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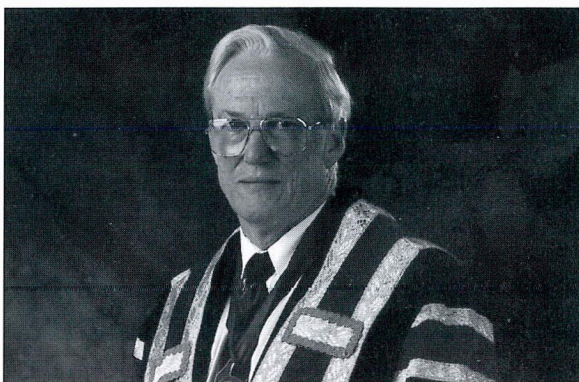
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The Australian and New Zealand College of Anaesthetists Bulletin is published four times per year by the Australian and New Zealand College of Anaesthetists, A.C.N. 055 042 852, 630 St Kilda Road, Melbourne, 3004, Victoria.
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PRESIDENT'S MESSAGE



In January, the Vice President Richard Walsh, Joan Sheales and I met with Dr. Michael Wooldridge, the Federal Minister of Health, to discuss issues relating to training. The Australian Medical Workforce Advisory Committee (AMWAC) had made a series of recommendations relating to the anaesthetic workforce in its January 1996 report. A key recommendation from the Minister's point of view was the provision of anaesthetic services to the community. We were able to inform him that the College had taken several steps to redress the shortage of anaesthetists, particularly in rural areas. These were firstly an increase in the number of recognised training posts, of which 25% were in rural hospitals; secondly an increase in the number of general practitioners training under the agreement between the College and the General Practitioners through the Joint Consultative Committee on Anaesthesia; thirdly the increased number of Overseas Trained Specialists referred to the College for review by the Australian Medical Council; and fourthly, the intent of Council to consider the role of Career Medical Officers in Anaesthesia. The opportunity was taken at this meeting to appraise the Minister of the establishment of the Certificate in Pain Management, and to seek his support for National Anaesthesia Day 1997.

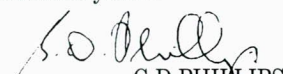
On the day before the February Council meeting, a Strategic Planning Day was held by Councillors, utilising the services of Mr. Rowan McClean, an external facilitator, and Mr. Michael Gorton, the College Solicitor.

The purpose of the day was to undertake a strategic review of the College, to identify directions and priorities. It began with an outline of legal issues, including the status of a Company Limited by Guarantee, its tax exemption status, and the duties of Councillors as Directors, with particular reference to issues such as acting in good faith, avoiding conflict of interest, and maintaining confidentiality. Next

followed an analysis of the College's strengths, weaknesses, opportunities and threats. Of these, strengths and opportunities far outweighed perceived weaknesses and threats. Emphasis was placed on having a clear purpose (education and the setting of standards in anaesthesia and related disciplines), a clear mission (to serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain management, through excellence in education, research and clinical standards), and a clear vision. The latter has not yet been defined, but the following draft statement will be considered by Council: "ANZCA will be a leader in anaesthesia and related disciplines in the Asia Pacific area with a strong membership, a range of education and other services, a custodian role for clinical standards, and industry and government support for research."

The report of the Strategic Planning Day will now be reviewed by the Executive and Council to establish priorities for the many issues raised. Two issues which appear to have a high priority in terms of probability of occurrence and impact on the College are the definition of relationships between the College and the Societies, and the potential for reduced opportunities for Fellows in the Operating Room due to developing technology and to the potential use of non-anaesthetists to provide service.

At February Council, Dr. Megan Robertson presented the report of the Younger Fellows' Conference held at New Norcia last October. The meeting, the theme of which was "Communication", was an outstanding success, and the report will be discussed by Council. I anticipate that the Younger Fellows' Conference to be held in New Zealand in May, with the theme of "Looking After Ourselves" will consolidate the place of these meetings in our education system.


G.D. PHILLIPS

NATIONAL DAY – JULY 2, 1997

A date has been confirmed for the 1997 National Anaesthesia Day – July 2, 1997.

The theme will be:

“PAIN RELIEF – A BASIC HUMAN RIGHT.”

A detailed information programme is being put in place to maximise the involvement of anaesthetists, and media coverage.

The ultimate degree of success will again depend on a high level of participation by hospitals and individual anaesthetists.

The focus of the National Day and associated information programmes will be on improving public knowledge of pain – in particular the important role of anaesthetists in pain management and palliative care services.

The Day will have the direct public support of the Federal Health Minister, Dr. Michael Wooldridge (*needs confirmation, of course*), who will be involved in a National launch of the event.

State, Territory and New Zealand Ministers are being approached for involvement at appropriate levels.

Anaesthetists' support for the Day is sought by way of specific activities in Pain Centres, and displays relating to acute, chronic, palliative care, and obstetric pain services.

Hospitals are invited to mount displays that reflect the general message on pain management and their particular involvement in such services. (An article on how to plan and conduct such activities appeared in the August, 1996 Bulletin.)

Planning for the 1997 Day reflects the responses contained in the questionnaires returned after the 1996 National Anaesthesia Day. These provided a valuable resource. (See article this edition, page 7)

A new National Day poster is being produced, retaining the specially created National Day logo, along with other posters that highlight specific elements of public education about pain.

An information leaflet will be available for handing out to the public, and stickers are again expected to be supplied.

The 1997 Day is being planned to have a greater focus on media coverage.

To assist participating departments, hospitals and practices, draft media release material is being prepared, designed to allow local targeting of media outlets.

Kits containing these various materials will be sent to Pain Centres, teaching hospitals and on request. These should be available in May.

The theme of pain management for the 1997 National Anaesthesia Day is timely, given the increasing media and community focus on the issue, and recent advances in specialised pain management techniques.

The role of anaesthetists in this vital field, the increasing scope of specialised training and facilities, and growing community concern make this an important information focus.

Pain recently has been identified as one of Australia's three major community health problems.

At the same time, there remains a major information gap about the greatly increased capacity to reduce suffering and disability caused by pain.

The 1997 National Anaesthesia Day is planned to help in part to increase community awareness of the part anaesthetists play in relieving suffering and improving lifestyles, and to focus on the developing multi-disciplinary approach to pain management.

EDDIE DEAN
COMMUNICATION CONSULTANT

DAY CARE ANAESTHESIA PRACTICE

DOCUMENTATION

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 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

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?

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 :

Honours and Appointments

Mr David E Theile, Qld – Officer of the Order of Australia, AO

Dr Brian E Dwyer, NSW – Member of the Order of Australia, AM

Dr Brian J Pollard, NSW – Knight Commander of the Order of St Gregory the Great (KCSG)

Associate Professor Vic I Callanan, Qld – Australia Day Council Medallion

Professor R Douglas M Jones, Qld – Visiting Professor, Department of Anaesthesia,
 Chinese University of Hong Kong

HEALTH INSURANCE ACT

PROVIDER NUMBERS

The changes to the Health Insurance Act include provisions which;

as a general rule, prevent a new doctor working in a way that attracts Medicare benefits unless they are undertaking, or have completed, general practice or specialist training (provisions with respect to trainees are detailed below);

impose a ten year moratorium on any new overseas trained doctor, who joins the workforce as a permanent Australian resident, before they can provide services that attract Medicare benefits; provisions are included to allow for exemptions under certain circumstances;

allow doctors who do not have the necessary general practice or specialist qualifications to work in a way that attracts Medicare benefits while working in certain approved placements specified under Section 3GA of the Health Insurance Act 1973, eg as a rural locum working in an approved placement;

establish a Medical Training Review Panel [MTRP] to oversee the take up rate of training places in both general practice and the specialties. ANZCA is represented on the MTRP.

In order to facilitate general practice or specialist training, provision is made in the legislation for the recognition of doctors participating in approved training programmes. Specialist Colleges whose trainees may need to be recognised as a Medicare provider as part of their training will need to be registered as an approved body in the regulations. The Australian and New Zealand College of Anaesthetists has been recognised in the regulations for this purpose.

A medical practitioner may apply to the Health Insurance Commission for Medicare access for the purposes of their training in an approved placement. The

College, as an approved body in the regulations, will be required to give written notice to the Health Insurance Commission stating that the applicant is enrolled in, or undertaking, a course or programme leading to recognition as a specialist; the period over which, and the location(s) in which, the applicant will be undertaking the course or programme, and, that eligibility to attract Medicare benefits for their services is essential if the trainee is to complete the training programme. This will allow the trainee to provide services for which Medicare benefits are payable during the period and in the location specified by the College.

Because of concerns expressed, the Government has established a Register of Medical Opportunity which will provide a means by which young doctors can make themselves known to prospective employers, and hospitals can advertise vacancies with greater certainty of reaching the target audience. In order to ensure that Australian residents have every opportunity to find meaningful medical employment any vacant medical practitioner position will need to first be offered to doctors listed on the Register before approval will be granted to allow the position to be filled from overseas.

The Commonwealth is offering a guaranteed opportunity of employment for doctors graduating from Australian universities in 1996, 1997 or 1998. If a doctor stays on the Register for 12 months without being able to obtain suitable work, the Commonwealth will negotiate with a state or territory to fund a suitable position for the practitioner.

The New Section 19AB of the Health Insurance Act

For overseas trained doctors and overseas doctors trained in Australia, the amendments set a minimum and mandatory period of 10 years from

the date they obtain Australian medical registration before the services they provide can attract Medicare benefits.

The Health Insurance Amendment Act (No 2) 1996 was passed by Parliament early on 14 December 1996. Section 19AB comes into effect on 1 January 1997.

This Act introduces a new section 19AB so that services provided by overseas trained doctors (including New Zealanders) and overseas doctors trained in Australia will not attract Medicare benefits for a period of 10 years from the time they become registered as medical practitioners with a state or territory medical board. The measures do not apply to doctors who, before 1 January 1997, have registered with a state or territory medical board or have commenced the process of having their qualifications assessed by the Australian Medical Council, and were eligible to do so.

An overseas trained doctor is any doctor who did not obtain their primary medical qualification in Australia. This includes medical schools in New Zealand that are accredited by the Australian Medical Council. An overseas doctor trained in Australia is a doctor who began studying in Australia under a temporary visa, but subsequently changed visa status to become a permanent resident.

It is important to note that New Zealand citizens enter Australia on a special class of temporary visa, and are not permanent residents. A person who is not an Australian citizen or does not hold a permanent resident visa requires a determination under Section 3J of the Health Insurance Act in order to provide services eligible for Medicare benefits.

In order to be eligible to provide services which attract Medicare benefits, or to provide services for or on behalf of another medical practitioner, an overseas trained doctor or overseas doctors trained in Australia must fit into one of the following categories:

the person was registered in Australia as a medical practitioner prior to 1 January 1997 (This does not include a person acting as a medical practitioner on a temporary visa);

the person, before 1 January 1997, made an application received by Australian Medical Council (AMC) to undertake examinations, successful completion of which would ordinarily enable the person to become a medical practitioner (and was eligible to do so at the time);

the person is a temporary resident doctor (including New Zealander) with a determination under Section 3J of the Health Insurance Act, while working in accordance with that determination; or

a period of ten years (beginning when the person was first registered in Australia as a medical practitioner) has elapsed.

Please note that the medical practitioner must also fulfil the relevant post graduate qualification requirements for their field of Medicine under Section 19AA of the Health Insurance Act in order to access Medicare benefits.

