Australian and New Zealand College of Anaesthetists

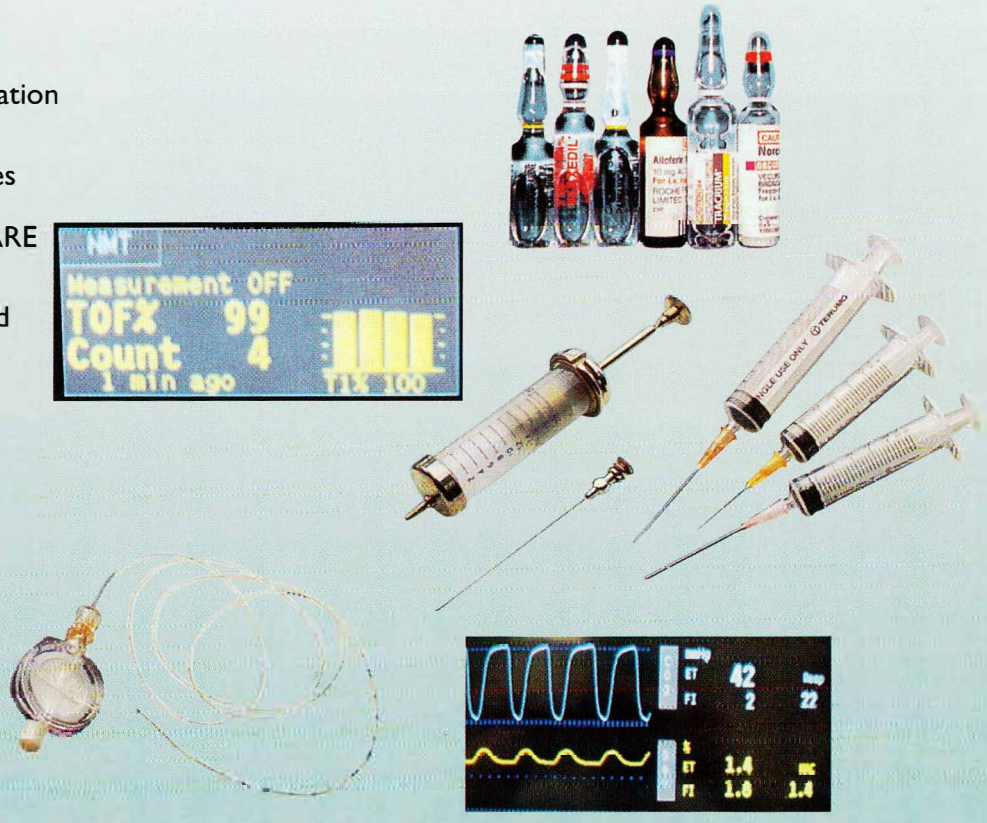
ACN 055 042 852

and Faculty of Intensive Care

Bulletin

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

Inside...



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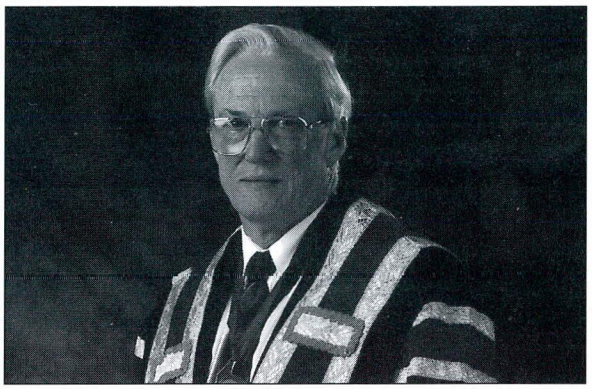
PRESIDENT'S MESSAGE



College Developments

Fellows may be aware that "Ulimaroa", our Headquarters building in Melbourne will, within a few years, provide inadequate space for the needs of the expanding College and Faculty of Intensive Care. A Working Party has been asked to prepare an options paper for Council on this matter. One of the options will be extension on site with a contemporaneous facade and a state of the art education facility within.

Dench McClean and Associates, who facilitated the Strategic Planning Day for Council in February, are nearing completion of a comprehensive review of the staffing, structure and function of all our offices, with the aim of streamlining office activities.

In October, a Maintenance of Standards Workshop enabled Council, Regional Education Officers, Younger Fellows and Rural Fellows representatives to review and plan an updated approach to MOS. The conclusions of this Workshop will be provided elsewhere and consultation will take place with Regional Committees and Fellows prior to introduction of any changes.

College - Asia Matters

As a follow up to my message in the August Bulletin, I am pleased to report that liaison between the College and Australian Society of Anaesthetists has taken a major step forward following discussions held during the recent ASA Meeting in Hobart. Meetings of the College/Society Liaison Committee, comprising both Presidents and Vice Presidents will now consider formally the Minutes of our Liaison Committees concerned with Overseas Aid/Asia Pacific, National Anaesthesia Day, Archive preservation, Anaesthesia/ Industry liaison and other matters. It has also been agreed that the two bodies continue to define their areas of responsibility, to avoid overlap, and to maximise efficient use of resources for the benefit of our specialty.

The last session of the Congress, chaired by Hugh Spencer from Waikato, contained papers on ASA activities in the Pacific (Steve Kinnear), Anaesthesia, Intensive Care and Pain Management in Papua New Guinea (Garry Phillips), Anaesthesia in the Solomon Islands (Narko Tutuo) WFSA activities in other regions (Kester Brown) and Anaesthesia in Difficult Circumstances and Remote Locations (Haydn Perndt). The session provided a clear message for anaesthesia organisations in the region to work together to help each other, starting at the level of the individual.

Medical Training Review Panel

The first report of the MTRP, established by the Commonwealth Minister for Health and Family Services, subsequent to the Health Insurance Amendment Act (No. 2) 1996, has just been published. This marks the beginning of a process aimed at not only examining the training available to new medical graduates in Australia, but also reviewing the transparency of arrangements for the selection of graduates into Medical College training Programmes.

Future reports will examine the training needs of the third postgraduate year and beyond, with emphasis on selection criteria, selection decision processes and appeals mechanisms.

Matters under consideration include the need for rural placements for doctors in training and provisions for overseas trained doctors, temporary resident doctors, occupational trainees, doctors temporarily out of the workforce, and those wishing to change or enhance their skills by undertaking further training. Most Colleges currently make provision for most of the above, but there is a striking lack of uniformity which calls for review. The College has made a submission, and been interviewed by the Consultants undertaking the works on trainee selection. A second consultancy will seek further information on the size and nature of the cohort of junior doctors affected by the "Provider Number" Legislation, including the training opportunities available to them,

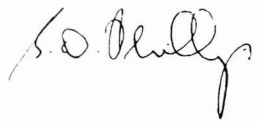
Academy of Medicine

The Committee of Presidents of Medical Colleges will consider shortly a proposal that it be replaced by an Academy of Medicine (of Medical Colleges) which could speak for the Colleges on relevant issues, within certain guidelines. Such bodies exist in different forms in a number of countries, including Hong Kong, the United Kingdom, Malaysia and Singapore. A detailed report on progress will be published in the next edition of the Bulletin.

Christmas Season

Christmas is coming and I would like to wish all Fellows, trainees, staff and their families a happy time and a good start to 1998. "If all the problems besetting us are seen as opportunities, the opportunities before as seem endless" (Anon).

