support simulator ("Sam") developed by CAE Electronics New York which was purchased for the Centre under the **Principal Sponsorship of Abbott Australasia**. Dr. Leonie Watterson was recently appointed as a Staff Specialist Anaesthetist and Medical Specialist to the Simulation Centre. She will be involved in research and development projects in the SMSC. The Centre is currently in the final stages of appointing a scientific officer who will have responsibility for day to day running of the simulator and for developing new medical simulation systems in collaborations with the

SMSC staff and with CAE Electronics. The Northern Sydney Area Health Service Biomedical Department will be contributing two biomedical engineers to work with the SMSC staff to complete the development of the heart/lung simulator and to develop further medical simulations. In the middle of 1997, staff of the Centre will move into a purpose designed facility.

In opening the Centre, **Dr. Refshauge** was given an opportunity to assist Dr. Morris in **dealing with a major anaphylactic reaction** that occurred in "Sam" following the administration of an intravenous dose of sedative. Dr. Refshauge commented afterwards that he became totally absorbed in the events that unfolded in the treatment of the anaphylaxis and felt enormously relieved when the treatment was successful! He wished that he had had an opportunity to experience this type of realism in his own undergraduate training. He congratulated the SMSC team in developing the artificial heart lung simulator and felt confident that it would be exploited world wide. He also commented that NSW Health was attracted to the opportunity that the Centre presented for rural and remote general practitioners to increase their skills in life support. He was particularly impressed by the potential for the Centre to allow health professionals from many disciplines to enhance their skills in critical decision making and thus make an impact on the substantial rate of errors in hospitals that has been identified in recent years.

Mr. Mark Haywood, Managing Director of Abbott Australasia, Principal sponsor of SMSC, commented "Abbott is delighted to be given the opportunity to be the "Principal Sponsor" of the Sydney Medical Simulation Centre of the Royal North Shore Hospital and the University of Sydney. This role for Abbott is very much in keeping with our objective to make a substantial contribution to anaesthesia/life support in Australia and the Asia Pacific Region. We are confident that this Centre will have a major impact on training and education, and that it also poses an exciting potential for research and evaluation of biomedical equipment and new pharmaceutical agents."

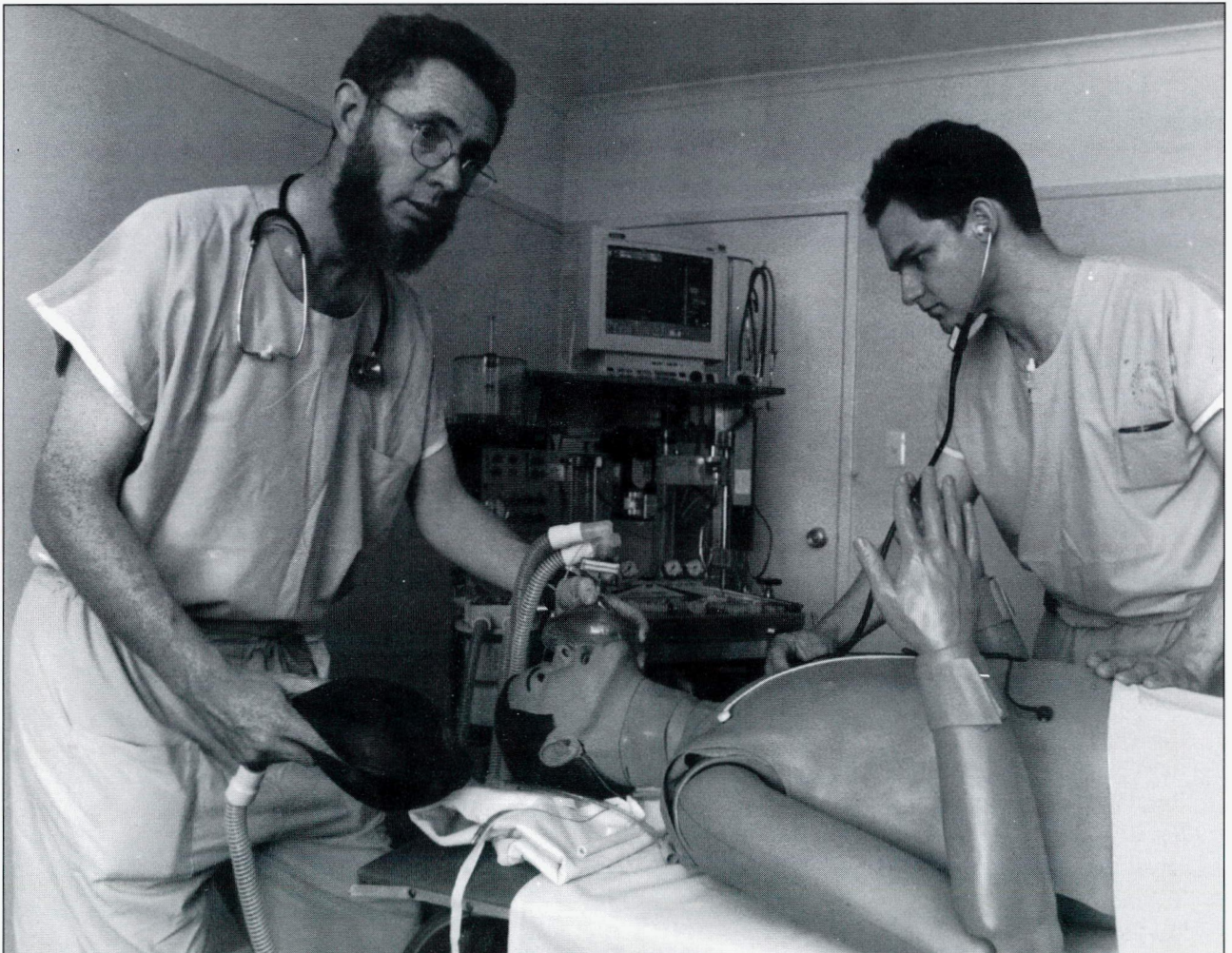
Representing CAE Electronics New York, Cathy Lamkin-Kennard announced an agreement between CAE Electronics and SMSC to develop medical simulation systems. CAE had been attracted to this collaborative relationship with SMSC by the broad range of specialist medical, biomedical engineering, clinical psychology and basic research personnel, including very strong resources in the field of pharmacokinetics/pharmacodynamics (Prof. Laurie Mather and Dr. Charles Minto) at the SMSC.

Also present at the opening were the ANZCA Vice President, Dr. Richard Walsh and Registrar Mrs. Joan Sheales; Professor Kerry Goulston, Associate Dean,

Northern Clinical School, Faculty of Medicine, University of Sydney; senior representatives from Abbott Australasia, including Dr. Cornelia Hentzsch, Divisional Director for Hospital and Nutritional Business and Mr. Damien Colehan, Business Unit Manager, Hospital Pharmaceuticals, Abbott Australasia.

The SMSC will operate under the umbrella of the Centre for Anaesthesia and Pain Management Research Limited, a tax exempt entity under the Chairmanship of Mr. Rick Turner (former CEO of Ernst and Young) and Deputy Chairmanship of Sir Ian McFarlane. Sir Ian represented the Board of CAPMR at the opening.

REPRINTED WITH APPROVAL, "THE WEEKEND AUSTRALIA"
 PICTURE: BOB FINLAYSON



Sydney Medical Simulation Centre Director Dr. Richard Morris with Dr. Stewart Montano and the anaesthesia/life support simulator, at the Opening of the Simulation Centre.