Provision is made in the Health Insurance Act to allow the Minister to grant exemptions to the moratorium and to impose conditions on those exemptions as the Minister sees fit.

Doctors not able to provide services for which Medicare benefits are payable

Under the new section 19AA of the Health Insurance Act (1973) ("the Act") there is now a class of medical practitioner for whose services Medicare benefits are not payable. Such doctors fall into two broad categories. The first group are those medical practitioners who are subject of the moratorium on overseas trained doctors while the second group are doctors first registering on or after 1 November 1996 without a post graduate qualification.

A medical practitioner in one of these categories is still defined as a medical practitioner in the Act, and will be able to refer patients to another medical practitioner, prescribe and order diagnostic tests. However, these medical practitioners will not be able to provide services that attract Medicare benefit, either on their own behalf or on behalf of another medical practitioner. A provider number can be issued to all medical practitioners for the purposes of prescribing, referring, and ordering.

The Act does not prevent a medical practitioner from practising privately in accordance with State or Territory laws, and charging a fee for those services. However if a medical practitioner's services are not eligible for Medicare benefits they are required by law to inform their patients of this fact prior to rendering those services.

Furthermore, it is illegal for a medical practitioner to use another doctor's provider number or to claim Medicare benefits when working on behalf of another doctor.

New medical practitioners will be able to provide services eligible for a Medicare benefit while in a recognised specialist or general practice training placement or in approved locum placements in rural areas. Should a medical practitioner enter a College training programme, or be involved in another approved placement (for example as a rural locum), they may only provide services eligible for Medicare benefits while working in that approved placement for the period of that placement. Medical practitioners who need access to Medicare benefits while in a recognised training placement should talk to their College in the first instance.

The Commonwealth, in association with the States and medical Colleges, is establishing a number of programmes to assist new doctors with the changes. The first of these is a Register of Medical Opportunity, which will assist doctors in identifying suitable vacancies.

The Government has also reached agreement with the Royal Australian College of General Practitioners (RACGP) to give privileged entry into the General Practice Training Programme to doctors occupying approved clinical assistantships in rural areas for a specified period. Provided they meet minimum standards required by the RACGP Training Program selection process, they will then be guaranteed a place in the Training Program.

Finally, the Government is establishing a Medical Training Review Panel, which will address complaints regarding the training programmes run by the Colleges.

Approved Placements for Rural Locums

Under the new sections 19AA and 19AB of the Health Insurance Act (1973) there are now two categories of medical practitioner for whose services Medicare benefits are not payable. These are medical practitioners subject to the 10 year moratorium on overseas trained doctors and doctors first registering on or after 1 November 1996 who are not eligible for recognition as either general practitioners or specialists. From 1 November 1997, temporary resident doctors will also need to be eligible for recognition to obtain a provider number.

These medical practitioners will not be able to provide services that attract a Medicare benefit, either on their own behalf, or on behalf of another medical practitioner. However, a provider number can be issued to all medical practitioners for the purposes of prescribing, referring and ordering.

As part of the development of the initiatives associated with the restrictions on access to provider numbers, the Federal Minister for Health and Family Services announced special consideration would be given for rural practice. One of these rural measures is an exemption whereby some doctors will be able to have access to a temporary Medicare provider number when working in an approved placement as part of a specified rural locum service. Doctors subject to the 10 year moratorium will need to seek an exemption from this moratorium if they wish to provide locum services through this arrangement.

This arrangement would enable doctors (otherwise not eligible to access Medicare) to do rural locum work through a structure that provides adequate supervision, quality assurance and backup arrangements while allowing Medicare billing.

The Commonwealth, in consultation with medical profession and state/NT-based rural division co-ordinating units and other appropriate organisations, is

developing guidelines for the administration of this scheme. Further discussions will be held with these organisations to finalise arrangements. The placements will only be in rural and remote areas and the administering organisation will oversee the placement of the locum to ensure that adequate supervision and backup is provided.

The New Section 19AA of the Health Insurance Act

These amendments set minimum proficiency requirements which new medical practitioners must meet before the services they provide attract Medicare benefits.

The Health Insurance Amendment Bill (No 2) 1996 was passed by Parliament early on 14 December 1996, and became law following Royal Assent on 17 December 1996.

This Bill introduces a new section 19AA which defines the classes of medical practitioners whose services attract Medicare benefits.

All new medical practitioners, including doctors who have not yet completed their intern training, will need to meet certain proficiency standards before being able to provide services which attract Medicare benefits. Provision will however, continue to be made to recognise certain situations where medical practitioners may not meet these standards but nevertheless require access to Medicare benefits. The main groups falling into this category are medical practitioners in post graduate training programmes where access to Medicare benefits is required as a part of their training. Such recognition is to be specified by either Ministerial approval or inclusion in regulations made under the relevant section of the Act.

The purpose of the key amendments is to require new medical practitioners to complete a recognised post graduate training programme (or be in an approved programme), and remain in an appropriate professional framework, in order to provide services which attract Medicare benefits.

In order to be eligible to provide services which attract Medicare benefits, or to provide services for or on behalf

of another medical practitioner, one of the following conditions must apply;

the person was a medical practitioner prior to 1 November 1996 (This does not include an intern or AMC candidate who has not completed a required period of supervised training, a person without the legal right to be in Australia on 1 November 1996, or a person acting as a medical practitioner on a temporary visa);

the person is a recognised specialist, consultant physician or general practitioner (ie FRAGP or vocationally registered);

the person is in an approved placement (such as a placement for a training programme or an approved rural locum placement) and providing services in that placement; or

the person is a temporary resident doctor (including New Zealander) with a determination under Section 3J of the Health Insurance Act, while working in accordance with that determination.

Any medical practitioner who does not satisfy one of these conditions is not eligible to provide services eligible for Medicare benefits. This does not affect the practitioners ability to prescribe, refer, order diagnostic tests. etc.

NATIONAL DAY – MEDIA REACH

A good proportion of the Australian and New Zealand populations was exposed to some form of media coverage of 1996 National Anaesthesia Day activities.

Reports of the occasion appeared in print, and on radio and television in both countries.

The coverage details are recorded in the strong response to the College questionnaire from participating anaesthesia departments, private hospitals and individual anaesthetists, and by way of College media monitoring.

Radio in every Australian capital city carried at least one major talkback interview with an ANZCA or ASA spokesperson.

Outside the capital cities, numerous regional centres gained radio coverage, too. The most successful, with multiple mentions, included Townsville, the Gold Coast and Ballarat.

In addition to this, National Day interviews were carried on at least two ABC regional radio networks, reaching a wide audience outside the capitals.

Television coverage, despite the always fierce competition for air time on all news bulletins, reached audiences in a wide range of centres.

There was coverage on Channels 7 and 2 in Melbourne (with audiences extending throughout Victoria and southern New South Wales).

WIN News in Ballarat aired a local story which went Victoria-wide, and WIN stations also carried stories in Tasmania, Queensland and parts of New South Wales.

The TV coverage was reported in centres ranging from Maryborough to Toowoomba, to the Sunshine and Gold Coasts, the NSW Hunter region, Hobart, Launceston and Alice Springs.

Christchurch TV reported the story, whilst Dunedin recorded something of a major coup, with no less than two 20-minute documentary segments on anaesthesia aired on consecutive nights (as well as local newspaper coverage).

Print media reporting of the day was excellent in some centres – including full-page “spreads” in the Hobart Mercury and the Townsville Bulletin.

Numerous local papers – country city, and suburban – ran stories of varying size and prominence.

A few days after the actual day, the Perth West Australian newspaper ran a double-page “spread” combining recognition of the 150th anniversary with a preview of the CSM and stories about present-day anaesthesia.

All major capital city newspapers, the national newsagency, major country print media and major suburban newspaper groups were supplied with targeted news copy.

There was, however, significant competition from major news events which occurred contemporaneously.

Conversely, the principal focus of the 1996 National Day was for anaesthetists and the community to interact on a face to face basis.

This was achieved in scores of locations around the nation, from the largest departments to the very small anaesthetic services.

Overall, feedback through the College questionnaires has been comprehensive and constructive.

Media planning for National Anaesthesia Day in 1997 will include additional input to meet specific local requirements and requests.

Already, several excellent ideas have been suggested for elevating media interest and the involvement of anaesthetists in this year’s entirely different issue of Pain.

A range of circumstances has caused a minor shift of timing for National Anaesthesia day this year, and the date is now July 2.

Detailed information and advice will be issued well in advance of the date.

EDDIE DEAN
COMMUNICATIONS CONSULTANT

1996 NATIONAL ANAESTHESIA DAY

QUESTIONNAIRE RESPONSES

A total of 290 questionnaires was sent to hospitals throughout Australia and New Zealand after the 1996 National Anaesthesia Day.

They went to hospitals either accredited for training with ANZCA, or which had contacted the College and obtained kits prior to the 16th October celebrations.

There were 117 replies (40%), which provided valuable feedback and comments to assist future planning.

Type of Activity

The majority (88%) of respondents had conducted displays in hospital.

These included foyer areas, outside departments, and even some as open days within the operating theatre complex. Some went further afield and mounted displays in shopping centres and malls.

There were quite innovative activities by 14% of the respondents, including school visits and the display in the New South Wales Parliament House.

The school visits were of particular note, with one hospital booking school groups to visit their anaesthetic areas, whilst another undertook educational visits to the local secondary schools and organised follow-up work experience in anaesthesia for some selected students.

Props Employed

The majority utilised the ANZCA produced posters (88%) and photographs (77%) which were sent out in the kits.

Displays of equipment were utilised by 42%.

However, 24% used other items including their own posters, audiovisual displays and information leaflets.

The ASA-produced stickers were utilised in 38% but many commented on their late arrival.

Publicity Sought

More hospitals than anticipated sought local and regional media coverage, with 41% approaching newspapers.

This resulted in extremely wide coverage in many regions of Australia and New Zealand. (See media coverage analysis on page 4)

Comments

There was overwhelming support for the National Day initiative and a desire to be involved again, along with many constructive suggestions.

These included a need for even greater advance notification, along with earlier access to kits. More material in the kits, including posters, leaflets and stickers, was suggested by many.

More specifically targeted news releases which could be modified to suit individual locations were also desired.

These comments and suggestions have been taken into consideration in planning for 1997.

THANK YOU

We are grateful to all those who put in considerable effort on the Day, and provided feedback and comments.

All the best for 1997!

MIKE MARTYN
COMMUNICATIONS OFFICER

1996 NATIONAL ANAESTHESIA DAY QUESTIONNAIRE RESPONSES		
TOTAL RESPONSES:	117	100%
TYPE OF ACTIVITY:		
Hospital	103	88%
Shopping centre / mall	11	9%
Rooms / offices	12	9%
Other	17	14%
PROPS EMPLOYED:		
Old / new equipment	49	42%
College photographs	87	74%
College posters	102	88%
ASA stickers	45	38%
Other	40	34%
PUBLICITY SOUGHT:		
Newspaper	48	41%
Radio	14	12%
TV	20	17%

HIGHLIGHTS FROM THE FEBRUARY 1997 COUNCIL MEETING

ELECTION OF PRESIDENT ELECT

Professor Garry D. Phillips, SA, was elected President Elect of the College to continue office until June 1998.

COLLEGE HONOURS AND AWARDS

Orton Medal

Council awarded the Orton Medal to Dr Jeanette Thirlwell-Jones, NSW.