Best wishes,



GARRY PHILIPS

ADMISSION TO FELLOWSHIP BY EXAMINATION

Toby Charles BRANSON, SA

Andrew CZUCHWICKI, SA

Carolyn Gaye FOWLER, NZ

Grace Nguk Kiat KOO, SA

Hong Joo LIM, Mal

Ian LOMAS, Qld

Nicola Jane Devenish MEARES, NSW

Suresh PATHY, Vic

Hugh Richard PLAYFORD, Qld

Andrew Winton REID, NZ

Bryan Reginald RUSS, WA

Hugh Keeley WELCH, WA

Cynthia Mun Ling WONG, Hong Kong

VICTORIAN CHAIRS OF ANAESTHESIA APPEAL

Peter Lowe, Chairman

On Friday the 15th of August an informal function was held at the College to "wind up" the Victorian Chairs of Anaesthesia Appeal. This was the culmination of an exercise commenced in 1988 when the Victorian Regional Committee agreed to establish a steering committee to investigate how academic activity in Anaesthesia in Victoria might best be promoted. It was apparent that the lack of University Units in our discipline was a major impediment to such progress and the establishment of one or more Chairs in Anaesthesia would make a major contribution to our specialty at the academic level.

The steering committee advised the Victorian Regional Committee of the need to establish chairs in the Victorian Medical Schools and had concluded that an appeal to raise funds would achieve this objective. As it is said "The rest is History." In 1989 an Appeal under the chairmanship of Mr R.K.W. (Bob) Bennett, a senior executive with the ANZ Banking Group, was launched by Professor Sir Gustav Nossal, then Director of the Walter and Eliza Hall Institute, at a function at the RACS. Prior to this an "In House" Committee under Dr John Paull's Chairmanship had commenced to raise funds from the Anaesthetic community and the remarkable result was to raise a sum in excess of $700,000 from a constituency of some five to six hundred. To the best of my knowledge this is one of the most successful results ever achieved by a professional group of this nature. This underpinned the approach the Appeal Committee made to various charitable trusts and the Medical Industry.

By 1992 sufficient funds had been raised to offer support to the establishment of a Chair of Anaesthesia in Victoria. On the advice of the Victorian Chairs of Anaesthesia Advisory Committee Monash University was awarded $1.25 million for the foundation Chair of Anaesthesia at that University and indeed the first full chair in the State. Since then further funds have been raised and it has given those associated with the appeal satisfaction to be involved with the early development of an academic unit in Anaesthesia at the University of Melbourne. In all, the Victorian Chairs of Anaesthesia Appeal has distributed $1,525,000 towards Academic units in Anaesthesia.

The success of this appeal was ultimately a result of the extraordinary support the Anaesthetic Community gave to this appeal. This was reflected in the support given by the Victorian Regional Committee, the Board of Faculty and subsequent College Council and most ably assisted by the administrative staff. Those associated with the appeal wish to thank all donors for their generosity and also for the support received from the medical industry.

Mr Bob Bennett has worked tirelessly with his Committee to ensure the success of this appeal and he was particularly supported by Dr John Paull who was succeeded by Dr Patricia Mackay. So many others gave generously of their time that it would be impossible to report their contributions other than to record publicly the contributions they all made. I also wish to record Dr Ian Rechtman's contribution who, as Chairman of the Victorian Regional Committee when this proposal was floated, successfully steered it through meetings of that committee and later as a College Councillor has strongly supported this development.

Finally it remains for me to say that it has been an honour to be involved in such an important development and to thank those of the College the ASA and the three non anaesthetist advisers who, as members of the Victorian Chairs of Anaesthesia Advisory Committee, have so ably advised the College Council on the distribution of funds.

CHLOROFORM SESQUICENTENARY

On 6th September, 1997 Professor Michael Cousins AM, delivered the Royal College of Anaesthetists Lecture entitlted "Pain Relief – A Basic Human Right" at the Chloroform Sesquicentenary (1847-1997) at the University of Edinburgh. This Meeting was sponsored jointly by the British Pharmacological Society, The Royal College of Anaesthetists, The Royal College of Surgeons and the Royal College of Obstetricians and Gynaecologists. In her introduction to the Meeting the Patron, Her Royal Highness, The Princess Royal stated

> "Somewhere I can hear Queen Victoria cheering the decision to celebrate the 150th anniversary of the discovery of the anaesthetic effects of chloroform. James Young Simpson was one of several remarkable 19th century British doctors who seized the opportunity to transfer the well-being of their fellow men and women. Of his many contributions to medicine the successful search for the means of relieving the pain of labour is probably the greatest and the one which Queen Victoria was so grateful for. Not only did he achieve the therapuetic means to realise his ambition but, perhaps even more significant, he strove to alter the attitudes of society to the pain of labour and of surgery.
>
> James Simpson had to overcome what we would regard now as surprising prejudice to the relief of pain in childbirth. The awareness that Queen Victoria was willing – even happy – to have chloroform analgesia for the first of her last two children, made an important impact on the acceptance of the procedure. The control and relief of pain has come a long way since then.
>
> It is fitting that four Medical Royal Colleges and the Pharmacologists have combined with the University of Edinburgh to launch this event and to welcome the many visitors from other countries who will join in the celebrations."

LAW REPORT

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

TRADE PRACTICES COMMISSION CHALLENGES DOCTORS

The Australian Competition and Consumer Commission announced on 14 October, 1997 that it proposed to institute proceedings against five Sydney anaesthetists and the Australian Society of Anaesthetists alleging price fixing in relation to after hours anaesthetic services at three Sydney metropolitan hospitals, and the potential boycott of those services at one of the hospitals.

It is also alleged that the Society and others will be involved in the proceedings, on the supposed basis that they "were knowingly concerned in, or party to, one or more of the agreements".

The allegations apparently arise out of a series of meetings and a recommendation to the ASA that it "recommend and set an appropriate on-call fee to be paid by private hospitals to anaesthetists, and that the fee should be $25.00 an hour".

As noted in previous Bulletins, the extension of the Trade Practices Act to the medical professions presents new challenges to doctors and their professional organisations. The Competition Policy Reform Act 1995 gave effect to amendments to the Trade Practices Act, which commenced on 21 July, 1996.

The Trade Practices Act operates to prohibit certain anti-competitive practices, including:

- Agreements which contain an exclusionery provision (a boycott or restriction on dealing with particular suppliers or customers).
- Agreements to fix, control or maintain prices.
- Agreements which have the purpose or effect of substantially lessening competition in a market.

In this case, the ACCC is challenging conduct by some professionals on the basis that it represents an agreement to set fees or prices. In addition, a boycott or group arrangements in dealing with health insurance funds or hospitals, either as to fees or prices, or in relation to terms and conditions otherwise, would potentially infringe the Trade Practices Act.

Of course, many medical professional societies, including the AMA and ASA, have traditionally played an industrial representation role. Now, however, the ability of doctors to combine to negotiate their services and terms is substantially limited by the Trade Practices Act. An attempt by doctors to collectively negotiate may breach the Trade Practices Act.

These provisions may apply, not just in cases where doctors collectively agree on pricing. They may also affect the ability of doctors to collectively negotiate with health funds, or in relation to "managed care contracts".

The Trade Practices Act also has the ability to affect restrictive arrangements between doctors and suppliers, such as links to radiology, blood and other testing services, etc.

As previously noted in the Bulletin, the ACCC has intervened in a dispute involving the Mildura Base Hospital in Victoria, in which it was alleged that doctors had colluded in a collective negotiation strategy on

terms and conditions with the hospital. In that case, whilst the ACCC issued a warning, it failed to take any further action.

In my previous Bulletin article on this subject, I suggested that the changes brought to the Trade Practices Act had commenced with a whimper - and that we should expect the "bang" in the not too distant future. This dramatic action by the ACCC indicates that the brave new world is now upon us.

ALLOCATING SCARCE MEDICAL RESOURCES

Most doctors will have experienced increased pressures in their practice arising from the contraction of resources in the hospital and medical sector. Government cut-backs to public hospital funding in particular have caused many stresses and strains to our health system. This may be leading to difficult decisions of rationalisation of medical services between hospitals, between departments, and, eventually, between patients.