SUPERVISORS OF ANAESTHESIA TRAINING

NEW SOUTH WALES

Albury Base Hospital
Auburn Hospital
Blacktown Hospital
Concord Repatriation Hospital
Gosford Hospital
John Hunter Hospital
Liverpool Hospital
Nepean Hospital, Penrith
Prince of Wales Hospital
Royal Alexandra Hospital for Children
Royal Hospital for Women
Royal North Shore Hospital
Royal Prince Alfred Hospital
St Vincent's Hospital
Sutherland Hospital
The St George Hospital
Westmead Hospital

Dr W. Fowler
Dr S. Killalea
Dr J. Scroope
Dr Y.L. Wan
Dr W. Lewis
Dr K. Streatfield
Dr G. Eruini-Bennett
Dr P. Dey
Dr G. Hill
Dr V.L. Harrison
Dr G. Goulding
Dr C. Sparks
Dr P. Kam
Dr L. Vyvyan
Dr P.S. Tong
Dr M. Bailey
Dr M. Priestley

VICTORIA

Alfred Hospital
Austin and Repatriation Medical Centre (Austin Campus)
Austin and Repatriation Medical Centre (Repatriation Campus)
Ballarat Health Services
Box Hill Hospital
Dandenong Hospital
Geelong Hospital
Mercy Hospital for Women
Monash Medical Centre
Mornington Peninsula Hospital
Preston and Northcote Community Hospital
Royal Children's Hospital Campus
Royal Melbourne Hospital
Royal Victorian Eye & Ear Hospital
Royal Women's Hospital Campus
St Vincent's Hospital
The Bendigo Hospital Campus
Western Hospital

Dr M. Langley
Dr P. McCall
Dr D. Tremewen
Dr B. Christie
Dr T. Lambert
Dr M. Sandford
Dr A. Plowman
Dr A. Ross
Dr N. Roberts
Dr D. Henry
Dr J.H. Briedis
Dr S. Robinson
Dr F. Rosewarne
Dr A. Strunin
Dr A. Hill
Dr A. Stewart
Dr S. Perrin
Dr E.M. Ashwood

QUEENSLAND

Cairns Base Hospital	Dr G. Clarke
Gold Coast Hospital	Dr J. Thatcher
Greenslopes Private Hospital	Dr M. Carroll
Ipswich Hospital	Dr W-N Tong
Mater Misericordiae Public Hospitals	Dr A. Newton
Nambour General Hospital	Dr C. Anstey
Prince Charles Hospital	Dr J. Avery
Princess Alexandra Hospital	Dr B. McKenzie
Redcliffe Hospital	Dr H. Muller
Royal Brisbane Hospital	Dr L. Patterson
Royal Children's Hospital	Dr C. Beem
Royal Women's Hospital	Dr R.K. Boyle
Toowoomba Base Hospital	Dr A. Thorne
Townsville General Hospital	Dr G. Gordon

SOUTH AUSTRALIA

Flinders Medical Centre	Dr D. McLeod
Lyell McEwen Health Service Campus	Dr A. Michael
Modbury Public Hospital	Dr R.J. Singleton
Repatriation General Hospital	Dr J. Cantor
Royal Adelaide Hospital	Dr C.K. Lai
The Queen Elizabeth Hospital	Dr G.M. Miller
Women's and Children's Hospital	Dr M.J. Gabriel

WESTERN AUSTRALIA

Fremantle Hospital	Dr E. Avraamides
Hollywood Private Hospital	Dr J. Storey
King Edward Memorial Hospital for Women	Dr M. Paech
Princess Margaret Hospital for Children	Dr M. D'Souza
Royal Perth Hospital	Dr J. Akers
Sir Charles Gairdner Hospital	Dr P. Platt

TASMANIA

Launceston General Hospital	Dr P. Ogden
Royal Hobart Hospital	Dr M. Lorimer

AUSTRALIAN CAPITAL TERRITORY

The Canberra Hospital

Dr M. Stone

NEW ZEALAND

Auckland Hospital
Christchurch Hospital
Dunedin Hospital
Green Lane/National Women's Hospitals
Hutt Hospital
Middlemore Hospital
North Shore Hospital
Palmerston North Hospital
Southland Hospital
Tauranga Hospital
Waikato Hospital
Wellington Hospital

Dr B. Hodkinson
Dr P. Smeele
Dr M. Zacharias
Dr R. Hall
Dr P. Yee
Dr A. Turley
Dr V. Hoggard
Dr A. McKenzie
Dr R. Wall
Dr R. McLeod
Dr J. Currie
Dr C. Pottinger

SINGAPORE

Alexandra Hospital
National University Hospital
Singapore General Hospital
Tan Tock Seng Hospital
Toa Payoh Hospital

Dr Lim Kim Seong
Dr Chen Fun Gee
Dr L. Nair
Dr Lim Siew Hoon
Dr Koay Choo Kok

MALAYSIA

General Hospital
University Hospital

Dr K. Misiran
Professor A.E. Delilkan

HONG KONG

Kwong Wah Hospital
Pamela Youde Nethersole Eastern Hospital
Prince of Wales Hospital
Princess Margaret Hospital
Queen Elizabeth Hospital
Queen Mary Hospital
United Christian Hospital

Dr K-O. Sun
Dr S. Onsiang
Professor C.S.T. Aun
Dr F-M. Lai
Dr E.T.K. Au
Dr A.M. O'Regan
Dr C. Yuan

COUNCIL 1997



Back Row:

Assoc.Prof. G.E. Knoblanche,
Drs R.S. Hendersen, R.N. Westhorpe

Middle Row:

Dr. I. Rechtman, Mrs Joan Sheales
(Registrar), Drs Diana Khursandi,
M. Martyn, Prof. M.J. Cousins,
Dr Moira Westmore

Front Row:

Prof. J.M. Gibbs,
Dr R.G. Walsh (Vice-President),
Prof. G.D. Phillips (President),
Dr R.J. Willis, Prof. T.E. Oh

Absent:

Dr G.M. Clarke (Dean)

**Group of former Queensland
Graduates:**

Professor Teik Oh (ANZCA Councillor),
Professor Barry Baker
(Past Dean of the Faculty),
Associate Professor David McConnel
(Former Faculty Board
Member and Councillor),
Professor Tess Cramond (Past Dean),
Professor Peter Livingstone (Past Dean
and College Inaugural President),
Dr Walter Briggs (Past Board Member)
and Dr Michael Hodgson
(Past President)



HONORARY TREASURER'S REPORT

The Annual Financial Statements of the College for the year ended 31 January 1997 are presented in their formal and required manner. All Fellows and Trainees should examine these Statements, which were verified by the Auditors and accepted by the College Council. As the Statements are found by many to be difficult to fully understand, I offer the following interpretation of the salient features, along with a diagrammatic summary.

REVENUE AND EXPENDITURE STATEMENT

This Statement summarises the total revenue and expenditure of the various Accounts and Funds operated by the College. Revenue increased moderately over the past year for many reasons while expenditure decreased marginally, and these are detailed further in the Statements. The operating surplus was just over \$1.7 million, with \$678,000 derived from Subscriptions and \$151,000 from the Trainees' Fund. Less than half the surplus was therefore raised from Fellows and Trainees. It is also important to note that the overall surplus does not reflect the actual gain to College cash reserves, which the Council has been attempting to significantly increase for future activities.