INTERNAL AFFAIRS

The President reported on a Meeting with the Federal Minister for Health which he attended with the Vice President and the Registrar.

In his Report of this Meeting, the President noted that items discussed with the Minister included the College's situation with regard to the AMWAC Report, Career Medical Officers and overseas trained doctors. The Minister was also briefed on National Anaesthesia Day, 1997.

Appointment of Finance Manager

Council noted the appointment of Mr Bill Peachey, Finance Manager, to the permanent staff.

Candidates for Election to Council Candidature Statement of information

Council agreed that in addition to the basic information regarding candidates, a statement of not more than 100 words setting out any additional matters which he/she considers would be of value to the Fellowship in helping them decide as to their vote, be circulated with ballot papers.

College Regulations

Council resolved that the College Regulations be amended to remove instances of discriminatory language. This process will also be followed in revisions of Policy Documents and the Memorandum and Articles of Association.

Library

Council resolved that the Library facility should be made available to non-Fellows of the College and Faculty of Intensive Care through approved mechanisms.

PAIN MANAGEMENT

Council noted the proposal of the Pain Management Committee to establish a Diploma in Pain Management by 1999. The College will develop its own accreditation process for Pain Management Centres together with an examination process of an appropriate standard.

Multi-discipline -Input from other Specialties

The President has written to the Royal Australasian College of Surgeons, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australasian College of Physicians and the Faculty of Rehabilitation Medicine advising of the development of a Diploma in Pain Management and seeking advice from these Colleges as to whether they wish to have input into the deliberations at this stage.

COMMUNICATIONS***National Anaesthesia Day 1997***

It is proposed that National Anaesthesia Day for 1997 will be held on the 2nd July. The topic will be "***Pain***" with a motto of "***Pain Relief - A Basic Human Right***".

The objective of this day will be to improve public knowledge about pain including anaesthetists' role in its diagnosis and management.

The Federal Health Minister has agreed to participate in the launching of this activity.

EDUCATION***Overseas Trained Doctors***

It was agreed that following assessment of overseas trained doctors who are required to complete the minimum requirements for College support for specialist registration in anaesthesia, they must

- a) register with the College and pay a registration fee;
- b) provide documentation of current medical registration (not necessarily local) and a Certificate of Good Standing;
- c) provide documentation of medical practice over the past two years;
- d) complete and submit the examination application form and pay the examination fee by the closing date for that Examination;
- e) present for the written and viva sections of the Examination in accordance with Regulation 15.3.3
- f) complete additional training specified by the College.

Assistant Assessor - New Zealand

Dr Malcolm Futter has been appointed Assistant Assessor for New Zealand for the purpose of assessing overseas trained doctors referred to the College from the Medical Council of New Zealand.

The Medical Council of New Zealand has requested all Colleges to establish a process in New Zealand for the assessment of overseas trained specialists. The MCNZ has accepted that the assessment examination comprise an examination identical in content with the ANZCA Primary Examination and will only be available to anaesthetists who have completed specialist training outside Australasia.

This Examination will be conducted by the College on behalf of the Medical Council of New Zealand in accordance with the ANZCA Regulations governing the Primary Examination.

Career Paths for Medical Graduates

After debate at Council stimulated by the AMWAC Report on the Anaesthetic Workforce, and by discussions at the CPMC, Council resolved that:

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 for consideration.

FINANCE**Subscription Concessions**

Council resolved that

1. Fellows permanently resident outside Australia or New Zealand be granted a 50% concession on their annual subscription.

2. Fellows permanently resident outside Australia, Hong Kong, Singapore and Malaysia be eligible for a 75% concession after five years of permanent residency outside these countries.

Request for support from Coalition for Gun Control

Council agreed to a "one-off" donation of \$500 to this appeal on the basis of its support for the concept of gun control.

Bequests to the College

Council noted the following generous financial bequests

- Dr Florence M. Belz (nee Hughes), Vic***
- Dr Ian C. Miller, WA***
- Dr Mary Burnell, SA***

**CONTINUING
EDUCATION**

In future, applications and Curriculum Vitae for the Younger Fellows' Conference should be considered by the Regional Committee and the nomination only forwarded to Council.

Younger Fellows' Conference - New Norcia, October 1996

Dr Megan Robertson, Victoria, presented the Report of the Younger Fellows' Conference together with their recommendations which were published in the previous edition.

Nominations for Younger Fellows' Conference at Akaroa, New Zealand.

Council ratified the appointment of the following nominees to the forthcoming Younger Fellows' Conference at Akaroa, New Zealand. Theme "Looking after Ourselves".

- | | |
|---|--------------------------------------|
| <i>Dr David Kinchington, ACT</i> | <i>Dr Julia Byatte, Qld</i> |
| <i>Dr Rob Laing, SA</i> | <i>Dr Elizabeth Boge, Qld</i> |
| <i>Dr Robert Singleton, SA</i> | <i>Dr John Currie, NZ</i> |
| <i>Dr Phoebe Mainland, Hong Kong</i> | <i>Dr Brian Lewer, NZ</i> |
| <i>Dr Antoniette Brennan, Vic</i> | <i>Dr Robert Burrell, NZ</i> |
| <i>Dr Peter Hebbard, Vic</i> | <i>Dr Annette Turley, NZ</i> |
| <i>Dr Greg Lindsay, NSW</i> | |

PROFESSIONAL

Policy Documents

Council approved the promulgation of the following Policy Documents which are published elsewhere in this Bulletin.

- EX1 Guidelines for Examiners with respect to Candidates suffering from Illness (or accident) at the time of Examination.***
- P21 Sedation for Dental Procedures***

National Anaesthetic Mortality Reporting

Council agreed that the College should facilitate the publication of the Report on National Anaesthetic Mortality for the past three years.

TECHNICAL**Latex Allergy**

Council noted with concern the health hazard relating to such allergy for Fellows and trainees and noted the publication of the article from Dr Helen Kolawole on this problem published in this Bulletin.

WORKFORCE**Analysis of anaesthetic stake-holders views**

Following a request from AMWAC as to whether the College preferred a survey of an identified group of people or the entire Fellowship seeking views on AMWACs recommendations, the Council has requested AMWAC to conduct this survey throughout the entire Fellowship.

POLICY DOCUMENT P18 VOLATILE ANAESTHETIC AGENT MONITOR

• UPDATE • UPDATE • UPDATE • UPDATE • UPDATE •

VOLATILE AGENT IDENTIFICATION

In the Bulletin last year, Council advised that to comply with Policy Document P18, volatile agent monitors should be able to automatically identify (as well as measure) the agent in use. Subsequent information suggests that at the present time the technology in this area does not justify this stand. The wording of Policy Document P18 remains unchanged and purchasers of this equipment should consider automatic identification in their decision, but it is not mandatory.

WHEN TO MONITOR

There has been correspondence from Fellows regarding certain circumstances where general anaesthesia is administered and it is argued, volatile agent monitoring may not be warranted.

Council discussed this matter at its February 1997 Meeting and concluded that in some special situations, such as where ECT may be administered, no volatile

agents may be available. It is then common sense that this monitor is not required.

However, in any situation where volatile agents are on the anaesthetic machine, even if not planned to be used in the particular case (eg TIVA), agent monitors must be available to protect the patient from the potential problems of overdose, underdose (and possible awareness), and the use of an incorrect agent.

DEADLINE

The wording of Policy Document P18 is to remain unchanged. Equipment to monitor the concentration of inhaled anaesthetics must be available "as soon as possible but in any case no later than 1 January 1998."

MOIRA WESTMORE
Pharmaceutical, Technical and Safety Officer

LAW REPORT

Michael Gorton
Partner, Russell Kennedy, Solicitors
College Honorary Solicitor

MEDICAL RECORDS – REVISITED



For a change, the High Court of Australia has made a decision in favour of the medical profession. In September 1996, in the decision of **Breen v. Williams**, the Court accepted that doctors owned their own medical records, and that there was no automatic right of access by patients.

The Breen decision was intended as a test case on this issue. As I have noted in previous Bulletin Articles, there was some concern that the High Court may follow Canadian decisions, which determined that it was part of a doctor's duty to permit his or her patient to have access to medical records kept and maintained by the doctor. The implications for Australian doctors of the Canadian decision would have been that doctors would be much more careful about the records they keep and the comments in their records they make. It had potential to hinder proper medical practice and a doctor's freedom to keep records in a meaningful way to them, as well as increasing administrative burdens.

The High Court has specifically rejected the Canadian authority. Whilst the High Court recognised that there was some community feeling that patients should have access to doctors' medical records, it suggested that this was a matter for parliaments to legislate, and not for the High Court to determine.

As has been previously noted, there are still legal and ethical requirements to ensure that patients have access to important information regarding their health. Doctors acting in public hospitals will be subject to freedom of information legislation, which requires that medical records of patients be available. Both the AMA and many Medical Boards also regard it as an ethical duty of doctors to ensure that information regarding a patient is available and transmitted to other consultants or representatives, as necessary, for the patient's health.

AMA Policy is summarised as follows:-

"AMA policy remains therefore that a patient has a right to be informed of all relevant factual information contained in the medical report, but all deductive opinion therein remains the intellectual property of the doctor maintaining the record. On request, a patient should be informed of all or any content of the following sections of the medical report:

- History
- Findings on physical examinations
- Results of investigations
- Diagnosis or diagnoses
- Any proposed plan of management.

The patient should only be allowed contents of the medical record, such as reports by specialists, beyond the materials above specified at the discretion of the doctor or doctors who completed such additional section, or sections, or as a result of a legal requirement.

Doctors are entitled to recoup their reasonable costs of providing information contained in the medical record from the patient or other legally authorised requester of the information."

It should be noted, however, that this decision may amount to a Pyrrhic victory. There is increasing pressure for the Australian Government to legislate in relation to

a patient's access to medical records. Extensions of privacy legislation have been foreshadowed and are currently the subject of a government review. Legislation in other jurisdictions, notably New Zealand and the United Kingdom, already extend these rights. It is assumed that, in the event of any legislation, it will be prospective, and not retrospective, so that past medical records will not be subject to the legislation. This does, however, depend on the nature of the legislation.

Doctors should therefore be free to maintain medical records meaningful to them, but mindful that they may ultimately be subject to scrutiny (whether by way of legal compulsion as the subject of legal proceedings, or by legislation) and, accordingly, adverse personal comments, etc. should be avoided.

(A detailed review of doctors' rights and obligations in relation to medical records is set out in previous Bulletin Articles.)

SUBPOENAS AND COURT PROCEEDINGS

Notwithstanding that medical records may now be regarded as being owned by the doctor, with no automatic right of access by a patient, medical records are still documents which may be producible in court proceedings.

In all types of legal proceedings, medical reports may form part of the evidence produced to the court. The proceedings may include:-

- Personal injuries claims (civil proceedings).
- Criminal proceedings and applications for compensation to victims.
- Custody or access issues in relation to children in family law matters, or proceedings relating to care of children under State child protection legislation.
- Administrative proceedings, which may involve decisions taken by hospitals, government departments, etc.

In the course of the proceedings, a party may have the court issue a subpoena to the doctor requiring the doctor to produce certain medical records to a court. Because the subpoena represents a decision or order of the court, the doctor has an onus to comply, and to produce the relevant documents to the court by the required date.

Failure to comply, may result in contempt of court proceedings against the doctor.

A subpoena is a court document and should have official recognition, stamping or other information signifying that it has been issued by a particular court. If in doubt, ring the court to ensure that the subpoena has been validly issued.

