

Australian and New Zealand College of Anaesthetists and Faculty of Intensive Care

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Bulletin

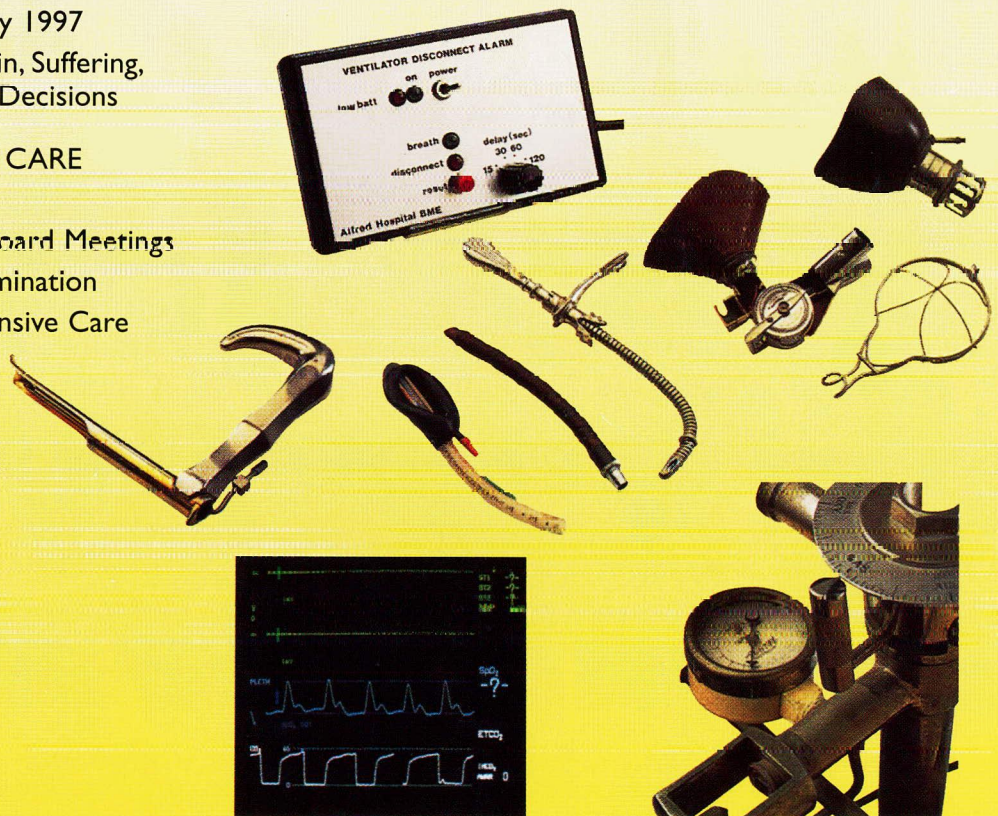
*'To serve the community by fostering safety and quality patient care
in anaesthesia, intensive care and pain management'*

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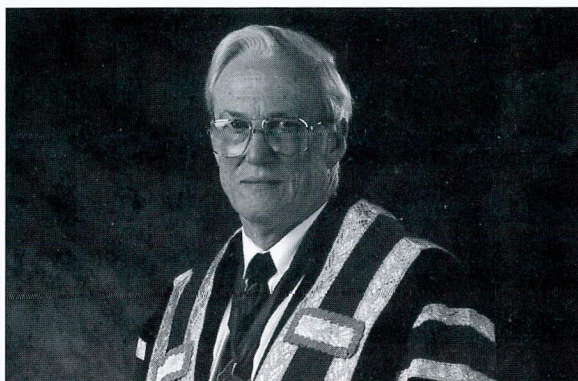
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PRESIDENT'S MESSAGE



There are a number of things on which I would like to comment in this message, half way through my two years as President of the College.

HISTORY

History has been a recurring theme, particularly in relation to its meaning for the present and the future. In 1996, we celebrated the sesquicentenary of anaesthesia, and this year, the sesquicentenary of anaesthesia in Australia. How far we have come in delivering the benefits of anaesthesia, intensive care and pain management to people. How far sighted the individuals were who contributed to the developments, and how much time and effort they put into a vision of the future, over and above their everyday commitments to their work and personal affairs. How pleased they would be to see the benefits which have resulted from their efforts.

In 1997, Anaesthesia, Intensive Care and Pain Management in Australia, New Zealand, and the Asian regions in which the College has influence have the highest standards of practice. Our Fellows have, and are contributing to the advancement of our specialty in the Pacific Region. As the College develops its Maintenance of Standards Programme to back up its training and examination system, its capacity to fulfill its Mission Statement will increase.

This year has seen the creation of a new platform from which the College will consolidate its position, and from which new initiatives will emerge. The Strategic Planning Workshop held in February has now been considered by Council, and several strategies are in

place, with others being discussed. I would like to expand on a few of these initiatives.

COLLEGE - SOCIETY LIAISON

Anaesthetists sometimes say to me "Why do we need a College and a Society? After all, they do the same things, are made up largely of the same people." Colleges have a particular role to play in the scheme of things. While they overlap in some areas with Societies, there are a number of specific things they do which cannot be done by Societies, and vice versa.

Anaesthetists, supported by a number of surgeons, saw the need for a national body to train, examine, and set standards in anaesthesia. At an appropriate time, intensive care was established, and then pain management. We now enjoy the benefits of an Australian and New Zealand College of Anaesthetists, within which there is a Faculty of Intensive Care, and a Pain Management Committee. The Australian Society of Anaesthetists, New Zealand Society of Anaesthetists, Australian and New Zealand Intensive Care Society, Australian and New Zealand Chapters of the International Association for the Study of Pain are all strong, active organisations.

In Asia, where we have some influence, increasing co-operation is being sought on relevant matters, particularly with Colleges and Academies in Hong Kong, Singapore and Malaysia, and advice and assistance is being offered to Universities and Schools involved in training in the Pacific Islands and Papua New Guinea.

The College also has roles in which it must act outside of its liaisons with Societies, partly because of its charter, and partly because other organisations refer to it for decisions on matters relating to training, examinations, and standards. These include such matters as accreditation of training posts and programmes, conduct of examinations and maintenance of standards programmes, creation of policy documents relevant to standards, liaison with other Colleges and with Government.

There are of course areas where the role of Colleges and Societies overlap, and where it is important that each organisation understands and respects the role of the other, and where co-operation results in formulation of an approach which benefits all. These include most obviously continuing medical education and public relations.

The College/ASA Liaison Committee has set out to review the respective areas of activity of the two organisations to ensure that while each fulfills its own aims and objectives, and there is good co-operation in areas of overlap.

GOVERNMENT LIAISON

To give a specific example, the College is not only responsible for accreditation of training posts, for training, assessment, examinations, awarding of Fellowship, and for maintenance of standards but is also the reference point for Government on issues such as training, specialist registration, assessment of overseas trained specialists, and of occupational visa applications.

At a meeting of the Committee of Presidents of Medical Colleges earlier this year, issues discussed included criteria for credentialing of medical practitioners, education of interns and resident medical officers, education, assessment and certification of career medical officers. The Medical Training Review Panel, set up last year by the Federal Minister of Health, has moved rapidly, in concert with the Colleges and the Australian Medical Workforce Advisory Committee, to establish a data base of trainees of all Colleges, and of the specialist medical workforce. New issues to be addressed are development of uniform criteria for selection of trainees, and a uniform appeals process. The international significance of these issues will be discussed at the Conference of International

Reciprocating Examining Boards of Anaesthesia in 1998, attended by the President and Vice-President.

PAIN MANAGEMENT

Two College programmes are developing rapidly. The first is in training and assessment for the Certificate in Pain Management, which has required the establishment of objectives of training, the setting of standards for units wishing to train, and the accreditation of those units. Our first graduation was this year. Planning has already commenced for institution of a Diploma in Pain Management by 1999, with the co-operation of other Colleges and Faculties. In a discussion paper prepared for the February strategic planning day, Professor Michael Cousins pointed out that Government and non-Government bodies are now recognising pain as a major medical, economic and societal problem. ANZCA is well placed to influence clinical practice, education and research in areas such as acute pain, chronic cancer and non cancer pain, and palliative care. Prominent Fellows like Brian Dwyer and Brian Pollard pointed the way in the 1960s. They must be pleased to see what is occurring now.

ASIA PACIFIC

The second is in the Asia Pacific region. In another discussion paper presented in February, Professor Teik Oh listed a series of forward planning issues which were subsequently accepted by Council. The areas in which it was agreed that we should concentrate our involvement include Malaysia, Singapore, Indonesia, Philippines, Thailand, Vietnam, Cambodia, Laos, Myanmar, Hong Kong, China, Taiwan, Japan, South Korea, North Korea, and Pacific Island countries, including Papua New Guinea.

Each issue in the discussion paper is now being addressed by Council, in dialogue with the appropriate people and bodies in these countries. In areas where liaison with the ASA and the NZSA is required, this is occurring. As a specific example, in 1996 the Royal Australasian College of Physicians was awarded the contract for the Medical Officer, Nursing and Allied Health Training Project scheme in Papua New Guinea.

Having been involved in education and examinations for the five year M. Med in Anaesthesia of the University of Papua New Guinea for several years, I see it as logical

that the College should continue contributions to this programme, recognising that the ASA and NZSA have legitimate claims to support training by funding visits of trainees to Australia and New Zealand, and by providing specialist visits to assist in on-site education and CME.

Anaesthesia in the Pacific Islands has developed differently, and both the ASA and NZSA have had a major commitment there for many years. In 1994, the Postgraduate Board of the Fiji School of Medicine agreed to the development of a two year DA based at the Colonial War Memorial Hospital in Suva. With support from AusAID, Steve Kinnear was appointed initial course co-ordinator, and the first examination took place in October 1996 - a major achievement by the ASA.

The Royal Australasian College of Surgeons won the tender to administer the Pacific Islands Project in 1995, and since then many surgical/anaesthetic teams have travelled widely to treat and to teach. This year, RACS has won the AusAID contract for the Fiji School of Medicine Post Graduate Medical Training Project. RACS will now co-ordinate postgraduate training in Fiji, as RACP does in Papua New Guinea. A two year M.Med. (Anaesthesia) is planned to commence this year. It is hoped that the content of the M.Med. (FSM) and the M.Med (UPNG) will be sufficiently similar to allow cross-recognition, and that the same applies to the two DAs. The College has offered any assistance it can to ensure that anaesthesia continues to develop in the Pacific, based on properly accredited local training programmes.

COLLEGE POLICY DOCUMENTS AND STATEMENTS


The College has a long history of publication of policy documents relating to training, examinations, education, standards etc. These have had considerable impact, not only in teaching hospitals, but also in non-teaching hospitals and are referred to by Government bodies. The National Road Trauma Advisory Council for example, based its recommendations regarding anaesthesia, intensive care and retrieval on College policy documents, when it published the Report of the Working Party on Trauma Systems in 1993. Similarly, the Australian Council on Healthcare Standards refers to such documents during their accreditation reviews.

The College has published joint documents with other

Colleges, when this has been perceived to be in the best interest of the public. In order to avoid the possibility of the document being revised at different times using different reference material in a rapidly changing scene, the College and ASA have agreed to publish a joint document on "Infection Control in Anaesthesia" again, in the interest of a clear statement to the community.

I will conclude with a comment on two matters agreed by Council in the last year which are of considerable importance. The first is promotion of its Mission Statement: "To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain management." The objectives of the Mission are detailed in the Bulletin, Vol. 5, No. 4, 1996.

The second is agreement on the statement which appears elsewhere in this Bulletin, on "The Relief of Pain and Suffering and End of Life Decisions." This is not a statement on Euthanasia, demonstrating that Council and Board of Faculty heed comments from Fellows and Regional Committees. But it is a statement of what Council and Board agreed unanimously should be said on issues surrounding relief of pain and suffering and end of life decisions.


GARRY PHILLIPS
President

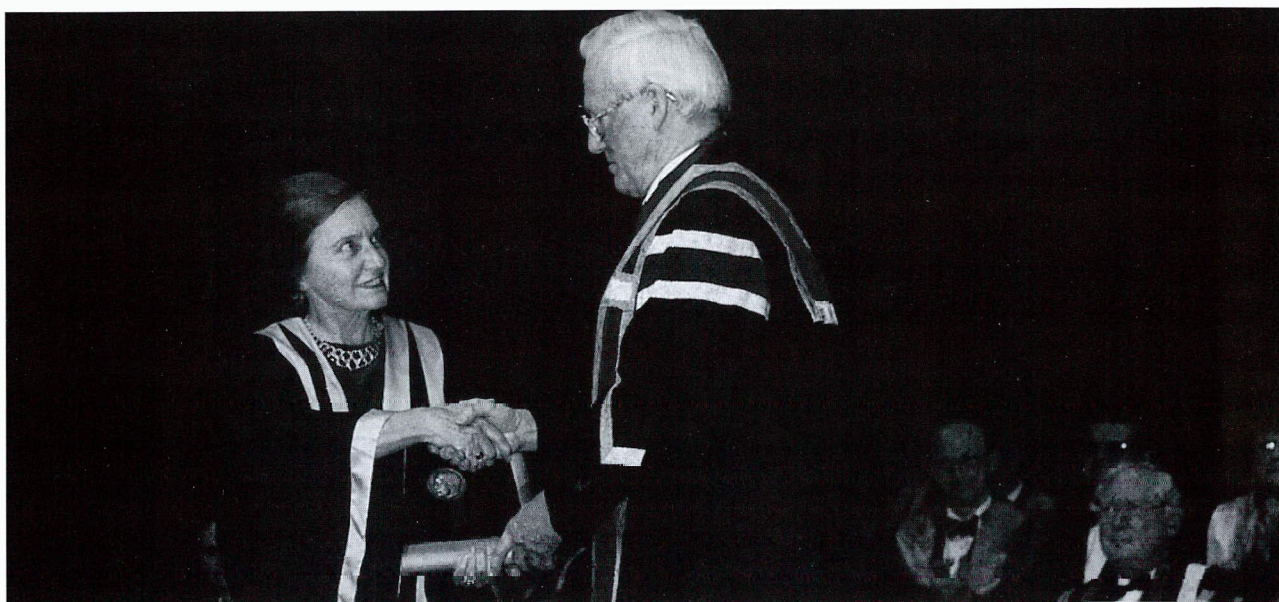
ANZCA DONATIONS

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

Professor Tess Cramond, AO, OBE	Queensland
Dr L C Hibbard	New South Wales
Professor R B Holland	New South Wales
Dr J I Munckton	South Australia

ROBERT ORTON MEDAL
CITATION -
JEANETTE RAE THIRLWELL JONES

"The Robert Orton Medal is the highest honour the College can award to its Fellows in anaesthesia. This award is made at the discretion of the Council, the sole criterion being distinguished service to anaesthesia."



Mr President, it is my great honour and pleasure to present to you Jeanette Thirlwell Jones for the award of the Robert Orton Medal.

Dr Jeanette Thirlwell Jones is well known to the anaesthesia communities in Australia, New Zealand and indeed the world as an outstanding motivator and administrator of successful anaesthesia publications, foremost being her 21 years of continuous involvement with our great Australian journal, "Anaesthesia and Intensive Care".

Jeanette Thirlwell Jones was raised in Sydney and attended North Sydney Girls High School, where she excelled in academic achievements, sporting activities and leadership qualities. She went on to study medicine at the University of Sydney, graduating in 1962. As an

under-graduate, she managed to continue her sporting interests, particularly on the hockey field, playing with Sydney University at the highest of grades. She also maintained her lifelong talents in music, playing both the piano and cello, and more recently becoming involved in the study of musicology.

After internship and residency in Sydney, she went to England to undertake anaesthesia training, embarking on a career with particular emphasis in paediatric anaesthesia. After two years in the UK and having obtained her Diploma of Anaesthesia from the Royal College of Surgeons in England, she returned to Australia to continue anaesthesia training, first at Royal Hobart Hospital, and following a year in paediatric anaesthesia in Holland, a year at the Royal Children's Hospital in Melbourne and two years at the

Royal Alexandra Hospital for Children in Sydney. She was admitted to Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (now our College of Anaesthetists) in 1968. In 1970, Jeanette served as an Assistant Professor at Stanford University in California, and returned to Sydney in 1971 to join the staff of the Royal Alexandra Hospital for Children, holding a visiting medical officer position from 1976 to the present. From my own brief experience at the hospital as a trainee in 1979, I recall her great attributes as a meticulous, careful and superb paediatric anaesthetist, who excelled as a teacher of clinical anaesthesia, particularly in the complex field of major surgery for congenital cardiac anomalies. Moreover, she was a fascinating and stimulating person to be with and remains so! She has presented and published many scientific papers at local and international meetings and in a variety of journals.

Jeanette Thirlwell Jones' outstanding clinical career was not enough in itself for this quiet but diligent achiever. In 1976, the Journal of the Australian Society of Anaesthetists was just four years old. Dr Ben Barry, as founding Editor of "Anaesthesia and Intensive Care", had established a journal which was embraced enthusiastically by our professional community and was proving to be a success beyond expectations. When an assistant was needed Jeanette was there and never has such an inspired choice by Dr Barry ever been so fortunate for our profession. She was appointed as the Assistant to the Editor for three years, becoming Assistant Editor in 1979 and Associate Editor in 1990. In 1993, she was appointed the Executive Editor, a position she holds to the present. She has been the backbone of the Journal throughout the last 21 years of its 25 years existence. In that time, she has not only diligently proof-read (and corrected!) nearly all published articles but also overseen the promotion, advertising, editorial policies, printing and all the many other aspects inherent to successful publication of the Journal. The result is "Anaesthesia and Intensive Care" being recognised, to quote the current President of the Royal College of Anaesthetists in Britain, as "one of the leading English language Journals in the World". The growth in size, status and circulation of our Australian Journal, and the concomitant international recognition of Anaesthesia and Intensive Care in Australia and New Zealand, is a very great and very recognisable tribute to Jeanette Thirlwell Jones.

The extraordinary editing and publishing skills of Jeanette Thirlwell Jones have been tapped by many others over recent years, and Jeanette, amazingly, has never balked at enthusiastically lending an expert hand, especially at crisis times. For our Australian and New Zealand College of Anaesthetists, she was a Co-Editor with Dr Dennis Kerr of the 1992 edition of "Australasian Anaesthesia", and from 1994 until its publication in 1996, she was the Editor (and what she describes as "Designer and Producer") of the definitive history of the earlier years of our profession in Australia, the great book by Dr Gwen Wilson, "One Grand Chain". In 1994, Jeanette became Editor of the Newsletter of the Australian Society of Anaesthetists, transforming it into a highly appealing, professional and informative publication. From 1994, Jeanette also enthusiastically served on the Publications Committee of the 11th World Congress of Anaesthesiologists, contributing in many ways to the success of that very significant 1996 event, particularly being responsible for promotion in international journals. It is interesting to note that in 1989, Jeanette must have had some self-doubts - she undertook and obtained a Diploma of Publishing and Editing at Sydney's Macleay College - an achievement which reassured her that she was doing her job correctly!

Through all this brilliant career, Jeanette and her husband, Bob Jones, have raised seven children. Her musical interests continue and have been inherited by her very talented off-spring. A sporting life is also not neglected, Jeanette being a very accomplished sailor and she continues with her cross-country skiing!

Jeanette Thirlwell Jones is a quiet and modest person with a highly focussed determination to produce the best results from every task at hand. There is no doubting that she is a forthright woman whose example and outstanding achievements have been an inspiration to all around her.

It is therefore needless to state that Jeanette Thirlwell Jones is an extraordinarily devoted and selfless servant of our profession, our College and Australian Society, all of which owe her a great debt. Mr President, it is my proud and great honour to present Dr Jeanette Thirlwell Jones for the award of the Robert Orton Medal.

RICHARD G. WALSH

ORATION

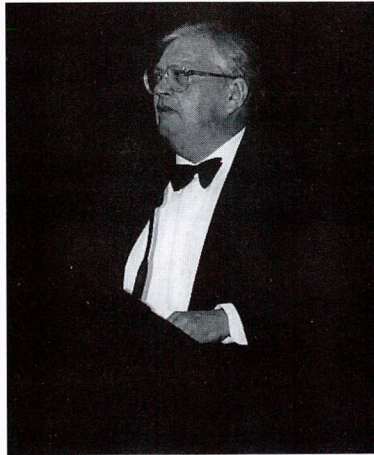
**(edited) delivered by The RIGHT HONOURABLE DAVID LANGE, CH,
former Prime Minister of New Zealand, during the College Ceremony
at the Annual Scientific Meeting, Christchurch**

Thank you Mr President, may I greet you, the office holders of the College, the Fellows, their partners and spouses and supporters and admirers, and greet you here in Christchurch New Zealand on this splendid occasion.

It's appropriate of course that I'm here, because this is an Australian and New Zealand College and we of a world now which is inextricably mixed, I am a half-caste Australian, my mother comes from Launceston where the first anaesthetic procedure was undertaken 150 years ago next month. She moved into the Royal Hobart and did her nursing training and came to New Zealand, married my father who was a Fellow of the Royal College of Surgeons in Edinburgh.

It is appropriate that I should acknowledge first of all the fact that I am which here is a tribute to the professionalism and competence of people who are in this room and there are some that I respect from my immediate family. The Vice Dean (Dr Ron Trubuhovich) is one, who nursed a member of my family through a time of great crisis. There are other people here who have been responsible for managing the anaesthetic process of the intensive care at the time, the pain relief as part of it, and who kept me on methadone for some time afterwards. I'd just like to acknowledge that there has been in my time a conspicuous consumption of the services of your profession, the result of which appears before you, somewhat worn, but certainly vertical, and rejoicing to be here. And I rejoice as well in the professionalism of people in your types of professions.

Professionalism really has nothing to do with money. It has been corrupted by that concept of payment for sporting services. Professionalism is the pursuit of an ethos where you have responsibilities which you assume



for yourself and where in the end you cannot seek to cast upon anyone else an ultimate responsibility for a judgement which can be from any minor matter up to the very issues of life and death.

I unashamedly wallow in the virtues of professionalism, it was part of my background. I grew up in a home where my father was called out at all sorts of hours of the day and night, I became a lawyer, I practised law for eighteen years

before I went straight and became a politician. But the truth is, that through all of that time in the law my engagement was a professional one. It was at the edge of the law where you live with the client through a trial, where you live with the client right through a liberty or confinement experience where judgements were your responsibilities throughout that time and in the end you could claim a credit for the ultimate liberation of the client or accept responsibility for errors of judgement, which may have resulted, very rarely, in his or her improper incarceration. But don't knock lawyers, there is an Australian who was cured of emphysema by a lawyer in Spain.

There is I suppose, about the ultimate test of professionalism when you can depart from what society in its statutory process requires of you and go that step further and you can create a collegiality which demands that you are reviewed by peers, that you pass tests, pass the level of acceptance of professional judges, people who are able to challenge you, and you with them raise the standards of the profession. It's one of the great things which happens in medicine, and in surgery, and very few other disciplines. An amazing number of practitioners of various crafts around New Zealand look to the law to determine what their standards should be. And of course, the law will never determine standards, the law

will maybe provide some sort of bottom line, but insofar as the law uplifting the quality of professionalism, it is profoundly pointless.

I suppose the ultimate test of professionalism is when you pursue your craft to the point where you are personally beset by the consequences of your commitments. And I want to speak very simply about that. I knew a number of years ago a man who I see by the programme tonight has been admitted as a Fellow by election to this College. He was as I recall him, an enthusiast about becoming a doctor, he was a quiet man, he was earnest, he was diligent, he was a good student and he became a medical practitioner and then he took up the practice of anaesthetics in Waikato. Now he was a person who I suppose would have been absolutely dedicated to his craft, certainly as a result of his arrest on charges which were brought by the police, arising out of the death of a patient in circumstances of great extremity. He had several months and years of torment and harrowing obligation to go through judicial process. The fact is that we were completely unable to demonstrate through our criminal system that there was any liability on his part at all. It was a scandal that he was prosecuted, it was a tragedy that he had to put up with it and it is of great fortune that as a result of his suffering there is now before a Select Committee in the parliament of New Zealand, a Bill designed to bring the criminal code with respect to the practice of anaesthesia, some way into a sensible equilibrium.

It's about fifty years ago since I went to the opening of Middlemore Hospital. The practice of anaesthetics then was widespread. It had nothing of the high tech drama of today. Someone that did that then wouldn't be able to cope with, any more than I could, the great mysteries of the procedures which are undertaken in surgeries and theatres throughout New Zealand and Australia. And there is a person who actually went that extra mile, in circumstances where a person conscious of their own standing and being preemptively self defensive, would have abandoned the whole quest entirely, and that's the tragedy of what happens when you get that type of judgement offered to a professional person such as that, because you cannot give your full commitment to the work you are doing, you cannot give your full commitment to the interests of your patient because there is the possibility that there will be moving against you, forces which don't understand your craft, don't understand the stresses and don't recognise that you have gone that extra mile in the interests of your patient.

The other thing that didn't happen on that occasion was that it never actually went to a jury. There are compelling reasons why certain jury trials should never take place. One of them is that many people on the jury are as silly as you and me and as stupid as you and me and know as much as about some matters which are determined as you or me. And the fact is that we have systems in Australia and New Zealand where twelve persons can adjudicate on matters of grave and weighty moment when they know nothing about them and when the complexity of the issue is so profoundly obvious. And there is a case to dispense with jury trial in such cases or at least to go back to the procedure we had many years ago of a special jury where we empanel people who have demonstrated their particular competence or ability. The fact is that unless we do pass that amendment, which is somewhat moot now, given the new composition of the parliament and our not knowing the track records and voting patterns of people in parliament today, there will be a retreat from the limit to which people will go in surgical and anaesthetic procedures. That would be tragedy for those who are depending on the commitment to the limit of those people.