BALANCE SHEET AS AT 31 JANUARY 1997

The Balance Sheet reflects the overall monetary value of the College as at 31 January 1997. The net assets are determined by the total College assets minus its liabilities, the latter mainly being subscriptions and trainees' fees held in advance until the following year. Net assets are shown in the Equity section of the Balance Sheet as held by the three funds of the College - the Project Fund, the Trainees' Fund and the Foundation Fund (ANZCA Foundation). The Subscription Account is not a fund but represents the use of income from Fellows' subscriptions during the year, at the end of which any surplus is transferred to the Project Fund.

On advice from professional advisers, investments of College funds have over the past two years been largely converted from long-term products as they matured to the short-term market and equities. Interest rates from new long-term fixed deposits are generally unimpressive. This

results in the Balance Sheet showing conversion of investments from "non-current assets" to mostly "current assets".

Of the \$9.6 million net assets of the College, \$2.5 million is represented by College properties, equipment and similar fixed possessions. A further \$3 million is held by the Foundation for use on Research and Continuing Education, leaving \$4.1 million as true cash reserves of the College. As stated in last year's Report, it is good financial sense to ensure that the College reserves can at least match its total liabilities and for the first time since the College purchased its headquarters in Melbourne, there is now a comfortable excess in these terms. However, expansion of College functions and physical facilities, which the Council envisages will be necessary over the next few years, will significantly reduce cash reserves.

ACCOUNTS AND FUNDS

Subscription Account

This Account shows distribution of funds received as subscriptions for the daily running of the College on behalf of Fellows. Any surplus at the end of the year is transferred to the Project Fund to add to College cash reserves. Revenue increased by 6.7% over the previous year (it was 15% last year) while expenditure marginally decreased as many potential activities were put on hold. As with previous years, 10% of income was allocated each to the Foundation Fund and to the Project Fund. The Trainees Fund contributed \$860,141 towards administration of the College.

The effective surplus of the Subscription Account was \$677,789 and accounts in part for the significant improvement in cash reserves of the College. It also enabled the College Council to hold the Annual Subscription for 1997 at the same level as for 1996. I believe, however, that future years will see significant increased expenditure from the Subscription Account as the costs of recent initiatives (such as the Maintenance of Standards Programme, Pain Management Certification, Library services expansion, computer services) and other new projects for Fellows are impacted.

Project Fund

This Fund represents the Fellows' share in the net assets of the College. Revenue is mainly from interest on investments, a "development" allocation from subscriptions, and the surplus from the Subscription Account. The interest shown as allocated from subscriptions in advance is actually transferred to the ANZCA Foundation for Research purposes.

Foundation Fund

This Fund represents the financial activities of the ANZCA Foundation, the balance of which has now reached \$3 million. While general donations to the Foundation were disappointingly low, revenue was boosted by a welcome surplus on the 1996 Annual Scientific Meeting and a World Congress satellite meeting. Regional Continuing Education income and expenses both decreased over the previous year, perhaps due to decreased activity in a year hosting the World Congress. The expenditure on research varies considerably from year to year due to variations in timings of payments for such purposes, resulting in a much lower than usual annual payment. The Foundation Fund continues to be a great and growing asset for Australian and New Zealand anaesthesia and intensive care, being extensively used for both Research and Continuing Education purposes.

Trainees' Fund

This Fund provides for the College training and examination system, aiming to run with a minimal but safe financial surplus. Revenue increased by nearly 20% although this is exaggerated in these financial statements by the first-time inclusion of income from regional lecture courses in this section. Total expenditure increased by 21% to over \$1.2 million, which includes administration costs (\$860,141). The College Council is determined to ensure that training of anaesthetists and intensivists in Australia and New Zealand remains amongst the best in the world and like all things, the cost of achieving this is not inconsiderable. The surplus from the Trainees Fund (\$151,025) marginally increased over the last year but resulted in a balance of the Fund of \$623,149. I regard this figure in current terms to be appropriate for future development of the College training and examination systems.

CONCLUSION

I am pleased to report, once again, that the College finances are in a healthy state, reflected by continued growth which will serve our professions in many ways. The overall financial surplus from College activities (and those of immediate past years) was anticipated in order to restore cash reserves of the College, which were severely depleted when the College was initially formed and purchased its official headquarters. Unlike other medical Colleges, ANZCA has not imposed special levies or fees in this time of establishment, increasing responsibilities and current developments.

Fellows' subscriptions and Trainees' fees are always unwelcome and the College Council is acutely aware of this fact. The annual increase in subscriptions has been falling over the past years, to the extent that the 1997 subscription remained the same as that for 1996. Administration costs of the College have deliberately been contained over the past few years. However, as the roles of the College continue to expand on behalf of Australian and New Zealand anaesthesia and intensive care, I predict these and other expenses will increase significantly in the immediate future.

In managing the College finances, I particularly thank (and welcome) the new College Finance Manager, Mr Bill Peachey. Bill has been ably assisted, of course, by the College Accountant, Miss Vivienne Lillis, the College Registrar, Mrs Joan Sheales, and all other staff of the College both in Melbourne and in each Region. I also note with thanks the important role undertaken by the Fellows who are Honorary Treasurers of each Regional Committee of the College, an often unrecognised but important function. I also thank my fellow Councillors who have been extremely diligent in ensuring that the best financial outcome for the College and therefore its Fellows is achieved.

I welcome any queries and comments from Fellows and Trainees regarding this Report and accompanying Financial Statements. I request that such inquiries be in writing.

Richard G Walsh
HONORARY TREASURER

FACULTY OF INTENSIVE CARE

DEAN'S MESSAGE



This will be my final Dean's Message. I cannot resist the temptation to reflect upon a few "significant" past events.

Faculty "roots" extend back to the old Section of Intensive Care of the Faculty of Anaesthetists, Royal Australasian College of Surgeons. Planning on what has evolved into our current training and examination system started back in 1976. The first Final examination in Intensive Care was held in 1979. Even back then it was possible to train purely in intensive care, though the training programme did contain a sizeable proportion of anaesthesia. This latter component has since been reduced to one year, six months of medicine have been added, two years minimum of intensive care made compulsory and the whole training programme has been extended to five years. It has been a fascinating business seeing our system evolve. I have no doubt that further changes will occur.

Today it is still possible to train purely in intensive care through the FIC, ANZCA system without undertaking primary specialty training in anaesthesia or medicine. Single specialty training in intensive care would require a mandatory 12 months anaesthesia and six months medicine. The remaining three and a half years could then be spent in the practice of intensive care medicine if one so desired. However, few Fellows exercise this option. Clearly the majority of trainees still want a primary specialty qualification either with ANZCA or the RACP. This is despite there being an army of "ageing" full-time intensivists in Australia and New Zealand who have proved wrong sceptics of earlier days who said career intensivists would never "last the distance".

In the past 18 months the opportunities for dual qualification have actually increased and are being exercised. This follows the setting up of the Joint Specialist Advisory Committee in Intensive Care (JSAC-IC) and the changes the Faculty made to its regulations. Physician trainees can now be exempt from the ANZCA primary provided they have completed basic training and been successful in the written and clinical section of the FRACP examination. Already there is one FRACP, FFIC, ANZCA who has utilised this mechanism and another 10 RACP trainees have registered with the Faculty trainee scheme since the above changes came into force in February 1996. Thus although most FFIC, ANZCA also hold the diploma of FANZCA, there will be a growing number of dual FFIC, ANZCA and FRACP intensivists in the future.