The subpoena must set out details or a description of the documents which are to be produced. Only documents in existence can, of course, be produced. A subpoena cannot require a doctor to create new documents, which have not already existed.

Only documents as described in the subpoena should be produced. Any documents which do not meet the requirements of the subpoena should be removed (to prevent privacy and a potential breach of doctor/patient confidentiality). Some careful consideration will be required to establish which documents are relevant and which are not.

There is always the possibility that the information contained in the records could embarrass the patient, the doctor or a third party. In issues relating to mental health particularly, some sensitivity may be required. It is appropriate, under these circumstances, to forward documents to the court in a sealed envelope and labelled "Confidential" or "Judge Only". In such circumstances, it is worthwhile forwarding a covering letter addressed to the court or the judge explaining the reasons for the confidentiality and why the material is sensitive.

In such circumstances, it is also recommended that the parties in the proceedings be advised that sensitive material has been sent to the court.

For obvious reasons, a patient should be notified where their records or documents have been sent to a court, particularly where they are a third party and not the party initiating the request for the information.

It is strongly recommended that, where original documents are sent, photocopies are retained in all cases.

In some cases, it may be sufficient that copies of documents are sent to the court. The solicitors issuing the subpoena can be contacted to establish whether originals or copies should be sent.

Doctors should be aware that the information being sent could, unless handled properly, amount to a breach of

patient/doctor confidentiality. Accordingly, documents should be couriered directly to the court, or sent or transported in such a way as to ensure that confidentiality is preserved. Whilst it is sometimes difficult to do so, the doctor should also attempt to get a receipt or acknowledgment from the court to confirm that the documents have been received, in accordance with the subpoena.

It should be noted that the subpoena requires that the document be produced before the court (or tribunal) involved. It does not require that the documents be produced to a particular party or solicitor. The subpoena will set out the address of the court or tribunal for delivery of documents.

The subpoena may also require that the doctor attend court. Each subpoena should be checked to establish exactly what is required. If the subpoena also requires the doctor to attend at court, some contact with the issuing solicitor will be required, in order to establish appropriate times of convenience to give evidence, etc.

If in any doubt, seek legal advice or contact your medical defence organisation.

COMMUNICATION AND PREVENTION

In recent years, a number of medical legal publications have emphasised that the best form of protection against litigation is good communication with patients – both before and after treatment. This is particularly so in the event of an adverse outcome (whether negligent or not).

Studies in America and Australia confirm that in only a small percentage of treatments involving an adverse outcome do patients consider and, ultimately, initiate litigation. There is now a strong suggestion that one of the factors why some patients choose to litigate is the communication and aftercare explanation given by the doctor after an adverse event has occurred.

This should not be surprising. Our common experience suggests that we are prepared to take matters further where the other party has been rude, inconsiderate or indifferent. A patient in the unfortunate circumstances of having an unexpected adverse event, and not having the training and experience of the doctor, will be partly suspicious, partly ignorant and partly just seeking an explanation. How the doctor handles the patient's concerns and fears may have a significant impact on any future claim, including whether a claim is made at all.

Studies of patients' complaints and why they complain, indicate that some of the following factors are relevant:

- They have not received an explanation which they can understand and accept.
- They believe their treatment has been negligent or below standard (whether, in fact, it has or not).
- They have not been treated with consideration, sympathy or courtesy.
- They have sought information, but have not received any explanation, or their reasonable requests have not been met.
- They have been discharged before they have fully recovered (or they thought they had fully recovered), or discharged without proper explanation or follow up.
- They are chronic complainers.

Proper handling of patients and their families can be an important part of the doctor's armoury to prevent litigious claims.

As has previously been noted in the *Australian Journal of the Medical Defence Union* (Allsopp, 1988):-

*"The patient is entitled to a prompt, sympathetic and above all truthful account of what has occurred. This should be given either by the practitioner concerned or, if appropriate, by a senior colleague such as the consultant in charge. It is plain that for a patient to hear of such an event from a third party, such as a porter or receptionist, is the worst of all possible options. It is very important that a sincere and honest apology is made. Any patient who has had the misfortune to suffer through an error of whatever nature should receive a proper expression of regret. **To apologise that such an instance should have occurred is, after all, only common courtesy and should not be confused with a formal admission of legal liability.**"*

Of course, a friendly smile and courteous demeanour are no replacement for competent treatment and professionalism in practice. However, they can be an important part of the overall doctor/patient relationship – and may help avoid the distress and cost of litigation in the future.

MEDICAL EDUCATION SIG

ANNUAL REPORT

FOR YEAR ENDING 31 DECEMBER 1996

1 Activities during 1996

The Medical Education SIG met three times by teleconference and one face-to-face at the CSM in Perth. The following were achieved:

1.1 Effective Teaching.

The SIG ran a very successful 90 minute session at the CSM entitled *Effective Teaching*. Presentations were delivered by Dr Mary Done, FANZCA, who is currently undertaking a Master of Education Degree and Mr David Price, a trained teacher who now works as a professional trainer in presentation skills.

1.2 In-training Assessment.

An issue of concern is the standardisation of this process that is new to our trainees. Professor Geoff Cutfield on behalf of the SIG has been exploring this issue and is preparing a report that will be forwarded to the Education Committee.

1.3 Hyperbaric Medicine.

During 1995 and 1996 Dr David Griffith on behalf of the SIG began to explore the options available for anaesthesia trainees with an interest in hyperbaric medicine. A document entitled *Minimal requirements for hyperbaric facilities for the registration of provisional fellowship posts in anaesthesia*, prepared by the Australian and New Zealand Hyperbaric Group, has been forwarded to the ANZCA Education Committee for discussion. Dr Chris Acott is currently preparing a draft "syllabus" of those issues in Hyperbaric Medicine that are of relevance in the training in anaesthesia and intensive care. In due course this will be submitted to the Education Committee for discussion.

1.4 Survey of Registrar Selection.

A survey undertaken by the SIG during 1995 was published in The Bulletin in August 1996.

2 Activities Planned for 1997

2.1 One-Day Simulation Meeting, May 9.

The SIG is convening a one-day meeting in Christchurch on May 9, the day before the ASM. The overseas speaker will be Assoc Prof Michael Good from Gainesville. Michael has been significantly involved in the development of the METI simulator. The meeting promises to be very exciting and will provide a summary of the current place of simulation in anaesthesia. METI are bringing a high fidelity simulator to Christchurch and registrants to the SIG one day meeting or to the ASM may have the opportunity to experience anaesthesia simulation, in a private setting during the course of the ASM.

2.2 Problem Based Learning.

Problem Based Learning (PBL) is an interactive, discussion-based form of education. It is established in the undergraduate education at many medical schools and over the past few years has become a popular form of CME at the American Society of Anesthesiologists Meetings. The SIG is to run three concurrent problem based learning sessions at the ASM in Christchurch 1997. This is a pilot exercise and similar sessions are being incorporated in both ASA and CECANZ Meetings during 1997.

2.3 Directory of Training.

It is thought that a directory of training may be of value for prospective provisional fellows, although the information may be difficult to promulgate in a useful form. Dr Garden is currently exploring this.

The SIG had a successful second year and I thank those who have worked hard to see this take place. I particularly wish to thank Ms Helen Morris for her administrative assistance and Dr David Griffith from Tasmania, who has resigned from the Executive of the SIG.

SANDY GARDEN,
Chairman, Medical Education SIG

RETRAINING IN ANAESTHESIA

Some twelve months ago, the Executive considered a discussion paper on "Retraining in Anaesthesia". The essential points raised in this paper were:

- historically, once a person obtained Fellowship of the Faculty or College of Anaesthetists, it was assumed that he/she could practise anaesthesia at their discretion.
- introduction of Maintenance of Standards implies that it is necessary to maintain standards post-Fellowship by a number of means, including a certain amount of regular clinical practice.
- when an anaesthetist ceases practice for a period of time, it would be reasonable to surmise that a period of retraining would be necessary to ensure the anaesthetist was practising at a certain standard before resuming independent practice.

In order to gauge support for the concept, the matter was referred to Regional Committees for comment, and these replies were then considered by the Continuing Education and Quality Assurance Committee, which came to the following conclusions:

- it will be difficult to define policies in relation to retraining as individual circumstances vary so widely.
- the need for and type of retraining will depend (among others) on:

- the period of absence from clinical practice
- the cause of the absence
- activities during the absence
- the length and nature of practice prior to the absence
- financial and family considerations
- individual and personality considerations

- the proposal from the New Zealand Regional Committee met with general support, i.e.,

<1 year absence	reorientation / advice
1-3 years absence	refamiliarisation (1-2 weeks supervision)
>3 years absence	retraining (minimum of 1 month's supervision)

- the role of mentor was considered by the Committee to be important.

Council, at its February meeting, decided that at this stage, information on progress of this matter should be recorded in the Bulletin for information of Fellows. It is clear that in time the subject of retraining will be closely linked to Maintenance of Standards.

GARRY PHILLIPS

Death of Fellow

Dr John M W Tully, Qld
- FFARACS 1970, FANZCA 1992

Admission to Fellowship

Under Article 12(c) Regulation 6.3.15

Cecilia Jane Sheila STEWART, NSW

Election To Fellowship

Under Regulation 6.2

Professor Gavin Kenny, Scotland
Professor Jerrold Lerman, Canada

Under Regulation 6.3.1(a)

Professor Donald G Moyes, South Africa

ADMISSION TO FELLOWSHIP BY EXAMINATION

Simon Claude ADAMO, NSW
 Constantine ARALI, NSW
 David Leslie BAIN, Vic
 Kevin Charles BAKER, NSW
 John Patrick Maurice BARNARD, SA
 Robert Arnold BARTOLACCI, NSW
 Fernie Elizabeth BOGE, Qld
 Russell Adrian BOURNE, Vic
 Damien Arthur BOYD, NSW
 Glen Anthony BURGIN, Vic
 Alexander CAVDARSKI, Qld
 Chris John COKIS, WA
 Paul Edward CORDATO, NSW
 Frank John DADAY, Qld
 Craig John FRENCH, Vic
 Meng Huat GOH, Singapore
 Kenneth HARRISON, NSW
 Richard James HAYWARD, New Zealand
 Martin Andrew HIGGS, Vic
 Richard George HORTON, Vic
 David Kenneth HOYLE, Vic
 Wan Chun Theresa HUI, Hong Kong
 Andrew John JEFFREYS, Vic
 Eganath KRISHNAPPA, SA
 Alison Margaret LILLEY, Vic
 Gregory Colin LINDSAY, NSW
 Simon Campbell MACLAURIN, New Zealand
 John Craig MARTIN, Qld
 Gerard James McHUGH, New Zealand

Colin Malcolm McKENZIE, Vic
 Michael-Angelo Paul MERSIADES, NSW
 Andrew John MILLER, WA
 Sean Denis NEWELL, Qld
 NGHON Hon Seng Ivan, Malaysia
 Susan Rosemary NICOLL, New Zealand
 Brian Russell O'CONNELL, Qld
 Kym David OSBORN, SA
 Thomas Edmund Allan PALMER, Qld
 Steven Brian PARKES, Qld
 Andrew John PATRICK, Vic
 Wendy Jocelyn PEDERICK, Vic
 Justin Michael REED, NSW
 Lindy Jane ROBERTS, WA
 David William ROBINSON, WA
 Graham Marshall ROPER, NSW
 David James SANDEMAN, NSW
 David Andrew SIDEBOTHAM, New Zealand
 Robyn Elizabeth SMILES, NSW
 Dianne Patricia STEPHENS, Vic
 David Andrew STORY, Vic
 Robin SWAINSTON, Qld
 Hilton David SWAN, WA
 Kim Hoe TAN, NSW
 Paul Cameron TUCKER, Qld
 Nedra Marguerite VANDENDRIESEN, WA
 Eric John VISSER, WA
 Venkata Lakshmi Siva Prasad VUTUKURI, NSW
 David Cameron WILKINSON, SA

LETTER TO THE EDITOR

Dear Sir,

I am writing to express my pleasure in participating in National Anaesthesia Day. The lapel stickers and publicity made this a great opportunity to draw patients and medical colleagues and assistants attention to what a wonderful thing anaesthesia is.