I want to come down to the next thing, which is collegiality. I think that I represent probably that peculiar end of an era in the law when individual practitioners could practice unmolested by restraint, by regulation and by too much control of their trust accounts, and where you could be an individual. And I got to have a totally wrong idea of what it meant to be a professional person. I thought that being a professional person was being robustly self-reliant and not engaging in undertakings and understandings with people. And then I made that worse by going into politics. Politics is a profession which of course has nothing of collegiality about it at all. My enemies were on my side, my friends were on the other side. My back has so much scar tissue in it you couldn't get another knife there! It would be impossible.

The truth is, there is something which is so extraordinarily different about the world that you inhabit and the world that competitive rivals inhabit. And it tells us something about the new culture that is going to come over us as we move away from the rugged selfishness of what are deemed to be the current standards of business and commercial ethical behaviour. And we start to find common cause, and a virtue in sharing which is, of course, now largely the Asian experience. It is something that we in Australia and New Zealand have not analysed properly.

We have been told, as I was told, that the best business outcome comes from the free market. And when I asked tertiary advisers where the free market was, they said Germany and Japan. That of course is absolute nonsense. If you put fifteen executives of a sector of Japanese industry in one room and tell them they're in a free market, they'd have a collective coronary. Japanese people are not stupid, they do not believe in dog eat dog, they believe in all dogs eat all cats and they do so with some flair.

I had a great experience a few years ago. I had a gastric stapling thing, and it was a wonderful experience, not so much for my stomach, but for me - after many years of being the person on whom people are dependent, and the person in law and in politics whom people came to for answers, and I was their perpetual crutch. I went one day, I did a will, had it executed in the post office by the post master. You can't do that now, we stopped that. Then I submitted myself to a very long procedure with extraordinarily good intensive care and anaesthetics and surgery. And the funny thing about that was that I looked upon that as a change in my life.

If I hadn't undergone that about 1982, I would never have been able to do later what I did in politics, because I started to learn about the benefit of not being stupidly self reliant, but of actually enjoying it in a strangely, awfully weird masochistic self-indulgent feeling, you know. There are people who look after you, you surrender yourself entirely to their skill and judgement and you're awfully happy to do it. And you can't move, and there's things coming out of every orifice and some new ones they've made, and it's all happening and they're there all the time and there's constant attention, there's green lights flashing and there's someone there and decisions are made for you and you can lie back and enjoy that stuff coming through the syringe into the drip.

It is a world absolutely different to the world that I inhabit. It's a world that I only ever came close to when I became a motor racing driver at the expense of the Ford Motor Company, when people worked like mad to make sure that at least I could get a good view from the back of the field. And what's happening, what's happening to you, your Fellows, your advisers, your careers, is that the challenges are becoming bigger and bigger, more and more is there an exponential enhancement in the technology with which you must contend.

I think that we have major problems in terms of what we determine to be your role as advocates in the greater

good and how you manage to do that without looking self interested. It's one of the terrible dilemmas of people who are professionals. Schoolteachers can never get any advances for the interests of their pupils because they look as if they are asking for more money. And we are facing a society in both our countries where there are new theories and new philosophies about the allocation of resources. Where we have failed abysmally in New Zealand is to determine certain key services which ought as a matter of absolute minimum be delivered to people and we have never been able to work it out because the ultimate determinant of a core service in New Zealand is the Holmes television programme. A few years ago in Australia it would have been the Willisee show wouldn't it, or Ray Martin on the Midday Report. So we haven't done that, and the role of professional people as advocates for change or bargainers for resources is still extremely limited. Your College will have to be developing whole new skills, whole new databases, new personal approaches to people who might be more useful than they appear when they get into the voting lobby.

The truth is that we have a changing world which is just simply so different from the one that I grew up in. See, I grew up in a world where the State did everything for me, I grew fat on school milk. I am the ultimate extension of the Plunket graph. I was delivered at the expense of the State, my father delivered people all over the place. We in Australia and New Zealand occupy a world which is vastly different from the one that I was born into and most of you were.

If we stand in Sydney and take a hemisphere from the Circular Quay, that hemisphere doesn't touch North or South America. It takes in the whole of China, it takes in burgeoning India, it takes in the dragon economics of Japan and Korea and Taiwan, it takes in intellectually astute, economically competent Singapore and those growth economies of Malaysia and Thailand. It takes in Indonesia which has changed from being the threat to the potential and it takes in the arid masses of Antarctica, the arid masses of Australia apart from its wonderful jewels on the coast, New Zealand and the micro states of the Pacific. And the thing about that world is that it's got 3.5 billion people in it and 24 million of them only look like most of you and all of me. Their culture is not ours, their language is not ours, their religious background is not ours, their instinct for jurisprudence is not ours, their expectation of their governments and their States is not ours. They have been given a mindset which puts us clearly apart from

them and they have gone into a sort of philosophical commitment to self-reliance and family, or degradation and poverty and decay. And we are facing a world where we must trade with them, and unless we get extra smart, enormously smart, enormously fast, we're going to have our standards slip, and that birthright which is part of my heritage and yours will not be there because we won't be able to sustain it. And we are seeing the first signs of that. That is why I honour people who engage in excellence in education and excellence in profession because the fact is that we have got ourselves in a rut in Australia and New Zealand in general, relative to the progress being made in other countries fairly near to us.

We in Australia and New Zealand fundamentally care for each other. We express that usually through state intervention or political involvement. But we're people who, despite the excesses and the occasional violence and the way we let ourselves down often, are people who do feel some sense of social cohesion. And we had that fundamental understanding and unity which is not the lot of other people in the world. But the truth is that unless people like yourselves are honoured and excel and

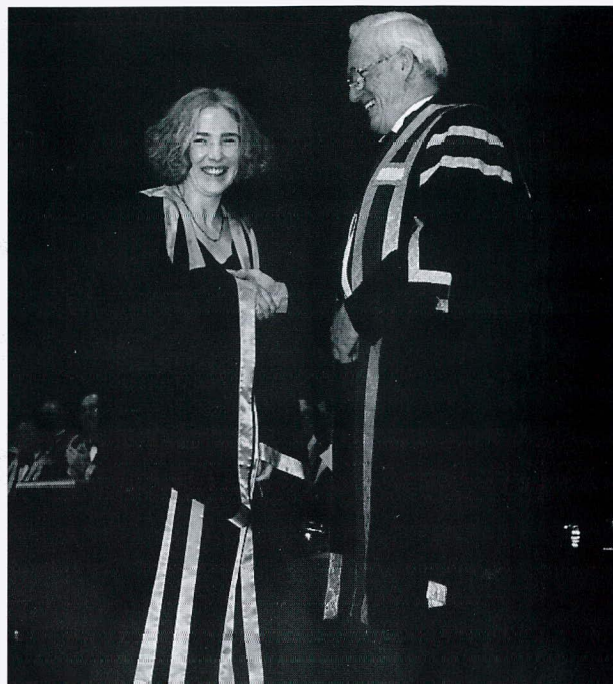
then pursue new goals, all of that will be lost and we will end up like Singapore which has just passed a wonderful law, whereby parents can sue their children for support. The complete antithesis of anything you'd ever see in New Zealand or Australia, but reflective of a different social outlook and a different view of community.

And so we come here tonight to celebrate many years of achievement, we come here tonight to reflect that there have been more challenges to the provision of health services in this country in the last fifteen years than there have been since the 30s. We ought tonight to pause to reflect that we have also seen tremendous benefit. No longer will your Fellowship Certificates be on a wall written in dog Latin, the source of your recognition for your academic and professional and practical eminence will not be written in languages alien to our countries and within our two societies we have developed a core of expertise and professionalism which enables us to be recognised throughout the world, to welcome into our ranks people of eminence from abroad and to honour extraordinary men and women such as the people here tonight. Thank you.

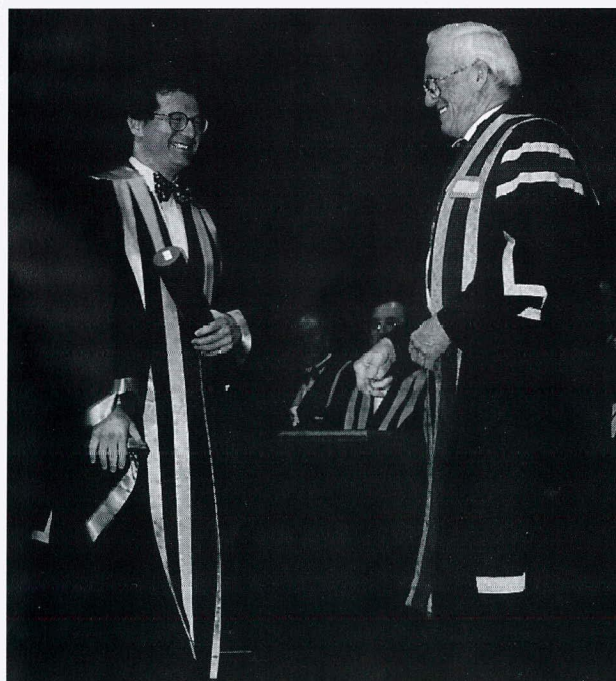




Mr Stuart Boyd (Product Manager, Pain Control / Hospital Products, Astra Pharmaceuticals) with Australasian Visitor Dr Brian Horan, NSW, and the President.



Dr Angela Playoust, NSW, being presented with the Renton Medal by Professor Garry Phillips, President.



Prof Jerrold Lerman, Canada (left) and Prof Gavin Kenny (Scotland) with Prof Garry Phillips following their presentations during the College Ceremony at the ASM in Christchurch.



LAW REPORT

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

CAN A DOCTOR REFUSE TO TREAT A PATIENT WHO FAILS TO GIVE CONSENT FOR AN HIV/AIDS TEST?



This has become a vexed question for doctors and the medical profession generally. At what point can a doctor or hospital refuse treatment for a patient, who refuses to disclose or allow testing for their HIV/AIDS status?

In addition, there is now some suggestion that universities, even medical colleges, may require doctors to disclose their HIV/AIDS status, and may prevent them undergoing training if they are HIV positive.

There are clearly competing interests in these issues:-

- the interest of the patient to be fully informed;
- public health and safety;
- the privacy of the patient;
- the protection of the doctor.

Anti-discrimination law plays an important role in ensuring equal opportunity for all members of our community, and preventing discrimination in employment and the provision of goods and services for those with particular attributes (gender, race, impairment, etc.). However, anti-discrimination law contains many exceptions recognising the competing rights of the community. For example, anti-

discrimination laws in most States recognise an exception for action which may be necessary to protect public health.

*So what **are** the rights of doctors to refuse to treat patients who fail to disclose their HIV status, or refuse to give consent for a HIV/AIDS test?*

1. The Law

In most jurisdictions, it is against the law to discriminate against someone, in providing goods and services, including medical services, because of their disability or impairment.

“Disability or impairment” is defined in most jurisdictions to include HIV/AIDS related illnesses.

In addition, in some jurisdictions (eg. Section 100 of the Equal Opportunity Act 1995 (Vic)), it is unlawful to request information that could be used to form the basis of discrimination against that person. There is an exception to permit the information to be requested “for a purpose that does not or would not involve, or lead to” discrimination. In other words, the information could be requested if there are other good reasons why the information is being requested. However, the onus is on the person requesting the information to show that the information is wanted for a non-discriminatory purpose.

Discrimination could be on a **direct** basis on the ground of disability or impairment. It could also be **indirect**, if discrimination measures are taken against people with a particular sexual orientation or race, or on some assumed basis that people of a particular class are more likely to be HIV positive.

2. Ethical Considerations

Medical practitioners are obliged to take into account relevant ethical considerations in their practice. Medical Boards, the AMA and bodies such as the NHMRC have issued various statements of ethical principles and guidelines.

3. Contractual and Other Legal Obligations

There is a raft of statutory obligations in relation to public hospitals, and doctors providing services in public hospitals, which may necessitate the provision of care and services.

However, there is no general obligation on the part of private health professionals or institutions to provide health care, except in the case of emergency situations. (Even in the case of emergency situations, there is some doubt as to the extent of the obligations on medical practitioners - some States have "good samaritan" legislative protection for doctors acting in emergency situations).

Generally, at law, a medical professional in private practice has the ability to decide whether or not to provide services for a particular individual (subject to the effect of discrimination laws).

4. Discrimination

Issues that have been identified in various reviews of HIV/AIDS discrimination include:-

- refusal to provide health services;
- different or discriminatory standards of health care provided;
- infection control measures which are extreme, unnecessary or excessive;
- testing without consent;
- breach of confidentiality, breach of privacy.

There is some uncertainty expressed in the literature as to the extent of protection afforded by "universal protection procedures".

Whilst "universal protection procedures" are recommended in all circumstances where infectious diseases may be involved or where there is some risk, there is always the possibility of needle-stick injuries, or some other unforeseen event, which universal protection procedures cannot address.

Accordingly, whilst the risk of injury through failure of universal protection procedures is relatively small, the harm that may arise can be significant. What are therefore the competing rights between patient, doctor and the public interest?

5. Under what circumstances can a doctor refuse to treat a patient with HIV/AIDS or an undisclosed status?

Whilst clearly the provisions of anti-discrimination legislation would be infringed if a doctor refused to treat a patient because of illness, impairment or disability, there are a number of exceptions:-

5.1 Protection of Public Health

Section 80 of the Equal Opportunity Act 1995 (Vic) provides that a person may discriminate on the basis of impairment if the discrimination is reasonably necessary to protect the health or safety of any person (including the person discriminated against), or the public generally.

Section 49P of the Anti-Discrimination Act 1977 (NSW) provides that conduct is not unlawful discrimination on the ground of disability, if the disability is an infectious disease and the discrimination is reasonably necessary to protect public health.

Other jurisdictions will have similar exemptions.

The onus on establishing that discrimination is necessary for the purposes of public health will rest with the person against whom a complaint is made.

There are many factors that may be involved in order to establish whether the particular discrimination (refusal to treat) was necessary to protect public health:-

- If a patient is simply refusing to reveal their HIV status, it should be noted that HIV testing provides only a "snapshot" profile of the patient's status at any point in time.
- It is argued that "universal precautions" provide effective protection in most situations, and therefore the refusal to treat may be unreasonable.

- There may be some instances where a patient's HIV status is relevant to diagnosis or the nature of treatment which might be considered, and therefore it may be clearly reasonable and competent to require disclosure of HIV status.
- Disclosure to others of a patient's HIV status (which may in itself constitute direct or indirect discrimination) may not be necessary in all cases, depending on the nature of the third party's involvement (whether as nurse, treating doctor, anaesthetist, etc.).

5.2 Acts done in Compliance with Other Legislation

Section 54 of the Anti-Discrimination Act 1977 (NSW) provides that it is not unlawful to do anything which is necessary in order to comply with the requirement of any other Act, regulation, by-law, etc., or an order of any Court or Tribunal.

Section 69 of the Equal Opportunity Act 1995 (Vic) provides that a person may discriminate if it is necessary to comply with, or is authorised by, a provision of any Act, rule, by-law, etc. of a legislative character.

Again, other jurisdictions will have similar exemptions, and the onus of establishing that a person's conduct comes within this exemption is on the person claiming the exemption. Therefore, it must be shown that any relevant conduct is **necessary**, or is **authorised** by the legislation. This would have to be explicitly so, rather than implicitly.

For example, there may be requirements under occupational health and safety legislation, or other health legislation, which permit or require particular conduct in relation to infectious diseases.

This area has been indirectly tested before the courts. In the New South Wales decision of **Ferguson v Central Sydney Area Health Service (1990) EOC 92-270**, a complaint by a gay man that he was discriminated against by a

hospital when he was refused minor elective surgery because his HIV status was not known, was determined not to be discrimination. Because the complainant was a sexually active male homosexual, it was assumed that he may be involved in a high-risk group. The Tribunal determined that the same detriment, suffered by the complainant, would have been imposed on any person (whether male or female, heterosexual or homosexual) who is discovered to be in a high-risk group.

There is some criticism of the "Ferguson" decision.

In a more recent New South Wales case of **G v L (1995) EOC 92-712**, a gay man alleged discrimination on the basis that he was refused surgery unless he underwent a HIV test. The matter was settled out of court, but was settled on the basis that the complainant receive some compensation.

It should be noted that recent guidelines issued by the NHMRC and ANZCA indicate that testing for HIV/AIDS should not be required as a pre-condition for the provision of most medical services. Some assessment should be made as to the direct relevance of testing of this nature before medical services are declined on this basis.

6. General

The answer to the question - **Can doctors refuse to treat patients who are HIV positive, or refuse to disclose their HIV status?** - cannot therefore be answered definitively. Whilst there are some exceptions upon which doctors may rely, these do require some detailed analysis of the reasons for the refusal to treat, and whether there is a real public health issue involved. Obviously, there are a number of procedures which can be carried out using universal precautions, which involve little or no risk to patient and doctor. However, it is acknowledged that there will be some invasive procedures, and some illnesses where treatment does require knowledge of the HIV status of the patient. In those cases, it would appear that the doctor may have a public health reason for refusing to treat.

What can be said for certain is, that doctors have no general or automatic right to refuse treatment to a patient who is HIV positive or whose status is unknown. There is no automatic right for a doctor to require a patient to undergo testing for HIV status, or refusing to treat simply because they may be in a high-risk group.

(This report attempts to generally canvass the issues of anti-discrimination law in Australia and New Zealand. It is based on information provided by the Equal Opportunity Commission in Victoria, and the Anti-Discrimination Board in New South Wales, whose contributions are gratefully acknowledged.

Doctors involved in issues relating to HIV/AIDS should seek advice in relation to any of these issues.

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

HIGHLIGHTS FROM THE JUNE 1997 COUNCIL MEETINGS

EXAMINATIONS

Publication of Examiners' Reports

Council agreed that the reports of the previous two years' Examinations be published in the College restricted area on the Internet.

Examiners participation in Trial Vivas

Council resolved that once Examiners have been appointed to the Roster, they should not participate in trial vivas for that Examination.

FINANCE

Subscription Exemptions and Concessions

Regulation 7.1.2 was amended to read "Conditions under which remission or exemption of the annual subscription may be granted are as detailed below and set out on the subscription notice. Such concessions are granted under one only of the listed concessions.

- | | |
|--|------|
| 1. Fellows over the age of 70 years | 100% |
| 2. Fellows over the age of 65 years, but less than 70 years | 50% |
| 3. Fellows over the age of 60 years, but less than 65 years | 25% |
| 4. Fellows under the age of 65 years practising medicine but not practising anaesthesia, intensive care or related discipline | 50% |
| 5. Fellows not practising any form of medicine | 100% |
| 6. Fellows permanently resident outside Australia and New Zealand (see below for Council Policy) | 50% |
| 7. Fellows working in a missionary or similar field where the income is small | 100% |
| 8. Fellows engaged in full-time College funded or College approved research and undertaking no more than two clinical sessions per week | 50% |
| 9. Fellows undertaking two or less sessions per week over one full year in anaesthesia, intensive care or related disciplines, not practising any other form of medicine or related activity | 50% |
| 10. Fellows permanently outside Australia, New Zealand, Hong Kong, Singapore or Malaysia (after five years) | 75% |
| 11. Fellows temporarily overseas (after five years) | 50% |

**ANZCA COLLEGE COUNCIL POLICY CONCERNING
OVERSEAS CONCESSION SUBSCRIPTIONS**

- (a) (i) Fellows permanently resident outside Australia and New Zealand - 50% subscription
- (ii) Fellows permanently resident outside Australia, New Zealand, Hong Kong, Singapore and Malaysia may be eligible for a 75% concession after five years of permanent residency outside these countries.

RE: CONCESSION 6

- (b) Australasian Fellows temporarily overseas - full subscription. However, after a period of 5 years residence outside Australia and New Zealand these Fellows may apply to the Council for a 50% reduction in their annual subscription.

**CONTINUING
MEDICAL
EDUCATION**

Foundation Visitors' Regional Visits

In view of the increasing number of overseas speakers participating in Meetings in Australia throughout the year, Council has resolved to seek advice from Regional Committees as to whether they wish to continue with the current practice of Foundation Visitors going to two other Regions in addition to the ASM or whether it would be acceptable that each Foundation Visitor visits one other Region for perhaps four to five days.

Annual Scientific Meeting - Newcastle 1998

Eva Cox, Sociologist and Social Commentator, has agreed to deliver the Oration during the College Ceremony at this Meeting.

Annual Scientific Meeting - Adelaide 1999

Professor David Rowbotham, UK has accepted the invitation to be a Foundation Visitor to this meeting and will deliver the Ellis Gillespie Lecture.

Annual Scientific Meeting - Melbourne 2000

Council has agreed to combine the Annual Scientific Meeting in 2000 with the Royal Australasian College of Surgeons. The Venue for this Meeting is The Crown Towers.

Combined Scientific Meeting - Asia Pacific 2001

Council agreed to explore holding a Combined Scientific Meeting, in place of its Annual Scientific Meeting, with Asia Pacific Colleges and Academies in the year 2001.

Younger Fellows' Conference - Faculty Board Member in Residence

Council resolved that a Faculty Board Member participate in Younger Fellows' Conferences in the capacity of Board Member in Residence.

Maintenance of Standards Workshop

Council has resolved to mount a Workshop on Maintenance of Standards prior to the October 1997 Council Meeting.

Special Interest Group Satellite Meetings

Council supported Special Interest Groups holding Satellite Meetings prior to the ASM. Such Meetings to be restricted to a maximum of one day and be subject to early application to the Council for approval.

Special Interest Group - Welfare of Anaesthetists

Council established a Welfare of Anaesthetists Special Interest Group.

INTERNAL AFFAIRS

Victorian Chairs of Anaesthesia Appeal

On the recommendation of the Victorian Chairs of Anaesthesia Committee that the Appeal be wound up and distributed, Council approved the distribution of \$100,000 to Melbourne University and a further distribution of the balance of the funds of approximately \$160,000 to Monash University.

Mechanism for College Appeals

Council approved a reviewed College Appeals Process which also has been adopted by other Colleges.

College Headquarters

Council agreed to proceed with the development of architectural plans outlining the feasibility of expansion of Ulimaroa.

Asia Pacific Region

Council agreed to sponsor access to CME in Anaesthesia, Intensive Care and Pain Management in Australia and New Zealand. There was also agreement that the College should co-ordinate placement of Asia Pacific anaesthesia health professionals in Australasian Hospitals.

College Statement Relating to Relief of Pain and Suffering and End of Life Decisions

Council approved the attached Statement relating to Relief of Pain and Suffering and End of Life Decisions which is published in this Bulletin.

College Bulletin

Council has agreed to publish in the Bulletin edited Obituaries for past Fellows. It will be the responsibility of the Region to arrange for such information to be submitted to the College Registrar.

College Constitution Review

The Constitution Review Committee has been requested to prepare Recommendations for Council and the Fellowship on amendments to the Memorandum and Articles of Association related to matters raised between 1992 and 1997.

Views of Regional Committees will be sought at that time.

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
AND FACULTY OF INTENSIVE CARE

STATEMENT RELATING TO
THE RELIEF OF PAIN AND SUFFERING
AND END OF LIFE DECISIONS

In early 1996, the Solicitor for the Northern Territory sought advice from the College on "the most appropriate drugs and doses" to use for euthanasia. The College replied that Fellows had "no experience or expertise" in the use of drugs for this purpose. Some Councillors felt that this reply was not altogether correct or appropriate, and that no statement could have any bearing if the College had no position on euthanasia. Council hence resolved to examine a College position, so as to better respond to future media and public enquiries.

The views of Fellows and Regional Committees were invited (August 1996 *Bulletin*, page 20, and November 1996 *Bulletin*, page 53). Five Regional Committees expressed opinions which were varied and conflicting. Seven Fellows (from over 2,500 Fellows) replied individually, and offered opposing views. Some Fellows misunderstood the purpose of the initiative, and instead perceived the College as wanting to "play moral guardian". This was never the case. The matter of euthanasia has been thrust upon all of us, and was not raised *de novo* by Councillors. No Councillor ever attempted to impose personal beliefs on this matter.

The public identifies anaesthetists, intensivists, and pain experts as having relevance to, if not expertise in, euthanasia. Sooner or later, more enquiries on euthanasia will be directed to College Office Bearers, including Regional Committee members. Without an

official position, *ad hoc* replies will always be unsatisfactory and will continue to attract criticism. Unfocussed, varied, personal, and conflicting replies can only suggest a confused and disorganised professional group to the public, perhaps one which is unassertive and unable to grapple with difficult issues (surely a recipe for poor public image?). Any disinclination to comment, as pointed out by the Immediate Past Dean, Dr Geoff Clarke (March 1997 *Bulletin*, page 39), "leaves the public with feelings of great mistrust in the individual or the organisation". Instead, we should speak officially with one same professional message, which may or may not parallel our personal views.

The resulting College and Faculty statement – *Statement Relating to The Relief of Pain and Suffering and End of Life Decisions* - represents a corporate view that best serves our specialties. It is consistent with our Mission Statement and our high professional standards. It also respects the individual rights of patients and Fellows. Emphasis is placed on what we do best for the terminally ill and critically ill, i.e. supportive care and relief of pain and suffering. The term "euthanasia" means different acts and acts of omission to different people. As its use introduces uncertainty and confusion, the term is omitted from the Statement.