As stated earlier, in Australia and New Zealand virtually all intensivists have either a primary speciality background in anaesthesia or medicine. This has not been so in all other countries. In the United States critical care specialists first obtain certification in one of the four primary specialities of medicine, anesthesiology, surgery or paediatrics. They then do a critical care training programme (which varies with the specialty) and a written examination. It is therefore of interest that one of the latest Colleges to develop a formal training scheme in intensive care and a final intensive care examination process, namely the Hong Kong College of Anaesthesiologists, is planning to accept primary examination from several other Colleges. This will broaden the group of people who can train in intensive care through their system.

Much has happened in intensive care in Australia and New Zealand in the last three years. With the formation of JSAC-IC significant progress towards commonality of training has been achieved. This includes content of training, in-training assessment, the formal project and, to a large degree, which units are suitable for training. Log books are currently being considered. Another major achievement has been the development of a paediatric intensive care training process and the first Final examination in Paediatric Intensive Care which is currently underway. Work continues on developing better communication with Fellows through internet services, improving library facilities, finalising a document relating to overseas trained doctors and finishing a major re-write of the Objectives of Training in Intensive Care.

A wonderful example of goodwill and generosity was the presentation to the Faculty of a Dean's Medal in February this year by Professor Barry Baker. It is a very tasteful badge of office. The Board has thanked Professor Baker for this thoughtful gesture.

It has been a great honour to be the Dean of this Faculty. It has definitely been a privilege to serve with a Board which has great depth of talent, is hard working and exercises initiative. The trust and support of Council, Mrs. Joan Sheales College Registrar, and our own Faculty Administrative Officer Ms. Carol Cunningham-Browne, are deeply appreciated. I wish the Dean Elect Alan Duncan every success. Under his leadership the Faculty will continue to grow and contribute to intensive care training, general standards and maintenance of personal professional standards, in a responsible manner which will benefit all working in this specialty.



G.M. CLARKE

FACULTY OF INTENSIVE CARE POLICY DOCUMENTS INDEX

- IC-1 (1994) Minimum Standards for Intensive Care Units
- IC-2 (1994) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts
- IC-3 (1994) Guidelines for Hospitals seeking Faculty Approval of Training Posts in Intensive Care
- IC-4 (1994) The Supervision of Vocational Trainees in Intensive Care
- IC-5 (1995) Duties of Regional Education Officers in Intensive Care
- IC-6 (1995) Supervisors of Training in Intensive Care
- IC-7 (1994) Secretarial Services to Intensive Care Units
- IC-8 (1995) Ensuring Quality Care – Guidelines for Departments of Intensive Care
- IC-10 (1996) Minimum Standards for Transport of the Critically Ill
- IC-11 (1996) In-Training Assessment of Trainees in Intensive Care
- IC-12 (1996) Examination Candidates Suffering from Illness, Accident or Disability

SUPERVISORS OF INTENSIVE CARE TRAINING FOR THE FACULTY OF INTENSIVE CARE

New South Wales

CareFlight Pty Ltd	Dr B. Hanrahan
The New Children's Hospital	Dr A.J. O'Connell
Concord Repatriation Hospital	Dr Y.V. Tran
Gosford Hospital	Dr A.J. McDonogh
John Hunter Hospital	Dr P. Saul
Liverpool Hospital	Dr G. Bishop
The Nepean Hospital	Dr A. McLean
The Prince of Wales/ Prince Henry Hospitals	Dr G. Hill
Royal North Shore Hospital	Dr R. Raper
Royal Prince Alfred Hospital	Dr R. Herkes
St George Hospital	Dr G. Skowronski
St Vincent's Hospital	Dr R.P. Lee
Westmead Hospital	Dr J. Gallagher

Victoria

Alfred Hospital	Dr D.J. Cooper
Austin and Repatriation Medical Centre	Dr G.K. Hart
Box Hill Hospital	Dr P.J. Cranswick
Epworth Hospital	Dr D. Ernest
Geelong Hospital	Dr C. Corke
Monash Medical Centre	A/Professor W.G. Parkin
Preston and Northcote Community Hospital	Dr G. Duke
Royal Children's Hospital	Dr J. Tibballs
Royal Melbourne Hospital	Professor J.F. Cade
St Vincent's Hospital	Dr J. Santamaria
Warringal Private Hospital	Dr G.K. Hart
Western Private Hospital	Dr P. Older

Queensland

Gold Coast Hospital	Dr R. Quinn
Greenslopes Private Hospital	Dr R.F. Whiting
Mater Misericordiae Children's Hospital	Dr B.F. Lister
Mater Misericordiae Public Hospital	Dr P.S. Lavercombe
Princess Alexandra Hospital	Dr J. Cockings
Prince Charles Hospital	Dr J. McCarthy
Royal Brisbane Hospital	Dr J. Morgan
Royal Children's Hospital	Dr J. McEniery
Townsville General Hospital	A/Professor V.I. Callanan

South Australia

Women's and Children's Hospital (Children's Campus)	Dr S. Keeley
Ashford Hospital	Dr A.D. Bersten
Flinders Medical Centre	Dr A.D. Bersten
Queen Elizabeth Hospital	Dr J.L. Moran
Royal Adelaide Hospital	Dr J. Myburgh
Wakefield Hospital	Dr D. Clayton

Western Australia

Fremantle Hospital	Dr F.X. Breheny
Princess Margaret Hospital	Dr A.W. Duncan
Royal Perth Hospital	Dr S.A. Edlin
Sir Charles Gairdner Hospital	Dr P.V. van Heerden

Australian Capital Territory

The Canberra Hospital	Dr H. Bidstrup
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Tasmania

Launceston General Hospital	Dr J. Blaxland
Royal Hobart Hospital	Dr A. Bell

New Zealand

Auckland Hospital	Dr L. Galler
Christchurch Hospital	Dr G. Downward
Dunedin Hospital	Dr M. Ramsay
Middlemore Hospital	Dr P.D. Crone
Palmerston North Hospital	Dr P. Hicks
Starship Children's Hospital	Dr B. Anderson
Waikato Hospital	Dr N. Barnes
Wellington Hospital	Dr R.A. Dinsdale

Hong Kong

Pamela Youde Nethersole Eastern Hospital	Dr B.H. Yong
Prince of Wales Hospital	Dr T. Buckley
Queen Elizabeth Hospital	Dr Cheng Fan

April 1997

FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
 A.C.N. 055 042 852

REPORT OF FELLOWSHIP EXAMINATION AUGUST/SEPTEMBER 1996

This report is prepared to provide candidates, their tutors and their supervisors of training with information about the way in which the examiners assessed the performance of candidates in the recent examination. Answers provided are not model answers but guides to what was expected. Candidates should discuss the report with their tutors so that they may prepare appropriately for future examinations.

WRITTEN SECTION

Performance was poor in this section. The section not only tested core knowledge but also clinical problem-solving and priority-setting. Candidates failed to answer the questions and were unable to provide an orderly priority. If a clinical scenario was provided they were expected to take control as a consultant and provide reasons for steps in management.

SHORT ANSWER QUESTIONS

1. *"What are the roles of corticosteroids and nebulised adrenaline in the management of croup."*

The candidate was expected to describe the actions, indications and contraindications for each agent and how it would be used.