"Just imagine if I wasn't here."

"This is a very special day for me. Do you know why?"

It was a wonderful opportunity to allay anxiety and build relationships.

I look forward to participating in national anaesthesia day again next year.

Yours sincerely,

Andrew Walpole
 Specialist Anaesthetist

“HMNZT ULIMAROA”



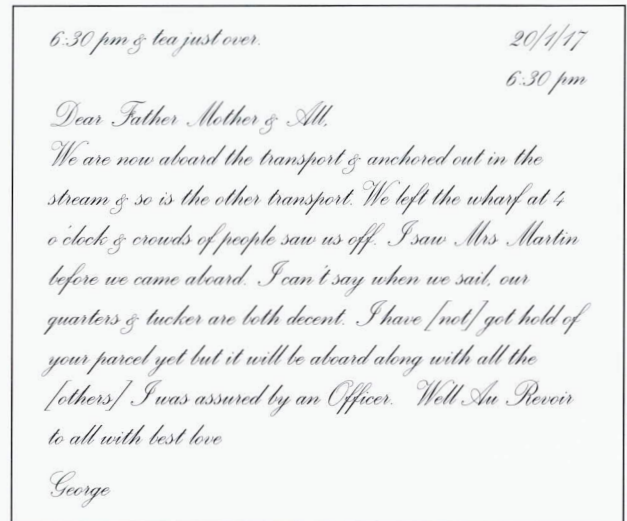
George Hutchinson in uniform, 1917

Michael Cooper’s article “Ulimaroa” (Bulletin, August 1995) gives an excellent account of the origin of our College headquarters’ name. I was pursuing a somewhat different course in 1994, tracing the origins of the ship “Ulimaroa”. That vessel of course was named by John Traill for his Huddart Parker Line, continuing the tradition begun with his Melbourne home. The 5777 ton twin

screw steamer “Ulimaroa” was launched on 20 July 1907, having been built by Gourlay Brothers of Dundee, Scotland. She arrived in Melbourne on 16 February 1908, then sailed to Sydney, her maiden voyage to New Zealand beginning on 29 February. “Ulimaroa” replaced “Wimmera” on the “horseshoe” route from Sydney to Auckland, Wellington, Lyttelton, Dunedin, Bluff, Hobart and Melbourne, then back again. She continued this service until 1916 when she was requisitioned by the New Zealand Government and converted to a troopship. She made a number of voyages to Egypt and other destinations in this role and was used after World War I to repatriate wounded soldiers to New Zealand. By March 1920 “Ulimaroa” had resumed her trans-Tasman voyages. On 5 April 1932 she arrived in Sydney following her final trip to New Zealand and made several trips to Tasmania before she was laid up in January 1933. “Ulimaroa” left Sydney on 23 May 1934 on her last voyage – this was to the shipbreakers in Osaka.

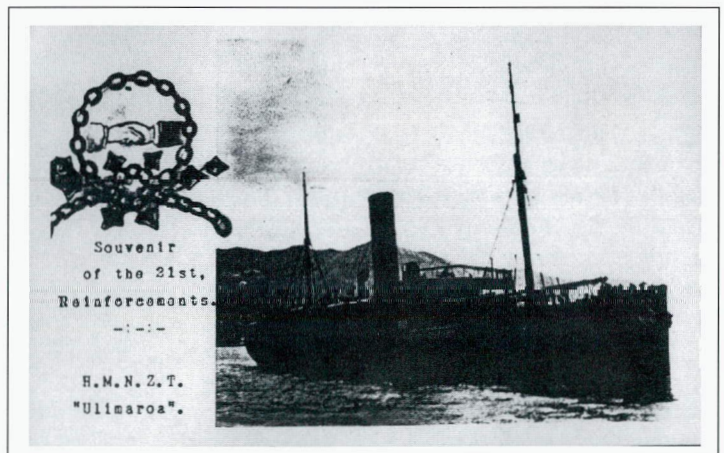
While going through some old family photographs recently, I came across an interesting if tenuous link with “Ulimaroa”. These were two postcards sent by my late uncle George to his family in Walton (Waikato district) in the troops’ final mail before he left New Zealand for World War I. One shows George Hutchinson in his uniform, the other shows the vessel by which he travelled to the war zone,

namely His Majesty’s New Zealand Transport “Ulimaroa”! I reproduce his message below:



One cannot help wondering how many other anaesthetists’ ancestors or family travelled on “Ulimaroa” when she was a troopship, or for that matter, a regular liner. Uncle George was one of the lucky ones. He and his brother Bob spent the latter part of the War in France and Belgium, but were spared to return to New Zealand, and both lived to a ripe old age.

BASIL HUTCHINSON
 AUCKLAND



LATEX ALLERGY, WHAT'S THE PROBLEM?

When asked to write an article for the Bulletin about latex allergy I had originally intended to spend most of the time writing about the perioperative management of latex allergic patients, but in the recently published Australasian Anaesthesia 1996 this particular topic has been well covered in the chapter Latex Allergy: a review by P McAleer and D Barker.

Instead I will take a somewhat different and at times personal view of the topic. My interest in latex allergy developed because I am one of the approximately 9% of health care workers who develop this allergy. I therefore wish to highlight some issues in patient management, present known risk factors for developing latex allergy; outline my personal history and finally give some recommendations for anaesthetists to reduce exposure to latex allergens.

Patient Management

I strongly recommend all anaesthetic departments prepare some guidelines for management of this condition as it is appearing more frequently. Our 300 bed hospital has had at least eight latex allergic patients in the last five months, and one presented for emergency LUSCS with a prolapsed cord! In the same time we have had one staff member diagnosed as allergic to latex and two previously diagnosed have had serious reactions at work.

Guidelines

The varying degree of sensitivity to latex among sensitised individuals means that guidelines will necessarily be excessively cautious for some patients, while for others they may be inadequate and it is always important to be prepared to treat anaphylaxis. Each hospital needs to consider guidelines for the entire hospital, since despite patients being at greatest risk in the operating suite, they are also in the best place to have anaphylaxis treated. There are still significant potential risks of exposure and reactions from a multitude of sources within a hospital that may lead to symptoms ranging from trivial to life threatening eg urinary catheterisation, pulmonary artery catheterisation.

While the position adopted by the Toronto Hospital for Sick Children of only changing to non-latex gloves¹ may be adequate for some patients, it is also possible that managing a patient who has acquired latex allergy as an adult may require greater vigilance.

I am on a working party set up by the Australasian Society of Clinical Immunology and Allergy which is going to formulate hospital and dental guidelines for latex allergic individuals.

Latex free lists

Until there is mandatory labelling of the latex content of medical devices the preparing and ongoing re-evaluation of a list of latex free equipment is a time consuming task.

Care is required when using published lists of latex containing products, as manufacturers are frequently changing ingredients, and different manufacturers of the same item may use varying ingredients. Since there is no standard for labelling, the terms "latex" and "rubber" are often used loosely.

Guidelines are being developed in a number of countries, including Australia, to require medical devices to be labelled if they contain natural rubber latex. Labelling is not straightforward as latex-containing adhesives may be used to seal packaging, while the product may be free of latex.

The guidelines in Australasian Anaesthesia 1996

The guidelines in Australasian Anaesthesia 1996 are detailed and in general accurate, in my opinion, but I wish to alert anaesthetists to the following specific issues:

- there is a report of anaphylaxis to an IV infusion² and anaesthetists should be aware that at present there is natural rubber latex in the bung of Haemaccel and so this intravenous fluid would be best avoided where a patient has a known latex allergy, and in cases of anaphylaxis where the cause may be latex allergy;
- oximeter probes may contain latex, but not all do;
- non latex rebreathing bags are available, but at present they are not reusable;

- some ventilator bellows are now only available in silicone ie latex free;
- glass syringes are often considered difficult to use and Terumo syringes are latex free;
- Solucortef 250 mg contains a latex bung within the vial and this preparation can lead to allergic reactions as liquid is in contact with the latex,³ instead use the 100 mg preparation where the vial only contains powder, but it is still necessary to remove the latex stopper.

Development of Latex Allergy, a risk for Anaesthetists

My motivation for writing this article is that there are other practising anaesthetists, and registrars in Australia and New Zealand who are either at risk, or at present not aware of the significance of atopic symptoms.

The Environment

The environment in which anaesthetists work is full of latex products. The most likely sensitizers are the powdered latex examination gloves, which are the gloves most commonly worn by anaesthetists.

The latex allergens can be leached from latex gloves by normal skin moisture, and absorbed on to the corn starch powder. Although many users of natural rubber latex gloves claim to be "allergic" to the powder, it is rarely an immediate or delayed type allergen.⁴ Corn starch may act as an abrasive agent increasing irritant reactions, and it creates airborne latex allergen in all locations where powdered latex gloves are used. Latex allergen levels are lower in powder free gloves, but there is a 3000 fold variation in the allergen content of gloves.⁵ In general, high protein gloves usually have high allergenicity, but individuals with type 1 hypersensitivity have variable sensitivity to different brands of latex gloves. These two observations may occur because gloves may have different protein compositions.

Latex aeroallergens present the most difficult problem within the health care setting. A study performed by the Mayo Clinic found levels of aeroallergen are highest (14-208 ng/m³) where powdered latex gloves are used, and lower in areas where powder-free or synthetic gloves are used (0.3-1.8 ng/m³). Operating rooms with laminar flow do not have improved clearance of latex aeroallergens.

Personal breathing zone samples have measured up to 974 ng/m³; with anaesthetists exposed to higher levels than surgeons. This is probably due to the use of numerous powdered latex examination gloves with a higher allergen content compared with the sterile surgical gloves. Leaving an operating room idle for 2.5 hours will reduce the contamination by 96%.⁶ Latex allergen can also be recovered from lab coats, theatre gowns, and surfaces where powdered gloves are used. Changing from powdered to powderless gloves has been shown to reduce significantly, or eliminate respiratory symptoms in affected healthcare workers.⁷

Latex gloves are preferred because of their strength⁸ and exclusion of viral particles.⁹ Synthetic gloves are required to pass Standards but they are still not as strong or impermeable. Synthetic gloves are also thicker and many users find them inferior to latex gloves. While Type 1 hypersensitivity to the synthetic gloves does not appear to be a problem at this stage, people with contact dermatitis may still have reactions to synthetic gloves.