As a consequence, and in keeping with other recent administrative trends, doctors are increasingly being called upon to act as managers, rather than health practitioners. Doctors will increasingly be part of the decisions that need to be made in allocating scarce resources within hospital environments.

In the circumstances, it would be interesting to see the extent to which the courts will be prepared to become involved in decisions on the allocation of scarce health resources. Whilst the courts will enforce various legislative provisions such as:-

- Anti-discrimination legislation
- Industrial relations legislation
- Trade practices and anti-competitive provisions
- Professional conduct legislation

courts have generally been reluctant to involve themselves in clinical decisions or in substituting their own decisions on such important matters in place of those of the professionals involved.

The situation has arisen in the case of **R v. Cambridge Health Authority**, a decision of the UK Court of Appeal in March 1995. A ten year old girl suffering from leukemia was refused further treatment, including a bone marrow transplant. Treating doctors had determined that palliative care was recommended. Other experts considered that a bone marrow transplant was possible, but the costs for the full course of treatment could have exceeded £75,000. The child's father requested that the National Health Service allocate funds for the proposed treatment, and the relevant Health Authority refused. The court determined that it could only consider whether the decision made by the Health Authority was lawful or not. It was not for the court to decide between conflicting medical opinions, or to decide how the Health Authority's limited budget should be allocated between opposing claims on its resources. The court indicated that it was not in a position to decide on the correctness of the difficult and agonising judgments which had to be made by Health Authorities as to how a limited budget was best allocated to the maximum advantage of the maximum number of patients.

In the Australian context, there is the additional complication of the Federal/State relationship, by which health funding is allocated. The public health system is largely funded from Federal resources, but is funded through State and Territory agreements. In the 1988 decision of the South Australian Supreme Court, in **Blyth District Hospital Inc v. South Australian Health Commission**, the Court was asked to enforce provisions to allocate funding to the Blyth District Hospital to enable it to provide the full range of hospital care and treatment, including obstetric treatment. It was argued that there was a public duty in an agreement between the Commonwealth and the State of South Australia for the funding of free treatment under the national health scheme - Medicare. The Court determined that there was no public duty on the South Australian Health Commission to provide funds to the hospital for any particular category of care or treatment. The decision largely turned on matters of administrative law, rather than public policy. However, the decision reinforces the reluctance of the courts to become involved in decision making of this nature. In that case, one of the Judges noted -

> ***"It was (urged) that the Hospital and Mrs B had a legitimate expectation that funding would continue without change. I cannot accept that argument. As I have suggested, Mrs B had and still has an expectation that she will be eligible for confinement and***

obstetrical services free of hospital charges at a recognised hospital not far from her home. Again I say, the Commission does not deny her expectations, she has and had no legitimate expectation that the services would be provided in the Blyth Hospital. Nor has the Blyth Hospital any legitimate expectations that its former funding will continue. All recognised hospitals in the State system are subject to change of funding. So long as the Commission acts to promote health and well-being, it may change the funding and, therefore, the role of any hospital."

The issue is reinforced, having regard to earlier English decisions. In a 1979 decision, **R v. Secretary of State for Social Services**, ex parte Hincks, orthopaedic patients at a hospital in Birmingham were waiting for treatment for periods longer than was medically advisable, because of a shortage of facilities, and a decision not to build a new block on the Hospital grounds. The patients sought court orders that the Department and regional Health Authority were in breach of their duty under National Health Service legislation to promote a comprehensive health service designed to secure improvement in health and the prevention of illness. The court determined that it was not its function to direct what funds were to be made available to the Health Service or how to allocate them. The court would only intervene where the decision by the Department or other Authority were so irrational or unreasonable, that they infringed the ordinary principles of administrative law.

These cases do not mean that individual doctors do not have the ability to generally refuse treatment, particularly in emergency situations. These cases merely deal with broad principles within a hospital context of the allocation of resources between departments, hospitals and services. How an individual doctor deals with an individual patient in a hospital context will depend on the circumstances. An immediate decision to refuse treatment to a particular patient by an individual doctor may still be reviewable on the ordinary basis of negligence and the doctor's duty of care.

Honours and Appointments

Professor Teik E Oh, HK – Chairman of the Health Services Research Committee of Hong Kong

Dr Robert M Wong, WA – Undersea and Hyperbaric Medical Society: Oceaneering International Award and the Craig Hoffman Memorial Award for contributions to Diving Medicine

Professor Garry D Phillips, SA – Fellow of the Academy of Medicine of Malaysia

DEATH OF FELLOWS

Dr Eustace Emanual Alfred, NSW – FFARACS 1971, FANZCA 1992
Dr Henry Edward Martyn Williams, NZ – FFARACS 1956, FANZCA 1992
Dr Reginald Abbot Lewis, Tas – Foundation Fellow, FANZCA 1992

WITHDRAWAL OF NIFEDIPINE 5MG CAPSULES

Bayer Australia Limited withdrew Adalat 5 capsules, containing nifedipine 5 mg, from the the Australian Register of Therapeutic Goods (ARTG) on 20 May 1997 on the recommendation of the Australian Drug Evaluation Committee (ADEC).

In October 1995 the ADEC considered reports relating to the safety of calcium channel blockers, and in particular short-acting preparations of nifedipine. On the basis of those considerations and previous discussion including adverse drug reaction reports, the ADEC strongly recommended that all nifedipine capsules be withdrawn from the Australian market. Bayer Australia Limited requested further consideration of this recommendation by the ADEC at the December meeting and provided an extensive submission relating to the literature reviewed by the ADEC.

The reanalysis of the previously considered papers by the ADEC did not refute adequately the association between short-acting nifedipine, when used for the management of angina, and an increased risk of myocardial infarction. The committee noted that the only approved indication for nifedipine capsules is the management of angina pectoris due to coronary heart disease. The submission from Bayer Australia Limited did not provide sufficient justification for the continued marketing of nifedipine capsules or allay the concerns of the committee in relation to safety in approved indication. The ADEC reaffirmed its previous recommendation that all nifedipine capsules should be withdrawn from the Australian market. The ADEC noted that a significant amount of anecdotal comment from specialist physicians in support of the continued availability of nifedipine 5 mg capsules had been received for various non-approved indications. It was therefore considered that the discontinuation of nifedipine 5 mg capsules should be deferred for a period of twelve months to allow the sponsor and the specialist physicians to develop the necessary data and/or information on the safety and efficacy to support an application to the Therapeutic Goods Administration (TGA) for such indications.

The TGA was advised by Bayer Australia Limited that the company had reviewed the data relating to these non-approved indications and had decided not to pursue registration approval. Bayer Australia Limited therefore removed Adalat 5 from the ARTG.

The ADEC is of the opinion that nifedipine tablets will be just as effective for the treatment of these non-approved indications as the capsule formulation, although the onset of action may be slower. Additionally, the safety issues associated with the use of nifedipine capsules have not been associated with use of the tablet formulation.

SUSAN ALDER MBBS PhD
Director
Drug Safety and Evaluation Branch
Therapeutic Goods Administration
20 August 1997

POLICY DOCUMENTS UNDER REVIEW

In line with College policy, the following Policy Documents are due for review in 1998

P5 – *Statement on Principles for the Care of Patients who are given Drugs Specifically to Produce Coma*

P11 – *Management of Cardiopulmonary Bypass*

The Executive will welcome any input or suggestions relating to these documents which will be considered during the review.

1997 National Anaesthesia Day Report

Questionnaires were sent out to all who had received a kit from the College for 1997 National Anaesthesia Day. This report tabulates the responses and comments but does not include all the activities who occurred on the Day such as many reported in the August Bulletin (page 37).

The responses provide excellent feedback that is being used in planning for future National Days.