For example:

- (a) Nebulised adrenaline produces immediate short term relief of symptoms in croup by vasoconstriction and relief of airway swelling. The dose is usually 0.05mls/kg of the 1% solution or equivalent repeated as necessary. Absorption is controlled by the child's minute ventilation. Rebound stridor may develop. It is used as a temporising measure before intubation or during transport.
- (b) Steroids have been shown to reduce the oedema of croup by their anti-inflammatory effect. They reduce the admission rate and hospital stay in the patient with croup. They take several hours to work and therefore should be given early in moderate to severe croup. Usual dose - 0.6mg/kg dexamethasone IMI

followed by 1 mg/kg prednisone twice daily. They are also used before extubation if there is risk of post-extubation airway oedema.

2. *"What is the role of percutaneous endoscopic gastrostomy in ICU."*

Again a question about "role". To answer this requires explanation of the procedure, its advantages, disadvantages, risks and its place relative to other procedures. For example, PEG is a moderately invasive technique for insertion of a gastrostomy tube. It requires an endoscopic procedure for placement with sedation and local anaesthetic. Its advantages are the absence of a tube through the nose, pharynx and oesophageal sphincter. It is therefore useful for long term placement in patients with inability to swallow, functioning GIT and at risk of regurgitation and aspiration eg. after severe head injury. The majority of ICU patients can be managed by nasogastric or nasoenteric PVC or polyurethane tubes but this procedure offers advantages in patients with sinusitis, # base of skull and trismus. It has the advantage of greater comfort and preserved oesophageal sphincter competence compared to a NG tube, but there is the risks associated with an abdominal procedure eg. peritonitis.

3. *"Critically compare heat and moisture exchangers and heated water bath humidifiers. Explain their roles in the ICU."*

Candidates could use a table to compare these pieces of equipment. It was expected that topics covered should have included:

- humidification capacity (a clear understanding of the terms absolute and relative humidity was necessary)
- heat exchange capacity
- cost, ease of use and portability
- infection control (risk of colonisation, filtration)
- dead space
- resistance and problems with obstruction
- electrical hazards
- "rain out"

Examples of different types of humidifiers within each group should have been given eg. there is marked variation between heated water bath humidifiers with or without heated wires and "blow over" or "bubble through" humidifiers. The aims of humidification (eg. prevention of mucosal damage and ETT blockage by blood/mucus) and airway warming in ICU should have been mentioned and how the devices met those aims in different situations (eg. transport, short term use or use in the patient with tenacious secretions).

4. "How would you clinically differentiate between an ulnar nerve lesion at the elbow and a radial nerve lesion at midshaft of the humerus?"

Clinical differentiation may involve history, symptoms and signs.

An ulnar nerve lesion at the elbow produces weakness of flexion and adduction of the wrist, flexion of 4th and 5th fingers, adduction of the thumb and adduction and abduction of the fingers. Long flexors and extensors of the fourth and fifth fingers are not intact so clawing is mild. A good test is to try to adduct and abduct fingers with the palm down on the table. There is also anaesthesia of the ulnar border of hand and dorsal aspect of the ulnar 1^{1/2} fingers.

A radial nerve lesion at the midshaft of humerus produces:

- wrist drop, inability to supinate the extended forearm and extend the wrist, thumb and fingers at the proximal joints
- a patch of anaesthesia on dorsum of hand between first and second metacarpals (snuffbox)

Chronic lesions will produce wasting of the affected muscles.

5. "What would make you suspect that a patient with left ventricular dysfunction and chronic complete heart block has pacemaker failure? How can this be confirmed?"

What sort of permanent pacemaker would be best for this patient?"

It was expected that the candidate cover:

- (a) Suspicion of pacemaker failure:
 - history (eg. syncope, dyspnoea, angina)
 - examination (eg. bradycardia, irregular pulse, canon waves)
 - investigations (eg. ECG-absent or non-conducted spikes, recurrence of complete heart block, CXR - fractured lead, pacemaker electrophysiologic assessment, Holter monitoring)
- (b) choice of pacemaker according to:
 - value of dual chamber pacing and sensing
 - value of responding to endogenous atrial activity
 - value of programmable and rate responsive pacemakers

Pacemaker terminology used should have been explained when used (eg. DDD).

6. "List the methods of drug administration during cardiac arrest in infants. What are the advantages and disadvantages of each method?"

It was expected that the list should include:

- peripheral IV
- CVC
- intra osseous
- endotracheal
- intracardiac, IMI and oral could be mentioned to reject them

Ease and time of insertion, reliability, drug delivery and potential complications should have been covered.

7. "What are the important risks of sending a trauma patient for abdominal CT with contrast?"

This simple practical question should have been answered with mention of the risks of:

- a) removing the patient from monitoring and supervision in ICU or ED making it possible to miss life threatening conditions and deterioration
- b) transporting, handling and moving the patient across trolleys, in lifts and long distances with risk of critical incidents (eg. tube removal)
- c) oral contrast: regurgitation/vomiting
- d) IV contrast: renal effects/allergy
- e) delaying definitive Rx (eg. urgent surgery)

- f) getting caught in lifts etc.
g) movement and stimulation increasing ICP, destabilising BP, increasing injuries to neck etc.

8. "**Outline** the principles of treatment of persistent pulmonary hypertension in the newborn."

Topics should have included:

- treatment of the underlying cause which may be:
 - (a) primary
 - (b) secondary (congenital-heart disease or diaphragmatic hernia) or
 - (c) acquired (meconium aspiration)
- oxygenation
- maintenance of temperature, electrolytes, BGL
- reduction of stress (sedation)
- hyperventilation or induction metabolic alkalosis
- vasodilators (tolazoline, PGE-1 or TNG)
- selective pulmonary vasodilator (inhaled NO)
- ECMO
- HFO

9. "**Explain** the advantages and disadvantages of the use of adenosine, amiodarone and sotalol for the management of supraventricular tachycardia."

It was easiest for each agent to be addressed separately. The candidate should have discussed success and failure rates in the various rhythms, speed of onset, duration of action, ease of administration and side effect profile.

10. "What determines the clearance of solute in the use of continuous veno-venous haemodiafiltration (CVVHD)? How may it be improved?"

Continuous veno-venous haemodiafiltration is also described as CVVHDF. The determinants of solute clearance to be covered included factors which:

- (a) determine diffusive exchange eg. counter current flow, solute concentration gradient, blood flow, membrane area, dialysate flow, solute characteristics.
- (b) determine convective exchange eg. ultrafiltration rate, transmembrane pressure gradient, arterial pressure, membrane characteristics (pore, size, charge, area), plasma protein concentration and solute characteristics.

Thus improvement in clearance may be produced by, for example:

- increased membrane area
- increased dialysate flow (limited effectiveness for

each haemofilter)

- increased blood flow by blood pump (limited effectiveness for each haemofilter)
- pre dilution
- increased transmembrane pressure by lowering the filtrate reservoir or applying suction
- changing a clotted filter if clearance is low and optimum anticoagulation.

11. "Ejection fraction measured by gated heart pool scan is an accurate indicator of left ventricular myocardial contractility". **Discuss this statement.**"

It was expected that the candidate would show an understanding of "contractility", "ejection fraction" and the technique of Gated Heart Pool scanning and problems with interpretation (arrhythmias, background radiation etc). The dependence of ejection fraction on preload and afterload means that it is a measure of LV "function" not contractility. This should have been stated clearly but was frequently misunderstood. Suggestions for better measures of contractility should have been given.

12. "What is the current status of selective decontamination of the gastrointestinal tract in ICU? Justify your practice."