Teik Oh
9 July 1997

**AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS**

ACN 055 042 852

and

FACULTY OF INTENSIVE CARE

**STATEMENT RELATING TO THE
RELIEF OF PAIN AND SUFFERING
AND END OF LIFE DECISIONS**

1. ANZCA's Mission Statement is *"To serve the community by fostering safety and quality patient care in anaesthesia, intensive care and pain management"*.
2. ANZCA Council and the Board of Faculty support the concept of death with dignity and comfort, and the right of terminally ill patients to receive expert palliative care. They further support the provision of adequate pain relief and treatment of other symptoms to relieve suffering in the terminally ill, even though this may shorten the patient's life. Such relief of pain and suffering and not the death of the patient is the primary intent.
3. ANZCA Council and the Board of Faculty recognise that there are many patients with severe pain associated with non-terminal cancer, or with conditions other than cancer, who have to suffer for prolonged periods because of ineffective treatment of the underlying disease. They are further committed to the relief of pain and suffering in such patients in order to restore quality of life, and to minimise the risk of such patients seeking to end their life.
4. ANZCA Council and the Board of Faculty respect the right of mentally competent patients to decline treatment or to request treatment to be withdrawn, even if such treatment may be life saving.
5. ANZCA Council and the Board of Faculty do not support the institution or continuation of therapies which offer no benefit to the patient.
6. ANZCA Council and the Board of Faculty do not support the application of medical therapies in which the primary intent is to end the life of the patient.
7. ANZCA Council and the Board of Faculty respect the individual convictions of Fellows and their patients.

DR WILLIAM RUSS PUGH SESQUICENTENARY MEETING

LAUNCESTON
JUNE 6-8, 1997

This meeting saw the combined input of anaesthetists, surgeons, historians, artists and the general Launceston community to celebrate the 150th anniversary of William Russ Pugh's first surgical anaesthetic in Australia.

The meeting had the support and interest of all Tasmania with a civic reception at the Launceston Town Hall to start the proceedings following with the official opening by Sir Guy Green, Governor of Tasmania. The Pugh Oration was delivered by local psychiatrist, author and historian, Dr. Eric Ratcliff.

Saturday the 7th of June was the exact day that Pugh gave his famous anaesthetic and was marked by a wonderfully entertaining series of historical lectures by local, national and international identities. These included anaesthetists, surgeons and historians and reflected the widespread interest in these events outside of the anaesthetic community.

The highlight of the day was the unveiling of the sculpture of William Russ Pugh in Prince's Square and its presentation to the City of Launceston. This significant artwork was created by Melbourne sculptor Peter Corlett and captures wonderfully the period and style that Pugh lived in. He is represented walking down the steps into the park from his home "Nelumie" heading towards St. John's Hospital on the other side, heavy in thought and would undoubtedly have been more than a little apprehensive about what he was going to undertake.



What was also impressive about this meeting was the amount of involvement that had occurred within the local community. The Launceston Historical Society had organised local historical walks and a delightful composition of music - "Anaesthesia" - was commissioned and performed at the Opening Ceremony.

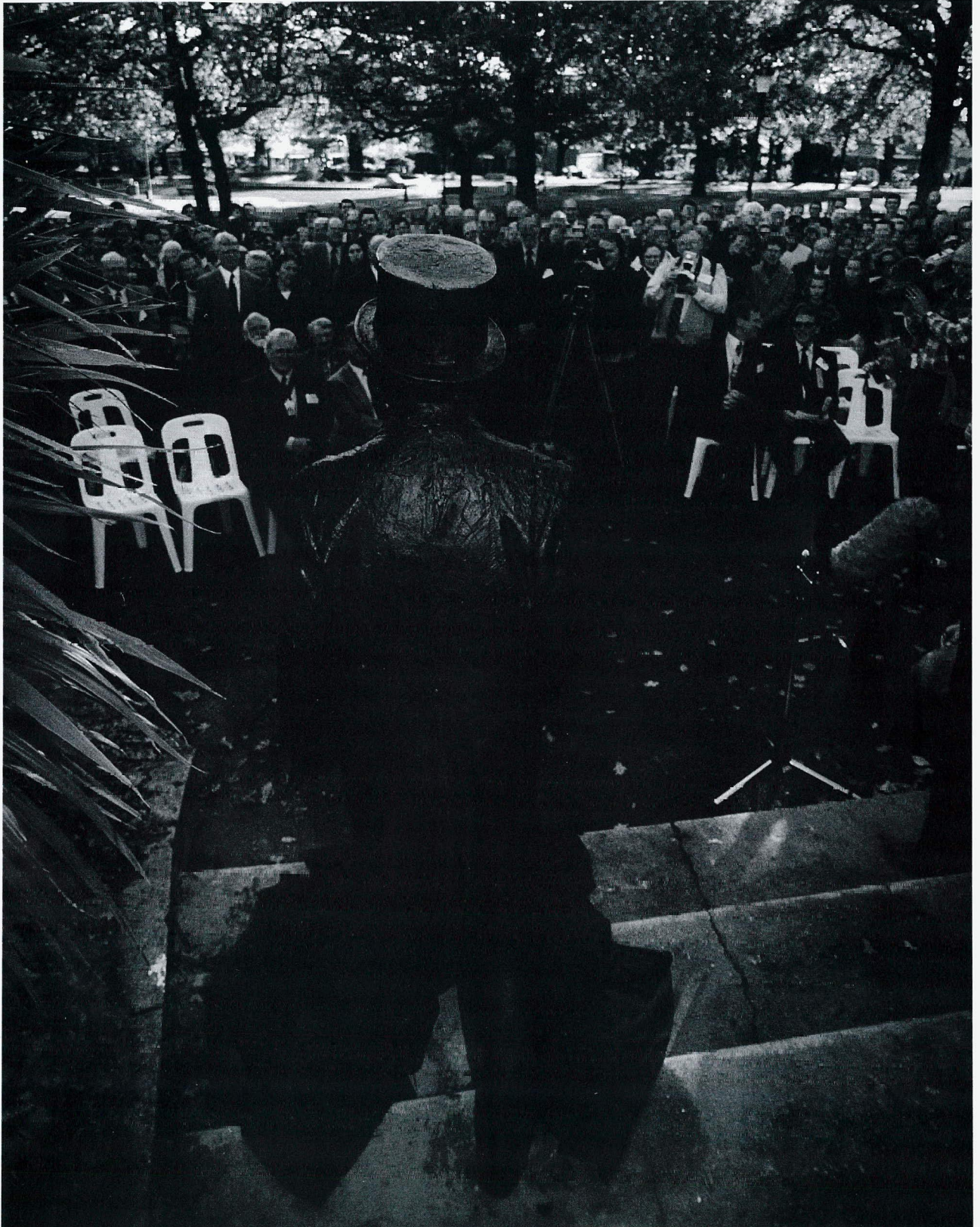
There was an excellent exhibition entitled "Ether Frolics" of early anaesthetic and surgical equipment and material relating to Pugh at Macquarie House. This was organised by curator Victoria Kimpton of the Queen Victoria Museum and Art Gallery, and even included equipment used by local high school chemistry classes who had actually distilled ether!

The Invited Speakers to the Meeting included Dr Gwen Wilson, MD, Professor Harold Ellis, CBE, Professor Barry Baker, Mr Donald Beard, AM, Mr Alan Scott, Dr Stefan Petrow and Mr Paul Richards.

Full credit for this wonderful weekend must go to the local anaesthetists and surgeons who organised it especially Simon Fraser, Stewart Bath, and also Pat Chilvers. Special mention must go to Phil Ogden who was the Overall Convenor and the driving force behind this historic event and the catalyst for the creation of the sculpture of William Russ Pugh.

This meeting did much to celebrate our origins and promoted anaesthesia and its heritage to the public.

MICHAEL COOPER
Hon. Historian



Reprinted with approval of The Examiner

ORATION

(edited)

delivered by DR. ERIC V.R. RATCLIFF, FRANZC,
during the Pugh Sesquicentenary Meeting,
Launceston, 1997

It is a very special privilege, and like all such privileges, a daunting task, to be asked to give the Oration in honour of Dr. William Russ Pugh on an occasion to mark the sesquicentenary of his first use of anaesthesia for a surgical operation in Australia, and probably the Southern Hemisphere.

Those of you who have read the brochure, or listened to the Chairman's introduction, may very well think that I would be more likely to be concerned with aesthetics than anaesthetics. This is not necessarily the case.

Despite the definition by an American colleague of a psychiatrist as 'a behavioural pseudoscientist on permanent vacation from medicine'⁽¹⁾, I would wish to acquaint you with a fact that is apparently not widely known - that every psychiatrist was once what some of my patients have called 'a proper doctor.'

As part of the preparation for this role, medical undergraduates at the University of Queensland Medical School (which still, in the 1960s, saw itself as the supplier of self-reliant doctors for the rural frontier) were required by the terms of the then Queensland Medical Act to have performed six supervised 'rag-and-bottle' ether anaesthetics, before being eligible for registration. This led to the curious survival of this venerable and primitive method of administering an anaesthetic within the otherwise rapidly sophisticating teaching hospitals of Brisbane.

My experience with the rag and bottle was later to prove invaluable in its application to an obsolete but effective psychiatric technique known as excitatory abreaction, where a patient half-etherised was enabled to relive the emotions of a terrifying event, and deal with them in safety. The technique made a virtue of the notorious difficulty of keeping anaesthesia deep enough with ether.

For those of you who are not medical, or too young to remember, a rag-and-bottle anaesthetic was carried out with a small bottle of ether with a rubber cork pierced

by two curved metal tubes of small calibre. The flow of ether through one was controlled by tilting the bottle as the ether was dripped on to the rag, a layered pad of gauze contained in a small metal cage shaped to fit over the patient's nose and mouth. This contrivance rejoiced in the name of Schimmelbusch's inhaler.

It appeared a far less sophisticated method than that used by Pugh in 1847.

Diethyl ether is funny stuff. It boils at only 35 degrees Celsius and vapourises readily at room temperature, evaporating so quickly as to act as an effective refrigerant, freezing the patient's exhaled water vapour into a frost. It produces a highly inflammable, indeed explosive, vapour that is heavier than air, and lurks in a miasmatic layer to a few inches above the floor, about the level of the power points, potential sources of a fatal spark.

Meditations of this kind were much in my mind many years ago when I assisted at an operation at the Toosey Hospital, Longford, where the anaesthetic was given by the late Dr. Howard Hill, one of the last exponents of the hot coil ether vapourising apparatus. This contraption, which had probably been with Howard on missionary duty in Manchuria before 1936, fizzed away merrily at the head end while the appendix came out from lower down, and all concerned survived.

Doctors are, on the whole, at least as fearful of falling into the hands of their colleagues as anyone else. For this and other reasons, they are particularly prone to demystifying each other by derogatory references to their various specialties. It would be improper on an august occasion such as this to regale you with any examples.

I will therefore refrain from telling a mixed audience that surgeons are described as doctors who have no faith in the *vis medicatrix naturae*, Nature's ability to heal, before the operation, and infinite faith in it afterwards.

I will avoid the riddle that asks, what is the difference between a physician and a surgeon? Answer: for a physician, most sins are sins of omission, for a surgeon, most sins are sins of commission.

Anaesthetists partake also of that dichotomy. With their knowledge of drugs and vital processes, they are essentially physicians, but by long and unavoidable association with surgeons, they are frequently led into sins of commission.

It should also not be divulged that within the medical profession, they are sometimes known affectionately as 'asphyxiologists', but more often as 'gas men' (and women). The latter appellation derives not only from their essential vapours, but also from the unmistakable resemblance of the familiar Boyle's apparatus in its usual form to an ancient gas stove on wheels of the type used by the Dreaded Batter Pudding Hurler of Bexhill-on-Sea.⁽²⁾

Invariably careful people, anaesthetists are critical of those they perceive as more casual. Nitrous oxide, 'laughing gas', is often associated in the public mind with dentistry. It comes in bright cobalt blue cylinders. An alleged ancient recipe for a dental procedure: give pure nitrous oxide until the patient matches the cylinder, then extract the tooth. This is unkind, in view of the crucial role that dentists have played in the early history of anaesthesia. It would seem that the ancient trade of surgery saw less need for anaesthesia than the new profession of dentistry.

The public face of medical humour owes much to Richard Gordon, himself an anaesthetist. We all recall his ferocious surgeon, Sir Lancelot Spratt (played in the cinema version of *Doctor at Large* by James Robertson Justice) berating the gas man who was flagging visibly as a result of a prior heavy evening, operating theatre boredom, and anaesthetic vapours - 'If this damned patient can stay awake during this operation, you can.'

Anaesthesia, like war, has been described as 90% boredom and 10% sheer terror.

In my resident days at Launceston General, I recall assisting at a very big operation, during the long reaches of which the then Director of Anaesthesia, Dr. Margaret Paterson was administering a tutorial to her registrar. She asked him what he would do in a certain emergency. He replied appropriately. And if that didn't work? He gave a satisfactory answer again. And if that

didn't work? Silence. And then from the surgeon, Mr. David Huish, "Get everyone who isn't scrubbed down on their knees facing towards Mecca."

Like all gallows humour, this fun conceals fear, and the fear is the fear of pain, and of death. Anaesthesia is about the conquest of pain, but even more, it is about the conquest of the fear of pain. It is this that has enabled the marvels of modern surgery.

As a result, the coming of surgical anaesthesia can be said to mark the beginning of what I shall call The Demand for Miracles, and its inevitable corollary, The Abolition of Hard Luck.⁽³⁾

Many of us have given a passing thought to what life might have been like before anaesthesia. We have looked with childish horror and fascination at pictures of amputations in progress, and tried to imagine what it must have felt like.

C. S. Lewis, in the Introductory chapter of his book *The Problem of Pain*⁽⁴⁾, asks his readers to, "Lay down this book and reflect for five minutes on the fact that all the great religions were first preached, and long practiced, in a world without chloroform." (He was writing in 1940.)

In his extended meditation on one of the most pressing of all theological questions, Lewis gives us a hint about the extreme importance in human affairs of the innovation that we celebrate today.

Few pictures of sufferings in that world between the dawn of surgery and the coming of modern anaesthesia are more vivid than Madame d'Arblay's account of her mastectomy in Paris on 30th. September, 1811.

Fanny d'Arblay (1752-1840) was the daughter of the 18th Century musicologist, Dr. Charles Burney, and a brilliant younger member of the circle of the great Dr. Samuel Johnson. She wrote three celebrated novels, and kept a diary from the age of fifteen to her death, posthumously published as *Diary and Letters 1778-1840*. She married General d'Arblay, a refugee from revolutionary France in 1793, and lived near Paris from 1802 to 1812. In 1810, she was found to have cancer of the breast, and almost eleven months after the first symptoms, Napoleon's personal surgeon agreed to operate. The experience she describes in the vivid epistolary account she wrote about six months after the operation can be taken to be 'state of the art' in the years before William Thomas Green Morton, Robert Liston, James Young Simpson, and William Russ Pugh.

Fanny Burney, Madame d'Arblay, was one of those people who, if they were to be hanged, would be found examining the knot with interest.

Her operation was performed by Baron Larrey with only a few hours notice to the patient. The day of the procedure had been withheld from her, so as to minimise anticipatory fear and distress. (I wonder if our public waiting lists with their long waits and sudden summonses to hospital have a similar function. I tend to doubt it.)

She describes how she concerned herself for the welfare of her husband and son, how she busied herself to control her dread, the coming of the dread doctors, and the premedication:

"... the Cabriolets - one - two - three - four - succeeded rapidly to each other in stopping at the door. Dr Moreau instantly entered my room, to see if it were alive. He gave me a wine cordial, and went to the Salon. I rang for my Maid and Nurses, - but before I could speak to them, my room, without previous message, was entered by seven Men in black, Dr. Larry, M. Dubois, Dr Moreau, Dr Aumont, Dr Ribe, and a pupil of Dr Larry, and another of M. Dubois. I was now awakened from my stupor...."⁽⁵⁾

Then came the immediate preparations, the moving of the bed into the middle of the room, the calling for 'two old mattresses' and an old sheet.

'I now began to tremble violently... more with distaste and horror of the preparations even than of the pain... I stood suspended, for a moment, whether I should not abruptly escape - I looked at the door, the windows, - I felt desperate - but it was only for a moment... My distress was, I suppose, apparent, ... for M. Dubois himself now softened, and spoke soothingly....

No one else attempted to speak, but I was softened myself, when I saw even M. Dubois grow agitated, while Dr Larry kept always aloof, yet a glance showed me he was as pale as ashes.

I mounted, therefore, unbidden, the Bedstead - and M. Dubois placed me upon the mattress, and spread a cambric handkerchief upon my face. It was transparent, and I saw through it, that the bed was instantly surrounded by the seven men and my nurse. I refused to be held; but when, right through the cambric, I saw the glitter of polished steel - I closed my eyes.'

She opened them again to see the surgeon silently indicating the broad area of the intended incision. She was moved to protest that the pain was more localised, but then submitted:

'... this resolution once taken, was firmly adhered to, in defiance of a terror that surpasses all description, and the most torturing pain....

I began a scream that lasted unintermittently during the whole time of the incision - and I almost marvel that it rings not in my ears still!

She goes on to describe the incision, the cutting of the flesh, then the scraping down to the breast bone, the decision that more needed to be done. We shall draw a veil over her description. She did not.

'To conclude, the evil was so profound, the case so delicate, and the precautions so necessary for preventing a return so numerous, that the operation, including the treatment and the dressing, lasted 20 minutes!..... Twice, I believe, I fainted; at least, I have two total chasms in my memory of this transaction, that impede my tying together what passed.'⁽⁵⁾

Fanny d'Arblay, having endured the best treatment that Europe could provide, survived the operation for nearly 29 years, living on into the decade of the discovery of surgical anaesthesia.

THE PLACE OF WILLIAM RUSS PUGH

When Launceston in Tasmania celebrates that event that took place at St. John's Hospital and Self-Supporting Dispensary one hundred and fifty years ago tomorrow, it is not merely a case of 'Local Man Makes Rivet for Moon Landing Vehicle.' It is our link with the heroic age of medicine, forged by a courageous innovator who, eight months after the first main stream surgical use of ether for anaesthesia in the world, overcame all problems of distance, professional isolation, and supply, to introduce it to the ordinary public of what was still a remote penal colony.

People from that bourne that Tasmanians call the Mainland often ask, why did it happen here ?

We meet tonight in a provincial city of a provincial state of what is arguably the most provincial nation on Earth. That was not its aspiration in 1847.

In that year, this island was still Van Diemen's Land, and still a colony whose chief purpose was to be a receptacle for the convicted criminals of the United Kingdom of Great Britain and Ireland. Despite this, free settlement had spread rapidly, commerce had developed accordingly, and despite the apparent luxury of convict labour, a vigorous movement to attain the abolition of transportation and responsible self-government had arisen.

These movements were perceptibly stronger in the self-reliant rural and commercial northern settlement than they were in Hobart Town, a place then, as now, much more clearly dependent on being the seat of Government and administration.

Launceston, the main centre of the third oldest settlement in the Australian colonies, begun in 1804, was a well-developed town by 1847. The settlement at Port Philip across the Strait, which local entrepreneurs had been instrumental in founding and nurturing, and which has since achieved some success, was only a decade old. Launceston merchants still expected that Launceston would become the great entrepot trading centre of the Bass Strait region, with its exports of timber, wool and grain, and the products of whaling and sealing.

It was a place where an enterprising young doctor might expect to develop a vigorous practice without undue intellectual isolation, and with all the urban amenities to be expected of a provincial English town.

Anti-transportationists and others had been in the habit of calling our island 'Tasmania' at least since the 1830s. (Lady Franklin's diaries record it as a familiar fact.) A precursor of the Royal Society of Tasmania, predominantly a scientific body, had been called the Tasmanian Society, possibly less out of nascent patriotism than because it sounded a little like the august name of the Linnean Society.

Natural philosophy, what we now call science, was a prominent interest among the educated men of Launceston. One of the notable Independent divines of this town, for example, demonstrated scientific experiments in early essays in adult education.

Launceston had, either in an instrument-maker or in Pugh himself, the necessary skill to make the apparatus for administering ether, and it is believed that Pugh made his own ether by the process of heating a mixture

of ethyl alcohol and concentrated sulphuric acid (alcohol and oil of vitriol) in an oil bath, then removing from the distillate surplus acid by neutralisation with sodium carbonate, alcohol and water with calcium chloride.⁽⁶⁾

Pugh was no stranger to the perils of experimentation with heat and volatile vapours. Our pioneering 'gas man' was in every sense just that, having lit his own house, 'Nelumie' (still standing as the home of Launceston Pathology) with coal gas of his own making in the early 1840s.

This is not the time for minor historical controversy. However, in one of his historical articles⁽⁷⁾, the late Sir William Crowther asserts that Pugh's apparatus, and the ether, were sent to him by Bishop Nixon in England, one of two sets of which the other was sent to Dr. Bedford in Hobart Town. He thus gives the Bishop of Tasmania the credit for our priority in anaesthesia in the Southern Hemisphere. The comment is his interpretation of the report in the *Hobart Town Courier* of September 8th., 1847. In a later pamphlet⁽⁸⁾, Crowther goes some way to correcting this impression, indicating that Pugh had lost confidence in ether, and regained it only after the receipt of the gift from Nixon. The *Launceston Examiner* report two days after those first operations clearly states, that 'Dr. Pugh had constructed apparatus similar to that figured in the *Illustrated London News*.' It is that 'had' that is ambiguous.⁽⁹⁾

In essence, what we had in Launceston in 1847 was a heady mixture, an aspiring, rapidly developing, enterprising town, with resources of skill and material that would have been rare in the Southern Hemisphere at the time, and an innovative, enthusiastic and humane professional man, who read the *Illustrated London News*, William Russ Pugh.

I have long believed that there is a great warehouse somewhere in which magazines are cellared for some years to put age on them before being supplied to doctors. For most of a century, and more, the *I.L.N.* was an essential part of all the better class of waiting rooms. One wonders if that was the fate of the copy that became the source of Dr. Pugh's well-merited fame.

For the details of his education, character, emigration, work, and subsequent career, I will defer to the expert who knows more about Pugh than anyone else, Dr. Gwen Wilson, who will speak on his life and work tomorrow morning.

This evening, I will attempt to place Pugh in his niche in history. The medical members of the audience will forgive a brief recapitulation of the familiar, and may doze briefly.

The coming of momentous discoveries often follows a shadowy prehistory. When a discoverer or inventor goes public, there are always others who will say, 'I thought of that ten years ago.' Disagreements about priority bedevil the history of anaesthesia as much as any field of discovery.

Outside of the laboratory, ether started its career in human affairs as a recreational intoxicant. Having had some experience of this, one Crawford Williamson Long, a young medical man practising in Jefferson, Georgia, decided in 1842 to try it as a surgical anaesthetic. He persuaded a patient, James Venable, to have two small swellings removed from the back of his neck under the influence of ether, by reducing the fee for the operation to 25c. He charged \$2 for the ether. He probably continued to use ether in his practice until dissuaded by mistrustful public rumour, and he neglected to publish his claim until 1849.⁽¹⁰⁾

In 1844, Horace Wells, a dentist of Hartford, Connecticut, noticed that nitrous oxide, 'laughing gas', produced not only intoxication but analgesia when used for an amusing public display in which one of the participants 'barked his shin', as we would say in Tasmania. He introduced the gas to his dental practice with varying success, and then went into partnership in Boston with another dentist, William Thomas Green Morton. A joint demonstration of nitrous oxide anaesthesia in 1845 proved a public failure, but Morton went on to experiment with sulphuric ether, possibly on the advice of the chemist, Charles Thomas Jackson.

In October, 1846, at the Massachusetts General Hospital, Morton acted as anaesthetist for a surgeon, Dr. John Warren, during the removal of a tumour of the jaw. Ether was the anaesthetic agent, and the apparatus used was diagrammatically illustrated in the *I.L.N.*

Surprisingly, the method was slow to be accepted in the United States, but more enthusiastically applied in Europe. Ether was in dental use in London before Robert Liston at the North London Hospital amputated a leg on 21st. December, 1846 after announcing,

'Gentlemen, today we are going to try a Yankee dodge for making people insensible.'

Less than six months later, ether was used for a dental procedure in Sydney, and then, on June 7th., 1847, William Russ Pugh used it for two surgical procedures in Launceston. The first of these was a tumour of the lower jaw, and the second, a pair of cataracts. He was assisted by a Dr. William Benson, and the Editor of the *Launceston Examiner*, James Aikenhead, was present as a witness. The *Examiner* in those days published not daily but twice a week, so Aikenhead's account of the proceedings appeared two days later. On the opposite page was reprinted an article from *The Lancet* about recent use of ether in London.⁽⁹⁾

Nine days after Pugh's operations, on June 16th., Dr William Guybon Atherstone used ether at Grahamstown in the Cape Colony, South Africa for an amputation through the lower third of the thigh. He used what he described as 'a simple contrivance somewhat resembling the Turkish narghili or hubble-bubble in principle'.⁽¹¹⁾

No related claims have come from New Zealand or South America, so William Pugh seems safe in the claim of priority for the Southern Hemisphere.