Altogether 360 questionnaires were sent out and 165 returned (46%) as well as four letters. Once again it was impressive to note the wide range of institutions which were involved and the enthusiasm of many individuals who contributed in making this Day such a success.

TYPE OF ACTIVITY

Display in hospital	159	96%
Display in shopping centre/mall	7	4%
Display in rooms/offices	9	6%
Other	40	24%

In 1996 responses indicated 88% for displays in hospitals and 14% for "Other". This later area includes activities in schools, libraries and other health institutions.

PROPS EMPLOYED

Old/new equipment	44	27%
Posters supplied by ANZCA	163	99%
Leaflets supplied by ANZCA	139	84%
Fact Sheet on Pain	88	54%
Stickers supplied by ASA	140	84%
Other	38	23%

In 1996 equipment was used in 42%, the ANZCA posters in 88% and ASA stickers in 38%. Following the responses from 1996 the 1997 kits contained more material including four different posters, leaflets, fact sheet, stickers and draft media material. There were many favorable comments regarding this wide range of material.

MEDIA ADVICE KIT

Used	56	34%

PUBLICITY

	Sought	Achieved
Newspaper	43	33
Radio	19	17
TV	12	11

As a result of an unexpected high level of activity in contacting local media in 1996 (41% sought newspaper coverage) there was more emphasis given towards supporting effort in this area for 1997. Once again this resulted in a very wide range of rural, regional and major city media coverage.

COMMENTS ON 1997

The majority were very positive and complimentary of the material and overall focus of the Day. These included: "excellent", "extraordinary interest from staff", "posters very good", "excellent information", "good experience - better next year", "thanks to the conceivers and doers".

Some suggestions included: "needed more time", "needed more enthusiasm from anaesthetists", "bad timing as fell during school holidays", "problem with naming a model centre", "with wording of the message".

SUGGESTIONS FOR 1998

There were many useful suggestions for 1998: "keep it simple", "should be the same time each year", "need more stickers", "get ANZICS and nurses involved", "discuss organ donation", "breath of life good theme - focus on ventilation", "make it a whole week", "posters need to be more eye catching - colourful", "need things for children".

THANK YOU

Once again we are grateful to all those who put in considerable effort and provided feedback and comments. All the best for 1998!

MIKE MARTYN
Communications Officer

HIGHLIGHTS FROM THE OCTOBER 1997 COUNCIL MEETING

PAIN MANAGEMENT

Guidelines for Assessment Criteria

The percentage weighting for assessment for the Certificate in Pain Management has been altered to:

Medical Director's Report	10%
Log Book	40%
Treatise	50%

Council noted that the Royal College of Anaesthetists is in the process of considering the establishment of a Diploma of Pain Management and agreed that the ANZCA Pain Management Committee develop a free interchange of information with the Council of the Royal College of Anaesthetists regarding the development of the Diploma.

EDUCATION

Eligibility for Fellowship by Examination

Regulation 14 has been revised and a copy is available from the College.

Training and Examinations

Regulation 15 has been reviewed extensively and a copy is available from the College.

Provision has been made for medical practitioners to register with the College after 12 months post graduation, however they must complete 24 months general hospital appointments to be eligible to commence approved vocational training.

EMST Course – Period of Validity

Council agreed that the completion of the EMST Course required by trainees could be undertaken at any time prior to the award of the Fellowship of the College.

Rural Rotations

Council endorsed the Education Committee's support that rural rotations be classed as highly recommended for College Trainees.

Points in support of the submission from the Rural Special Interest Group included:

- Value of rural rotation confirmed by the trainees;
- Return to rural areas to work following completion of training;
- Limitations of training restricted to the cities;
- Role models;
- Casemix;
- Workforce considerations;
- Social obligations;
- Political consideration

Ten Year Rule – Completion of Training Requirements

Council resolved that in the case of trainees losing time under the ten year rule, the Regulations applying at the time of the revised commencement of the approved vocational training be applied.

FINANCE

Annual Subscription

That the Annual Subscription for 1999 due and payable on the 1st February 1998 be $920 for all Fellows and payable to the Melbourne Office.

Examination Entry Fee for 1998	A$1,850
Register of Training Fee for all trainees for 1998	A$850

Annual Training Fee for 1998

Australia and Hong Kong	A$900
New Zealand	NZD900 + GST
Singapore and Malaysia	$900 (local currency converted into Australian Dollars.)

Certificate in Pain Management

Registration Fee	- Australia	A$200
	- New Zealand	NZD200 + GST
Annual Training Fee	- Australia	A$900
	- New Zealand	NZD900 + GST

Maintenance of Standards Programme

Annual Fee for Non-Fellows Participation in the MOS Programme	*A$200*
Occupational Training Visa Assessment Fee	*A$75*
Overseas Trained Doctors Assessment Fee	*$500*

Fees for Fellows seeking double endorsement

A Registration Fee is payable to both the College and Faculty of Intensive Care. In addition, only one Annual Training Fee for that particular year is payable to the College or Faculty (depending on the year of training.)

Daily Living Allowance

The Daily Living Allowance for Fellows involved in College business required to stay away from home overnight be increased to $200 per night for 1998.

CONTINUING MEDICAL EDUCATION

2000 ANZCA ASM

Council resolved that:

1. This Meeting will be held at The Crown in Melbourne from 6-10 May.
2. The 2000 ANZCA ASM and RACS ASC be held as separate Meetings in Melbourne each with its own Regional Organising Committee.
3. That ANZCA and RACS Regional Organising Committees be requested to organise Combined Scientific Sessions and at least one combined major social function.
4. That all delegates to either the ASM or ASC may attend any scientific session, exhibition and social function organised by either Regional Organising Committee.

Combined ANZCA/ASA/NZSA Mailing Lists for Continuing Education Purposes

- Council agreed to establish a joint mailing list with the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists to enable information regarding continuing education activities to be disseminated to all Fellows, Trainees and Members.
- Each Fellow and Trainee will be asked to indicate in writing whether he or she is willing to have his/her name included on the joint data base for continuing education purposes only. The combined database will be updated at regular intervals.
- All parties will agree that the information included in the mailing list not be released, under any circumstances, to any organisation other than the Australian and New Zealand College of Anaesthetists, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

EXAMINATIONS

Papua New Guinea – M.Med Prize

Council has agreed to provide an annual prize known as the Australian and New Zealand College of Anaesthetists' Prize in the form of a text book to be awarded to the best candidate in the Master of Medicine Final Examination in Anaesthesia, University of Papua New Guinea.

Trial Vivas

Council resolved that Examiners should not participate in trial vivas for College Examinations, once the roster for a particular Examination has been established and they have been selected to examine.

INTERNAL AFFAIRS

Overseas Trained Doctors

All enquiries from overseas trained anaesthetists recognised as specialist anaesthetists in their country of origin should be referred to the Australian Medical Council or the Medical Council of New Zealand for assessment.

Enquiries from overseas trained doctors who are not recognised as specialist anaesthetists in their country of origin may be dealt with directly by the College. This should include advice to the effect that specialist registration in Australia or New Zealand is the responsibility of the respective State Medical Boards or Medical Council.

Physical Facilities – Melbourne

Council resolved: *"That the general options regarding physical facilities be kept open and that the College pursue an option to expand at Ulimaroa and further develop plans and the concept for approval by Council. That a Sub-committee comprising the Vice-President and Registrar be established to report to the Executive and Council."*

National Day 1998

Following the success of the previous National Anaesthesia Days, which carried the themes of ***"History of Anaesthesia"*** and ***"Pain Management"***, this year the theme of "**Intensive Care"** has been adopted and will be co-ordinated by the Faculty of Intensive Care and the College with the support of the Australian and New Zealand Intensive Care Society, the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists.

The focus of the day will be the Intensive Care Team and offer the opportunity to share the challenges and achievements of Intensive Care with the public.