This topic has been prominent in the literature for some years and it was expected that the candidate be familiar with current research and problems with experimental methods. The pros and cons of SDD use in different patient groups should have been reviewed eg. trauma, medical or neutropenic patients, including colonisation, nosocomial pneumonia and effects on length of stay ICU and mortality, but the answers were often disappointing.

13. "A brain dead patient is awaiting transfer to the operating suite for organ donation. He is hypotensive, hypothermic and polyuric. How will you optimise his care?"

The candidate was expected to address the general care of the organ donor and the specific issues:

- the principles of fluid resuscitation and possible use of inotropic or vasoconstrictor drugs should have been straightforward and comprehensively detailed.
- the use of intravenous T3 should have been considered.
- arguments for and against accepting a level of hypothermia should have been discussed and techniques for preventing further temperature drop should have been covered.
- causes of polyuria and their management should

have been covered. In particular confirmation of diagnosis and treatment of diabetes insipidus should have been detailed.

14. "What is meant by barotrauma and volutrauma? What measures would you undertake to prevent them in the ventilated asthmatic?"

The question refers to pulmonary barotrauma and volutrauma. It was expected that the terms be defined and an understanding of the argument about the contributing effects of volume and pressure on ventilator-induced-lung injury be shown. The important work of Dreyfus implicating alveolar distension in ventilator-induced-lung injury would have helped to clarify the argument.

Most candidates showed a safe approach to initial ventilator settings in the asthmatic (eg. low resp rate 8-10 breaths/min, long expiratory time, ? flow rate) means of assessing progress (eg. clinical, measuring auto PEEP, VEI) and treating the patient (eg. sedation, bronchodilators).

15. "What is cholesterol embolisation? What are its causes and effects and how may it be treated?"

This is an increasingly observed problem but many candidates were obviously not aware of it. It is also called cholesterol atheroembolism. It refers to the shedding of atheromatous cholesterol debris from arteries into the peripheral circulation usually from atheromatous plaques in lower aorta and femoral arteries.

It is caused by and associated with any manoeuvre which may disturb stable atheromatous plaque eg.

- aortic cross clamping and instrumentation
- angiographic catheterisation
- warfarin or streptokinase therapy
- abdominal trauma

Severe hypercholesterolaemia is not a prominent feature. Cholesterol atheroembolism is usually manifest by combinations of hypertension, livido reticularis, "trash" skin, declining renal function, eosinophilia and GIT ischaemia.

It can be diagnosed by the above clinical picture and confirmed by skin biopsy or renal biopsy.

There is no specific therapy beyond measures to improve peripheral perfusion:

- vasodilators (nitroprusside, prostacyclin)
- fluid loading
- inotropes

LONG ANSWER QUESTIONS

The candidate was expected to reveal a safe and comprehensive approach to the clinical situation. Rather than lists of options, a decisive plan of action with reasoning was expected.

QUESTION 1

"A three year old girl is brought to the Emergency Department by ambulance after being involved in a house fire. She had been trapped on the second storey. She is confused and restless and appears to have suffered burns to her face, upper limbs and torso. She has an obvious fractured midshaft of femur and swollen ipsilateral ankle.

OUTLINE your initial management and why you would take this course of action. What therapy is necessary for the next 24 hours?

LIST the most serious complications after the initial 24 hours ICU stay and how may they be prevented and treated.

(a) This is not a simple case. There is a skin burn, perhaps major trauma, potential inhalation of smoke and airway burn in a young child. The child would be about 14 kg. The issues that were expected to be addressed included:

- primary survey for life threatening injuries
- IV access (also asked in SAQ's) (peripheral, CVC, femoral, interosseus)
- prompt securing of airway. The technique should have been discussed in detail as there is a risk of difficult intubation (size of tube and drug dosage were expected).
- secondary survey for burn estimation, other injuries
- complete history of mechanism of injury
- fluid resuscitation. If the child was found to be shocked 20mls/kg initial bolus is reasonable or 10ml/kg if not shocked. Further fluid administration dependent on response. Hartmanns initially then Albumin or FFP at 8-10 hours.
- a cause for the child's confusion should have been sought and treated (including head injury, CO poisoning and CN from inhalation of smoke)
- other injuries (eg. CT of abdo or DPL)
- consideration should have been given to early

tracheostomy because of difficulties in tube fixation and need for prolonged intubation.

- escharotomy of circumferential burns of arms, chest, etc.
- early fixation of fractures
- early grafting of hands etc. if tendons involved
- psychologic support of the family and team approach to management
- transfer to specialist paediatric burn unit

(b) Complications which should have been considered in detail include:

- hypothermia
- ARDS from smoke inhalation
- burn infection (?early debridement and grafting)
- lung infection
- eschar impeding respiration and raising abdo pressure
- cicatrisation of neck and chest
- nutritional depletion (?TPN, ? enteral feeding)
- neurological deficits from head injury, CO poisoning
- pain
- psychological stress

QUESTION 2

"A 65 year old, 80 kilogram male is admitted to ICU after undergoing a right hemicolectomy, primary anastomosis and peritoneal washout for faecal peritonitis due to aschaemic perforation. On arrival he is hypotensive (BP80/60), with cold extremities and in atrial fibrillation with a ventricular rate of 130.

1. *Detail your initial management and explain its rationale.*

2. *The next day he deteriorates with worsening gas exchange. PaO₂ 50 PCO₂ 45 on F₁O₂ 1.0, tidal volume 800 mls, ventilator rate 12 and PEEP 5. How would you manage this problem?*

(a) This is a common ICU scenario. The patient is acutely unwell post-op. The candidate was expected to show an organised and detailed approach to the problem, including:

- (i) a safe system for accepting transfer of a patient from the Operating Theatre
 - full history of comorbidities (IHD, COAD) and acute problems (?cause of ischaemic colitis)

- head to toe examination and check of equipment (ETT, lines, ventilator etc)
- establish monitoring
- investigations with rationale (Swan Ganz, CXR for ARDS, tube positions etc)

(ii) addressing the immediate apparent problems

- atrial fibrillation (? cardioversion, ? digoxin/amiodarone)
- shock (? cause → treat)
- sepsis

(iii) ongoing management

- antibiotics to cover potential pathogens (choice and regimen)
- ventilation, fluids
- monitoring
 - investigation of cause of "ischaemic colitis" ? occlusive or ? embolic → anticoagulants
- is there a place for supra normal DO₂

(b) The management of the acute deterioration into hypoxaemic respiratory failure required a holistic approach (not fiddling the ventilator). Discussion should have covered:

- seeking a cause and commencing specific treatment
- supporting O₂ delivery

(i) causes could include lung infection, pneumothorax ARDS secondary to intra-abdominal catastrophe (leaking anastomosis), fluid overload, cardiogenic pulmonary oedema secondary to an infarct. Management should have included relevant examination and investigations to elucidate the cause and guide specific treatment.