In November of 1847, James Young Simpson of Edinburgh experimented on himself with chloroform. He used it in his obstetrical practice against claims that it interfered with divine prerogatives. Eve, following the Fall, had according to *Genesis (ch.3, v.16)* been told, *inter alia*, 'In sorrow thou shalt bring forth children.' Simpson countered this with *Genesis (ch.2, v.21)*:

'And the Lord God caused a deep sleep to fall upon Adam, and he slept: and he took one of his ribs, and closed up the flesh instead thereof.'⁽¹²⁾

Even by Bishop Usher's conservative dating, that is a priority hard to contradict, both for a rib resection and an anaesthetic, and even though the publication occurred long after the event!

Simpson became accoucheur to Queen Victoria, and all opposition collapsed when the Queen gave birth to Prince Leopold under chloroform in 1853.

The heroic age was over.

PUGH AND THE ABOLITION OF HARD LUCK

There is a major sense in which Pugh, along with the other pioneers of surgical analgesia and anaesthesia,

was part of the 'Abolition of Hard Luck'⁽³⁾. Their motives were chiefly the Relief of Suffering, a humane motive, full of loving kindness and tender mercy. They were not about cost-effectiveness. Even today, our governments and administrators who know the cost of everything and the value of nothing might find surgery without anaesthesia to be much cheaper. Rum is cheaper than ketamine or isoflurane, and without the meditative approach to an operation that such agents as these make possible, the surgeons would have to work faster, thus minimising both shock and theatre time. The higher death rate from such a policy would meet the Scroogian wish to decrease the surplus population.

Innovation in the relief of suffering is like all other innovation - a scalpel with two edges. It widens human possibilities, and creates new demands and expectations. Since Pugh's time we have moved from the expectation that the doctor will 'do what he can' to the expectation that there must be a miracle available for all conceivable circumstances. And if there is no miracle, somebody has to pay.

The Heroic Age in medicine has been succeeded by the Triumphal Age, where all seems possible. We have, I understand, colleagues who believe that it is a reasonable ambition for medical science to abolish aging and even death itself.

Our profession has become the victim of its own success. As greater and greater costs are incurred in producing advances which, if not marginal, are never likely to be available to the majority of people who need them, we are met with a rising public demand and a declining capacity to deliver.

Politically, this demand by the electorate is met with attempts to reorganise the profession from without, and to control costs in ways that intrude on clinical judgment.

We can already achieve individual results at a cost that no community will ever be able to afford. It is worth remembering that Pugh's procedure occurred in a charitable institution, funded by subscriptions and donations, not a five star private clinical technopark. It was to be for the many, and most of its posterity has benefited the many.

The increasing public perception that technical advances have brought new problems, economic, environmental, and ethical, has bred a widespread

cynicism, a generalised mistrust that embraces medical advances. I detect in our patients a clear ambivalence, a continuing hope that the needed miracle can be produced, and a deep suspicion of the means of its production.

It is my belief that one of the major milestones along the path to the Age of Mistrust occurred in my medical lifetime with the coming of the Pill. For the first time, there was a commodity that had to be controlled by doctors but which the public felt entitled to demand. Before the Pill, patients were entitled to our best advice and efforts in their interest. Since the Pill, they have inexorably tended towards becoming customers instead of patients, and we have commensurately become service providers in place of healers. There have come to be a range of what I will call Consumer Electives, for example, cosmetic procedures for those in search of a fashionable 'perfection' rather than the relief of gross deformity, and arguably some aspects of reproductive technology. We have lost some of the mystique of a learned healer and replaced it with some of the aura of a shopkeeper. It is not surprising that, in search of magic, the former patients have begun to turn to other healers who still present to them as such.

Others have tried to educate themselves so that they can share clinical decisions with their doctors. Unfortunately, most of them have not spent six or more years learning the healing arts, nor have the majority the type of education that can enable them to make a judgment between the competing claims of 'orthodox' scientifically-based medicine and the multiplicity of doctrines from megavitamins to snake oil that feed on, and feed the anxiety of the community about personal health.

As students, we relished that celebrated sally by George Bernard Shaw,

'All professions are conspiracies against the laity.'⁽¹³⁾

We have usurped the position of priests, and have inherited an anticlerical movement. We may no longer conspire in peace, even for the most benign of purposes. We have never been more 'accountable', and there is an incessant demand for more accountability.

Where would Dr. William Russ Pugh stand today?

Would the Ethics Committee of the St John's Hospital and Self-Supporting Dispensary regard his procedure as risky and unproven?

Would a paper in *The Lancet* and an article in the *Illustrated London News* be sufficient documentation to institute a clinical trial?

Would he be bound by protocols demanding the continuous monitoring of the patients' blood gases and serum rare earths during the procedure?

What would his medical defence organisation say to him?

Pugh belonged to a different time. It was not the infancy of scientific medicine, but the end of the Enlightenment, a time when the obvious was obvious to a thoughtful observer, and did not need a cloak of flawless algebra.

Despite the advances that are constantly being made, the news media daily crying 'breakthrough', we move more deliberately nowadays. We advance by plodding research costing vast sums of money, and not often by the serendipity of a Wells noticing that laughing gas dulled pain, or even that of a Fleming noticing that bacteria would not grow where a mould had formed.

As always, advances in medicine can only be brought to the individual patient by human practitioners, people prepared to constantly relearn their skills, to question and update their knowledge, to change and to grow, to

observe and report, to learn what is known and to innovate when nothing can be known.

Since Pugh's time, Launceston has had its share of these. Sir John Ramsay is remembered for his successful cardiac resuscitation 'by means of compression of the heart through an epigastric incision' in 1906⁽¹⁴⁾, and later for an attempt to treat diabetes mellitus by pancreatic transplant. His son, Hugh, became an anaesthetist in Launceston.

William Woodward is remembered for treating cardiac arrest under anaesthesia by 'filling the heart by expelling blood from the limbs'⁽¹⁵⁾, and also for an unsung open cardiac resuscitation of a drowned child.

Dr. Keverall McIntyre, an obstetrician, is remembered for applying his engineering expertise to the production of a tiny Drinker respirator to overcome the malignant effects on the neonate of a diabolical hyoscine compound called 'twilight sleep', used to relieve the pains of labour. His contraption saved my life, among many others.

These, and others now practising, many of them my honoured mentors, and happily, many of them here on this occasion, are the inheritors of the Heroic Age, and of Dr. William Russ Pugh.

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YOUNGER FELLOWS CONFERENCE

AKAROA – May 1997

27 May 1997

Dear Professor Phillips,

I would like to thank you, and the College Council for the recent opportunity to attend the Christchurch annual A.N.Z.C.A. scientific meeting. As a new Fellow I appreciated the College Ceremony on the Saturday evening, and was glad to be part of the formal proceedings. My parents, who happen to be natives of Christchurch, were especially proud to see their son in such esteemed company.

The present college policy of involving new Fellows at such occasions is to be heartily congratulated. The road to this point for most is often not without its cost in terms of family, social and personal sacrifice and the ceremonial acknowledgement of this is certainly a watershed in terms of leaving the training years behind and looking forward to a productive future as a specialist anaesthetist.

Thank you for your financial support for myself and others, thus enabling our registration at the accompanying scientific meeting. Overall it was a wonderful week, and I would thoroughly recommend that all embryonic Fellows take the opportunity to be involved in such future presentations.

Kind regards

Nigel Skjellerup

AUSTRALIAN DAY SURGERY COUNCIL

DAY SURGERY DEFINITIONS

The Council, at a meeting in October 1996, unanimously supported the concept of extended recovery for day surgery patients, and it was considered essential that all facets of day surgery practice be defined. At a further meeting of Council, February 1997, the following Day Surgery Definitions were identified.

- **Office or Outpatient Surgery / Procedure**
An operation/procedure carried out in a medical practitioner's office or outpatient department, other than a service normally included in an attendance (consultation), which does not require treatment or observation in a day surgery/procedure centre (facility) or unit, or as a hospital inpatient.
- **Day Surgery / Procedure**
An operation/procedure, excluding an office or outpatient operation/procedure, where the patient would normally be discharged on the same day.
- **Day Surgery / Procedure Patient**
A patient having an operation/procedure, excluding an office or outpatient operation/procedure, who is admitted and discharged on the same day.
- **Day Surgery Centre (Facility)**
A registered centre (facility) designed for the optimum management of a day surgery/procedure patient.
- **Day Surgery / Procedure – Extended Recovery Patient**
A patient treated in a registered day surgery/procedure centre (facility) or unit, free standing or hospital based, who requires extended recovery including overnight stay, before discharge.
- **Extended Day Surgery / Procedure Recovery Centre / Unit**
Purpose constructed/modified patient accommodation, free standing or within a registered day surgery centre (facility) or hospital, specifically designed for the extended recovery of day surgery/procedure patients, and registered with Commonwealth/State Governments for this purpose.
- **Limited Care Accommodation**
Hotel/hostel accommodation for day surgery/procedure patients where professional health care is available on a call basis.
- **Hotel / Hostel Accommodation**
Accommodation for day surgery/procedure patients without professional health care, when required for domestic, social or travel reasons.

Honours and Appointments

Associate Professor Neville J Davis, WA – Member of the Order of Australia (AM)
 Dr Stephen P Gatt, NSW – Medal of the Order of Australia (OAM)
 Dr Ronald V Trubuhovich, NZ – Officer of the New Zealand Order of Merit (ONZM)
 Associate Professor Vic I Callanan, Qld – Australia Day Medallion
 Professor Garry D Phillips, SA – Elected Fellow, Hong Kong College of Anaesthesiologists
 Dr Judith A Williams, NSW – Elected Roll of Fellows, Australian Medical Association

ADMISSION TO FELLOWSHIP BY EXAMINATION

John Raymond AWAD, NSW
 Tsong Huey (Sophia) CHEW, Singapore
 Mark Ewan COLSON, Vic
 Rodger John FITZGERALD, NZ
 Anne FRANKL, Vic
 Murray Lennard HARTY, NZ
 Betty Pik-Yee HO, Hong Kong
 Beverley Suzanne JAN, NSW

Teik Hooi KHOO, Malaysia
 Adam PURDON, NSW
 Christopher Matthew RYAN, NSW
 Andrew Julian SILVERS, Vic
 Ka Lok Tommy SUEN, Hong Kong
 Ian Richard WILLIAMS, WA
 Ho-Shan Steven WONG, Hong Kong
 David Wayne WRATHALL, WA

DEATH OF FELLOWS

Dr Janie Una Blacker, NSW – FFARACS 1953, FANZCA 1992
 Dr Peter Lawrence Hann, NSW – FANZCA 1994
 Dr Donald John Taylor, Vic – FFARACS 1961, FANZCA 1992

Award of Certificate in Pain Management

The following Fellows have completed the requirements and were awarded the Certificate in Pain Management:

Dr Chris Hayes, NSW
 Dr Gillian Lamacraft, NSW
 Dr Lindy Roberts, WA
 Dr Bronwyn Williams, Qld

EXAMINATION PRIZE WINNERS

The Renton Prize for the period ending 30th June 1997 was awarded to Dr Stephen Gibson of New South Wales.

The Cecil Gray Prize for the period ending 30th June 1997 was awarded to Dr John Torrance of Wellington, New Zealand.

WELFARE OF ANAESTHETISTS GROUP SEMINAR REPORT

SURVIVING YOUR ANAESTHETIC TRAINING AND BEYOND

Sydney Children's Hospital NSW
16th November 1996

This meeting was organised by Dr Genevieve Goulding and Dr Matthew Swann on behalf of the ASA NSW Section and the NSW Regional Committee of ANZCA. It was aimed specifically at new anaesthetic trainees and their partners. There were over a hundred registrants, two-thirds of them trainees and partners.

The meeting was to have been opened by the late Dr John Matheson, whose interest in welfare issues equalled his enthusiasm for improving the status of anaesthetists in the eyes of our colleagues and the public. His place was ably taken at short notice by Professor Geoff Cutfield.

After the introduction, the first speaker, Dr Richard Walsh, talked about the various organisations (ASA, ANZCA and the AMA) influencing professional work patterns on behalf of anaesthetists.

He was followed by Assoc Prof. Peter Klineberg, who gave an overview of training and educational matters pertaining to FANZCA and FFICANZCA. Dr Ajay Kumar, a third year trainee, then spoke of his work and the stresses associated with it.

The second part of the morning began with a talk from Dr Murray Wright on "The Medical Personality". Dr Greg Purcell spoke on stresses specific to anaesthetists, including the high suicide levels.

Dr Kay Wilhelm, a psychiatrist involved with the DHAS and the NSW Medical Board, discussed the high incidence of depressive illness in doctors, and matters related to its recognition and treatment.

Dr Matthew Swann then spoke on chemical dependence, as an introduction to the video "Wearing Masks". Discussion ranged widely following this session; it seems that statistical analysis of population data suggests

anaesthetists might not have a higher incidence of suicide than an age-matched medical population.

The long afternoon session commenced with a number of anaesthetists giving their personal perspective on various problems – including depression, leaving the profession during training, marital breakdown and divorce, and the stress of dealing with a medico-legal problem.

Dr Di Khursandi spoke about the Welfare of Anaesthetists Group, after which Professor Barry Baker gave a talk on the pros and cons of the Mentor system for trainees.

The next presentation was "Life outside the OR" – on the maintenance of relationships – by Ms Elisabeth Shaw, from Relationship Australia. Finally Dr Patsy Tremayne, a psychologist, spoke on stress management.

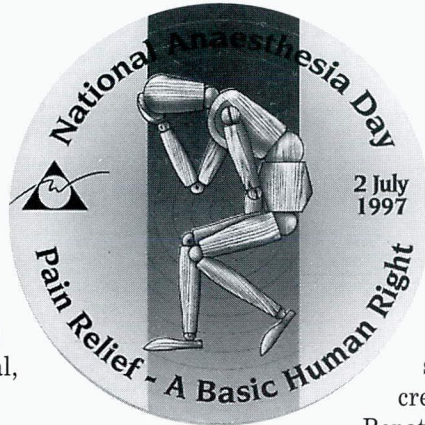
The day-long programme was an extremely valuable pilot project in the education of trainees in addressing their own welfare; the programme could be used as a model for the presentation of such topics to trainees in other centres.

There could be more opportunity for trainee and partner participation, perhaps by use of small group discussion periods. One topic which could be added to such a seminar is the identification of resources of potential value to trainees.

A vote of thanks must to Drs Goulding and Swann for their initiative, hard work and enthusiasm in organising this seminar. Other centres please copy!

JOHN GIBBS

NATIONAL ANAESTHESIA DAY 1997



Generous praise for the work of anaesthetists from the Federal Minister for Health and Family Services, the Hon. Michael Wooldridge, was a highlight of National Anaesthesia Day on 2 July.

The Minister launched the National Day at St. Vincent's Hospital, Melbourne.

Dr. Wooldridge noted the "many outstanding achievements" in anaesthesia "over a short period of time."

He strongly supported the newly developing field of multi-disciplinary pain management and the purpose of National Anaesthesia Day in helping people with pain "to know about the benefits of the revolution in the practice of anaesthetics."

Dr. Wooldridge announced a Federal Government contribution of \$250,000 towards the establishment of a pain management centre at St. Vincent's in Melbourne.

Response to the National Day from anaesthetists around Australia and New Zealand was strong.

More than 350 information kits were issued by the College this year, compared with just over 200 in 1996.

The kits contained a set of posters on the theme for the Day: Pain Relief - A Basic Human Right, supplies of a leaflet on pain management, a Pain Fact Sheet, National Day stickers (provided by the Australian Society of Anaesthetists), and an advisory package on getting into the media.

To mark the National Day, the Department of Anaesthesia and Pain Management at Sydney's Royal North Shore Hospital launched a public information website, developed by specialists there.

It features interactive programmes on postoperative pain, pain in childbirth and chronic and cancer pain.

In Hobart, the State Minister for Community and Health

Services, the Hon. Peter McKay, visited the Anaesthesia Department at the Royal Hobart Hospital, and announced \$1.25 million upgrade of the hospital's anaesthesia equipment.

Another example of the hospital support for the Day was the programme created by Melbourne's Austin and Repatriation Medical Centre.

There were internal displays at the hospital's two campuses, displays at three local libraries and two major RSL venues, including the League's State Conference.

As well, the hospital sent information packs to schools, and arranged for local secondary college students to spend a morning at the Medical Centre with an anaesthetist.

Initial reports indicate that good media coverage was obtained in a number of centres.

To better assess how the Day was celebrated, the College will again distribute a questionnaire to all recipients of National Day kits.

Information from these questionnaires helps in assessing the impact achieved, in planning the next National Anaesthesia Day, and deciding what support the College is best able to give.

Input on the contents of the kits, and how they were used, is particularly valuable.

The leaflet distributed this year was produced for on-going use, and not just for National Anaesthesia Day.

The leaflet can be handed to patients and relatives wherever relevant. Additional supplies can be obtained from the College.

National Anaesthesia Day in 1998 will focus on the role of anaesthetists in life support.

EDDIE DEAN, Communications Consultant

**FEDERAL MINISTER FOR HEALTH AND FAMILY SERVICES
HON DR MICHAEL WOOLDRIDGE MP**

LAUNCH OF NATIONAL ANAESTHESIA DAY

MELBOURNE – 2 JULY 1997

Excerpts from Speech

It is hard to image a more vital part of health care than the management of pain and even harder to over-estimate the importance of National Anaesthesia Day.

Right now, perhaps within metres of this room, a newborn child will be delivered, their mother spared the worst of labour with a simple epidural.

Perhaps just a floor away, someone will be dying with dignity, freed from the agonies of pain that can stretch and break the human spirit. Thanks to high standards of palliative care, they can now be provided with advances such as patient-controlled analgesia and the development of improved drugs such as midazolam and the newer non-steroidal anti-inflammatory agents.

Yet, despite these advances, millions of Australians live with the hidden burden of pain. Arthritis affects almost 1.8 million Australians; one million people experience acute pain in post-operative care; each year 75 million work-days are lost due to pain.

Pain affects people and, by Professor Michael Cousins' own estimate, costs our community almost \$15 billion.

National Anaesthesia Day, therefore, is important because those burdened with pain need to know about the benefits of the revolution in the practice of anaesthetics.

And it reminds us that much more needs to be done to lessen the burden of pain in our community.



In medicine, the best solutions don't have to be the most expensive or the most technically complex. I particularly welcome the pivotal role of the Australian and New Zealand College of Anaesthetists in encouraging evidence-based practice in pain management - in setting standards, and in communicating these standards to members, to health professionals in all fields, and to the general public.

I am pleased, too, that the College includes pain management as a major area of experience for all specialty trainees and that in 1996, the College initiated a

Certificate in Pain Management, based upon a post-qualification year of experience in an approved multidisciplinary pain centre which manages acute, chronic and cancer pain.

I am now pleased to be able to say that the College has decided to go a step further and introduce a Diploma in Pain Management which will commence in 1999. This is currently being finalised and a curriculum is now being developed.

This is an important step as it will significantly raise the profile of pain management, not just for anaesthetists but for other doctors, nurses and allied health workers. It is also an important step for the College and the role of Australian medicine in New Zealand and South East Asia where there has been strong interest from a number of countries.

I congratulate the College for taking the step of introducing the Diploma in Pain Management.

I also welcome the development of the work of the multidisciplinary pain clinics now developing across Australia. Recently I visited the Pain Centre at Royal North Shore Hospital and was impressed by the results that they had been able to achieve - in some cases nothing short of miraculous.

In the past, if you visited a surgeon to manage your pain, you got an operation; if you visited a physician you got a drug; and if your condition was eventually deemed to be all in your head you were sent to a psychiatrist for counselling. The principle behind multidisciplinary teams recognises that in many cases this piecemeal approach is unlikely to be successful, and brings together a range of health professionals to offer a holistic care focussed on the patient and not just an organ or limb.

New pain centre opening in St Vincent's Hospital

In fact, I am pleased to be able to say that another centre will soon be opening here in St Vincent's Hospital, based on the highly successful model established by Professor Michael Cousins at the Royal North Shore Hospital in Sydney. I am delighted to

announce that the Commonwealth Government will be contributing \$250,000 towards the establishment of this new unit. This is a great opportunity for people in Melbourne who will be able to benefit from the multi-disciplinary services offered in such a centre.

This multidisciplinary approach provides a good model for the provision of all health care services. Indeed, multidisciplinary teams are proving successful in a number of other areas as well, including mental health, aged care and palliative care.

I would now like to launch officially National Anaesthesia Day. The discipline of Anaesthesia has indeed come a long way from the days of people being offered a chloroform-soaked rag or a bottle of rum prior to surgery. There have been many outstanding achievements in this area over a very short period of time, so that anaesthetics is well-established as a specialty in its own right from which we all benefit. I am sure that the theme of this day, that 'pain relief is a basic human right' is one which will bring hope to all those in our community afflicted with pain.

I am pleased to launch "National Anaesthesia Day" and to lend by voice to this message.



Professor Michael Cousins (Chairman, Anaesthesia and Pain Management, Royal North Shore Hospital, NSW), Dr Michael Wooldridge, Dr Michael Davies (Director of Anaesthesia) and Dr Clive Wellington (Executive Director - St Vincent's Hospital).

Dr Michael Wooldridge spoke with Ms Carolyn Blyth and former St Vincent's Hospital patients Mrs Ann Latchford and Mr Leonard Brayley and Dr David Scott.

COURT OF PRIMARY EXAMINERS

APRIL 1997



Front Row (left to right)

Drs Ted McArdle, Malcolm Futter, Gillian Bishop, Matthew Crawford, Mark Langley

Back Row (left to right)

Drs Jim Bradley, Bob Wong, Rob Eyres, Noel Roberts

ULIMAROA - NEW HOLLAND

REPRINTED WITH PERMISSION,
SYDNEY MORNING HERALD

JUNE 5

May I add a footnote to the history of cultural disposition of our various Aboriginal nations?

On August 13, 1887, *The Macleay Argus* at Kempsey published an excerpt from a letter that had earlier appeared in the *Meblourne Argus* from a correspondent (unidentified) who appears to have been of Swedish origin. The letter referred to an article about finding a new name Australia and reads, inter alia:

"... Now I have strong reason for believing that there was a native name and that it was Ulimaroa, for so this large island was designated on the first school atlas put into my hands some 50 years ago.

"I have certainly never come across this name afterwards but I have no doubt that it was taken from some old Dutch chart, for it could not have got into a Swedish school book without some very substantial ground.

"As the Dutch pronounce the letter U somewhat like the English double-O, you will perceive that the word has a distinctly Australian sound, bearing strong affinity to many native names both on this continent and in New Zealand. Of course, the fact of such a name having existed could easily be ascertained. The full name given in my school atlas was 'Ulimaroa or New Holland'."

Patricia Riggs, Crescent Head

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

FELLOWSHIP EXAMINATIONS

PRIMARY FELLOWSHIP EXAMINATION

March/April 1997

The written section was held in all capital cities in Australia, Newcastle, Townsville, Auckland, Christchurch, Wellington, Hong Kong, Kuala Lumpur and Singapore.

The viva examination was held at College Headquarters in Melbourne.

SUCCESSFUL CANDIDATES

S G Apana, NSW	J F Lambert, NSW	C A Phillips, QLD
M M Buckham, NSW	C D Lang, TAS	D J Price, NSW
L K Cantwell, VIC	Lee Pik-Lin, Monica, HKG	R M Purcell, QLD
S D P Chandrasekara, VIC	S Lim, WA	A W E Robinson, WA
C M Cole, WA	E Y I Lin, NSW	M P Shaw, NSW
P A Corby, VIC	T J Mann, WA	J Shen, HKG
D A Cowie, VIC	C B McFadyen, NSW	J M Shirley, QLD
L E Cox, QLD	C S McFarlan, NZ	P Sinclair, NSW
M J Duane, VIC	A G McGirr, NSW	J C Standen, NSW
K L English, NZ	D R McIlroy, VIC	R G Steele, VIC
N I Ferch, NSW	I M Miles, NSW	M J Stokan, NSW
S J Ferguson, NSW	S L Misso, QLD	D A Sun, NSW
C H Fernandez-Cornejo, NSW	J L Morris, QLD	V Swainsbury, VIC
D K T Fok, HKG	C L Murray, NSW	S C Tan, MALAY
K P Fortier, QLD	P A Newell, NZ	Tan Soo Guan, S'PORE
R W Frengley, NZ	Ng Man Wai, Vivian, HKG	Tham Kok Meng, MALAY
S B Gibson, NSW	H F Nicol, VIC	F N Thomas, NZ
R G Griffiths, NZ	D G Noble, QLD	B H Webster, VIC
C R Hastie, QLD	N R Orford, NSW	J Wellington, QLD
P G Herreen, SA	N V Pal, NSW	K Wong, NSW
E H Hewitson, SA	M R Patch, NSW	S J Worboys, VIC
A R Imison, WA	Pay Lu Lu, S'PORE	Yeo Khee Sim June, HKG
C S H Johnstone, NZ	L Pfitzner, NSW	Yuen Shiu Tim Timmy, HKG
C Kolivas, VIC		

COURT OF FINAL FELLOWSHIP EXAMINERS

MAY 1997



Front Row (left to right):

Drs Glenda Rudkin, Brian Trainer, Mary O'Reilly, Nick Radford, Maggie Bailey, Peter Klineberg (Chairman), Vic Callanan, Graham Sharpe, Roman Kluger, Geoff Mullins.

Second Row:

Drs Peter Peres, John Madden, Kersi Taraporewalla, Peter Habersberger, Peter Dawson, David Scott, Patrick Moran, Craig Morgan, Phillipa Hore, Andy Pybus.