Copyright

Council agreed that there should be transfer of copyright to the College from all those carrying out work on behalf of the College. This copyright would include contributions to any reports on all activities.

PROFESSIONAL

Format of Policy Documents

Council has agreed that all future policy documents will be published in an A4 format. These changes will be incorporated as documents are reviewed.

Re-classification and Renumbering of Policy Documents

Council has agreed to the re-classification and re-numbering of policy documents into two categories. Training and Examination documents will be prefixed with the letters (TE) and Professional Standards Documents (PS).

The following policy documents were reviewed and approved and have been renumbered in line with the new prefixes. These documents are published elsewhere in this Bulletin.

TE4 (1997): Duties of Regional Education Officers
TE5 (1997): Supervisors of Trainees in Anaesthesia
TE11 (1997): Guidelines for Completion of a Formal Project
PS17 (1997): Endoscopy of the Airways
PS31 (1997): Protocol for Checking an Anaesthetic Machine

The following new policy documents was approved.

PS29 (1997): Anaesthesia Care of Children in Healthcare Facilities without dedicated Paediatric Facilities.

PS12 (1996) Statement on Smoking as Related to the Perioperative Period was approved by Council at its meeting in October 1996 and is published elsewhere in this Bulletin.

Women in Surgery Workshop

The Women in Surgery Section of the Royal Australasian College of Surgeons is holding a Workshop in November which will be attended by three Anaesthetic Fellows.

COLLEGE HONOUR, AWARD AND ELECTION

Honorary Fellowship

Mr Michael Gorton, the College Honorary Solicitor, has been invited to accept Honorary Fellowship of the College.

ANZCA Medal

The ANZCA Medal was awarded to Dr Peter Anderson Lowe, Victoria.

Admission to Fellowship by Election

Under Regulation 6.3.1 (b):

Dr Neville John Opie, WA
Dr Douglas William Wilson, Qld
Dr Thilakeswari Ramalingam, Qld
Dr Michael John Harrison, NZ
Dr Stuart Thomas Inglis, WA
Dr Robin Lindsay Rund, NZ
Dr John Daniel O'Reilly, Qld

Under Regulation 6.3.1 (c):

Dr Wallace Chiu, Hong Kong

Under Regulation 6.3.1 (d):

Dr James A. Birrell, Vic

RESEARCH

Florence Marjorie Hughes Research Award

Following a bequest from the Estate of the late Florence Marjorie Hughes, an annual Research Award has been established which is to be awarded for Research to be carried out in Victoria. Details of the Inaugural Winner of this Award are published elsewhere in this Bulletin.

Advertisements for 1999 Research Grants

Advertisements for the 1999 Awards will appear in this Bulletin with a closing date of February 27, 1998.

EXAMINATION PRIZE WINNERS

The Renton Prize for the period ending 31st December, 1997 was awarded to:

Dr David Raoul Rivlin Lardner
of Napier, New Zealand.

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 31st December, 1997 be awarded to:

Dr Catherine Susan Downs
of New South Wales.

AWARD OF CERTIFICATE IN PAIN MANAGEMENT

***Dr Andrew Muir**, NSW*

has completed the requirements and has been awarded the Certificate in Pain Management.

"COMMUNICATING BETTER"

Objectives of Training

October Council accepted the recommendation of the Education Committee for the inclusion of communication skills objectives into the Objectives of Training in Anaesthesia.

Specific objectives have been developed as a result of recommendations of the 1996 Younger Fellows Conference, deliberations of the Communications Committee and two workshops "Communicating Better" run by Eddie Dean and Mike Martyn at the Christchurch ASM.

The addition of a communication skills focus into the Objectives of Training is not only relevant to trainees but also to existing specialists who may wish to improve their own skills or who are involved in teaching or assessing trainees.

OBJECTIVES

Fundamentals of Written and Verbal Communication

This is aimed at specifically improving individual skill levels. There are many techniques that can be learnt in order to improve individual skills.

Patient and Peer Communication

This is considered to be the most important topic with specific emphasis on patient consultations. Good communication skills support the increasing emphasis on the development of a good doctor-patient relationship. There are also specific skills relating to communicating with other specialists and health professionals.

Stress Management Communications Skills
Crisis Management Communication Skills
Conflict Resolution Communication Skills
Mediation and Negotiation Skills

These above four areas are the basis of considerable workshop activity by commercial consultants but with only partial relevance to anaesthetists. Specific elements relating to communication techniques and to anaesthesia are to be included in the Objectives.

Audiovisual Aids

This currently only appears in the Research section of the Objectives of Training but needs to be addressed in a much broader focus.

Media Relations

This includes some understanding of how the media works and of the basics of media relations.

TEACHING METHODOLOGY

As an initial step a Study Guide is being developed along with a collation of existing relevant resource material. The College may be required to develop anaesthetist specific training material.

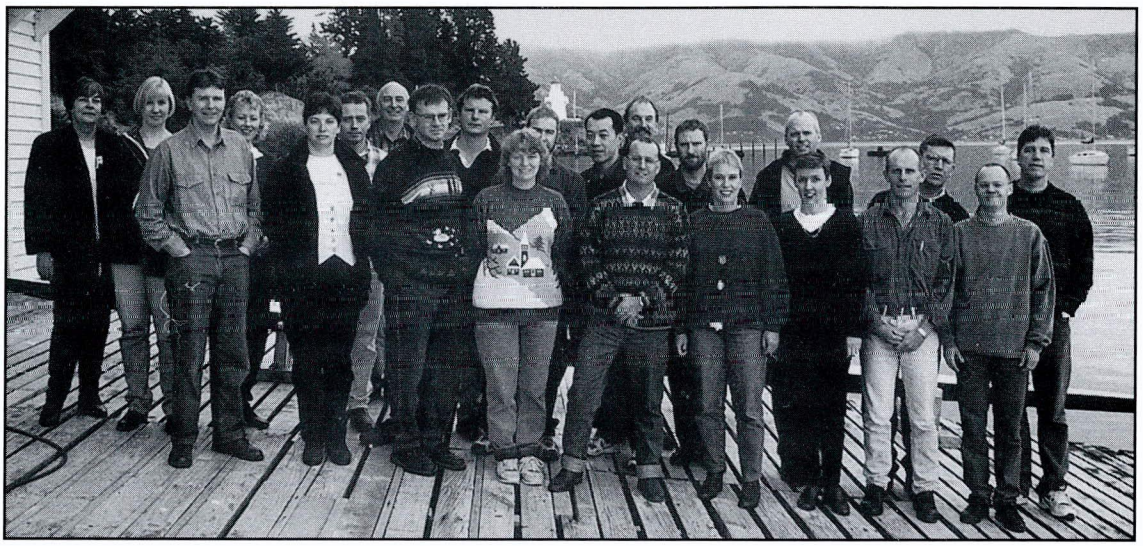
Interactive workshops are particularly suitable for teaching these topics and are being planned as part of ASM and other CME activities. The 1997 Younger Fellows Meeting also addressed some of these areas.

ASSESSMENT

There needs to be appropriate assessment of outcomes both in assessing improvement of individual performance and also of the objectives as a whole.

MIKE MARTYN
Communications Officer

YOUNGER FELLOWS CONFERENCE
AKAROA, NEW ZEALAND
May 8-10, 1997
CONVENOR'S REPORT
"LOOKING AFTER OURSELVES"



INTRODUCTION

The Younger Fellows Conference was held at the harbourside village of Akaroa, approximately 1.5 hours journey from Christchurch prior to the Annual Scientific Meeting in 1997. The theme of the meeting was "Looking After Ourselves". In organising this conference I was assisted by the following individuals.