(ii) support of oxygen delivery including discussion of

- maintenance of cardiac output
- maintenance of haemoglobin
- maintenance of oxygen saturation > 90% "permissive hypoxaemia"
 - * titration of PEEP according to DO₂, compliance inflection point etc.
 - * adjustment of ventilator mode (eg. pressure control, IRV, permissive hypercapnia)
 - * reducing lung water (diuretics etc)
- NO
- ?? ECMO etc
- reduction of VO₂ (paralysis, normalisation of temp)

(iii) Novel therapy (only mentioned well down the list) such as:

- anti cytokine ibuprofen
- anti endotoxin n-acetyln-acetylcysteine

ORAL SECTIONS

1. **Investigations** were generally well handled. Commonly encountered XRays, ECGs and CT scans were presented. (Adult and Paediatric)

2. **Cross Table Vivas** covered a wide range of ICU topics:

- initial management and treatment of a one-year old with raised ICP
- advice to a country GP handling a 3 year old with acute epiglottitis
- 18 year old with Duchenne’s muscular dystrophy and respiratory failure
- prognosis in persistent vegetative state
- sternal wound breakdown management
- VRE
- post partum collapse
- evidence based medicine
- ischaemic hepatitis
- complications of PA catheterisation
- management of chest injury, (thoracic epidural etc) who to admit
- status epilepticus management
- side effects of ICU therapy
- universal precautions
- intraortic balloon counterpulsation - mechanisms, timing, etc.
- open lung biopsy - indications, complications, techniques
- laryngeal/tracheal complications of ETT
- management of hyponatraemia
- management of pyloric stenosis in an infant
- management of acute severe asthma
- ventilator emergency
- haematemesis and melaena management
- CRRT

CHD

- 48 year old male with severe bronchiectasis
- 61 year old male with scleroderma and pulmonary fibrosis
- 50 year old female with alpha-1 anti-trypsin deficiency
- 87 year old female with aortic stenosis
- 50 year old female with Marfans Syndrome and MV prolapse
- 67 year old male with bilateral ulnar nerve palsies
- 71 year old male with dilated cardiomyopathy and valvular disease
- 30 year old female with multiple sclerosis
- 68 year old male with hepatomegaly

ICU cases included:

- 19 year old male with SLE, ARDS (fibrotic stage) and muscle wasting
- 60 year old male with severe neuromuscular disease
- 70 year old male with digital gangrene on CRRT
- 18 year old male post craniotomy with SJO₂ catheter
- 30 year old female with septic shock after BMT
- 30 year old female with DKA, ARDS and pericardial effusion

R.P. LEE
Chairman,
Fellowship Examination

CLINICAL SECTION

Candidates were expected to perform at a consultant level in their approach to patients, ability to elicit signs and subsequent discussion.

Cold cases included:

- 60 year old female with acromegaly
- 49 year old male with Eisenmengers Syndrome after

POLICY DOCUMENTS

Review P24 (1997)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

and

GASTROENTEROLOGICAL SOCIETY OF AUSTRALIA

ACN 001 171 115

and

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

ACN 004 167 766

SEDATION FOR ENDOSCOPY

1. INTRODUCTION

Sedation for endoscopy includes the administration by any route or technique of all forms of drugs which result in depression of the central nervous system. The objective of these techniques is to produce a degree of sedation of the patient, without loss of consciousness, so that uncomfortable diagnostic and minor surgical procedures may be facilitated. The drugs and techniques used should provide a margin of safety which is wide enough to render unintended loss of consciousness unlikely.

These techniques are not without risk because of:

- 1.1 The depression of protective reflexes.
- 1.2 The wide variety of drugs and combinations of drugs which may be used.
- 1.3 The possibility of excessive amounts of these drugs being used to compensate for inadequate local analgesia.
- 1.4 The individual variations in response to the drugs used particularly in the elderly or infirm.
- 1.5 The wide variety of procedures performed.
- 1.6 The differing standards of equipment and

staffing at the locations where these procedures are performed.

Thus it is important to understand the variability of effects which may occur with sedative drugs, however administered, and that over-sedation or airway obstruction may occur at any time. To ensure standards of patient care, the following guidelines are recommended.

2. GENERAL PRINCIPLES

2.1 The patient should be assessed before the procedure and this assessment should include:

- 2.1.1 A concise medical history and examination and identification of risk factors. Patients should be assessed for risk prior to endoscopy. The American Society of Anesthesiologists' classification system is convenient for this purpose (see Appendix 1). Patients in Grades III to V, including the elderly and those with severely limiting heart disease, cerebrovascular disease, significant lung disease, liver failure, acute gastrointestinal bleeding and cardiovascular compromise, severe

anaemia, morbid obesity and shock require special attention during endoscopy.

2.1.2 Instructions for preparation of the procedure (including fasting where appropriate), the recovery period, and discharge of the patient.

2.1.3 Informed consent for the procedure and sedation.

2.2 Staffing - During an endoscopic procedure, a person must be present who is trained in acute resuscitative measures whose principal responsibility will be to monitor the patient's level of consciousness and cardiorespiratory status and assist resuscitation if required. The use of pulse oximetry for every sedated patient will assist this monitoring process. Reliable venous access should be in place for all endoscopies. If major risk factors are identified (as in 2.1) or difficulties can be anticipated, involvement of an anaesthetist in monitoring and administering sedation is recommended.

2.3 Most complications of endoscopy are cardiopulmonary. Sedation should be kept to a minimum required for patient comfort, particularly in the elderly. Increasing the level of sedation to allow more forceful passage of the endoscope, particularly in colonoscopy, carries an unnecessary risk of iatrogenic trauma; excessive pain during endoscopic procedures often signals poor technique and may mean impending perforation. It should be noted that the combination of benzodiazepines with an opioid increases the risk of cardiopulmonary complications. Opioids should be given first, then the benzodiazepine dose increased slowly according to clinical status. Benzodiazepine antagonists should always be available but these drugs are not to be used simply to obtain greater sedation. Their duration of effect is less than the benzodiazepines and so late "resedation" may occur in recovery. The practitioner administering sedative drugs requires sufficient basic knowledge to be able to:

2.3.1 Understand the action of the drug or drugs being administered.

2.3.2 Detect and manage appropriately any complications arising from these actions.

2.3.3 Anticipate and manage appropriately the modification of these actions by any concurrent therapeutic regimen or disease process which may be present.

2.4 Oxygenation

Degrees of hypoxia are not uncommon during gastrointestinal endoscopy. Oxygen delivered at 2-3 litres/minute diminishes hypoxaemia during endoscopy. All patients undergoing endoscopic procedures should have supplemental oxygen.

2.5 A written record of the dosages of drugs and the timing of their administration must be kept as a part of the patient's records. Such entries should be made as near to the time of administration of the drugs as possible. This record should also note the readings from the monitored variables.

3. FACILITIES

The procedures must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This should include:

3.1 Adequate uncluttered floor space to perform resuscitation should this prove necessary.

3.2 An operating table or trolley which can be readily tilted.

3.3 Adequate suction and room lighting.

3.4 A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.

3.5 A means of inflating the lungs with oxygen (e.g. a range of pharyngeal airways and self-inflating bag suitable for artificial ventilation).

- 3.6 Appropriate drugs for cardiopulmonary resuscitation and a range of intravenous equipment (see Appendix).
- 3.7 A pulse oximeter which must be used whenever sedation is employed.
- 3.8 Ready access to an ECG monitor and defibrillator.
- 3.9 Drugs for reversal of benzodiazepines and opiates.
- 3.10 Equipment suitable for measurement of blood pressure.

4. RECOVERY

Recovery should take place under appropriate supervision in the procedure room or an adjacent area designated for this purpose and adequately equipped and staffed.

Prior arrangements which enable transfer in an emergency to be accomplished smoothly and effectively with a minimum of delay and under adequate medical supervision should exist.

5. DISCHARGE

The patient should be discharged only after an appropriate period of recovery and observation in the procedure room or in an adjacent area which is adequately equipped and staffed. Discharge of patients should be authorised by the practitioner who administered the drugs, or another qualified person. The patient should be discharged into the care of a responsible adult to whom written instructions should be given. Written instructions should include prohibition of driving and the operation of machinery and undertaking responsible business until the next day, and eating and drinking instructions.