Back Row:

Drs Bruce Burrow, Peter Moran, Rob Beavis, Patrick See, Patrick Farrell, David Jones, Ed Loughman, Wally Thompson, David Sage

RETIRING EXAMINERS

are presented with a certificate in acknowledgement of their twelve years on the Examiners Panel by the Chairman of the Final Examination Committee Assoc Prof Peter Klineberg



Assoc Prof Vic Callanan



Dr Ian Rechtman



*Dr Nick Radford and
Dr Peter Habersberger*

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

FELLOWSHIP EXAMINATIONS

FINAL FELLOWSHIP EXAMINATION (ANAESTHESIA)

April/May 1997

The written section was held in all capital cities in Australia, Newcastle, Townsville, Auckland, Christchurch, Wellington, and Hong Kong.

The Viva Examination in anaesthesia and medicine was held at College Headquarters and the Alfred Hospital, Melbourne.

SUCCESSFUL CANDIDATES

D L H Austin, SA
 M J Barrington, NSW
 K J Benfield, VIC
 R Block, WA
 M E Brooker, NZ
 A U Buettner, VIC
 E I Cohen, VIC
 A R Corbett, WA
 M A Corkeron, WA
 M G H Davies, NSW
 K E Dilworth, WA
 E T K W Douglas, NZ
 F B Dyall, WA
 G J Emery, VIC
 N P Gan, NSW
 E K Giles, QLD
 M E Hack, QLD
 R J D Harris, SA
 C J Hingham, SA
 K M Ho, VIC

A C Hogan, QLD
 J B K Jacob, SA
 T D Jaensch, SA
 B S Jan, NSW
 K L Jones, VIC
 J L Leong, VIC
 M P Levestam, NZ
 T Li, HKG
 J A MacPherson, NZ
 R D MacPherson, NSW
 J W Martyr, WA
 D R Matthews, NZ
 S L McCracken, NSW
 P J McMahan, SA
 K K K Ng, VIC
 B Orr, NSW
 O S M Page, QLD
 E J Pemberton, VIC
 T B Pepall, WA

A A Pinto, NSW
 L M Power, WA
 A N Purcell, VIC
 F E Purcell, VIC
 S I Roche, NZ
 G N Russell, NSW
 G E Silk, NSW
 R S Simpson, SA
 V Singh, SA
 C J Tippett, VIC
 J M Torrance, NZ
 A H Umraniyar, VIC
 R M Vaughan, SA
 D A P F Vote, VIC
 F M Walden, QLD
 W C Waldow, SA
 J Wheelahan, VIC
 M Y M Wong, VIC
 P Wongprasartsuk, VIC

REPORT FROM THE PRESIDENT TO THE FELLOWS OF THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS AS AT THE 13TH JUNE 1997

It is my pleasure to report on behalf of Council on the affairs of the College since the last Annual General Meeting.

COLLEGE AFFAIRS

Two very successful Younger Fellows Conferences have been held in the last 12 months. The first, in association with the Perth Combined Scientific Meeting, tackled the topic of "Improving Communication" and made recommendations to Council regarding communication with colleagues, the public and patients. The second, in association with the Christchurch Meeting, analysed the challenging subject "Looking After Ourselves". Recommendations to Council from this Conference will be considered at the October Meeting.

The Communications Committee has been active in a number of areas, the most visible being National Anaesthesia Day on the 16th October 1996. The sesquicentenary of Morton's demonstration of anaesthesia for surgery was an obvious choice for the Day. The wide range of activities has been well publicised by the College, with the assistance of Eddie Dean, our Communications Consultant.

Co-ordination of activities in the Asia Pacific Region in relation to standards, training, examinations and continuing education, consultative services and research is being actively pursued by the Asia Pacific Committee. Close links have been established with the Australian Society of Anaesthetists, Royal Australasian College of Physicians and Royal Australasian College of Surgeons to ensure maximum benefit to the Pacific Islands and Papua New Guinea.

Government liaison concerning issues of training and Workforce has escalated with increased activity of the Australian Medical Workforce Committee (AMWAC),

the Committee of Presidents of Medical Colleges (CPMC), and the new Federal Ministerial Committee, the Medical Training Review Panel (MTRP), on all of which the College has representation.

Progress in the refinement of the examinations process has continued, with particular emphasis on quality control.

Development of a Diploma in Pain Management, a natural sequel to the Certificate, is being considered. The Pain Management Committee has communicated with other relevant Colleges and Faculties seeking their involvement.

Council has assumed the responsibility for co-ordinating publication of the next National Anaesthetic Mortality Report, being prepared by a Committee of Chairmen of State Anaesthetic Mortality Committees.

Council held a Strategic Planning Day in February, and agreed that development of strategic plans should be a high priority. The topics to be pursued in the immediate future are:

- Physical facilities
- Communication
- Continuing Medical Education
- Pain Management
- Asia Pacific involvement
- Maintenance of Standards
- ANZCA/ASA relationship

A vote of thanks is due to the Organising Committee of the Pugh Sesquicentenary Meeting held in Launceston from the 6th to the 8th June 1997. The organisation of the Meeting and the unveiling of Pugh's statue in Princes Square were a great tribute to the local Committee.

AWARDS, HONOURS AND APPOINTMENTS

During the past year many of our Fellows have been the recipients of Awards, Honours and Appointments.

Mr David E Theile (Qld) was awarded the Order of Australia (AO).

Dr Agnes M Daly (Qld), Dr Brian E Dwyer (NSW) and Associate Professor Neville J Davis (WA) were invested as Members of the Order of Australia (AM).

Dr Stephen P Gatt (NSW) was awarded a Medal of the Order of Australia (OAM) in the Queen's Birthday Honours.

Dr Ronald V Trubuhovich (NZ) was invested as an Officer of the New Zealand Order of Merit (ONZM).

Dr Brian J Pollard (NSW) was invested as a Knight Commander of the Order of St Gregory the Great (KCSG).

Professor Garry D Phillips (SA) was invested as an Officer in the Order of St John and was admitted to Fellowship of the Academy of Medicine of Singapore.

Associate Professor Vic I Callanan (Qld) was awarded the Australia Day Council Medallion.

Professor David Glass (USA) was elected President of the American Board of Anesthesiology and Dr John Paull (Vic) elected President of the Asian Oceanic Society of Regional Anaesthesia.

Dr Richard G Walsh (NSW) was presented with the Gilbert Brown Award of the Australian Society of Anaesthetists in October 1996. Dr Walsh also was awarded the Pask Certificate of Honour from the Association of Anaesthetists of Great Britain and Ireland for his outstanding contributions to the World Congress in Sydney.

Dr Richard J Bailey (NSW) and Professor Lucien E Morris (USA) were awarded the Paul M Wood Fellowship of the American Society of Anesthesiologists.

Dr Jack Burkhart (NSW) was awarded the AMA NSW Branch President's Award.

Dr Walter R Thompson (WA) was elected President of the Australian Society of Anaesthetists and awarded the Society's Gilbert Troup Prize in October 1996.

Dr Rod N Westhorpe (Vic) was elected Vice- President of the Australian Society of Anaesthetists and awarded the ASA President's Medal in October 1996.

Dr Greg P Wotherspoon (NSW) was awarded the Pask Certificate of Honour from the Association of Anaesthetists of Great Britain and Ireland for his contributions to the World Congress in Sydney.

Dr T C Kester Brown (Vic) and Dr John G Roberts (SA) were awarded the Society's Gilbert Troup Prize in October 1996.

Professor Michael J Cousins (NSW) was elected as a Councillor of the National Health Medical Research Council.

The posthumous award of the Australian Society of Anaesthetists' President's Medal was made to Dr John N Matheson (NSW).

Dr Judith A Williams (NSW) was elected to the Roll of Fellows of the Australian Medical Association.

Professor Teik E Oh, Hong Kong was Visiting Professor to the University of Alberta, Canada in July 1996, and Professor RDM Jones (Qld) Visiting Professor, Department of Anaesthesia, Chinese University of Hong Kong.

HONORARY FELLOWSHIP

During my attendance at the American Society of Anesthesiologists' Meeting held in New Orleans in October 1996, it gave me great pleasure to confer Honorary Fellowship on Professor Emanuel Papper (USA).

Death of Fellows

It is with regret that I report the death of the following Fellows:

Dr Janie U Blacker, NSW
- FFARACS 1953, FANZCA 1992

Dr Mary T Burnell, SA
- Foundation Fellow, FFARACS 1952, FANZCA 1992

Dr Preston C Calvert, New Zealand
- FFARACS 1961, FANZCA 1992

Dr Rosemary A Faul, New Zealand
- FFARACS 1961, FANZCA 1992

Dr Peter L Hann, NSW
- FANZCA 1992

Dr Gordon Houseman, Vic
- FFARACS 1955, FANZCA 1992

Dr Lucy G MacMahon, NSW
- Foundation Fellow, FFARACS 1952

Dr John N Matheson, NSW
- FFARACS 1970, FANZCA 1992

Dr Ian C Miller AM, WA
- FFARACS 1968, FANZCA 1992

Dr Judith N Nicholas, NSW
- FFARACS 1956, FANZCA 1992

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

RESEARCH

Douglas Joseph Professorship - 1997

The 1997 Douglas Joseph Professorship of \$65,000 was awarded to Professor A B Baker, Nuffield Professor of Anaesthetics, University of Sydney, Royal Prince Alfred Hospital. Professor Baker's project relates to development in the use of low flow and closed circuit anaesthesia which allows for the breath by breath measurement of the patient's oxygen consumption (vO_2) and nitrous oxide uptake (vN_2O), together with computer driven control of the gas inflow to the anaesthetic circuit. He will be the Australasian Visitor to the 1998 Annual Scientific Meeting in Newcastle.

Academic Anaesthesia Enhancement Grant - 1996

The 1996 Academic Anaesthesia Enhancement Grant of \$75,000 was awarded to the Department of Anaesthesia, Christchurch School of Medicine, University of Otago.

Research Grants for 1997

In the past year the College received applications for Research Scholarships and Grants totalling \$392,631. College funds available for distribution and awarded in 1997 amounted to \$184,000, plus \$30,000 allocated but not awarded in 1996. A Research Committee was established by Council to consider Grant and Scholarship applications.

The following Scholarship was awarded:

Dr Megan S Robertson \$30,000
The Gut, Stress and Infection: Helicobacter Pylori in the Critically Ill Patient

Grants were awarded to:

1. Dr Lawrence Doolan and Dr Philip Peyton \$20,000
Randomised Multicentre Trial of Epidural Anaesthesia (Master Anaesthesia Trial)
2. Dr John Loadsman \$15,000
Perioperative Sleep and Breathing
3. Dr Guy Ludbrook \$25,000
Co-induction of Anaesthesia - A Pharmacokinetic Study
4. Dr Ross MacPherson \$3,100
The Effects of Inhalation of Anaesthetic Agents in the Myogenic Response
5. Dr Paul Myles \$15,000
Development of a Post-Operative Quality of Recovery Score
6. Dr Michael Paech \$15,000
Combined Spinal-Epidural Analgesia (CSEA) During Labour
7. Dr Neil Pollock \$25,000
Genetic Test for Malignant Hyperthermia
8. Dr Johan Van der Walt \$12,000
Treatment of Acute Hypoxic Episodes in Children under Anaesthesia
9. Dr Adam Tucker \$25,000
An Evaluation of the Contributions of Spinal and Supraspinal Action of Drugs to their Overall Analgesic Effects in Man
10. Dr Brian Anderson \$9,327
Analgesic Effects of Paracetamol and Diclofenac in Children Using Tonsillectomy as a Pain Model

11. Professor Duncan Blake \$20,000
*Modification of Autonomic
 Cardiovascular Control by
 Alpha 2 Adrenergic Agonists*

Harry Daly Research Fellowship

On the recommendation of the adjudicators, the Harry Daly Research Fellowship was awarded to Dr Neil Pollock, New Zealand.

The Council 1997 - 1998

Membership of the Council to take office after the Annual General Meeting, its Office Bearers and Committees are published elsewhere in this Bulletin.

**ADMISSION TO FELLOWSHIP
 BY ELECTION**

Under Regulation 6.2

The Council elected to Fellowship under Regulation 6.2 Professor Bruce Cullen, USA, Professor Pierre Coriat, France, Professor Gavin Kenny, Scotland and Professor Jerrold Lerman, Canada.

Under Regulation 6.3.1(a)

Professor Donald George Moyes, South Africa

Under Regulation 6.3.1(b)

- Dr Phillip Thomas, New Zealand
- Dr Bruce John McLeod, WA
- Dr Aileen Margaret Donaghy, WA
- Dr Geoffrey Thomas Long, New Zealand
- Dr Frances J Beswick, New Zealand
- Dr Colin Leonard Smith, Vic
- Dr Haydn Keith Stevenson Perndt, Tas

Under Regulation 6.3.1(d)

Dr David John Foley, SA

Under Regulation 6.3.1(e)

Dr Bryan Peter Hodgkinson, New Zealand

Under Article 12(c) Regulation 6.3.15

Dr Cecilia Jane Sheila Stewart, NSW

PRIMARY EXAMINATION

July/September, 1996

The written section of the Examination was conducted in all capital cities in Australia, Cairns, Newcastle, Townsville, Auckland, Christchurch, Dunedin, Wellington, Hong Kong and Kuala Lumpur.

The Oral Examination was held in Melbourne.

	TOTAL NO CANDIDATES	INVITED TO ORAL	APPROVED
MELBOURNE	114	102	74

March/April, 1997

The written section was held in all capital cities in Australia, Newcastle, Townsville, Auckland, Christchurch, Wellington, Hong Kong, Kuala Lumpur and Singapore.

The Oral Examination was held in Melbourne.

	TOTAL NO CANDIDATES	INVITED TO ORAL	APPROVED
MELBOURNE	94	79	63
HONG KONG	11	9	7
TOTAL	105	88	70

The Renton Prize for the period ending 31st December, 1996 was awarded to Dr. Angela Gay Playoust of New South Wales and to Dr Stephen Bruce Gibson of New South Wales for the period ending 30 June, 1997. Dr Playoust was presented with the Renton Medal during the College Ceremony at the ASM in Christchurch.

**FINAL EXAMINATION
 (ANAESTHESIA)**

August/September, 1996

The Written Examination was conducted in all capital cities in Australia, Newcastle, Auckland, Christchurch, Dunedin, Wellington, Hong Kong and Kuala Lumpur.

The Viva Voce and clinical examinations were conducted at Royal North Shore Hospital, Sydney.

Seventy-seven (77) candidates presented in Sydney and fifty-four (54) were approved.

Successful Candidates

B T Anderson, NSW	E Krishnappa, SA
B C Anderson, NZ	J P Lew, Vic
H K Au, HKG	E A Mackson, NSW
G S Austin, NSW	M G Mallat, NSW
S J Bignell, QLD	J J Matheson, NSW
C D Brooker, NSW	R J Maynard, NSW
S J Bruce, QLD	R McKay, NSW
S A Cairo, VIC	N L McKeivitt, QLD
R M Campbell, SA	B McKinney, QLD
M Chan, NSW	A E Meads, NZ
S K Chan, NSW	A S Michael, MLY
S J Clark, QLD	K D O'Connor, NZ
P J Corke, NSW	G S Oberoi, SA
P S De Witt, NZ	A P Padley, NSW
D J Devonshire, VIC	A J Penberthy, VIC
D W Elliott, NSW	A L Rother, VIC
C J Fisher, NSW	M I Rudelic, VIC
R A French, NZ	S D Sherlock, VIC
R F Grace, NSW	G Singh, NSW
M D Grubb, NZ	M W Skinner, WA
E S Hanna, VIC	R I Thomas, QLD
P J Harms, QLD	C K Thorn, NZ
D Heffernan, VIC	A Vasic, NSW
T J Hunter, NZ	T Visvanathan, SA
G T Joyce, VIC	L J Webb, SA
C P King, NZ	A C Wilkins, SA
G N Koo, SA	S M Winship, NZ

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31st December, 1996 be awarded to Stephen John Bruce of Queensland. The Medal was presented to Dr Bruce during the College Ceremony in Perth.

April/May, 1997

The written section was held in all capital cities in Australia, Newcastle, Townsville, Auckland, Christchurch, Wellington and Hong Kong.

The Viva Voce Examination was held at College Headquarters and the clinical examination at the Alfred Hospital, Melbourne.

Seventy-eight (78) candidates presented in Melbourne and fifty-eight (58) were approved.

Successful Candidates

D L H Austin, SA	R D MacPherson, NSW
M J Barrington, NSW	J W Martyr, WA
K J Benfield, VIC	D R Matthews, NZ
R Block, WA	S L McCracken, NSW
M E Brooker, NZ	P J McMahon, SA
A U Buettner, VIC	K K K Ng, VIC
E I Cohen, VIC	B Orr, NSW
A R Corbett, WA	O S M Page, QLD
M A Corkeron, WA	E J Pemberton, VIC
M G H Davies, NSW	T B Pepall, WA
K E Dilworth, WA	A A Pinto, NSW
E T K W Douglas, NZ	L M Power, WA
F B Dyal, WA	A N Purcell, VIC
G J Emery, VIC	F E Purcell, VIC
N P Gan, NSW	S I Roche, NZ
E K Giles, QLD	G N Russell, NSW
M E Hack, QLD	G E Silk, NSW
R J D Harris, SA	R S Simpson, SA
C J Hingham, SA	V Singh, SA
K M Ho, VIC	C J Tippett, VIC
A C Hogan, QLD	J M Torrance, NZ
J B K Jacob, SA	A H Umranikar, VIC
T D Jaensch, SA	T M Vaughan, SA
B S Jan, NSW	D A P F Vote, VIC
K L Jones, VIC	F M Walden, QLD
J L Leong, VIC	W C Waldow, SA
M P Levestam, NZ	J Wheelahan, VIC
T Li, HKG	M Y M Wong, VIC
J A MacPherson, NZ	P Wongprasartsuk, VIC

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30th June, 1997 be awarded to Dr John McKinnon Torrance of Wellington, New Zealand.

ANNUAL SCIENTIFIC MEETINGS**Combined Scientific Meeting - Perth 1996**

Due to the World Congress being held in Sydney in April, a Combined Scientific Meeting with the Australian Society of Anaesthetists was held at the Hyatt Regency Perth from the 26th to the 30th October 1996.

During the College Ceremony it gave me the greatest pleasure to present the Robert Orton Medal to Dr Geoffrey Clarke (WA), Dean of the Faculty of Intensive Care.

The Honourable Fred Chaney delivered a most interesting Oration entitled "Individual Excellence and the Common Good".

Our Foundation Visitors were Professor Bruce Cullen from the United States of America and Professor Pierre Coriat from France.

The Ellis Gillespie Lecture entitled "Preoperative Risk Stratification in Vascular Surgical Patients" was delivered by Professor Coriat.

Professor Cullen delivered the second Mary Burnell Lecture entitled "Anaesthesia for Trauma".

Dr David Crankshaw (Vic) delivered the Australasian Visitor's Lecture, "Variability in Anaesthesia".

The Gilbert Brown Prize was awarded to Dr Paul Stewart Myles, Victoria, for his presentation "Haemodynamics and Timing of Extubation with Propofol Analgesia for CABG Surgery".

The Formal Project Prize was awarded to Dr Deborah Jane Wilson, Western Australia, for her presentation "Analgesia and Plasma Levels After Amethocaine Cream for Venepuncture in Children: Comparison with Emla Cream".

Annual Scientific Meeting - Christchurch 1997

The 1997 Annual Scientific Meeting was held in the Christchurch Town Hall from the 10th to the 14th May.

During the College Ceremony Dr Jeanette Thirlwell-Jones (NSW) was presented with the Robert Orton Medal.

The Rt. Hon. David Lange, CH delivered a most interesting and entertaining Oration "Been There, Done That".

The Foundation Visitors to this Meeting were Professor Gavin Kenny from Scotland and Professor Jerrold Lerman from Canada.

The Ellis Gillespie Lecture entitled "A Decade of Change in Paediatric Anaesthesia" was delivered by Professor Lerman.

Professor Kenny delivered the third Mary Burnell Lecture entitled "Technology - Friend or Foe".

Dr Brian Horan (NSW) delivered the Australasian Visitor's Lecture, "Anaesthesia, the Unique Specialty".

The Gilbert Brown Prize was awarded to Dr Warwick Dean Ngan Kee, Hong Kong, for his presentation "Addition of Adrenaline to Epidural Pethidine".

The Formal Project Prize was awarded to Dr Ho Kwok Ming, Victoria, for his presentation "A Comparison of Common Iliac Vein Pressure and Superior Vena Cava Pressure in Mechanically Ventilated Patients".

POLICY DOCUMENTS

Policy Document P23 - Minimum Standards for Transport of the Critically Ill was withdrawn as this topic is now covered by the Faculty of Intensive Care's Policy Document IC-10 of the same title.

The following Policy Documents were reviewed and promulgated during the past twelve months:

- T2 - Protocol for Checking the Anaesthetic Machine
- E1 - Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia
- E13 - Guidelines for the Provisional Fellowship Year
- EX1 - Examination Candidates Suffering from Illness, Accident or Disability
- P1 - Essential Training for General Practitioners Proposing to Administer Anaesthetics
- P2 - Privileges in Anaesthesia
- P9 - Sedation for Diagnostic and Surgical Procedures
- P21 - Sedation for Dental Procedures
- P24 - Sedation for Endoscopy

COUNCIL

In accordance with the provisions of the Articles of Association, nominations were called for two vacancies on Council. Professor John Gibbs was eligible for re-election to Council for a normal term and Professor Garry Phillips was eligible for re-election for one further year.

The following is the result of the Ballot:

Votes Counted	848	
Less Informal	<u>3</u>	
	845	
	x2 =	1690
G D Phillips		683
J M Gibbs		618
K J Bandis		389

provided by Miss Lara Milvain, Administrative Assistant (Education).

To provide assistance in the Education Department, Mrs Janet Devlin was appointed Secretarial Assistant (Education) in February 1997.

Following Mrs Helen Cody's resignation from the New South Wales Office, Ms Janice Taylor was appointed in August 1996 to provide the secretariat for the College's Regional Committee.

Miss Catherine Green has been employed as part-time Archivist at Ulimaroa since January 1996. Miss Green is also working in the RACS' Archives.

I would like to express my sincere thanks to Members of Council and Regional Committees for all the work they have done for the College in the past year. The Council could not function however without the great effort put in by the College staff at Ulimaroa and in the Regions.

GARRY D PHILLIPS, June 1997

COLLEGE ADMINISTRATION

A number of staff changes have occurred during the past twelve months.

Following a review of the College's Finance Department, Mr Bill Peachey was appointed Finance Manager in August 1996.

The College assumed the secretariat for the Committee of Presidents of Medical Colleges for a three year period from 1997, and support to this Committee will be

ANZCA COUNCIL ELECTION MAY 97

Position on ballot	Votes	% of votes
3 Garry Phillips	683	81%
2 John Gibbs	618	73%
1 Kerry Brandis	389	46%

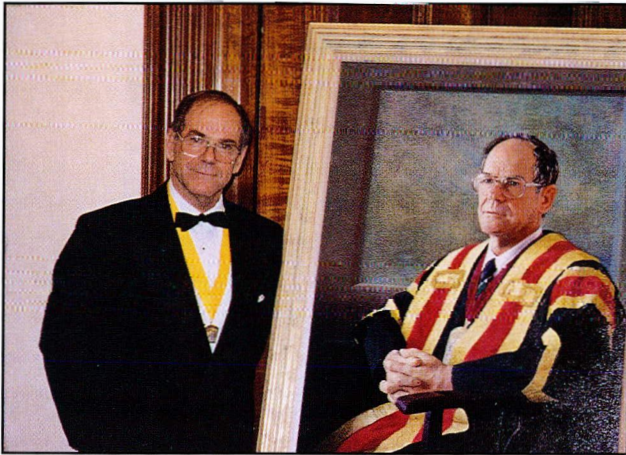
1997 COUNCIL BALLOT

Envelopes Received	862
Less Invalid	<u>14</u>
Votes Counted	848
Less Invalid Votes	<u>3</u>
	<u>845</u> x 2 = 1690

REGIONAL BREAKDOWN OF VOTES

REGION	ENVELOPES RECEIVED	NUMBER OF FELLOWS	PERCENTAGE
Victoria	185	488	36%
New South Wales	214	670	32%
ACT	8	29	27%
Tasmania	22	48	46%
Queensland	136	315	43%
South Australia	82	216	38%
Northern Territory	3	6	50%
Western Australia	46	171	27%
New Zealand	112	291	38%
Hong Kong	21	94	22%
Malaysia	1	46	11%
Singapore	5	46	2%
USA and Canada	8	65	12%
United Kingdom	14	61	23%
Other Overseas Countries	5	31	16%
Invalid Envelopes	14		
TOTAL	862		** 33%

** Figure does not include invalid envelopes or votes.

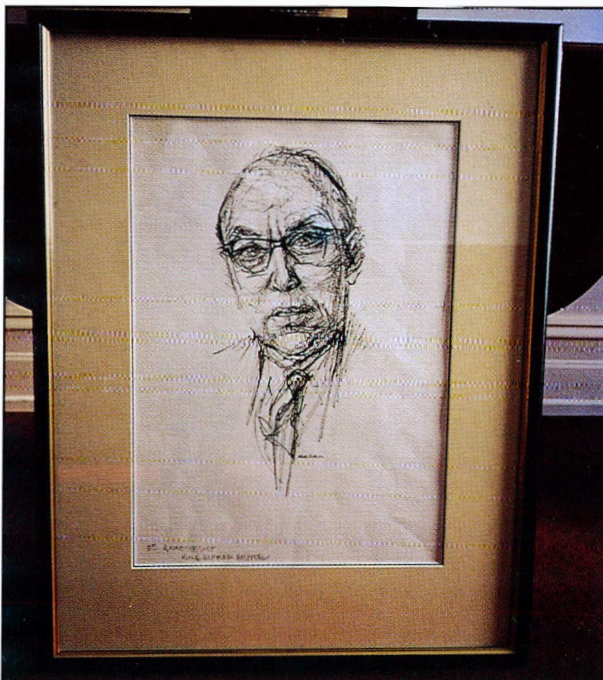


Dr Neville Davis at the unveiling of his portrait by Ben Joel.