- Dr Vaughan Laurenson, Consultant Anaesthetist, Christchurch Hospital and Medical Director of CECANZ.
- Dr John O'Hagan, Consultant Respiratory Physician and, until recently, Post Graduate Dean at the Christchurch Clinical School of Medicine.
- Millie Laurenson who, besides being married to an Anaesthetist, has qualifications in nursing, education and counselling.

The above three individuals donated their time to the conference. Their input, particularly that of John O'Hagan, had a major impact on the structure and content of the conference and this contributed greatly to its success. The theme "Looking After Ourselves" was the theme chosen for the conference. Dr Di Khursandi and Genevieve Goulding of the Welfare of Anaesthetists Group gave valuable input and background material for the conference.

At John O'Hagan's suggestion, a discussion group involving the younger Anaesthetists and Intensivists at Christchurch Hospital was convened to determine which issues relating to anaesthetist's welfare they felt were of most interest to themselves. It was interesting that such topics as substance abuse, psychological and physical illness, loss of competence and financial planning did not rate highly with this group. They also

made it clear that they felt the conference should focus on the positive rather than the negative.

With these comments in mind, the programme for the Younger Fellows Conference was drawn up.

The venue chosen for the conference was the Akaroa Village Inn. The conference room was a recently renovated boat shed which provided spectacular views across the harbour. It helped create the appropriate atmosphere that is so important to the success of these meetings.

PROGRAMME

Session 1 – "Conflict Strategies"

This session was planned to be an icebreaker. Before coming to the conference the Younger Fellow Representatives (YFRs) were given a questionnaire to complete which looked at how they behaved in conflicts. The individual results of this questionnaire were discussed and a number of different stereotypes of how people behave in conflicts was presented.

An exercise in negotiation was then carried out in an attempt to illustrate the differences between "win-lose" and "problem solving" approaches.

The group then divided into two. Each group explored two common clinical scenarios where conflict often occurs using role-plays.

Session 2 – "Transition from Registrar to Consultant" - A model for coping with change.

This session was facilitated by Millie Laurenson. During this session the YFRs were asked to look at their occupations and to compare them with other professions and occupations. They were also asked to consider the outside influences that were having an impact on how their jobs were changing. Millie then presented one psychological model of the process that individuals go through when confronted with a change. She also explored what may happen if individuals are unable for whatever reason to adapt to change in circumstances.

It is interesting that the YFRs present did not find the transition from registrar to consultant to be that stressful. I wonder if this reflects the calibre of the individuals chosen to attend this conference. It might also reflect the fact that by the time people reached consultant level they have had to make a number of previous transitions such as from medical student to house surgeon and house surgeon to registrar.

Session 3 – "Critical Incident Debriefing"

This session was facilitated by Rod Westhorpe. Rod directed the most elaborate role-play that I have ever had the pleasure of witnessing. The role play started with an unexpected death in theatre and took the players through subsequent events, culminating in informing the relatives. This was followed by the playing of Andrew Bacon's video on "Critical Incidence Debriefing".

Session 4 – Debate: "That full-time public hospital practice is superior to private practice"

This session used the vehicle of a debate to explore the advantages and disadvantages of various practice styles. The resulting debate was both entertaining and thought provoking. The adjudicators awarded the debate to the protagonists who consisted of at least two individuals who are in full time private practice.

Session 5 – "Handling Patient Concerns"

This session utilised John O'Hagan's not inconsiderable experience in the use of actors to teach and test doctors' skills in communicating with patients. This session flowed naturally from the earlier session on critical incident debriefing. This session utilised the services of three trained actors who acted the following scenarios:

1. A relative of a patient who had died unexpectedly in the operating theatre.
2. A patient who had been aware during a general anaesthetic for a procedure on the lumbar spine.

3. A distressed labouring patient whom the obstetric staff thought required an epidural, but who had considerable reservations about having one.

From the reaction of the YFRs this session was the most valuable of the conference. The use of actors enables the scenarios to be played in an extremely realistic fashion, more realistic than that achieved with simple role-playing.

The actors had considerable experience with acting as patients for doctors from various branches of medicine and commented favourably on the way the Younger Fellows handled the situation compared to other groups of doctors.

Session 6 – "Conference Summary and Report"

Dr Pheobe Mainland was chosen to present the report of the Younger Fellows Conference to the College Council. Her summary of the sessions which includes specific recommendations to the College follows.

CONFERENCE DINNER

This was held at the French Farm Vineyard, approximately 10 minutes drive from Akaroa Village. The conference dinner was attended by Professor Garry Phillips, President of ANZCA and Dr Geoff Clarke, Dean of the Faculty. Dr Matt Keneally, CEO of Axon Computer Time was the guest speaker.

RECREATIONAL ACTIVITIES

Following an afternoon tea on the second day, some time was set aside to explore the various attractions that Akaroa has to offer. Activities included golf, a harbour cruise on the Canterbury Cat, mountain biking, walking and shopping.

PAUL SMEELE, Convenor

YOUNGER FELLOWS' RECOMMENDATIONS

The theme "Looking after Ourselves" covers important issues. Personal well-being is relevant to all anaesthetists. The subject should be addressed in anaesthesia training, and in ongoing professional education.

- **Training**

  Role playing is a good method for teaching conflict resolution skills. Involvement of surgical trainees is desirable.

  Intensive Care specialists frequently discuss death or dying with patients' families. During their ICU attachments, anaesthesia trainees should be involved with these discussions.

  The important role of the Supervisors of Training must be recognised. The College should arrange teaching skills workshops for them.

- **Provisional Fellows**

  The ASA is commended for its registrar conferences and asked to continue organising them. A regular PF conference should be arranged to prepare PFs for changes occurring after their provisional year.

  Supervision of trainees is a skill. Programmes should be available to guide or teach those involved in this area.

  The College Policy Document, "Guidelines for the Provisional Fellowship Year" (E13), should be reviewed. The transitional role of the post should be emphasised. The document outlines objectives for the PF year. PF posts should be assessed to see whether they meet these objectives.

  A survey of Provisional Fellows is desirable to ask: "Are you getting out of the year what you expected?"

- **New Registrars**

  Conferences should be organised for new registrars. They should be told what will be expected of them during anaesthesia training, and what changes and stresses they might encounter. They should know where to find support during their training if they need it.

- **Departments**

  All Anaesthesia Departments should develop their own Critical Incident Plan with which all department members must be familiar. Dr. Bacon's video programme on this topic is recommended.

  The existence of a Departmental Critical Incident Plan should be required for a department to be accredited by the College.

  Unhelpful reactions to these issues can be modified with training and education. Methods of learning how to deal constructively with these issues are available to all anaesthetists.

- **Constructive responses can be learnt**

  During the conference Younger Fellows were exposed to various methods of teaching, which were used to bring awareness and anticipation of, and preparation for dealing with potential issues.

  Some of these methods which can be applied to all anaesthetists, include:

  - Simple questionnaire asking for one's opinion of various conflict strategies. According to the scoring for each conflict response, the most frequent strategy of responding to conflict would be one of five: Withdrawing, Forcing, Smoothing, Compromising or Confronting.

    This self assessment helped show how we respond to a conflict situation, and that other approaches may be more constructive.

  - Discussion of issues with colleagues. Role playing typical operating room conflict situations, and the debate, were entertaining forums to exchange ideas, and to broaden our outlook to appreciate alternative views.

    These could be used in registrar teaching programmes. Joint sessions with other specialty colleagues, such as surgeons and obstetricians would expand the exchange of ideas, and increase the benefit of the exercise.

  - Anticipate changes, and preemptively gather information. In anticipation of a job change, informal discussions with colleagues, and more organised information sessions are useful. An example of the latter is the conference held by the Australian Society of Anaesthetists, for Provisional Fellows.

    The transition from registrar to consultant was discussed at length, with reference to preparation for the change. The change from registrar to consultant was mainly to do with administrative duties and management, rather than changes in clinical practice.