References

1. Australian and New Zealand College of Anaesthetists' Policy Document :Guidelines for the Care of Patients Recovering from Anaesthesia" (P4).
2. British Society of Gastroenterology. Endoscopy Committee Working Party. Recommendations for standards of sedation and patient monitoring during gastrointestinal endoscopy. Gut 1991; 32:823-827.

Appendix I

The American Society of Anesthesiologists' classification of physical status:

- Class I** A normal healthy patient
Class II A patient with mild systemic disease.
Class III A patient with a severe systemic disease that limits activity but is not a threat to life.
Class IV A patient with an incapacitating systemic disease that is a constant threat to life.
Class V A moribund patient not expected to survive 24 hours.

In the event of an emergency procedure, precede the number with "E" (I - IV only).

Appendix II

Emergency drugs should include at least the following:

- adrenaline
- atropine
- dextrose 50%
- lignocaine
- flumazenil
- naloxone

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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 Reviewed: 1997
 Date of current document: Apr 1997

Review P1 (1997)

ESSENTIAL TRAINING FOR RURAL GENERAL PRACTITIONERS IN AUSTRALIA PROPOSING TO ADMINISTER ANAESTHESIA

1. INTRODUCTION

The role of general practitioners in a location where no specialist anaesthesia services are available is acknowledged. Where such a location is so remote that referral of certain types of surgery is impracticable, the College believes that a specific level of competence is required for a general practitioner to undertake anaesthesia.

It should be clearly understood that this Document is not intended in any way to endorse, reflect on or prejudge the issue of surgery being undertaken in these circumstances. Furthermore, the question of hospital facilities and infra-structure is crucial to this matter, and anaesthesia is only one of a number of considerations which must influence any management decisions to be made in the best interests of the patient.

2. OBJECTIVES OF TRAINING

The objectives of the training of rural general practitioners proposing to administer anaesthesia are as follows:

- 2.1 To provide general knowledge, experience, skills and competence in the management of common anaesthesia procedures, and in the early management of severe trauma.
- 2.2 To provide specific knowledge and practical skills as they relate to a rural general practitioner anaesthetist, including relevant aspects of general medicine, surgery, paediatrics, obstetrics, intensive care and pain management.
- 2.3 To provide understanding and insight for decision making about local management,

further consultation and referral for anaesthesia and related procedures.

- 2.4 To develop skills to act appropriately as a member or leader of a therapeutic team, to contribute to the education of nursing, paramedical and medical staff, and to conduct clinical audits, research and quality assurance activities in their anaesthesia practices.
- 2.5 To ensure a commitment to self directed learning and other forms of continuing education in anaesthesia, to adaptability to changes in anaesthesia practice relevant to safer management of patients, and to act according to ANZCA recommendations on rural general practitioner anaesthesia practice.
- 2.6 To foster a commitment to rural general practice anaesthesia where sufficient specialist anaesthesia services are unavailable.

3. TRAINEES SELECTION CRITERIA

The following criteria are recommended for selection of trainees:

- 3.1 Completion of two years of the Rural Training Programme which may have included a three month term in Anaesthesia, Emergency Medicine or Intensive Care.
- 3.2 Successful completion of the Early Management of Severe Trauma Course (EMST) or a secure position within a future course.
- 3.3 Demonstration of relevant anaesthetic knowledge, skills and experience including, or

similar to, that of an RMO in a term of anaesthesia.

- 3.4 Demonstration of a commitment to rural general practice including experience of at least one term in rural general practice.

4. MINIMUM TRAINING EXPERIENCE

A minimum period of experience under instruction is required. This should preferably be part of the four year Rural Training Programme of the Rural Faculty, Royal Australian College of General Practitioners. This experience should be:

- 4.1 At an accredited Rural Training Unit.
4.2 Of twelve or more months duration.
4.3 As per curriculum requirements (Advanced Training Curricula in Anaesthetics, Rural Faculty, RACGP).

The curriculum is designed for two periods of attachment:

- 4.3.1 attachment to an anaesthetic unit in the RTU (nine months minimum), three months of which may have been in the first two years of the Rural Training Programme;
4.3.2 three months of the twelve months may be an attachment to Accident and Emergency or Intensive Care, or a rural anaesthetic practice.
4.4 In a full-time anaesthesia training post with a significant case load.

5. ACCREDITATION AND MAINTENANCE OF KNOWLEDGE AND SKILLS

This should be in accordance with the "Guidelines for Accreditation/Re-Accreditation of Rural GP Anaesthetists" as outlined by the Joint Consultative Committee on Anaesthesia (JCCA) 1995.

Accreditation is based on the following principles:

- 5.1 There are areas of Australia where there will always be a requirement for general practitioners to be administering anaesthesia. There are some situations where GPs may

and should work in co-operation with specialist anaesthetists.

- 5.2 These general practitioners must have appropriate training and must be administering safe, conventional anaesthetics. This training is fully outlined in the Rural Training Curriculum. (The DA (UK) will continue to be acceptable as appropriate training for Rural Anaesthesia, but Diplomates will be required to submit themselves for Accreditation).

- 5.3 These general practitioners should maintain their anaesthetic skills and knowledge by administering an acceptable number of anaesthetics per year and by participating in ongoing Continuing Medical Education (CME) in the field of anaesthetics.

There are two main areas of accreditation/re-accreditation.

300 points/3 years should be accumulated.

5.4 *A Caseload*

Assuming all techniques are appropriately applied, 0.5 point is allowed for each anaesthetic administered or in any situation where anaesthetic skills are needed and utilised. This will include sedations for endoscopy, neonatal resuscitation, near drowning, trauma resuscitation, regional blocks, CVP lines etc, but will exclude minor blocks or inserting an IV.

No minimum number.

Maximum - 150 points/3 years.

5.5 *CME in Anaesthetics*

- 5.5.1 Journal Subscriptions/reading:
50 points per specialist anaesthetic journal.

Maximum 100 points/3 years.

- 5.5.2 Conference/Meeting attendance:
10 points / day for meetings accredited as being suitable for GP anaesthetists by the JCCA (these points may be different to those allocated for attendance by Fellows of ANZCA, as

subjects may not be relevant to general practitioners e.g. neuroanaesthesia, cardiothoracic anaesthesia).

Maximum - 100 points/3 years.

5.5.3 Refresher Courses and time spent in Anaesthetic Departments of provincial referral Hospitals:

20 points/day (must be certified by Head of Department as useful experience/teaching rather than being a pair of hands).

Maximum - 100 points/3 years.

5.5.4 EMST Course - 100 points (a one-off in any triennial).

5.5.5 Supervised lists by visiting specialist anaesthetists - 10 points/half day list.

Maximum - 100 points/3 years.

5.5.6 Any other activity deemed to be of value as CME in anaesthetics, point value to be determined by the JCCA on application, e.g. participation in retrieval teams, practice research relevant to anaesthetics.

5.6 Audits

Each GP Anaesthetist must keep a log book of his or her anaesthetic caseload, if he or she wishes to claim caseload as part of his or her accreditation points. This log book must also include a record of CME activities, for the same reason. Log books should contain the following information:

- date, age, gender, ASA status of each patient
- operation, drugs used, anaesthetic technique and equipment
- problems (if any) and any subsequent morbidity and mortality.

Log books are now available from the JCCA.

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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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

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