A group of anaesthetists at the AMA Federal Conference Dinner.

GIFTS TO THE COLLEGE



Dr Ian Rechtman presented the College with a pen drawing by Louis Kahan of the late Dr Robert Orton.



Dr Moira Westmore presented the Dean, Dr Geoff Clarke, on behalf of the Faculty (middle) with a painting titled "Seascape" by artist Chelina Gates and the President, Prof. Garry Phillips, on behalf of the College (above) with a painting by D'Hange Yammanee titled "Hidden Valley" on behalf of the 1996 CSM Committee.

OBITUARIES

JOHN MARCUS TULLY, Qld

MBBS, DA, FRCA, FANZCA, MRCP (UK), FRCP (Edin)

John "Jack" Tully practised anaesthesia in Toowoomba from 1969 to 1997. He was a first class anaesthetist with an enquiring mind and a sense of humour that endeared him to all.

Right throughout his life, he was an excellent student. He won an open scholarship to university from St Joseph's College, Gregory Terrace, where he was a prefect in his final year. He graduated in medicine in 1963 from the University of Queensland. He then completed post-graduate exams in Anaesthesia and Medicine.

Jack was a lateral thinker. He questioned everything, but always listened carefully to opposing views. He employed nurse assistants in his private practice long before they became the norm. He studied and practised acupuncture to add to his busy life. He was widely read.

Rugby for Jack was a passion. He represented his school in the first XV and played First Grade for Brothers and University Clubs. His physique dictated his position on the field, that of a Rugby prop, although he always aspired to be a fly-half. When playing the game he was known to carry a rule book in his shorts, and if he disagreed with the referee, he would produce his rule book and argue the point. He was a ground life member of Ballymore and rarely missed a game.

Jack had an interesting personality. He could be sensitive and shy on the one hand, then gregarious and even outrageous on the other. His wit was sometimes acerbic. A surgical colleague who rarely used his anaesthetic services once called him by his nickname "Jack". He replied, "You can call me John, only my friends call me Jack!" His company was appreciated by the surgeons and dentists with whom he worked. He was loved by the theatre staff, where his jokes were legendary and often completely irreverent.

He enjoyed a happy family life with his wife Helen and their three children, Stephen, Lisa and Richard to whom he was devoted. He will be sadly missed.

PETER MORRIS

DR JUDITH NELLA NICHOLAS, NSW

FFARACS 1956, FANZCA 1992

Dr Nicholas made a number of contributions to anaesthesia in Australia, in addition to her busy clinical life. She was Secretary and, later, Chairman of the NSW Section of the Australian Society of Anaesthetists and a Member of the NSW Regional Committee of the Faculty of Anaesthetists for nearly ten years. This participation in the work of both bodies was very influential in her appointment in 1967, as Secretary of the Third Asian/Australian Congress of Anaesthetists held in Canberra in 1970.

Judith Nicholas paved the way for participation by women anaesthetists in the World Federation of Anaesthesiologists' work, with the success of the 1970 Congress of the Asian-Australian Section of the Federation. The Australian Society of Anaesthetists, at the closing ceremony of the Congress in Canberra, recognised her contribution by presenting to her its highest award, the Gilbert Troup Medal.

I have stressed this aspect of Judy's work because it makes her an historical figure in world anaesthesia, but a careful historian of several aspects of Australian life will also find her name has a place. In 1960, at the Annual General Meeting of our Society, she made a detailed formal proposal that anaesthetists should undertake the teaching of the new methods of resuscitation to surf life saving associations and other such organisations. The proposal was accepted almost unanimously and after further discussions eventually resulted in anaesthetists training life savers on beaches at the weekend, ambulance drivers and personnel, and even climbing electricity poles to demonstrate these new techniques, still in use today.

Thus the life of Dr Judith Nicholas, which virtually tragically ceased some three years ago, even if it only finally ended on the 11th March 1997, has had positive effect on many people, and her work must call for much admiration.

GWEN WILSON

DR JANINE UNA BLACKER, NSW
FFARACS 1953, FANZCA 1992

Una Blacker came from country New South Wales and went to Sydney University in 1933, graduating in 1939. She was at the Women's College with such luminaries in the same year as Dr Gwen Wilson and my mother, Dr Helen Walsh (nee Tooth), all graduating in 1939.

Una Blacker was not one who contributed enormously to anaesthesia per se as she had a lot of outside interests. She was admitted to Fellowship in 1953 having previously worked in England. In 1957 she was appointed to Western Suburbs Hospital in Sydney and worked also at the private Masonic Hospital in Sydney over the next 20 years. She retired in the early 1970s and followed some of her other interests, particularly renovation of houses and real estate in general.

I knew her all my life and saw her regularly every couple of years. She was a very interesting person who died following a series of cerebro-vascular accidents over a number of years.

RICHARD WALSH

DR PETER LAWRENCE HANN, NSW
FANZCA 1994

Peter Hann was a young Fellow who went through the University of New South Wales and subsequently went through the system of College training at the Prince of Wales/Prince Henry Hospital. He passed his Fellowship Examination in 1992 and was awarded the George Davidson Medal for outstanding performance at that Hospital. He moved to Orange in early 1994 having spent the previous year at the Royal Alexandra Hospital for Children as a Provisional Fellow. He was the New South Wales representative to the Younger Fellows' Conference at Cradle Mountain in 1994 and presented the recommendations of that Group to Council at its June Meeting.

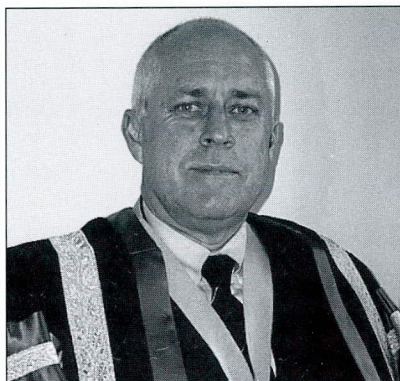
Peter Hann was well known around Sydney and his move to Orange was received with great enthusiasm. He proved to be a very enthusiastic anaesthetist and a gifted teacher. He introduced many innovations to Orange, especially in the area of paediatric anaesthesia which was his special interest. He was Supervisor of Studies for all Registrars at Orange and conducted an exceptional programme for his trainees.

Dr Hann was attending a Continuing Education Seminar in Sydney on 4th May and died in a car accident prior to heading home. He is survived by his wife Jill and their four very young children.

RICHARD WALSH

FACULTY OF INTENSIVE CARE

DEAN'S MESSAGE



The Faculty of Intensive Care is about to embark on the next stage of its evolution. The Inaugural Board has completed its term, a new Board has taken office and the Faculty has its second Dean.

It is an appropriate time, therefore, to acknowledge the remarkable Deanship of Dr Geoffrey Clarke who has guided the Faculty's development to this point, guaranteeing its sound foundations. The achievements during his term are endless but special mention should be made of the progress made in commonality of training with the Royal Australasian College of Physicians including the formation of the Joint Specialist Advisory Committee in Intensive Care, the formation and involvement of Regional Committees, close liaison with ANZCA and other bodies, the development of Faculty Regulations and Administrative Instructions and the creation and review of Policy Documents. In addition, a Maintenance of Standards Programme has been introduced, In-training Assessment is in operation and the review of "The Objectives of Training" is nearing completion. Dr Clarke remains on the Board and his wise counsel will be invaluable.

It is also a great pleasure to acknowledge the honour bestowed on Dr Ronald Trubuhovich, our Inaugural Vice Dean, who has been awarded the Officer of the New Zealand Order of Merit (ONZM). This is the first such award to an intensivist in New Zealand.

The contribution of Dr Robert Whiting to the Inaugural Board is also acknowledged. Dr Whiting did not seek re-

election to the Board and is replaced by Dr Gillian Bishop.

One of the first tasks of the new Board was to hold a preliminary workshop on "Future Directions". A range of topics relating to broad activities such as training and examinations, specialty recognition, physical facilities and staffing, Board administrative functions and communication, external relations with other bodies and workforce issues were canvassed. A summary of these preliminary discussions will be circulated to Regional Committees in due course. The new Board is determined to remain responsive to Regional Committees, Faculty Fellows and input into these issues and other strategic planning workshop is envisaged following wide consultation.

Finally, it has been determined that the theme of National Anaesthesia Day in 1998 will be devoted to intensive care. Possible themes are being discussed. The Faculty's contribution will be co-ordinated by Dr Trubuhovich, our Communications Officer. Once again input from the Regional Committees and other involved bodies will be welcomed. The support of Fellows will be crucial to its success.

ALAN W DUNCAN
DEAN

ANNUAL SCIENTIFIC MEETING

CHRISTCHURCH



Dr Neil Matthews and Dr John Myburgh at the Intensive Care Dinner at the Casino.

"Perspectives on the Changing Health Environment" (Dr Martin Rowley), "Gastrointestinal Tract and Critical Illness" (Dr David Bihari), a symposium on Burns, "Hyperbaric Oxygen", "Toxicology", "Brain Death and Organ Donation" and two free paper sessions. Dr Jim Judson's summary on "Update on Brain Death" and Ms Oliver's talk on the ADAPT programme were especially impressive.

The Social Programme was tremendously successful and enjoyed by everyone, including the Reception following the College Ceremony, the Health Care Industry Cocktail Party, the first Intensive Care Dinner and a night at the Theatre.

N.T. MATTHEWS

The Annual Scientific Meeting was convened in Christchurch between 10th and 14th May, 1997. The Conference Convenor was Dr Sharon King, and Dr Alastair Gibson organised the Intensive Care component, which was combined with the New Zealand Regional ANZICS Meeting. Prior to the Meeting, the Younger Fellows Conference (the theme of which was "Looking After Ourselves") was attended by the Dean, the President and 18 Younger Fellows.

Three Faculty Fellows presented for admission to Fellowship during the College Ceremony, after which the Right Honourable Mr David Lange spoke impressively on the importance of professionalism in today's society.

The Faculty Foundation Visitor was Associate Professor Keith Walley of Vancouver. Other invited speakers included Associate Professor David Bihari (Sydney) and Dr Martin Rowley (Newcastle). Professor Walley's Plenary Lecture was titled "Pathophysiology and Treatment of Sepsis", and Keith also spoke on Oxygen Delivery, and Intropes. Intensive Care sessions included



Dr Geoff Clarke presents Professor Keith Walley with the Foundation Visitor's Medal.

ITEMS OF INTEREST FROM THE JUNE 1997 BOARD MEETINGS

HONOURS AND APPOINTMENTS

The Board noted the following appointments:

Dr R.V. Trubuhovich, ONZM

Dr S.P. Gatt, OAM

EDUCATION AND TRAINING

Log Books

Four intensive care units around the country continue to trial logbooks and the matter remains under review at the Joint Specialist Advisory Committee in Intensive Care.

Accreditation of Training

The review of accreditation continues, with the Board considering results of a survey undertaken with accredited units. Analysis of the data revealed that just over half the number of accredited posts are occupied by Faculty trainees. Most ICUs had rosters where trainees spent a significant proportion of their time doing night and evening duty. Teaching is conducted during the daytime.

A discussion document is now being prepared on the implications of changing Faculty policy regarding approval of posts.

Training Fees

The Board agreed that as from February 1998, the Faculty Training Fee will be payable by 31st October each year.

Objectives of Training in Intensive Care

The Objectives of Training are in final draft form and it is expected that they will be promulgated following the October meeting of the Board.

Academic Intensive Care

A database detailing academic appointments in intensive care has been developed and will be maintained.

Changes to the Administrative Instructions

The Board resolved to amend Administrative Instruction 1.5.1.1 to clarify the requirement for the twelve months component of continuous core intensive care training to be undertaken in the one unit.

EXAMINATIONS

The dates for the Faculty Examinations in 1998 were approved and appear elsewhere in this Bulletin.

PROFESSIONAL***Specialist Recognition***

The Board has sought approval from the National Specialist Qualifications Advisory Committee for recognition of paediatric intensive care as a sectional speciality. The application is currently under consideration by NSQAC and the specialist colleges.

Maintenance of Standards

It was noted that currently 143 Fellows are registered with the Faculty's MOS Programme.

Joint Specialist Advisory Committee in Intensive Care

Following discussion at the JSAC-IC, the Board resolved:

1. That the Board supports in principle the appointment of an RACP intensivist to Faculty Regional Committees provided this is cost neutral to both the Faculty and the RACP and that this representative be recommended by the ANZICS Regional Committee.
2. That the Board supports the co-option of an RACP intensivist onto Faculty Hospital Accreditation Teams, provided this is cost neutral to the Faculty and the RACP.
3. That the Board agrees in principle to the co-option of a New Zealand physician intensivist to the JSAC-IC provided it is cost neutral to both the Faculty and the RACP. That person will be nominated by the Co-ordinator of Physician Training in New Zealand.

It was considered that the RACP intensivist co-opted to the New Zealand Regional Committee would be co-opted to the JSAC-IC as appropriate.

Policy Documents

The Board approved the promulgation of the revised Policy Document IC-1 "Minimum Standards for Intensive Care Units". This document is published elsewhere in the Bulletin.

Statement relating to the relief of pain and suffering and end of life decisions

The Board endorsed the statement on this matter which was accepted during the recent Council Meeting. This statement is published elsewhere in the Bulletin.

Fee for processing applications for assessment of Overseas Trained Doctors

The Board resolved that the Faculty Fee for Assessment of Overseas Trained Doctors will be in line with the College fee (at present \$500).

**CONTINUING
EDUCATION**

1998 ASM, Newcastle

The Board appointed Dr Gordon Doig as Faculty Foundation Visitor for 1998. Dr Doig is based at the University of Western Ontario. The theme of the intensive care component of the meeting will be 'Improving the Performance of an Intensive Care Unit using Quality Management and Evidence'. John McClenahan of the King's Fund Management College, London, will also be an invited overseas speaker and there will be an associated course held at the Centre for Leadership and Learning in Newcastle.

Younger Fellows' Conference

The Board resolved that the Younger Fellows' Conference should be attended by a Board member-in-residence. It was also agreed that a nominee of the Faculty Younger Fellows' Conference will be invited to report to the Board on the Conference.

INTERNAL AFFAIRS

National Anaesthesia Day, 1998

The Board agreed to consider themes and activities for National Anaesthesia Day 1998, which will focus on intensive care. Any ideas from Fellows would be most welcome.

Communication

Dr Megan Robertson delivered an informative talk on Communication, a submission developed at the Younger Fellows' Conference in 1997.

Business Meetings

It was agreed that in view of the limited time available at Annual Scientific Meetings, a Regional Education Officers' Meeting will no longer be held but its function will be served by the General Business Meeting.

Appeals Mechanism

The Board approved an amendment to Regulation 16 regarding the Appeals Process of the Faculty.

Gift to Faculty

The Board noted the generous gift of a painting entitled "Seascape" by Chelina Gates, from the Western Australian Combined Scientific Meeting Committee.

REPORT FROM THE DEAN TO THE FELLOWS

OF THE FACULTY OF INTENSIVE CARE, ANZCA

AS AT THE 26TH JUNE 1997

It is my pleasure to report on behalf of the Board of Faculty on its affairs since the last Annual Meeting.

AWARDS, HONOURS AND APPOINTMENTS

Dr R.V. Trubuhovich has been awarded the Officer of the New Zealand Order of Merit (ONZM). This is the first such award to an intensivist in New Zealand.

The Faculty congratulates Associate Professor N.J. Davis on his recent award of the Member of the Order of Australia. Dr Stephen Gatt, a Fellow of both the College and Faculty was also named in the recent Queen's Birthday Honours List, receiving the Medal of the Order of Australia.

Dr G.J. Dobb was elected President, Australian and New Zealand Intensive Care Society.

FELLOWSHIP

When the Faculty was established by the ANZCA Council in November 1993 there were 155 Foundation Fellows.

As of April 1997 there are now 200 Fellows:

129 by examination
71 by election
193 are endorsed in anaesthesia (7 are FFICANZCA only since Nov 93)

NSW	53	SA	22	NZ	22
VIC	29	WA	6	HK	7
ACT	4	TAS	0	Other o/s	21
QLD	22	NT	0		

Since June 1996, 17 new Fellows have been admitted to the Faculty.

Admitted to Fellowship by Examination:

D.H.F. Buckley, NZ	P.T. Clark, NSW
M.E. Finnis, SA	A. Flabouris, SA
B.Y.Y. Ng, WA	D.C. Simes, SA
E.R. Stachowski, NSW	B.E. Trytko, NSW
I.J. Webb, Qld	K.K. Young, HK

Admitted to Fellowship by Election:

J.W. Stokes, Qld	R.F. Salamonsen, Vic
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BOARD OF FACULTY

Results of the Election, 1997

The results of the Election for eight positions on the Board of Faculty are as follows: (see also attached - Addendum 1).

<i>Position on ballot</i>	<i>Votes</i>	<i>% of votes</i>
CLARKE, Geoffrey Malcolm	115	100
DUNCAN, Alan William	112	97.4
HAWKER, Felicity Helen	112	97.4
COOPER, David James	110	95.7
MATHEWS, Neil Thomas	105	91.3
BISHOP, Gillian Frances	105	91.3
THOMAS, Peter Dean	97	84.3
TRUBUHOVICH, Ronald Valentine	91	79.1
BARNETT, Robert James	73	63.5
	920	

TRAINEES

Total number of Registered Trainees	86
Registered for Faculty training only	35
Registered for Faculty and RACP	11
Registered for Faculty and ANZCA	40

EXAMINATIONS

There has been an increase in candidates for the Fellowship Examination:

INITIATIVES AND ACTIVITIES SINCE THE INTRODUCTION OF THE FACULTY

1. Joint Training FIC,ANZCA/RACP

Negotiations started in February 1994. By the end of 1995 the Board, ANZCA Council and the RACP had accepted the proposal and Terms of Reference of the Joint Specialist Advisory Committee in Intensive Care. This Committee oversees:

- training of all intensive care trainees
- advises on educational/training issues
- matters relating to specialist recognition.

Much has been achieved in moving toward commonality of training.

1. Both RACP and FFIC,ANZCA now have:
 - in-training assessment
 - requirement for a formal project.
2. It is likely that RACP core intensive care training in Australia and New Zealand will only be undertaken in Faculty approved core posts. Joint site visits are under consideration.
3. RACP trainees who have passed the FRACP examination and completed basic training are eligible to sit the FIC,ANZCA final examination providing they comply with other Faculty requirements. To date one person has taken advantage of the mechanism and has been admitted to Fellowship of both the Faculty and the RACP. Currently there are 11 RACP trainees registered with the Faculty.
4. Using the original model for combined RACP/FIC,ANZCA training, a paediatric programme which enables access to the FIC,ANZCA system for RACP trainees has now been established.
5. JSAC-IC to consider possibility of co-option of RACP representatives to FIC,ANZCA Regional Committees.
6. Both RACP and FIC,ANZCA training programmes offer considerable flexibility and compatibility each with the other.

2. G. A. (Don) Harrison Medal

Professor Malcolm Fisher's initiative (Feb 1994) in offering to establish a fund for an intensivist's prize

for the final examination in intensive care eventually lead to the Don Harrison Medal being established in September of the same year. Winners have been:

A. Belessis	1994
Ho Kwok-Ming	1995
Ed Stachowski	1996

3. Faculty Foundation Visitor and Faculty Component of ASM

Dr. Charles Hinds was our inaugural Faculty Foundation Visitor in	1995
Dr. Keith Walley	1997
Dr. Gordon Doig	1998

The Faculty components of the 1995, 1996 and 1997 Annual Scientific Meetings were extremely well attended and judged to be a great success.

4. Faculty Administrative Officer

Carol Cunningham-Browne appointed in September 1995.

5. Regional Committees

These are functioning well and useful feedback on a variety of issues have been obtained.

The JSAC-IC and the Board will be considering the possible co-option of an RACP representative onto these committees.

6. Review of Faculty Administrative Instructions, Policy Documents etc.

These have been extensively reviewed and new documents developed.

There has been an exhaustive and extensive review of the Objectives of Training in Intensive Care document. This is currently being released in draft form for comment before final updating and publication.

7. Library

Dr. Jim Love was appointed Faculty library representative in February 1996.

8. Summary of Events of the Past 12 Months

- MOS programme approved and circulated to Fellows.
- Formal project requirement of trainees approved to apply from 1997.
- In-training assessment promulgated.
- "Objectives of Training" review nearing completion.
- Paediatric intensive care training programme adopted and endorsed by the Australian College of Paediatrics - first examination held April/May 1997.
- Log books for trainees being trialed in selected centres.
- Detailed review of our accreditation of posts, units or programmes for training purposes continues.
- Website approved and development commenced.
- Board currently considering:
 - statement relating to the relief of pain and suffering and end of life decisions
 - policy on assessment of overseas trained doctors
- New and separate fees introduced for Faculty trainees.

- Presentation of the Dean's Medal by Professor Barry Baker to Dr. Geoff Clarke.
- Dr. Alan Duncan elected Dean-elect.

IN CONCLUSION

Much has been achieved in the short life of this Faculty and there is no sign that the pace is slowing down.

Many obvious needs have been attended to and the time is now ripe for the new Board to consider strategic planning for the next five years. Undoubtedly the Regional Committees will be invited to participate in this process.

I extend my sincere thanks to the Board, our Faculty Administrative Officer Carol Cunningham-Browne, Mrs Sheales and the College Council for their hard work and support of this fledgling Faculty.

GEOFFREY M. CLARKE
Dean

1997 BOARD BALLOT	
Envelopes Received	117
Less Invalid	2
Votes Counted	115
Less Invalid Votes	0
	115 x 8 = 920

Regional Breakdown of Votes			
<i>Region</i>	<i>Env. Received</i>	<i>No. of Fellows</i>	<i>Percentage</i>
Victoria	22	29	76%
New South Wales	33	53	62%
ACT	1	4	25%
Queensland	15	22	68%
South Australia	18	22	81%
Western Australia	12	17	70%
New Zealand	9	22	41%
Hong Kong	2	7	28%
USA	1	4	25%
United Kingdom	4	12	33%
Canada		3	-
Other	1	2	50%
Invalid Envelopes Address not known	2	3	
TOTAL	115	200	57% **

**Figure does not include invalid envelopes or votes

FACULTY OF INTENSIVE CARE

ANNUAL REPORTS

FOR YEAR ENDING 30TH APRIL 1997

NEW ZEALAND

Office Bearers

Dr Forbes E Bennett

Treasurer, Regional Education Officer and representative of NZRC-ANZCA

Dr Jack H Havill

Dr Ron Trubuhovich

Chairman and Secretary, NZRC and NZ member of Board, Faculty of Intensive Care (ex-officio)

Although this committee was elected in late 1994 for a two year term of office, elections were not held in April 1997.

- (a) It had not completed two years of office
- (b) By waiting to the succeeding April the NZRC could come in line with election of other Regional Committees of the Faculty.

Accordingly, nominations were called for in June 1997 and three were received.

Dr FE Bennett

Dr JH Havill

Dr JA Judson

As there were only three positions to be filled on the Committee, no election was required. Endorsement of these members awaits the Board's June meeting. The New Zealand representative on the Board will be a member of the committee also, ex officio and possibly a Younger Fellow will be included. We await discussion at the Joint Specialist Advisory Committee on Intensive Care re a Physician Intensivist attender.

Activities

(The considerations set out in last year's Annual Report re the specific characteristics of the NZRC are equally relevant today).

1. The NZRC held three meetings in the last year, in July 1996, November 1996, and March 1997. The next meeting will be in June 1997.

The NZRC for intensive care holds its meetings in association with the meetings of the NZRC for anaesthesia. The Chairman of NZRC-IC attends the ANZCA meeting ex officio to report from the Board of Faculty. The hospitality of the NZRC-ANZCA extends to the whole meeting and this is important from the intensive care viewpoint because as long as we are not recognised as constituting a speciality in our own right, we are not receiving enquiries, letters, etc from government sources (ANZICS does so occasionally, though!). So our involvement with NZRC-ANZCA allows acquaintance with national issues in a way that is very advantageous to intensive care in NZ. Accordingly, the NZRC is particularly grateful to the anaesthetists for the opportunities provided which include meeting several noteworthy guests and at each meeting, the RACS representative.

Activities of NZRC-ANZCA with which NZRC-IC have been particularly involved with include:

The Medical Manslaughter issue, The Medical Law Reform Group and the Crimes Amendment Bill (No. 5).

Also The Medical Practitioners Act 1996.

As Drs Bennett and Havill are currently elected members of the NZRC-ANZCA, all three NZRC-IC members share in NZRC-ANZCA national matters.

2. The second Annual Business Meeting of the New Zealand Region of FIC was held in Wellington in

October 1996 at the ANZICS-MERCK SHARP & DOHME One Day Intensive Care Meeting.