Atopy and Latex Allergy

Atopic individuals are at greater risk of developing this allergy, particularly if they work in an area with increased exposure to latex. A French study of 569 subjects who had latex skin prick testing found that:

- individuals with no risk factors 0.37% were positive;
- nonatopic individuals exposed to latex 6.85% were positive;
- atopic individuals not exposed to latex 9.44% were positive and
- atopic individuals exposed to latex 36.36% were positive.¹⁰

To add to the complexity of the condition there are also associated food allergies. Banana, avocado, chestnut, kiwi fruit, tomatoes, potatoes have all been found to cause allergic symptoms in latex allergic individuals. The food allergies can precede the development of latex allergy but the reverse is also true. These food allergies can lead to symptoms which range from minor skin irritation to anaphylaxis.¹¹

There have been occasional reports of latex allergy associated with drug allergies.^{12, 13}

Personal experiences of a latex sensitised anaesthetist.

When I first read about latex allergy in 1993, I remember thinking that it would be quite difficult to manage patients with this problem. At this time I was already symptomatic myself developing severe allergic conjunctivitis after using the powdered latex examination gloves and severe abdominal pain after eating avocado, but did not understand the significance of my symptoms. As someone who had lived with atopic symptoms (perennial allergic rhinitis, and mild flexural eczema) all my life it was easy to miss the development of a further more serious allergy. I gradually changed to only using non-powdered latex gloves.

I attributed my symptoms to a reaction to the powder, until three years later I started getting the same symptoms with powderless latex gloves and so I sought diagnosis in November 1995. I immediately stopped wearing latex gloves, but it took another three months, after the recurrence of symptoms, to search the literature and find out about latex aeroallergens. I realised that I was reacting to inhaled powder from latex gloves worn by others, and so I stopped the use of powdered latex gloves by all staff members working in my immediate environment.

Despite workplace changes a further five months later I began to get symptoms from the latex powder left in a theatre from the day before, and the latex powder left by the blood collecting staff on patients and their bed linen before my preanaesthetic rounds.

Despite workplace changes, in 12 months I had progressed from having temporary skin, and eye symptoms to episodes of light-headedness, chest tightness and dyspnoea.

With my knowledge of the condition I realised that my plan to limit sensitisation had failed, and after only five years as a fully qualified anaesthetist I decided I had to limit my practice to only working in areas where powdered latex gloves were never used. I have had to give up all emergency work, and all anaesthesia for major surgery and I am unable to safely visit many areas of a hospital including outpatients and labour ward. I have no expectation that I will be able to continue to work in a hospital and I am now having to consider work outside a hospital. I am now working as an HMO mentor, and giving anaesthetics to patients in the ECT suite and from the short stay unit who come from powder-free

wards and are operated in a powder-free theatre. I still work in areas where there is latex equipment, but I never knowingly touch it. Ironically I now have to wear cotton, synthetic or leather gloves almost continuously to protect myself from latex.

What can we do to reduce the risks of sensitisation?

Acknowledging the variability of the allergenicity of latex gloves, it is advisable for anaesthetists to be involved in choosing the gloves they wear, just as they are involved in choosing other equipment. Glove manufacturers are already aware of this issue, but are not always able to provide information on the allergenicity of their latex gloves.

From the view of latex sensitisation it would be ideal if powdered latex gloves were no longer used, and there is evidence of this occurring in some hospitals in Australia, but mainly overseas.

Atopic individuals need to be aware of their increased risk and it would be prudent for them to use latex gloves with care, and then only use powderless latex gloves. They should be alert to changes in atopic symptoms, which may not be necessarily skin rashes, but worsening of asthma, or the development of asthma at work.¹⁴ Hand dermatitis is not always present.

What can we do about those already sensitised?

There are few longitudinal studies of sensitised individuals, but many sensitised health care workers are no longer able to work.¹⁵ I know that my story is not necessarily typical. I have met nursing staff who have continued to work within a hospital for up to 15 years after diagnosis with little increase in their sensitivity. I am personally only aware of one other anaesthetist, in the USA, with this allergy and he is no longer able to work in a hospital.

At present there are no workplace guidelines for latex allergy staff. But if they are to continue to work in a hospital they must be aware that increasing sensitivity is a real and significant risk.

While anaesthetists do have skills that can be used outside a hospital eg pain clinic consultancy, preoperative assessment consultancy, these are not satisfactory options for all. Medical Administration may not appeal to individuals who enjoy patient contact and

have always considered themselves clinicians. Then there is always editing a journal, which was suggested to me at the World Congress!

Outside of hospitals there is still latex, and so moving out of a hospital does not stop symptoms eg balloons, condoms, some racquet handles, toys, balls, elastic in underwear and clothing, some telephone keys, some EFTPOS keys, door seals in cars, tyres, some inks, some copy paper, adhesives, and dressings. Although anaphylaxis is most commonly associated with medical interventions, anaphylaxis has been reported with the use of condoms¹⁶, balloons¹⁷, and after playing squash¹⁸.

The development of latex allergy requires an individual to carry a letter detailing the significance of this condition for emergency care personnel, and adrenaline, to ensure his/her safety in the case of emergencies. Nonlatex gloves may not be used by emergency personnel, so it is advisable for latex allergic individuals to carry a supply of nonlatex gloves. All elective medical interventions need to be planned, and it is necessary to find out whether those who are to care for you having any knowledge of latex allergy and how to manage an allergic patient.

The food allergies are an added burden. Apart from the foods on the cross sensitivity list, I am also aware that I get symptoms if I eat food prepared with latex gloves.

For those who are already sensitised the future is unclear. At present there is no immune therapy available and avoidance is the only means of preventing further sensitisation.

I believe that there is a need for the College of Anaesthetists to have some idea of the number of

anaesthetists who are already affected, and I am prepared to be a contact person. I am also happy to be of whatever assistance I can be to individuals who are trying to cope with the daily realities of this condition.

Conclusions

Latex allergy presents anaesthetists with challenges in patient management. The potential for anaphylaxis in patients highly sensitive to latex requires hospital-wide coordination. Anaesthetists may be the first to suspect that a patient has this problem, and must be prepared to coordinate emergency management. Postoperative investigation of such patients is essential, and should be done in centres familiar with testing for latex allergy.

Anaesthetists may also be involved in providing emergency treatment to other hospital workers who develop acute symptoms while at work. Development of latex allergy is also an occupational risk for anaesthetists. Consequently, anaesthetists need to be more aware of the products they use to reduce their risk of sensitisation. Atopic individuals, in particular, need to use latex gloves with the lowest allergen content. Any symptoms suggestive of latex allergy should prompt early diagnosis. Education is the key to reducing the consequences of this allergy.

I can be contacted through the Mornington Peninsula Hospital Anaesthetic Department on 03 97847445.

DR HELEN KOLAWOLE
Department of Anaesthesia
Mornington Peninsula Hospital

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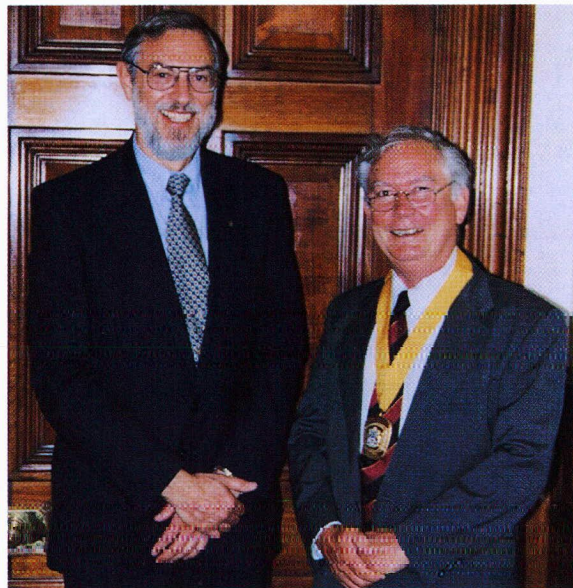
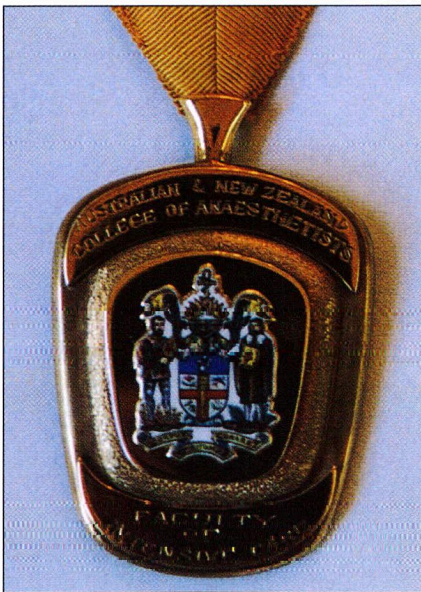
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Editors of Australasian Anaesthesia 1996 Drs John Keneally (left) and Micheal Jones (right) at its launch with President, Prof Garry Phillips, Mr Damian Colehen, Business Unit Manager and Ms Natasha Monin, Hopsital Products Specialist, Abbott Australasia.



Dr Michael Davies with Mrs Judy Davies, Mr Robert Davies and Mrs Pauline Bilsborough at the unveiling of Dr Davies' Portrait.



Professor Baker and Dr G.M. Clarke

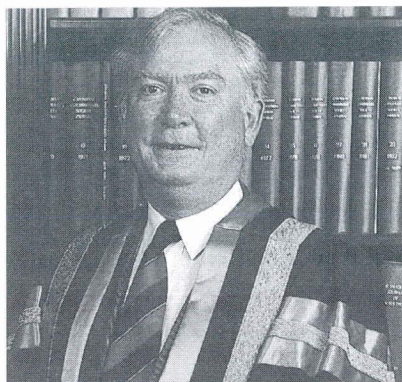
GIFT TO THE FACULTY

Professor Barry Baker presented Dr Geoff Clarke with the Dean's Badge of Office during the February 1997 Board Meeting.

Professor Baker assisted in the design of the medal and played a major role in the development of the College Crest which is featured on the Medal.

FACULTY OF INTENSIVE CARE

DEAN'S MESSAGE



Have you ever tried to herd cats? I have not, but I have no difficulty imagining them running in every possible direction. I suspect Fellows' views on euthanasia may be a bit like that. Why then pursue the issue?

Because the Faculty is involved in training and certification of Intensive Care Specialists, it is highly likely that we will be asked questions on euthanasia and related issues. This is especially so in the current climate of the euthanasia debate. If we totally refuse to comment, it could be like those television programmes where the reporter says, "Mr X was asked to comment on these questions but declined to be interviewed." It leaves the public with feelings of great mistrust in the individual or the organisation they represent.

In any discussion on these issues it is important that people define exactly what they are talking about. A set of definitions provided by Professor T.E. Oh is being circulated to Regional Committees. A recent paper in the *Medical Journal of Australia* (MJA 1997;166:191-196) also sets out definitions and provides useful data on "end of life decisions in Australian medical practice."

In Australia and New Zealand euthanasia (a direct act with the primary intent of ending a patient's life) is illegal, except under certain specified circumstances in the Northern Territory. If challenged to adopt a position on euthanasia, I would prefer to move the discussion to some common important related issues. Included would be withdrawal of futile therapy, decisions not to introduce advanced life support, and respecting a competent patient's wish not to introduce or continue unwanted therapy. Under appropriate circumstances none of these are to be regarded as euthanasia.

Fellows, through their Regional Committees, are asked for views on what opinions the Faculty should express. No one is expecting a black and white answer to all the issues involved. What we are seeking is sensible middle ground which will reassure the public that Intensive Care Units are not places where things happen without open discussion (where possible) between patients, their relatives, the ICU and primary referring teams.