    It was noted that the Provisional Year should be positively transitional, with the PF taking over increasing responsibilities and administration in preparation for the new role after that year. The Younger Fellows were of the opinion that the College Policy Document, "Guidelines for the Provisional Fellowship Year" (E13) which describes increased responsibility as an objective of the PF Year, was not being adhered to in all PF Year posts. Learning how to supervise was identified as a potentially stressful issue.

- **Continuing Medical Education**

  The College's self development programme should include the theme "Looking After Ourselves". Continuing Medical Education sessions on communication should be considered, using professional actors in simulated situations.

- **Younger Fellows**

  A Younger Fellows' Representative to be co-opted at College level.

  The Younger Fellows' Conferences are invaluable forums, and should continue.

ACKNOWLEDGMENTS

Congratulations to the conference Convenor, Dr. Paul Smeele, who together with Drs. Vaughan Laurenson and John O'Hagan and Mrs. Millie Laurenson conducted an excellent programme. Thanks to Dr. Rod Westhorpe, College Councillor in Residence, for his contributions, and to the President, Professor Garry Phillips, and the Dean, Dr. Geoff Clarke, for joining the conference dinner.

PHOEBE-ANNE MAINLAND
Younger Fellows' Representative

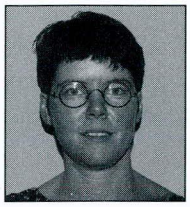
RESEARCH AWARDS FOR 1998

Academic Anaesthsia Enhancement Grant for 1997

This Grant of $75,000 was awarded to the University of Sydney, Royal Prince Alfred Hospital.

.Dr John Boyd Craig Award

$11,250 was awarded to Dr Lindy Roberts, WA for her project "Prospective Evaluation of Endocrine Function in Patients Receiving Intra-Thecal Opioids for Chronic Non-Malignant pain."



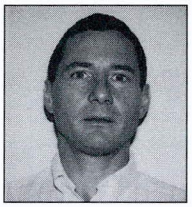
RESEARCH SCHOLARSHIPS & GRANTS FOR 1998

Applications totalling $809,804 were received for a Budget of $199,235.

A new process of review based on the NHMRC format was adopted. Three independent External Reviewers assessed each application. On the advice of the External Reviewers, Council endorsed the Research Awards for 1998.

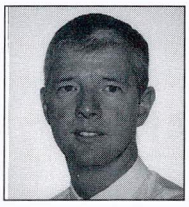
GRANTS

Dr Kate Leslie, Vic
The Effect of Mild Hypothermia on Emergence from Anaesthsia $26,647

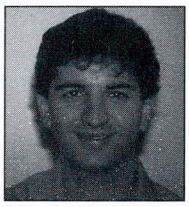


Dr Brendan Silbert, Vic
Early Neuropsychological Function After Coronary Artery Surgery: Effect of Perfusion Device $24,000

Dr Arthur Penberthy, Vic
Investigation of Mechanisms by which Pain Sensation is Transmitted in the Spinal Cord $18,000



Dr Paul Myles, Vic
Smoking Cessation: Use of Transdermal Nicotine Therapy in Patients Awaiting Elective Surgery. A Cost-Benefit Analysis $28,000



Dr Cyrus Edibam, WA
Effect of Glutamine Supplementation on Skeletal Muscle Histopathology in Critically Ill Patients $14,822

Dr Timothy Short, NZ
Development of a Fully Validated Anaesthesia and Surgical Impact Profile A$30,000

Dr Julia Fleming, NSW
Neuron-Glial Interactions in Midbrain after Chronic Nerve and Spinal Cord Injury $30,766

SCHOLARSHIP

Dr Meagan Roberston, VIC
The Gut, Stress and Infection: Helicobacter Pylori in the Critically Ill $30,000

Dr Kate Leslie of Victoria was awarded the Harry Daly Research Award for her project ***"The Effect of Mild Hyphothermia on Emergence from Anaesthesia"***.

Dr Brendan Silbert, Victoria, was the Inaugural Winner of the Florence Marjorie Hughes Research Award, for his project ***"Early Neuropsychological Function after Coronary Artery Surgery: Effect of Perfusion Device."***

MAINTENANCE OF STANDARDS

Gerald Moss, Christchurch

As physicians we are well established in a culture of continuing education. We attend (and deliver to varying audiences) lectures, tutorials and demonstrations. We read journals and textbooks, along with attending M&M sessions. We may feel that we are maintaining our standards quite well.

It would be useful to have some guidance, some goals, some reference points, in order that we might be more certain of the depth and appropriateness of our activities. While we might possibly find the quantity satisfactory and the range of activities nearly ideal, in all honesty we may not be sure whether all this is actually effective. Since it is our aim to do the best possible for our patients, effectiveness is of concern to us.

The Maintenance of Standards Programme first offered by the College in 1995 is timely for a number of reasons.

- A more formal approach will encourage us to do better and give us increased satisfaction through attainment.
- We will see an increased range of activities and be drawn into them through interest or the need to gain more points.
- Audit will become significant and will be seen as a useful tool, aiding self assessment.
- Simulators will become important training aids allowing practice and instruction in a safe and non-threatening environment.
- Unobtrusive Peer Review, where say, two anaesthetists work together is likely to become well established.
- New, innovative modalities will be sought after, discussed, facilitated and encouraged.

There is another reason why the programme is timely and that is for the purpose of annual registration as a medical specialist. Those who have satisfactorily completed the five year MOS programme will receive a certificate, which should be acceptable to the registration authority. Of course another five year programme would then be commenced. Consumer interest is also high and MOS activity of a high standard will perhaps reduce pressure on us from that direction.

- Just as those useful College Policy Documents on many subjects are reviewed and revised so will the MOS guidelines be treated.
- Feedback in the way of questions, comments and ideas are vital, but support should be forthcoming from Fellows as well.
- The actual allocation of points for some activities has caused some dissent. Helpful comment could be made to the Committee but overall it is fairly easy to get points and there are a lot of activities.

Staff at teaching hospitals have a great advantage in that CME and MOS activities are easily accommodated. It has been suggested that such staff, therefore, do not need to take part in the above formal exercises. This must be seen to be done! Certificates cannot be issued unless returns have been forwarded and records may be requested. Every anaesthetist should be keen to follow the programme, more so perhaps if from a teaching environment.

There will be a requirement from employers that employees undertake a MOS programme, and that is good because then they must provide time money and resources for this. For those solely in private practice there will be a requirement from the accrediting authority that the hospital ensure those with practising rights are in a MOS programme, so there will be no escape.

Some larger institutions are already offering assistance to small centres. Those in smaller centres should determine their requirements and ask for help from larger centres as appropriate and then require support from their employers.

The College is providing leadership and is facilitating our participation in the Maintenance of Standards programme. These activities should be enjoyable and worthwhile.

We have to actually do it ourselves.

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

WORKSHOP ON MAINTENANCE OF STANDARDS

2nd October 1997

The College organised a workshop on Maintenance of Standards (MOS) at "Ulimaroa" on 2 October 1997. Apart from the Registrar, Mrs Joan Sheales, and the Administrative Assistant (Continuing Education), Ms Helen Morris, there were 32 other participants, including Councillors, Regional Education Officers, and Fellows representing rural Fellows, Younger Fellows, and simulator centres. Professor Garry Phillips who was the initial MOS Officer, and Professor Teik Oh, the current QA/MOS Officer, were the facilitators.

The purpose of the workshop was to examine the objectives, structure, properties, and problems of the MOS Programme, and to propose improvements. It was the first review of the Programme since implementation in 1995. Five speakers briefly provided background for the two workshop sessions. The morning workshop examined improvements to the Programme, and the afternoon one looked at new strategies to develop.