Speciality Status for Intensive Care in NZ

Intensive care is handicapped in New Zealand by not being recognised by the Medical Council as a principal speciality. Moves towards this started in 1994 but despite considerable representations to the MCNZ, both locally and from Melbourne, progress has been slow, apart from acknowledgement of our cause. Originally a new speciality had to be gazetted as such from Parliament and the MCNZ did not want to pursue that avenue while a prospective new Medical Practitioners Bill which would do away with that circuitous route, was going through its stages. Now that the Bill has been passed in 1996 the MCNZ has only just formed its Specialist Registration Subcommittee which is defining its criteria for recognition of new specialties. It has not been able to advance further in this matter yet.

The Chairman of NZRC has met Dr Ken Thompson, Chairman of MCNZ on two occasions re this.

The failure to gain specialist recognition was the principal cause for the failure of the Faculty to gain representation on the Council of Medical Colleges in New Zealand, despite the repeated efforts of successive chairmen of NZRC-ANZCA (Dr Jack Havill then Dr Alan Merry) and the NZRC-IC itself. Intensive care has been virtually guaranteed representation once it achieves speciality recognition.

Education

1. Training programmes. As yet not undertaken in New Zealand.
2. Log books. Not general in New Zealand but in use at Intensive Therapy Unit at Waikato Hospital.
3. Trainees. Currently the Education Officer has eight listed.
4. Training posts. In New Zealand there are 14 core training posts and three others for elective training spread among seven units.

The count of Fellows of the Faculty currently practising intensive care in NZ appears to be 19.

Election to Fellowship

The NZRC supported the election of Dr John Stokes last year and this was ratified by the Board.

Examinations

There was no candidate from New Zealand in the year of this report.

Academic Appointments in Intensive Care.

This is still at a preliminary stage in New Zealand. The only Fellow of the Faculty in such an appointment is Dr Jack Havill at Waikato Hospital who is an Honorary Senior Clinical Lecturer in Intensive Care. (There are three other non-Faculty appointees however). Appointments are pending at DCCM at Auckland Hospital.

Clinical Training Agency

A draft for intensive care training has been completed, modelled on the CTA's draft for anaesthesia (which has now been "priced", although intensive care has not yet). The required standard is four hours per week for 30 weeks in the year to be dedicated to training.

Assessment of Overseas Trained Doctors for Vocational Registration

As yet there has been no assessment for intensive care, although assessment for anaesthesia has started. The NZRC is contributing to the intensive care assessments of the latter.

The NZSPEX examination to be offered will be the primary examination of the College.

A Maintenance of Standards Programme

New Zealand participants total 18, of whom 10 made an annual return.

Ritchie Anaesthesia Trust

Intensive Care trainees of the Faculty will now be eligible to apply for this scholarship to enable overseas study for a year, probably post Fellowship.

ANZICS

Cordial interchange on matters of joint concern continues with ANZICS and its Chairman of the NZ Region. There will be a joint meeting at the ASM at Christchurch in May.

The New Zealand Regional Committee expresses its thanks to Mrs Lorna Berwick of the Secretariat at ANZCA Headquarters, Elliott House Wellington for her unfailing support and dedication.

RV TRUBHOVICH
Chairman and Secretary NZRC
NZ Member of Board and Vice Dean,
FICANZCA

All the Perth teaching hospitals have co-operated in providing teaching sessions for the current trainees.

This commitment has increased significantly as the number of trainees in the State has increased.

The Faculty ASM as part of the combined ANZCA/ASA scientific meeting in Perth in October was organised by Dr Stephen Edlin. The sessions were well attended.

The Regional AGM will be held in June at which time it is proposed to hold an educational meeting.

Elections for new office bearers are not due until 1998.

JOHN WEEKES
Chairman

WESTERN AUSTRALIA

Regional Committee meetings have been largely concerned with gathering input from local Fellows on various Board initiatives and forwarding this to the Faculty.

On the question of training posts, the WA members have repeatedly expressed strong support for retaining Faculty inspection of Intensive Care Units. They support the concept of Unit recognition as opposed to a strictly defined number of posts.

The Committee has discussed the question of establishing a course in intensive care medicine in WA. When examined in detail it was recognised:

- (a) that two excellent courses have already been established, and
- (b) the isolation of WA would add a very significant cost and time factor to any potential candidates from the East coast.

The latter was confirmed by an informal survey of trainees.

Therefore in spite of considerable support for the idea, it has not been pursued.

VICTORIA

Office Bearers 1996-97

Chairman:	Dr Peter Morley
Deputy Chairman and Regional Education Officer:	Dr Graeme Duke
Honorary Secretary and Treasurer:	Dr John Green

Co-Opted Members

Dr Graeme Hart
Dr John Reeves

Board Representatives

Dr Jamie Cooper
Dr Felicity Hawker

Meetings

The Victorian Regional Committee has met on three occasions in the last year (March, July, November 1996) and April 1997. The timing of these meetings (planned for three each year) was changed to facilitate receipt of information from the Board, dissemination for discussion, and feedback for the next Board Meeting.

Consultative Council on Road Traffic Fatalities

The Victorian Regional Committee, with co-ordinated input from ANZICS Victorian Branch, has had input into the production of a draft report, putting forward recommendations for implementation of strategies to counter the deficiencies identified by the CCRTF.

Hospital Inspections

Dr Graeme Duke joined the Faculty Accreditation Team for the Royal Hobart Inspection and Dr Peter Cranswick and Dr Peter Morley joined the Faculty Accreditation Team for the Royal Children's Hospital.

In Training Assessment Forms

In-Training Assessment Forms have been circulated to all Supervisors for completion of the 1996 year. However there are still many 1996 outstanding ITA forms and it is very important that these forms are maintained up to date for both Faculty and Non-Faculty Trainees especially if at a later stage they may wish to have their Intensive Care Training accredited.

Victorian Regional Scientific Meetings

In accordance with Regulation 4.3.4 Regional Committees are required to hold at least one Scientific Meeting per year. In view of the fact that this may be a joint meeting with other relevant bodies, preliminary discussions will have been held with the ANZICS

Chairman (Victoria Branch) regarding the possibility of a Combined Scientific Meeting. The first of these combined meetings (with the possibility of four overseas invited medical speakers) is planned for May 1998, immediately following the Faculty/College ASM in Newcastle.

Other Issues

The Victorian Regional Committee has had input into the credentialing process of hospital appointments for intensive care staff.

No Younger Fellow Representative from Victoria was nominated to attend the Younger Fellows' Conference in Christchurch.

Ongoing communications with the Board with regard to the proposed Certificate of Training for Overseas Doctors, Minimum Standards for Intensive Care, Euthanasia and Formal Project Criteria.

Information continues to be collected for an Australia wide database regarding Academic positions in Intensive Care and Post-Graduate Research qualifications amongst Intensivists.

The value of the Victorian Regional Committee to the Fellows of the Faculty depends on the quality of input from the individual Fellows, the communication between the Fellows and the VRC, and the communication between the Board of the Faculty and the VRC. Hopefully all these aspects will be improved significantly over the next 12 months.

CHANGES TO ADMINISTRATIVE INSTRUCTION

The Board made the following amendment to Administrative Instruction 1.5.1.1, which clarifies that the twelve months component of continuous intensive care training must be undertaken in one Unit.

1.5.1.1 For the two core years of Intensive Care training (Administrative Instruction 1.4.1).

The core years of Intensive Care Training must be spent in Intensive Care posts approved by the Board for core training.

One core year of Intensive Care training must be continuous and undertaken in the one unit.

The second core year Intensive Care training may be spent discontinuously in two periods of six months each. A period not less than three months may be approved when it is part of an approved training programme. For attachments less than six months, prior approval must be sought from the Censor.

This amendment will apply from the commencement of 1998 Hospital Year.



The Faculty Court of Examiners share a glass of champagne with the successful candidates at the first exam held at the Austin & Repatriation Medical Centre, Vic.

*Successful candidates of the recent Faculty Intensive Care Examination (from left):
Dr Balasubramanian Venkatesh, Dr David Green, Dr Dianne Stephens, Dr Dorothy Breen,
Dr Clive Woolf, Dr Mark Oliver, Dr Richard Leonard*





The Inaugural Court of Examiners for the Faculty Examination in Paediatric Intensive Care celebrate with the first candidate: (from left) Drs Neil Matthews, Jim Tibballs, Martin Rowley, Trevor Duke, Tony O'Connell, Richard Lee and Bruce Lister.



Dr Trevor Duke, the Inaugural Candidate for the Paediatric Intensive Care Exam, toasting his success with the mascot of the Royal Children's Hospital, Vic.

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

REPORT OF GENERAL FELLOWSHIP EXAMINATION
APRIL / MAY 1997

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

WRITTEN SECTION

These notes are a guide and not ideal answers. Nevertheless if all the areas mentioned below were well covered, the candidate would receive an excellent mark. The written section is aimed not only to test knowledge but also :

- Priority setting
- Problem solving
- Clinical judgement
- Experience

Hence the candidate is expected to provide a comprehensive and safe response as expected from a consultant or senior registrar about to enter independent practice.

Random lists, irrelevant information and failure to answer the specific question are marked down.

QUESTION 1

You are preparing to intubate a hypoxic patient. What would make you suspect that the intubation will be difficult?

This question requires an organised approach. Candidates failed to think of the diverse ways that a "difficult airway" may present.

In general difficult intubation may be suspected because of :

- (i) association with chronic conditions
 - goitre
 - rheumatoid arthritis
 - radiation, surgical or burn scarring
 - congenital (Klippel Feil syndrome, Hurlers syndrome etc...)
- (ii) acute airway problems
 - infections (epiglottitis, tonsillitis)
 - trauma to face or neck
 - abscess (tonsillar, pharyngeal)
 - tumour
 - airway burns
- (iii) anatomical or facial characteristics
 - prominent teeth, bull neck, receding mandible, massive breasts

This is assessed by Mallampati classification, grading of atlanto occipital extension and size of anterior mandibular space.

- (iv) History of previous difficulty
- (v) Compounding factors
 - #cervical spine, severe hypoxia, confusion, hiatus hernia, full stomach

In other terms it may be suspected because of :

- (a) history
 - previous difficulty
 - medical disorders (RA)
 - symptoms of stridor, swelling, dysphagia,

- dyspnoea
- etc as above
- (b) examination
- as above

QUESTION 2

What would make you suspect systemic candidiasis in a critically ill ICU patient? How would you confirm the diagnosis? Outline your management once the diagnosis is confirmed.

This is a contentious subject because definitive diagnosis is often difficult. An answer along these lines was sought :

- (a) Systemic candidiasis may be suspected because of unexplained fever, sepsis syndrome and clinical deterioration in the presence of immunocompromise, vascular catheterisation or colonisation by candida (eg. bladder, respiratory tract, wounds or intraperitoneal cavity) particularly multiple sites.

Major recorded risk factors include : colonisation by fungus, the number of antibiotics received, Hickman catheters and haemodialysis.

- (b) Confirmation may be by repeated blood cultures, examination of the retina, bronchoalveolar lavage or aspiration of abscess (eg hepatic). Serological tests appear to have a low specificity.

- (c) Management should include :

- resuscitation
- treat the cause - remove foreign bodies (Hickman catheter etc...)
- drain abscesses
- intravenous antifungal agent, dependent on sensitivities (fluconazole v amphotericin, Rex 1996). Dosing regimen, administration and complications
- improve immunocompetence
 - reduce steroids etc...
 - nutrition
- reduce colonisation load
 - oral antifungal, bladder washouts

QUESTION 3

During the resuscitation of a patient with septic shock how will you decide the adequacy of O₂ delivery to the tissues?

Another contentious issue. The candidate should have shown a detailed approach to this common problem by explaining his/her own guidelines not a theoretical approach from a textbook. The question was not meant to address measures to improve DO₂ (fluid, inotropes, transfusion etc.) rather how adequacy of organ perfusion is assessed.

There is obviously no ideal measure of adequacy of tissue perfusion so discussion should have included simple clinical indices :

- blood pressure and heart rate (What level? How measured?)
- urine output (what rate?)
- skin perfusion / capillary return
- mental state
- cardiac output particularly in relation to PAOP and SVR (what endpoints?)
- arterial lactate and acid-base status

And more invasive:

- mixed venous oxygen consumption
- cardiac output and DO₂ by PA catheter
- pH_i
- experimental measures of organ flow (RBF, CBF)

Rationale and information gained should be explained for each index.

QUESTION 4

What are the possible adverse effects of hypothermia in the postoperative ICU patient?

Accidental hypothermia in the postoperative patient has been shown to be an independent predictor of morbidity and mortality.

Adverse effects discussed should have included:

- | | |
|------------|---|
| cardiac - | hypotension, bradycardia, arrhythmias (VF) (shift of O ₂ dissociation curve impaired O ₂ release) |
| vascular - | vasoconstriction, increased viscosity |
| immune - | all levels of function impaired |

- (eg decreased ciliary activity, chemotaxis and killing)
- susceptibility to infection (NB pneumonia)
- haematology - DIC, thrombocytopaenia
- prolonged coagulation times
- renal - oliguria (polyuria during rewarming)
- pharmacology - impaired drug metabolism
- GIT - pancreatitis, ileus
- CNS - obtundation, hyporeflexia
- Compensation - during rewarming shivering requires a marked increase in metabolic rate, DO_2 , HR, CO, minute volume, myocardial work.

QUESTION 5

What is the role of nitric oxide synthetase inhibitors in the management of septic shock?

Essentially the role of NOS inhibitors remains experimental but the candidate in explaining this should have expanded on what NO's role is in sepsis, what is the function of NOS (inducible and constitutive) and what is the theoretical advantage of blocking i-NOS or c-NOS. Concerning non-selective NOS blockers, the recent trials showing advantages (eg. restoration of BP) and disadvantages (eg. splanchnic vasoconstriction) should have been mentioned. The future role of finding a selective i-NOS inhibitor should have been mentioned.

See Critical Care Medicine 1996 Vol 24 No.11

QUESTION 6

A young woman is being ventilated 36 hours after suffering severe pulmonary contusion in a motor vehicle accident. Suddenly she becomes cyanosed, tachycardic and distressed. What is your immediate management?

This clinical scenario of a life threatening crisis is similar to that addressed by the AIMS study and their proposed algorithm of COVER ABCD for anaesthetic emergency.

The candidate should have an organised plan for diagnosing and treating the numerous potential causes of this crisis (ventilator, tube, patient or interfaces).

Steps could include:

- detach patient from ventilator and bag with 100% O_2
- check the tube for leak, obstruction, malposition (bag, listen for leak, pass suction catheter, check tube length, auscultate chest)
- check the patient for pneumothorax, bronchospasm, atelectasis (observe chest movement, auscultate, CXR, ABG).
- treat according to findings - replace ETT - insert ICC etc.

QUESTION 7

A 60 year old man is returned to ICU after emergency resection and grafting of an abdominal aortic aneurysm. He is noted to be severely hypertensive. Describe your management of this problem.

Again a common scenario. The simple comprehensive approach was sought covering these points:

- (A) check oxygenation and ventilation
 - ABG, CXR examination,
- (B) check BP reading - zero transducer etc... (Pick transducer off the floor)
- (C) seek other causes and treat
 - pain
 - urinary retention
 - rewarming/shivering/vasoconstriction
- (D) vasodilate with short acting agent (eg. SNP)
 - rewarm
 - fluid load

QUESTION 8

A four week old infant is admitted with severe dehydration and obtundation. You are asked to assist in his resuscitation and preparation for surgery for pyloric stenosis that afternoon. What is the best management? Provide a plan for fluid therapy.

- (a) It should have been stressed that the best initial management is conservative - ie fluid resuscitation, nasogastric drainage, restoration of acid-base status.

Surgery should be delayed till this is achieved.

- (b) The fluid plan should take into account :

- the need for initial restoration of plasma volume with colloid
- the need for H₂O, NaCl and K to restore electrolyte and acid base in the face of hyponatraemic, hypochloraemic, hypokalaemic, alkalotic hypovolaemia
- the size of the infant

QUESTION 9

What is meant by "Universal Precautions"? How would you implement them in your ICU?

- (a) A general definition sufficed, eg : Universal Precautions are the measures to be undertaken when handling all body fluids (blood, faeces etc) and include measures to be undertaken in handling contaminated sharps and waste.

Essentially all blood and body fluids are to be regarded as potentially infectious.

- (b) For effective implementation the candidate should have mentioned :
- delineation and propagation of a detailed unit policy
 - education via in-service and orientation programs. Education material via posters and articles
 - ready availability of equipment including gloves, masks, sharp bins, eye protectors at each bedside
 - positioning of sinks and design to allow hands-free function
 - surveying compliance

The unit policy ideally covered:

- when to use protective clothing
- care of patient linen
- disposal of contaminated garbage
- disposal of contaminated sharps
- disinfection, sanitisation and sterilisation of all reusable equipment in patient contact
- housekeeping (mopping, dusting etc....)

QUESTION 10

What are the indications for "Total Parenteral Nutrition" in ICU? What would you prescribe?

- (a) It was expected that the candidate should state that whenever possible enteral nutrition is

preferred. TPN is indicated in an ICU patient who is malnourished or is likely to develop malnutrition (eg expected to be NBM for 7-10 days) **and** has gastrointestinal failure (eg, ileus, fistula, obstruction, malabsorption). It should be remembered that parenteral nutrition has been associated with increased morbidity in perioperative patients who were not severely malnourished (Veterans administration trial).

- (b) The candidate was expected to show a general idea and range of nutritional requirements in terms of:

protein -	crystalline amino acids (1.5 g/kg/day protein, 0.2 g/kg/day nitrogen)
calorie source -	carbohydrate or fat (40 kcal/kg/day, cal : N ₂ g = 150 : 1)
H ₂ O -	30 to 40 mls / kg / day plus replacement of excess losses (eg NG)
Electrolytes -	Na, K, Cl, Mg, Ca, PO ₄
Vitamins -	water soluble (immediately B, C.
-	fat soluble (after 1 month poor intake) A, D, E.
Trace elements -	particularly Zn
Essential fatty acids	

and explain how a basic prescription may be changed to suit the patient's needs eg:

- Stressed, septic patients require lower cal to N₂ ratio feeds (eg 75:1) and less carbohydrate.
- Renal failure patients require limited K, N₂, PO₄ input and strict fluid balance.
- Hepatic failure patients may require salt and water restriction.
- Respiratory failure patients require a restricted CHO load and fat supplements.

Discussion might also have included the use of indirect calorimetry to estimate caloric requirement and CHO fat ratio or nutritional assessment to guide implementation.

QUESTION 11

What is the role of hypertonic saline in fluid therapy?

Essentially hypertonic saline is used :

- (a) in the treatment of hypotonic states
- (b) in "small volume" resuscitation of hypovolaemia

Discussion of these two areas should have included these ideas:

- (a) Treatment of hypotonic states runs the risk of inducing pontine myelinolysis if too rapid. Hypertonic saline is usually reserved for emergency treatment of hyponatraemia in conjunction with a diuretic if the patient is either euvolaemic or hypervolaemic (eg. due to SIADH).

Serum Na should not be allowed to rise rapidly. Asymptomatic hyponatraemia requires conservative therapy. Symptomatic patients should be corrected so that serum Na rises slowly (eg. no more than 20-25mmol/l in 48 hours).

- (b) Small volume resuscitation has been suggested for field emergencies. The smaller volume is more portable and by giving a hyperosmotic solution burn oedema or cerebral oedema in head injury may be prevented. Hypertonic saline has been used in combination with colloid solutions and positive inotropy and peripheral vasodilatation have been ascribed to its use. This is not a common technique. Experimental still. An accumulating literature.

QUESTION 12

A toddler is admitted after swallowing an unknown number of her mother's iron tablets. What are the possible effects and how will you manage this emergency?

A devastating illness occasionally seen in toddlers who mistake Fe tablets for M & M's.

- (a) The iron is a mitochondrial poison and direct irritant to GIT mucosa.

The possible effects mentioned include:

- GIT - haemorrhagic necrosis of the GIT tract, perforation, peritonitis, scarring, obstruction
- CVS toxicity - hypovolaemia, myocardial depression, collapse
- Metabolic toxicity - severe metabolic acidosis due to mitochondrial

- dysfunction and cardio-vascular collapse
- Hepatic toxicity - hepatocellular damage leading to hepatitis and necrosis
- CNS - obundation to coma

- (b) Management should include :
 - resuscitation (airway protection, volume infusion etc.)
 - diagnosis on history and serum iron level
 - gastric lavage with HCO₃
 - whole bowel irrigation
 - laparotomy and tablet removal (if iron tablets are still seen on plain X-Ray of abdomen)
 - desferoxamine to bind free iron
 - supportive measures - treatment of acidosis, hypovolaemia, hyperglycaemia, coagulopathy etc.

QUESTION 13

Briefly outline the gross anatomy observed when doing a general bronchoscopy in a endotracheally intubated patient? Sketches may help to illustrate.

The aim of this question was to test the candidates practical experience. The candidate was expected to describe the landmarks which allow a complete procedure, detection of anatomic abnormalities and ability to locate a specific area and orientate within the bronchial tree. Namely:

- the appearance of the trachea (shape, rings anteriorly, colour)
- the carina (shape)
- the right main bronchus
 - right upper lobe bronchus laterally after 4 cm
 - right middle lobe bronchus anteriorly
 - lower lobe bronchus (separate apical segment bronchus posteriorly)
- the left main bronchus
 - left upper lobe bronchus laterally
 - lower lobe bronchus straight ahead

The segmental bronchi should have been listed.

The positions of the major bronchi may be orientated on a clock as seen when looking down the bronchoscope from above the patient,

Eg: RUL at 3 o'clock
 RML at 12 o'clock
 RLL apical segment 6 o'clock
 L UL 9 o'clock

or by diagram.

QUESTION 14

You are asked to assess a patient in the ward with acute asthma. How would you confirm the diagnosis and what would indicate the necessity for this patient's admission to ICU?

The candidate was expected to be experienced in this setting and able to assess severity of asthma.

- (a) The diagnosis could be confirmed by :
 - history of intermittent wheeze, steroid/bronchodilator therapy, previous admissions, allergies, chronic cough, atopia
 - examination - hyperinflated chest, wheeze, prolonged expiration, reduced FEV₁, PEFr
 - CXR if appropriate to exclude other causes (cardiac failure, foreign body etc) and complications (atelectasis, pneumothorax)
- (b) Admission may be indicated by :
 - florid respiratory failure (cyanosis, coma, etc.)
 - failure to respond to adequate therapy
 - tiring and worsening of clinical signs despite adequate therapy in prolonged attack
 - previous history of ventilation and brittle asthma

Clinical signs include sweating, use of accessory muscles, inability to talk or put sentences together, cyanosis, gasping, silent chest, worsening objective measures (ABG, PEFr, FEV), RR > 30, HR > 120, pulsus paradoxus > 20, normal or high PCO₂ metabolic acidosis, hypoxia despite O₂ therapy.

QUESTION 15

What do you do to prevent laryngotracheal damage associated with an endotracheal tube? What is the role of a large volume cuff?

This is basic ICU practice.

- (a) It was hoped that the candidate include:
 - choose the right size of tube (7.0 mm for small female etc.)

- choose the right shape of tube (avoid oxford etc.)
- choose the right tube material (avoid red rubber etc.)
- on insertion ensure a rigid sylet is not protruding, observe the larynx and insert the tube gently.
- prevent excessive movement (fixation, sedation, explanation)
- inflate the cuff to the appropriate volume to prevent pressure necrosis
- warm and humidify gases
- atraumatic suctioning

- (b) The candidate was expected to explain that all adult long term intubations should be with a high volume cuff and that high residual volume cuffs prevent tracheal damage by :

1. Conforming to the shape of the trachea
2. Allowing measurement of the lateral wall pressure exerted on the trachea.
3. Allowing a safety margin if slightly overinflated. Excess volume leads to a small increment in lateral wall pressure.

The cuff circumference at residual volume should be greater than the trachea circumference. Intracuff pressure (=lateral wall pressure) should be controlled by automatic device or regular measurement.

LONG ANSWER QUESTIONS

The most common problem was failure to answer the specific points of the question and the assertions of the quote.

QUESTION 1

"The Swan-Ganz Catheter is an accurate monitoring tool for every ICU patient. It provides unique and essential information on fluid status and left ventricular preload."

Critically analyse this statement giving your indications for the catheter's use and information gained.

This is a topical subject and a frequently used technique so a detailed answer was expected. Vague generalisation

did not suffice. The specific points in the question had to be addressed.

The question could have been approached by dissecting the quote:

- “an accurate monitoring tool”
 - the candidate would discuss the validity of data obtained and possible errors of interpretation and acquisition.
- “for every ICU patient”
 - the candidate should have stated which patient categories will benefit and in whom the “cost” benefit analysis favours catheter use. A list of potential complications was useful.
- “unique and essential information on fluid status and left ventricular preload”
 - is the information obtained unique to the device and essential in all ICU patients.
 - the candidate should have displayed an understanding of “preload” and its relationship to fluid status. Then shown how pulmonary artery occlusion pressure differs from preload and has no direct relationship. LVEDP/LVEDV relationship is best described as a series of curves.

Finally the candidate should have listed the potential information to be gained and how it may be used.

Unfortunately, candidates asserted that preload is synonymous with LVEDP, provided irrelevant history or failed to address the issues set.