Possible starting points for discussion might be:

1. The Faculty does not support illegal practices.
2. The Faculty considers the institution or continuing of futile therapy undesirable and in many situations unethical. (The problem of definition of "futile therapy" is appreciated and comments on this matter are sought.)
3. The Faculty respects the autonomy of mentally competent patients. In this case with specific reference to not instituting or continuing unwanted treatment.
4. The Faculty supports provision of adequate pain relief and other measures to relieve suffering in the terminally ill, even though this may possibly shorten the patient's life, provided that such relief of pain and suffering, and not the death of the patient, is the primary intent.

G.M. CLARKE

ITEMS OF INTEREST FROM THE FEBRUARY 1997 BOARD MEETING

EDUCATION AND TRAINING

Logbooks

It was noted that logbooks are currently being trialled in a number of Units prior to deciding whether to introduce them as a mandatory requirement for trainees.

Objectives of Training in Intensive Care

The review of the Objectives of Training is nearing completion and will be circulated for comment.

Paediatric Examination

The first paediatric Fellowship Examination will be conducted in April/May 1997. An outline of the structure of the Paediatric Examination is printed elsewhere in the Bulletin.

Library

The Board agreed that a recommended reading list for trainees should be developed, and a list of relevant journals and books is published in this edition of the Bulletin.

Accreditation of Training

The Board is currently reviewing accreditation of training.

Factors which affect accreditation are sufficient numbers of patients with a suitably broad casemix and sufficient severity of illness, adequate exposure to intensive care specialists and the variety of procedures performed in the unit and available to the trainee.

It was agreed that information will be sought from Supervisors of Training regarding details of rosters, the level of the post occupied by trainees and the number of hours of formal teaching.

PROFESSIONAL

Maintenance of Standards

In discussion of the Faculty's Maintenance of Standards Programme, it was agreed that non-Fellows will be able to participate in the programme for an Annual Fee of \$200.

Overseas Trained Doctors

The Board considered its policy for processing requests from the Australian Medical Council for assessment of overseas trained doctors as specialists in intensive care. It was agreed that such requests will be considered by an assessment panel comprising three members of the Board. A revised document outlining the procedure for applications will be considered at the next Board meeting.

Joint Specialist Advisory Committee in Intensive Care

Following a suggestion from the JSAC-IC, the Board supported the proposal for a representative of the RACP to participate in hospital inspections, provided the process is cost neutral. The matter has been referred to the JSAC-IC for further development.

Policy Documents

A draft statement of patients' rights and responsibilities is currently being circulated to Regional Committees. A revision of Policy Document IC-1 "Minimum Standards for Intensive Care Units" will be circulated to Regional Committees and other bodies for comment.

Statement on Euthanasia

In response to a request from Council for input on this issue, a draft statement will be circulated to Regional Committees for comment. It was noted that the statement should address the issue of patient autonomy and withdrawal of futile therapy, whilst stressing that the Faculty does not support any illegal act.

INTERNAL AFFAIRS***Regional Committees***

The question of co-opting representatives of the RACP to Faculty Regional Committees has been referred to the Joint Specialist Advisory Committee for consideration.

Faculty Website

The Board agreed that Fellowship Examination Reports will be available on the Faculty Website and published in the College Bulletin.

Election of Dean-elect

Following a secret ballot, Dr A.W. Duncan was elected Dean-elect. Subject to re-election to the Board, Dr Duncan will take office from June 1997.

FACULTY OF INTENSIVE CARE

THE FELLOWSHIP EXAMINATION IN PAEDIATRIC INTENSIVE CARE

INTRODUCTION

From 1997 the Faculty is offering a training programme in Paediatric Intensive Care. To be eligible for admission to Fellowship the trainee will have to satisfactorily complete:

1. A training period of five years in approved posts.
2. In-training assessment
3. The Primary Examination of the College or Equivalent
4. The Fellowship Examination (Paediatric Intensive Care)

Candidates may present for the Fellowship Examination (Paediatric Intensive Care) after thirty-six months of approved vocational training provided that at least twelve months of core paediatric intensive care training have been completed.

TIMING

At first the examination will be available annually. The written papers will usually be sat in April and the oral sections in May.

VENUES

It will be possible to sit the written papers in any capital city in Australia, Auckland, Wellington, Christchurch, Dunedin, Singapore, Kuala Lumpur or Hong Kong.

The oral sections will initially be held at the Royal Children's Hospital, Victoria.

FORMAT

The exam will cover the theory and practice of Paediatric Intensive Care including relevant basic sciences, anaesthesia and clinical medicine. It will follow the

same format as the Adult Intensive Care Examination and there will be overlap of content. The great majority of examiners will be Paediatric Intensive Care Specialists.

The written section will consist of:

- a short answer paper of 2½ hours with 15 questions
- a long answer paper of 2 hours with 2 questions

The oral sections will comprise:

- an investigation section of ½ hour
- a viva section of two exposures each of ½ hour with 2 examiners
- a clinical section of 1 hour with acute and 'cold' cases

Short Answer Questions

This paper allows coverage of a large number of topics in outline. Any topic relevant to Paediatric Intensive Care is examinable including procedures, physiology, anatomy, equipment, medical and surgical problems.

Such examples from past 'general' intensive care papers include:

"What are the roles of corticosteroids and nebulised adrenaline in the management of croup?"

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

These are particularly paediatric questions but the paper may contain questions common to both exams, eg:

"Outline the important principles in institution and mechanical ventilation in a patient with respiratory failure secondary to acute severe asthma."

"Briefly outline your approach to diagnosing the cause of a serum sodium of 120 mmol/l..."

Long Answer Questions

This paper allows the candidate to expand on the principles of management or provide in-depth knowledge of Intensive Care controversies (eg: equipment use, techniques). Rather than lists of possible options, the candidate is expected to provide a decisive plan of action with reasons or detailed evidence for opinions.

A recent example includes:

“A three year old girl...house fire...Confused and restless....Burns to her face, upper limbs and torso...obvious fractured femur...”

Outline your initial management...

List the most serious complications... How may they be prevented and treated?”

ORAL SECTIONS

Investigations

Common paediatric radiological, biochemical, nuclear medicine and cardiac and respiratory investigations relevant to Intensive Care practice will be presented. The candidate will be expected to recognise abnormalities, suggest a cause and a very brief line of management. The value and relevance of particular investigations may be explored. If the format of investigation is unfamiliar, time will be provided. ECG's, X-ray's, CT scans, biochemical profiles and arterial blood gas results can be expected.

Cross Table Vivas

The candidate can expect to be asked to discuss any topic which impinges on common Paediatric Intensive Care practice.

For example:

- the value of microbiological surveillance
- central line policy
- effects of hypothermia in neonates
- management of status epilepticus
- management of paediatric cardiac arrest

Clinical Section

The hour of this section is spent examining and discussing a mixture of patients in Intensive Care (2-3) and patients from the wards or outpatients (2-3).

The case is introduced as a clinical problem relevant to Paediatric Intensive Care - eg: “this patient presents with increasing breathlessness” or “jaundice” or “confusion”. The candidate is asked to examine a system (eg: respiratory or cardiac) or part/s of the body (eg: lower limbs). Emphasis is placed on an efficient, purposeful and considerate examination.

The candidate may describe findings while examining the patient or remain silent until able to synthesize the findings. The candidate is then expected to derive an acceptable diagnosis, (not necessarily the correct diagnosis) and suggest differential diagnoses. The candidate may also be asked to suggest or interpret investigations relevant to the case, and an outline of management may be touched upon. Also equipment or medications encountered at the bedside may briefly be discussed.

FACULTY OF INTENSIVE CARE

MAINTENANCE OF STANDARDS PROGRAMME

In 1996, a Maintenance of Standards (MOS) Programme was offered to all Fellows of the Faculty. Whilst the Programme is voluntary, it is highly recommended, as participation will enable Fellows to demonstrate commitment to maintaining and enhancing a high standard of professional intensive care practice. In time, other bodies may require evidence of participation in such a programme.

The Maintenance of Standards Programme has three components:

1. Provision of a declaration that a minimum of 30% of professional life has been spent in clinical intensive care (over five years).
2. Provision of evidence of current registration and accreditation at an institution of practice.
3. Provision of evidence every five years of a total of 500 points or more gained from Quality Assurance activities, continuing medical education, teaching, research and other related activities.

Application in writing should be made to the Faculty, after which an MOS kit will be forwarded, containing a Manual, an Annual Return and guidelines. Substantiating documentation is to be held by the participant, and a Return form lodged annually. A Certificate of Participation is issued every five years.

I urge your participation, and I am happy to receive queries from Fellows on the framework of the Programme and allocation of Credit Points. I would also welcome suggestions which may enhance the Programme.

Annual Returns for 1996 are due. New forms will be circulated shortly.

N.T. MATTHEWS
Maintenance of Standards Officer

ADMISSION TO FELLOWSHIP BY EXAMINATION

Barbara Elise Trytko, NSW
Mark Edward Finnis, SA

THE G.A. (DON) HARRISON MEDAL 1996

has been awarded to

EDWARD RICHARD STACHOWSKI

*for his outstanding performance at the
Fellowship Examination*

FOUNDATION VISITOR 1997

CHRISTCHURCH ANNUAL SCIENTIFIC MEETING

DR KEITH WALLEY

Dr Keith Walley undertook undergraduate training in Winnipeg, Canada at the University of Manitoba, receiving his MD in 1981. He trained in Internal Medicine at McGill University in Montreal and then in Pulmonary and Critical Care Medicine at the University of Chicago with Professor Larry Wood. While in Chicago he developed an interest and expertise in the assessment of myocardial dysfunction in critical illness.

Since 1988, Dr Walley has been an Associate Director of the Critical Care Department at St. Paul's Hospital in Vancouver, British Columbia, and in addition is an Associate Professor of Medicine at the University of British Columbia. Over the past 8 years he has built a productive research programme based at the UBC Pulmonary Research Laboratories. In recent years major research foci have been systolic and diastolic myocardial dysfunction during septic and hypovolemic shock,

investigating the limits to oxygen transport in critical illness of many types, and investigating the role of inflammatory mediators and cells in organ system dysfunction during critical illness. A central role in particular for polymorphonuclearleukocytes during non pulmonary organ dysfunction during shock has been postulated.

Dr Walley has had the unusual ability to successfully combine a full time clinical intensive care position, with an active and constantly expanding research programme. Close interrelationship between the patient ICU and the Pulmonary Research Laboratories has assisted this development. He is also widely recognised as a clear and innovative thinker and as an outstanding lecturer.

D. J. COOPER

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

POLICY DOCUMENT

Review P21 (1996)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

and

ROYAL AUSTRALASIAN COLLEGE OF DENTAL SURGEONS

SEDATION FOR DENTAL PROCEDURES

1. INTRODUCTION

Sedation for dental procedures 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 whereby rational communication with the patient is continuously possible, so that uncomfortable and/or stressful 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 difficulty in predicting absorption, distribution and efficacy of drugs when administered orally or rectally.
- 1.4 The possibility of excessive amounts of these drugs being used to compensate for inadequate local analgesia.
- 1.5 The individual variations in response to the drugs used particularly in the elderly or infirm.
- 1.6 The wide variety of procedures performed.
- 1.7 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 that standards of patient care are satisfactory, equipment and staffing of the area in which the patient is being managed should satisfy the requirements as laid down in this Policy Document.

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 relevant examination such as might be available from the patient's General Practitioner, and must include blood pressure measurement.