QUESTION 2

A twenty-six year old woman is admitted with fitting, severe hypertension and an apparent thirty-week-size uterus. There is a history of prolonged amenorrhoea.

What is your plan of initial management?

What are the complications of the most likely condition and how will you prevent or treat them?

This is an emergency and presumably a case of eclampsia. The candidate was expected to work through a stepwise approach including formation of a differential diagnosis.

(a) Topics discussing management should have included the headings :

- resuscitation securing the airway and ventilation (including rationale, potential difficult intubation, full stomach etc)
- termination of convulsions (eg. Diazepam, potential problems)
- prevention of further convulsion (Mg SO₄, phenytoin, dose, administration)
- control of hypertension (choice of agent, pros and cons)
- plasma expansion (assessment, monitoring)
- monitoring (invasive arterial, CVP, PAC)
- differential diagnosis by history, examination, investigation
- diagnosis of pregnancy and assessment of foetal wellbeing :
 - CTG
 - Ultrasound
- consultation with obstetrician, paediatrician re further management (timing of delivery, IV steroids etc)
- detection of complications :
 - liver function tests
 - coagulation profile
 - FBC (NB platelet count)
 - electrolytes, urea, creatine
- organisation of urgent caesarean section (rationale, technique, risks)

Recent evidence for the use of Mg SO₄ should have been quoted.

(b) Complications covered should have included:

- placental insufficiency and foetal abnormalities
- cerebral problems (cerebral oedema or haemorrhage)
- renal failure
- liver failure (HELLP syndrome)
- thrombocytopenia, DIC, haemolysis (HUS)
- cardiovascular complications
- pulmonary oedema

Prevention of complications revolves around meticulous control of maternal hypertension, volume status, coagulation status and support of ventilation. Delivery of the foetus is central.

The candidate was expected to explain the pathophysiology and theories of genesis of eclampsia

and show an understanding of the multiorgan disease.

Candidates failed to consider a differential diagnosis or even gather history from available sources. Initial handling of the obvious problems was usually good but other causes (SAH, meningitis etc) were often not mentioned. The difficult issues of when to deliver the baby and how to treat persistent fitting were often sidestepped.

ORAL SECTIONS

The candidates are recognised as often being nervous and this is taken into account in assessment. They are advised to not exchange information with other candidates as this is usually misleading.

INVESTIGATIONS

It is important to be able to recognise normals and not feel compelled to find imaginary abnormalities. If the candidate does not recognise the abnormality, this should be stated. To seek help and consult is good practice. Confabulation is dangerous.

The candidates encountered:

Haematology	eosinophilia, anaemia
Biochem	hepatitis, hyponatraemia
ABG	acid base abnormalities
ECG	SVT, paced rhythm, myocarditis, infarct
CSF	meningitis, bloody tap
X-Ray	pneumothorax, mediastinal tumour, foreign body in bronchus epiglottitis, HMD, ectopic tubes
	(The candidates should make use of a bright light to look for detail if appropriate.)
CT	extradural, intracerebral, Arnold-Chiari
MRI	cerebral oedema
Urine	normals

The investigations are usually introduced with a clinical scenario.

CLINICAL

Coverage included:

Cold cases:

Horners syndrome
AS + AR
HOCM
COAD
Chronic liver disease

ICU cases:

- cerebral infarct, axillary vein thrombosis and severe COAD with acute bronchospasm
- varicella, staph septicaemia, ARF
- liver failure, encephalopathy
- polio with respiratory failure
- spinal injury

CROSS TABLE VIVAS

Topics covered included:

Brain death DKA
Hyponatraemia
Postoperative weakness
Independent lung ventilation
Status epilepticus
GIT bleeding
ICU diarrhoea
Needle stick injury
Management issues
Ethics
Heliox

Candidates were also asked to perform CPR, ICC or CVC insertion.

R.P LEE
Chairman, Examination

POLICY DOCUMENT

Review IC-1 (1997)

FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ACN 055 042 852

MINIMUM STANDARDS FOR INTENSIVE CARE UNITS

INTRODUCTION

An Intensive Care Unit (ICU) is a specially staffed, and equipped, separate and self-contained section of a hospital for the management of patients with life-threatening or potentially life-threatening conditions. Such conditions should be compatible with recovery and have the potential for an acceptable future quality of life. An ICU provides special expertise and facilities for the support of vital functions, and utilises the skills of medical, nursing and other staff experienced in the management of these problems.

The concentration of staff and equipment to care for these critically ill patients in one area of the hospital encourages efficient use of expertise and limited resources. The concept of a general ICU, rather than separate specialised units such as medical, respiratory and surgical has developed in Australasia. This is because the skills and resources necessary to care for the critically ill are common, and most efficiently concentrated in one area. This does not preclude the division of one ICU into a higher level (eg. for ventilated patients) and lower or "step-down" level (eg. for post-operative patients), nor does it preclude the siting of specific high dependency areas elsewhere (eg. neurosurgical, post-operative cardiothoracic area). Neonatal and Paediatric Intensive Care Units are preferably separate from general ICU's. Coronary care patients and children are sometimes managed in a general ICU.

Within each Unit, policies should be available for the admission criteria of patients as well as protocols for transferring and retrieving patients.

LEVELS OF INTENSIVE CARE UNITS

The level of intensive care available should support the delineated role of the particular hospital. The role of a particular ICU will vary, depending on staffing, facilities and support services as well as the type and number of patients it has to manage.

1. LEVEL III ADULT INTENSIVE CARE UNIT

A Level III ICU is a tertiary referral unit for intensive care patients and should be capable of providing the highest level of care including complex multi-system life support for an indefinite period. It must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardiovascular monitoring for an indefinite period. It should have extensive backup laboratory and clinical service facilities. All patients admitted to the Unit must be referred for management to the attending intensive care specialist.

A Level III ICU should be a self-contained area, with easy access to the emergency department, operating theatres and organ imaging. It should have:

- 1.1 Defined admission, discharge and referral policies.
- 1.2 At least six staffed and equipped beds.
- 1.3 More than 350 mechanically ventilated patients per annum.

- 1.4 A medical director who is recognised by the Joint Specialist Advisory Committee in Intensive Care (JSAC-IC) as a specialist in intensive care. The medical director must have a clinical practice predominantly in intensive care medicine.
- 1.5 Sufficient supporting specialist(s) so that consultant support is always available to the medical staff in the Unit. There should be sufficient specialist staff to provide for reasonable working hours and leave of all types and to allow the duty specialist to be available exclusively to the Unit; all attending specialists in the Unit should be recognised by the JSAC-IC as specialists in intensive care.
- 1.6 At least one of the supporting specialists exclusively rostered to the Unit (or to more than one Unit in the same building) at all times. During normal working hours this specialist must be predominantly present in the Unit, and at all other times be able to proceed immediately to it.
- 1.7 In addition to the attending specialist, at least one registered medical practitioner with an appropriate level of experience exclusively rostered and predominantly present in the Unit at all times.
- 1.8 A minimum of 1:1 nursing for ventilated and other similarly critically ill patients, and nursing staff available to greater than 1:1 ratio for patients requiring complex management.
- 1.9 A nurse in charge of the Unit with a post registration qualification in intensive care or in the clinical specialty of the Unit.
- 1.10 The majority of nursing staff must have a post registration qualification in intensive care or in the specialty of the Unit.
- 1.11 All nursing staff in the Unit responsible for direct patient care should be registered nurses.
- 1.12 A nurse educator and formal nursing educational programme.
- 1.13 24 hour access to pharmacy, pathology, operating theatres and tertiary level imaging

services, and appropriate access to physiotherapy and other allied health services.

- 1.14 Suitable infection control and isolation procedures and facilities including ideally one wash basin per bed, and at least one isolation room with controllable air flow.
- 1.15 Formal audit and review of its activities and outcomes.
- 1.16 Support staff as appropriate, eg. biomedical engineer, clerical and scientific staff.
- 1.17 Educational programmes for medical staff.
- 1.18 Adequate office space.
- 1.19 An active research programme.
- 1.20 An orientation programme for new staff.

2. LEVEL II ADULT INTENSIVE CARE UNIT

A Level II ICU should be capable of providing a high standard of general intensive care, including complex multi-system life support which supports the hospital's other delineated roles, eg. general medicine, surgery, trauma management, neurosurgery, vascular surgery, etc. It should be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for at least several days. All patients admitted to the Unit must be referred for management to the attending intensive care specialist.

A Level II ICU should be a self-contained area with easy access to the emergency department, operating theatres and organ imaging. It should have:

- 2.1 Defined admission, discharge and referral policies.
- 2.2 A medical director recognised by the JSAC-IC as a specialist in intensive care. The medical director must have a clinical practice predominantly in intensive care medicine.
- 2.3 At least one other specialist recognised by JSAC-IC as a specialist in intensive care.
- 2.4 The Unit needs sufficient specialist staff to provide reasonable working hours and leave of all types and to allow the duty specialist to

be rostered and available exclusively to the Unit.

- 2.5 In addition to the attending specialist, at least one registered medical practitioner with an appropriate level of experience exclusively rostered to the Unit and immediately available at all times.
- 2.6 A nurse in charge of the Unit with a post registration qualification in intensive care or in the clinical specialty of the Unit.
- 2.7 All nursing staff responsible for direct patient care being registered nurses and the majority of nursing staff having a post registration qualification in intensive care or in the clinical specialty of the Unit.
- 2.8 Nursing staff : patient ratio of 1:1 for all ventilated and other critically ill patients; the capacity to provide greater than 1:1 nursing for selected patients: some patients may require less than 1:1 nursing.
- 2.9 Access to a nurse educator.
- 2.10 Educational programmes for medical and nursing staff.
- 2.11 An orientation programme for new staff.
- 2.12 Formal audit and review of its activities and outcomes.
- 2.13 Suitable infection control and isolation procedures and facilities including ideally one wash basin per bed, and at least one isolation room with controllable airflow.
- 2.14 24 hour access to pharmacy, pathology, operating theatres, basic imaging services and appropriate access to physiotherapy and other allied health services.
- 2.15 Support staff as appropriate, eg. biomedical engineer, clerical staff.
- 2.16 Adequate office space.

3. LEVEL I ADULT INTENSIVE CARE UNIT

A Level I ICU should be capable of providing immediate resuscitative management for the critically ill, short term cardio-respiratory support,

and have a major role in monitoring and prevention of complications in "at risk" medical and surgical patients. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours.

The patients most likely to benefit from Level I care include:

- (a) patients with uncomplicated myocardial ischaemia;
- (b) post-surgical patients requiring special observations and care;
- (c) unstable medical patients requiring special observations and care beyond the scope of a conventional ward, and
- (d) patients requiring short term mechanical ventilation.

A Level I ICU should be a self-contained area with easy access to the emergency department, operating theatres and organ imaging. It should have:

- 3.1 Defined admission, discharge and referral policies.
- 3.2 A medical director who is recognised by JSAC-IC as a specialist in intensive care.
- 3.3 Consultant support always available.
- 3.4 At least one registered medical practitioner who is available to the Unit at all times.
- 3.5 A nurse in charge of the Unit who has a post registration qualification in intensive care or in the clinical specialty of the Unit.
- 3.6 All nursing staff of the Unit responsible for direct patient care being registered nurses; and the majority must have a post registration qualification in intensive care or in the clinical specialty of the Unit.
- 3.7 A nursing staff : patient ratio of 1:1 for all critically ill patients.
- 3.8 A minimum of two registered nurses present in the Unit at all times when there is a patient admitted to the Unit.
- 3.9 Educational programmes for both medical and nursing staff.

- 3.10 An orientation programme for new staff.
- 3.11 Audit of its activities and their outcome.
- 3.12 24 hour access to pharmacy, pathology, operating theatres and basic imaging services and appropriate access to physiotherapy and other allied health services.
- 3.13 Support services, eg. technical, clerical.
- 3.14 Adequate office space.

4. PAEDIATRIC INTENSIVE CARE UNIT

A Paediatric Intensive Care Unit must be a separate area in the hospital capable of providing complex, multi-system life support for an indefinite period. It should have easy access to the Emergency Department, Operating Theatres and Organ Imaging. It must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period to infants and children less than 16 years of age. It must be a tertiary referral centre for children needing intensive care and have extensive backup laboratory and clinical services facilities to support this tertiary role. All patients admitted to the Unit must be referred for management to the attending intensive care specialist.

A Paediatric Intensive Care Unit should have the following:

- 4.1 Defined admission and discharge policies.
- 4.2 A medical director who is recognised by the JSAC-IC as a specialist in intensive care.
- 4.3 Sufficient supporting specialists so that consultant support is always available to the medical staff in the Unit. There should be sufficient specialist staff to provide for reasonable working hours and leave of all types and to allow the duty specialist to be available exclusively to the Unit.
- 4.4 At least one attending specialist who is predominantly present during normal working hours and who is exclusively rostered and able to proceed immediately to the Unit at all times.
- 4.5 In addition to the attending specialist, at least one registered medical practitioner with an appropriate level of experience who is in the hospital, predominantly present in the Unit and exclusively rostered to the Unit at all times.
- 4.6 A nurse in charge of the Unit holding a post-registration qualification in intensive care or in the clinical specialty of the Unit.
- 4.7 A minimum of 1:1 nursing for ventilated and other similarly critically ill patients, and nursing staff available to greater than 1:1 ratio for patients requiring complex management: some patients may require less than 1:1 nursing.
- 4.8 The majority of nursing staff should have a post-registration qualification in intensive care or in the specialty of the Unit.
- 4.9 At least one nurse with a post-registration qualification in paediatric intensive care on duty in the Unit at all times.
- 4.10 A nurse educator and formal nursing education programme.
- 4.11 Twenty four hour access to pharmacy, pathology, operating theatres and tertiary level imaging services and appropriate access to physiotherapy and other allied health services.
- 4.12 Suitable infection control and isolation policies and facilities including ideally one wash basin per bed, and at least one isolation room with controllable air flow.
- 4.13 Formal audit and review of its activities and outcomes.
- 4.14 Support staff as appropriate, eg. biomedical engineer, clerical and scientific staff.
- 4.15 Active medical and nursing education programmes in the Unit that are relevant to the specialised facilities of the Unit.
- 4.16 Adequate office space.
- 4.17 Unit-based quality activities.
- 4.18 An active research programme.
- 4.19 An orientation programme for new staff.

MINIMUM STANDARDS GUIDELINES

5. OPERATIONAL

All Units should have defined policies for admission, management, discharge and referral of patients. The Unit should be under the direction of a single medical specialist. This person should institute agreed policies, develop a team approach for management and be responsible to the hospital administration through appropriate channels. Clinical management of the patient must be achieved within the framework of agreed policies (eg. procedural and infection control, including defined antibiotic policies for both standard and research antibiotics). The Unit should have procedures for formal audit, peer review and quality assurance. In Level II units, an active research programme should be encouraged, while in Level III units, an active research programme must exist. Services required on a 24 hour basis include imaging, laboratory and other diagnostic facilities. All patients admitted to Level II and Level III units must be referred for management to the attending intensive care specialist.

6. STAFFING

6.1 Medical Staff

The medical director of Level II and III units and all senior medical staff appointed to Level III units, should be recognised by the JSAC-IC as a specialist in intensive care. Sufficient specialist staff with experience in intensive care to provide for administration, teaching, research, reasonable working hours and leave of all types are necessary. In Level II and III units there must be at least one specialist exclusively rostered to the Unit at all times. There should be 24 hour full-time junior medical staff with an appropriate level of experience rostered exclusively to Level II and III units at all times. In Level III units there must be access to a broad range of specialty consultants.

6.2 Nursing Staff

The nursing staff: patient ratio and the total number of nursing staff required by each unit depends on many variables such as the

total number of patients, severity of illness of patients, as well as individual policies for support and monitoring in each unit. Level I and II units should be capable of providing a nursing staff:patient ratio of 1:1 for all critically ill patients. Level III units should be capable of providing nursing care to greater than 1:1 ratio for critically ill or unstable patients. All nurses involved in direct patient care should be registered nurses and the nurse in charge and the majority of nursing staff in each Unit should have a post registration qualification in intensive care or in the specialties of the Unit.

An artificially ventilated patient needs at least one nurse at the bedside at all times. A ventilated patient with more complex support such as dialysis and inotropic support may need two nurses per patient for at least some of the shift. Others such as post-operative patients admitted for overnight monitoring and treatment with a continuous epidural and supplemental oxygen, may require only one nurse per 2-3 patients. Allowances must be made for meal breaks, handover times, holidays, sickness, study leave, etc.

6.3 Other Staff

Depending on the needs of the Unit, physiotherapists, radiographers, dietitians, technicians including biomedical engineering and scientific officers, cleaning staff, social workers, occupational therapists, interpreters, pastoral, secretarial and clerical staff are all required. Secretarial services should be available to support educational and administrative activities. These should be separate from ward clerk duties in the ICU.

6.4 Educational

The Unit should have an educational programme for medical, nursing and other staff. Units at Level II or III should have a nurse educator and a formal educational programme.

7. STRUCTURE OF AN ICU

7.1 Siting

The ICU should be a separate Unit within the hospital with easy access to the emergency department, operating theatres and organ imaging.

7.2 Design

A high standard of intensive care medicine is influenced by good design and adequate space. Whenever renovations or new structures are being planned there are certain features which should be considered.

7.2.1 *Patient Area* - in adult intensive care units at least 20m² floor area is required for each bedspace in an open area exclusive of service areas indicated below. At least one wash basin for every two beds is recommended and one for each bedspace is preferred. At least one single room should be available for every six open space beds. Each single room needs to have its own wash basin. There must be an adequate number of service outlets depending on the purpose of the Unit. A Level III unit will require at least three oxygen, two air and three suction outlets, and at least 16 power points for each bedspace. The electrical wiring and protection of patient treatment areas must be Cardiac Protected Status AS3003. Adequate and appropriate lighting for clinical observation must be available. Service outlets and lighting must comply with standards prescribed by the appropriate authority. For the psychological well-being of patients and staff, windows and bed access to the exterior are desirable features. Design of the Unit should take into account the need for patient privacy.

7.2.2 *Working Area* - the working area must include adequate space for staff to work in comfort while maintaining visual contact with the patient. Adequate space must be allowed for

patient monitoring, resuscitation equipment, and medication storage areas (including a refrigerator). The Unit needs space for a mobile x-ray machine, and the x-rays themselves, while the x-ray viewing facilities must enable simultaneous viewing of multiple x-rays. There should be adequate room for telephones and other communication systems, computers and data collecting, also for the storage of stationery. Adequate space for a receptionist and/or ward clerk must be available.

7.2.3 *Environment* - the Unit should have appropriate air conditioning which allows control of temperature, humidity and air change.

7.2.4 *Isolation area* - the Unit must be capable of isolation procedures.

7.2.5 *Equipment storage area* - eg. for monitors, ventilators, infusion pumps and syringes, dialysis equipment, disposables, fluids, drip stands, trolleys, blood warmers, suction apparatus, linen, large items of special equipment.

7.2.6 *Dirty utility* - area for cleaning appliances, urine testing, emptying and cleaning bed pans and urine bottles. Unit design should provide appropriate movement pathways for contaminated equipment.

7.2.7 *Staff Facilities* - should be sited close to the patient area and have adequate communication with it.

7.2.8 *Seminar Room* - should be situated close to the patient area with adequate communication, and be equipped with seating, audiovisual aids, wall boards and other teaching aids.

7.2.9 *Nursing Offices* - separate offices must be provided at least for the Nurse in Charge and Nurse Educator.

- 7.2.10 *Medical Offices* - each senior doctor should have adequate office space.
- 7.2.11 *Relatives' area* - a separate waiting area must be available (with drinks dispenser, radio, television and comfortable seating desirable). A separate interview room and a separate area for distressed relatives, should be available and overnight rooms for relatives should also be considered.
- 7.2.12 *Secretarial area* - a separate area should be available for departmental secretarial assistance. Records storage has to be accommodated.
- 7.2.13 *Computing facilities* - a separate area should be designated for computerised patient data entry and analysis. Confidentiality should be built into any system.
- 7.2.14 *Cleaners' area* - for storage of equipment and materials.
- 7.2.15 *Workshop and Laboratory* - should be considered for any unit which does not rely on centralised services.
- 7.2.16 *Library facilities* - an appropriate range of bench manuals, textbooks and journals for rapid access 24 hours a day should be available within the Unit complex.

8. EQUIPMENT

- 8.1 The type and quantity of equipment will vary with the type, size and function of the Unit and must be appropriate to the workload of the Unit, judged by contemporary standard.
- 8.2 There must be a regular system in force for checking the safety equipment.
- 8.3 Basic equipment should include:
- ventilators
 - hand ventilating assemblies
 - suction apparatus
 - airway access equipment, including bronchoscopic equipment

- vascular access equipment
- monitoring equipment, both non-invasive and invasive
- defibrillation and pacing facilities
- equipment to control patient's temperature
- chest drainage equipment
- infusion and specialised pumps
- portable transport equipment
- specialised beds

Other equipment (for example haemodialysis and intra-aortic balloon counter pulsation equipment etc) for specialised diagnostic or therapeutic procedures should be available when clinically indicated and in order to support the delineated role of the ICU.

Protocols and inservice training for medical and nursing staff need to be available for the use of all equipment, including steps to be taken in the event of malfunction.

9. MONITORING

Monitoring of certain fundamental physiological variables should be carried out.

Some or all of these basic recommendations will need to be exceeded routinely depending on the physical status of the patient. Occasionally some of the recommended methods of monitoring may be impractical or inappropriate. Intensive care units should establish policies to deal with such circumstances.

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

The health care facility in which the intensive care is being carried out is responsible for provision of equipment for intensive care and monitoring on the advice of one or more designated intensive care specialists, and for effective maintenance of this equipment.

9.1 Personnel

Clinical monitoring by a vigilant nurse is the basis of intensive patient care. This should

be supplemented by appropriate devices to assist the nurse.

9.2 Patient Monitoring

9.2.1 Circulation

The circulation must be monitored at frequent and clinically appropriate intervals by detection of the arterial pulse, ECG display and measurement of the arterial blood pressure.

9.2.2 Respiration

Respiratory function should be assessed at frequent and clinically appropriate intervals by observation, supported by capnography and blood gas analysis.

9.2.3 Oxygenation

The patient's oxygenation should be assessed at frequent and clinically appropriate intervals by observation, pulse oximetry and blood gas analysis as appropriate.

9.3 Equipment (including portable equipment used for patient transports)

9.3.1 Piped gas supply failure alarm

There must be piped gas supply failure alarms.

9.3.2 Oxygen supply failure alarm

An automatically activated device to monitor oxygen supply pressure and to warn of low pressure must be fitted to ventilators.

9.3.3 Oxygen analyser

An oxygen analyser must be available to measure the oxygen concentration delivered by ventilators or breathing systems.

9.3.4 Alarms for Breathing System

Disconnection or Ventilator Failure

When an automatic ventilator is in use, a device capable of warning promptly of a breathing system disconnection or ventilator failure must be in continual operation.

9.3.5 Ventilator volumes and pressures

When a ventilator is in use, ventilatory volumes should be measured although it is accepted that this is not always possible with some ventilators used for paediatric and neonatal patients. Airway and respiratory circuit pressure must be monitored continuously and prompt warning given of excessive pressures.

9.3.6 Humidifier temperature

When a heated humidifier is in use monitoring of the inspired temperature must be available which alarms at high temperature.

9.3.7 Electrocardiograph

Equipment to monitor and continually display the electrocardiograph must be available for every patient.

9.3.8 Pulse Oximeter

A pulse oximeter must be available for every patient in intensive care.

9.3.9 Air embolus

When a patient is treated by haemodialysis, plasmapheresis or circulatory perfusion, monitoring for air embolus must be in use.

9.3.10 Other Equipment

When clinically indicated, equipment should be available to measure other physiological variables such as intra-arterial and pulmonary artery pressures, cardiac output, inspiratory pressure and airway flow, intracranial pressure, temperature, neuromuscular transmission, expired carbon dioxide.

OTHER DOCUMENTS RELEVANT TO INTENSIVE CARE

- IC-2 "The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts"
- IC-3 "Guidelines for Hospitals seeking Faculty Approval of Training Posts in Intensive Care"
- IC-4 "The Supervision of Vocational Trainees in Intensive Care"
- IC-6 "Supervisors of Training in Intensive Care"
- IC-7 "Secretarial Services to Intensive Care Units"

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

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

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

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

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

- E1 (1996) Guidelines for Hospitals seeking College Approval of Posts for the First Four Years of Vocational Training in Anaesthesia *Bulletin Nov 96, pg 64*
- E3 (1994) The Supervision of Trainees in Anaesthesia *Bulletin Nov 92, pg 41*
- 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
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- T4 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT)
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- T5 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries *Bulletin Nov 95, pg 65*
- T6 (1995) Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites *Bulletin Nov 95, pg 61*
- P1 (1997) Essential Training for General Rural Practitioners in Australia Proposing to Administer Anaesthesia
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- 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
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- P6 (1996) Minimum Requirements for the Anaesthesia Record *Bulletin Mar 96, pg 48*
- P7 (1992) The Pre-Anaesthetic Consultation *Bulletin Nov 92, pg 47*
- P8 (1993) Minimum Assistance Required for the Safe Conduct of Anaesthesia *Bulletin Nov 93, pg 33*
- P9 (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*
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- P13 (1992) Protocol for The Use of Autologous Blood *Bulletin Aug 92, pg 49*
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- P15 (1995) Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery *Bulletin Aug 95, pg 62*
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