2.1.2 Informed consent for the procedure and sedation.

2.1.3 Appropriate written instructions for preparation for the procedure (including fasting when appropriate), the recovery period, and discharge of the patient, including advice to avoid driving, operating dangerous machinery, or undertaking responsible business.

2.2 If the patient has any serious medical condition or danger of airway compromise then an anaesthetist should be present to monitor the patient during the procedure.

2.3 The practitioner administering these 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 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 the time of administration of the drugs as possible. This record should also note the readings from the monitored variables, and should contain other information as indicated in ANZCA's Policy Document P6 "*Minimum Requirements for the Anaesthesia Record*".

2.5 Pulse oximetry, when available, will assist in monitoring every sedated patient.

2.6 Techniques which compensate for excessive anxiety and/or for inadequate local analgesia by means of heavy sedation must not be used unless an anaesthetist is also present.

3. STAFFING

There must be an assistant present during the procedure, appropriately trained in resuscitative measures, who shall monitor the level of consciousness and cardio-respiratory function of the patient. The need for a second assistant will depend on the complexity of the procedure.

3.1 The operator may provide the sedation and be responsible for care of the patient provided that rational communication with the patient is continuously possible during the procedure.

3.2 If at any time such **rational communication** is lost, then the operator must cease the procedure and devote his/her entire attention to monitoring and treating the patient until such time as the patient recovers consciousness or another practitioner becomes available to monitor the patient and take responsibility for any further sedation, analgesia or resuscitation.

3.3 If loss of consciousness or loss of **rational communication** is sought as part of the technique, then an anaesthetist must be present to care for the patient.

4. TRAINING

Dental practitioners who administer sedation must be able to demonstrate an appropriate level of training.

4.1 All dental practitioners must be capable of administering the correct oral medications for such conscious sedation.

4.2 Practitioners wishing to administer relative analgesia must attend a special course and demonstrate competence in the technique and such associated resuscitative measures which may be required.

4.3 Practitioners wishing to administer intravenous drugs for sedation must attend a further special course and demonstrate competence in these techniques and their associated resuscitative measures which must include management of artificial ventilation and external cardiac massage.

5. FACILITIES

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

5.1 A chair which can be tilted readily to the horizontal position.

5.2 Adequate uncluttered floor space to perform resuscitation.

5.3 Equipment suitable for the measurement of a patient's blood pressure.

5.4 Adequate suction and room lighting.

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

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

5.7 Appropriate drugs for cardiopulmonary resuscitation (see Appendix) and a range of intravenous equipment.

5.8 A pulse oximeter must be used to monitor the patient when intravenous sedation techniques are used.

6. SPECIALISED EQUIPMENT FOR NITROUS OXIDE SEDATION

A machine which may be a completely portable device with attached oxygen/nitrous oxide cylinders or be able to be connected to piped gases must be available which is capable of delivering nitrous oxide sedation in accordance with the following requirements:

- 6.1. A continuous gas flow.
- 6.2 A minimum flow of two and a half (2.5) litres of oxygen per minute at any time that nitrous oxide is delivered, or in machines so calibrated a minimum of 30% oxygen in the gas mixture.
- 6.3 A maximum flow of 7-10 litres of nitrous oxide per minute.
- 6.4 Easily read flow meters.
- 6.5 A fail safe device - in the event of oxygen failure the nitrous oxide cuts off immediately and the air inlet valve opens and the patient breathes air.
- 6.6 A non-return valve to prevent rebreathing and a three litre bag which acts as a reservoir.
- 6.7 Wide tubing of approximately 2 cm internal diameter leading up to the nasal harness.
- 6.8 A light-weight nose piece incorporating an air dilution valve and a low tension expiratory valve.
- 6.9 Emergency oxygen button (oxygen flush).
- 6.10 Installation and maintenance of piped gases must be carried out by a registered professional using appropriately coded copper piping or reinforced nylon tubing for connection to the nitrous oxide sedation machine.
- 6.11 Servicing of equipment and piped gases by an appropriate organisation must be carried out on a regular basis, and at least annually.
- 6.12 For anything other than occasional use, a commercially supplied scavenging device must be used as an adjunct to nitrous oxide sedation. The accepted non-toxic level of circulating nitrous oxide is set at 25-50 parts per million. One half hour session of nitrous oxide sedation in a poorly ventilated area

would produce a level well in excess of 100 parts per million for several hours.

7. SPECIALISED EQUIPMENT FOR INTRAVENOUS SEDATION

- 7.1 Patients undergoing intravenous sedation must be monitored continuously with pulse oximetry. This equipment must alarm when easily set limitations are exceeded. Digital readings of saturation must be easily visible from two metres. Alteration in pitch as the oxygen saturation changes is desirable.
- 7.2 Intravenous equipment must be available which will keep access to a vein patent throughout the procedure.
- 7.3 Suitable reversal agents must be available depending upon the drug used.

8. DISCHARGE

- 8.1 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.
- 8.2 Discharge of the patient should be authorised by the practitioner who administered the drugs, or another appropriately qualified practitioner where oral or other intravenous agents have been used. The patient should be discharged into the care of a responsible adult to whom written instructions should be given.
- 8.3 Adequate facilities must be available in the Recovery Area for managing patients who have become unconscious, or who have suffered some medical mishap. These facilities should be similar to those listed under 5 above.
- 8.4 Should the need arise the patient must be transferred to appropriate medical care.

9. ASSOCIATED POLICIES

A number of Policy Documents from the Australian and New Zealand College of Anaesthetists should be noted where appropriate in conjunction with this Policy Document on Sedation for Dental Procedures. These Documents include the following:

- T5 Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries
- P4 Guidelines for the Care of Patients Recovering From Anaesthesia
- P7 The Pre-Anaesthetic Consultation
- P9 Sedation for Diagnostic and Surgical Procedures
- P15 Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery
- P18 Monitoring During Anaesthesia
- P19 Monitored Care by an Anaesthetist

They are available from the Registrar, Australian and New Zealand College of Anaesthetists, 630 St Kilda Road, Melbourne 3004

dextrose 50%
 lignocaine
 flumazenil) if benzodiazepines and
 naloxone) opioids are used for sedation

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

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

Whilst the Colleges endeavour to ensure that policy documents are as current as possible at the time of their preparation, they take no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

APPENDIX

Emergency drugs should include at least the following:

adrenaline
 atropine

Promulgated: 1990

Reviewed: 1992

Date of current document: Dec 1996

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Notice of Meeting

***THE CARDIOTHORACIC, VASCULAR & PERFUSION
 SPECIAL INTEREST GROUP
 (CVP Group)***

Fourth Continuing Education Meeting

ISSUES IN CARDIAC AND VASCULAR ANAESTHESIA

Date: 17-19 October, 1997

Commencing as a joint session in Adelaide with the Australian and New Zealand Chapter of the International Society of Cardiovascular Surgery, and continuing at the Wirrina Cove Paradise Resort, South Australia.

For information contact:

*Ms Helen Morris, ANZCA Continuing Education
 630 St Kilda Road, Melbourne, Vic 3004
 Telephone: (03) 9510 6299 Fax: (03) 9510 6786*

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

POLICY DOCUMENTS INDEX

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

- E1 (1996) Guidelines for Hospitals seeking College Approval of Training Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
- E3 (1994) The Supervision of Trainees in Anaesthesia *Bulletin Nov 92, pg 41*
- E4 (1992) Duties of Regional Education Officers *Bulletin Nov 92, pg 44*
- E5 (1992) Supervisors of Training in Anaesthesia and Intensive Care *Bulletin Nov 92, pg 45*
- E6 (1995) The Duties of an Anaesthetist *Bulletin Nov 95, pg 70*
- E7 (1994) Secretarial Services to Departments of Anaesthesia *Bulletin Nov 94, pg 43*
- E9 (1993) Quality Assurance *Bulletin Mar 93, p38*
- E11 (1992) Formal Project *Bulletin Nov 92, pg46*
- E13 (1996) Guidelines for the Provisional Fellowship Year *Bulletin Nov 96, pg 66*
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia *Bulletin Aug 94, p62*
- E15 (1996) Guidelines for Trainees and Departments seeking College Approval of Posts for the Certificate in Pain Management *Bulletin Mar 96, pg 50*
- EX1 (1996) Examination Candidates Suffering from Illness, Accident or Disability *Bulletin Nov 96, pg 70*
- T1 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites *Bulletin Nov 95, pg 52*
- T2 (1996) Protocol for Checking an Anaesthetic Machine *Bulletin Nov 96, pg 67*
- T3 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities
Bulletin Nov 95, pg 56
- T4 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT)
Bulletin Nov 94, pg 59
- T5 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries *Bulletin Nov 95, pg 65*
- T6 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites *Bulletin Nov 95, pg 61*
- P1 (1991) Essential Training for General Practitioners Proposing to Administer Anaesthetics *Bulletin Mar 91, pg 44*
- P2 (1996) Privileges in Anaesthesia *Bulletin Nov 96, pg 72*
- P3 (1993) Major Regional Anaesthesia *Bulletin Mar 93, pg 36*
- P4 (1995) Guidelines for the Care of Patients Recovering from Anaesthesia *Bulletin Aug 95, pg 64*
- P5 (1991) Statement on Principles for the Care of Patients who are given Drugs Specifically to produce Coma
Bulletin Aug 91, pg 50
- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 95, pg 48*
- P7 (1992) The Pre-Anaesthetic Consultation *Bulletin Nov 92, pg 47*
- P8 (1993) Minimum Assistance Required for the Safe Conduct of Anaesthesia *Bulletin Nov 93, pg 33*
- P9 (1996) Sedation for Diagnostic and Surgical Procedures *Bulletin Nov 96, pg 73*
- P10 (1994) The Handover of Responsibility During an Anaesthetic *Bulletin Nov 94, pg 44*
- P11 (1991) Management of Cardiopulmonary Bypass *Bulletin May 91, pg 43*
- P12 (1991) Statement on Smoking *Bulletin Nov 91, pg 37*
- P13 (1992) Protocol for The Use of Autologous Blood *Bulletin Aug 92, pg 49*
- P14 (1993) Guidelines for the Conduct of Epidural Analgesia in Obstetrics *Bulletin Mar 93, pg 37*
- P15 (1995) Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Aug 95, pg 62*
- P16 (1994) The Standards of Practice of a Specialist Anaesthetist *Bulletin Nov 94, pg 45*
- P17 (1992) Endoscopy of the Airways
- P18 (1995) Monitoring During Anaesthesia *Bulletin Nov 95, pg 68*
- P19 (1995) Monitored Care by an Anaesthetist *Bulletin Nov 95, pg 60*
- P20 (1996) Responsibilities of the Anaesthetist in the Post-Operative Period *Bulletin Mar 96, pg 52*
- P21 (1996) Sedation for Dental Procedures *Bulletin Mar 97, pg 56*
- P22 (1996) Statement on Patients' Rights and Responsibilities *Bulletin Mar 96, pg 53*
- P24 (1992) Sedation for Endoscopy *Bulletin May 92, pg 45*
- P25 (1996) Requirements for Multidisciplinary Pain Management Centres Offering the Certificate in Pain Management
Bulletin Mar 96, pg 54
- P26 (1994) Guidelines on Providing Information about Anaesthesia *Bulletin Aug 94, pg 61*
- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion *Bulletin Nov 94, pg 46*
- P28 (1995) Policy on Infection Control in Anaesthesia *Bulletin Mar 95, pg 38*