Development of current ANZCA MOS Programme

Professor Phillips reviewed the development of the Programme and compared our requirements with those of other Australasian medical Colleges. A lack of uniformity between the Colleges' programmes was noted. The five year ANZCA MOS Programme has three components:

1. A declaration "that a minimum of 30% of professional life has been spent in clinical anaesthesia".
2. Credentialling, by providing evidence of Medical Board registration.
3. Evidence of activities. A minimum of 500 points is required every cycle; points being credited for the following activities:
    1. Quality Assurance (QA),
    2. Continuing Medical Education (CME),
    3. Teaching and Research, and
    4. Other activities.

Structure of a MOS Programme

Professor Oh led a discussion on the objectives and structure of the MOS Programme. The group looked at two important issues - what is the *main* objective of the MOS Programme, and whether participation should be compulsory. Is the main objective educational, i.e. one of promoting CME and professional development, or is it to maintain competence? With the former, the Programme monitors and validates CME and QA activities. Competence is presumed but cannot be taken for granted, and recertification of any form is not necessarily inclusive. With the latter, if MOS is the arbiter of competence, the role of MOS is policing, and competence must be assessed. Recertification is then intrinsic, and CME and QA activities are presumed.

The majority of participants favoured an educational role for MOS. Implications of credentialling competence for the College were noted to be significant, not the least of which are difficulties in assessing competence. To do that, all desirable qualities that collectively define competence such as *knowledge, clinical skills, clinical judgement, humanistic qualities, communication skills, continuing scholarship, and management skills* must be evaluated. Impairment and misconduct need to be excluded. Workshop participants also supported the current voluntary basis of participation. ANZCA is in no position to enforce non Fellows to participate, but it was noted that eventually, hospitals and Medical Boards are likely to require specialists to show evidence of participation.

Some time was spent on concepts of QA. Using CME and QA to achieve quality care is inherent in a MOS Programme, but many Colleges report that QA is poorly understood by their Fellows. QA can be defined as *"that process which assesses and evaluates overall performances in the delivery of health care, to achieve quality health care"*. Quality health care means *"services and care achieving desired patient outcome consistent with current professional knowledge"*. Another commonly used term, Continuous Quality Improvement (CQI), is a form of QA, meaning *"small continuous improvements in services and care to the patient, made as a result of ongoing efforts of examination and evaluation"*.

As regards the name of the programme, the group preferred a change from MOS to "Maintenance of Professional Standards, or MOPS". This would bring ANZCA in line with the other Australasian Colleges. In the discussion on properties of a MOS programme, it was unanimously agreed that the duration of each cycle should remain at five years, the same as those of most Colleges. It was noted that a MOS programme should have credibility, simplicity, feedback, outcome indices, confidentiality, and the flexibility to apply to individual practices and yet allow returns to be verified. Methods which can be used in a MOS programme include crediting points for time or effort spent in CME and QA activities, on-site practice quality review, hands-on period in a teaching hospital, and a diary of activities. The diary method is used by the Royal College of Physicians and Surgeons of Canada and the Royal College of Pathologists of Australasia. It requires recording items of group or self learning activities. The participant can compare his/her annual profile with peers in terms of items, hours and points, case mix, and outcome on practice. Emphasis is on CME, self improvement, and peer comparison, and minimum points are not required.

Role of Simulators in MOS

Dr Brendan Flanagan explained the variety of uses that an anaesthesia simulator could offer, from demonstrating physiology and pharmacology to integrating management of complex crisis events. Simulators offer educational aspects different from other CME modes, such as a high level of interaction, video de-briefing, and an unique experience. Despite some obvious potential obstacles, mainly accessibility and cost, simulators can play an important role in MOS. Possible MOS activities include basic skills training, more realistic EMST courses, difficult airway training, and crisis resource management training. ANZCA could be a world leader in this respect.

View of MOS by Younger Fellows

Dr Phoebe Mainland reported on the views of Younger Fellows obtained from a questionnaire survey she conducted. There was general support for MOS, but opinions on making this compulsory were mixed. About two thirds of correspondents currently participate; reasons for not participating varied. The objective of the Programme was unclear; answers ranged from CME, QA, to government driven recertification requirements. Correspondents noted that standards of practice are not assessed. Some Younger Fellows felt that the Programme discriminates against rural and part-time colleagues and those temporarily out of clinical practice or working overseas. Suggestions to improve the format and contents were offered, including clarification of documentation, provision of log book or database formats for user-friendly participation, and recognition of CME activities of other specialties.

View of MOS by Rural Fellows

Dr Frank Moloney presented views of rural Fellows. Compulsory MOS is not favoured. Rural Fellows face difficulties with locums and costs of travel and accommodation when engaging in CME. Sometimes few MOS points are gained for a relatively large financial and time outlay. Participation in QA activities is also difficult without technical and extra resources. However, it was noted that difficulties in CME and QA participation are also experienced by city private practitioners.

Dr Moloney outlined some suggestions for improvement. The MOS Programme must be flexible to cater for different practice situations. Credit should be given for a feedback-mechanism whereby a rural practitioner reports on a conference attended to those unable to go. There should be some reciprocal recognition and standardisation of activities with other Colleges. Staff exchange programmes and distance learning modules and CME activities should be developed. Points should be credited for non clinical administrative work and, seemingly contradictory, for pure clinical workload on the basis that "practice makes perfect". However, the latter two strategies would detract from, and not enhance, the credibility of the MOS Programme.

Morning Workshop

Participants were divided into five groups for the morning workshop. Four groups looked at how the activities of the current MOS Programme (i.e. QA, CME, Teaching and Research, and Other Activities), could be improved. The fifth group discussed how the Programme could cater to individual practices. Each group reported on the strengths and weaknesses of their particular activity and made some recommendations. One was better definition and clarification of some listed activities. Another was re-scaling of points allocated for some activities; examples were given of areas of perceived unfairness. QA was seen to be difficult for participants, as activities made up only 15% of returns. Fostering an evidence based approach was considered important. Credit should be give for time spent under supervision in a FANZCA training-accredited hospital, rather than a teaching hospital as currently specified. Restructuring of this activity was recommended.

The fifth group noted that the first component of the current Programme, "that a minimum of 30% of professional life has been spent in clinical anaesthesia" is unclear and difficult for those with non mainstream appointments to comply with. They recommended that participants should declare their specific commitments and learning needs at the start, and individual feed back on their programmes should then correspond to those needs.

A number of points and recommendations were repeatedly made by all groups. The Programme should focus more on the individual. Templates should be developed to help individual practitioners undertake activities they are inexperienced with, QA activities being the major example. Use of log books and diaries were raised a number of times. Provision of a template log book/diary to record activities was recommended. Recognition of activities of other Colleges - "commonality" - was agreed. Outcome reporting and feed back to individuals were considered important; methods need to be developed, and extra resources are likely to be required. Verification was noted to be necessary, although difficult in practice.

Afternoon Workshop

In the afternoon, the five groups looked at new activities, implementing feedback and verification, assessing outcome, catering for rural colleagues, and identifying incompetent/ impaired "at risk" individuals. Use of simulators in MOS was recommended. Details on implementation need to be developed. Use of the Canadian diary method was favoured. Such a record of an individual's activities could be termed a "Portfolio of Activities". The importance of feed back was again raised. Data fed back should allow participants to compare their activities with those of peers. Verification of returns detects compliance with required activities but not impairment. The usual outcome variables in anaesthetic practice are unsuitable for use in MOS to show benefits of CME and QA. Clinical practice guidelines and better clinical databases may help develop more appropriate MOS outcome indices. It was felt that the College needs to develop CME materials, especially interactive ones and those relevant to distance (rural) requirements. Impairment has different manifestations and is very difficult to identify. However, it is more important to develop a climate of help, and to identify impaired colleagues prospectively, and not after events.

Summary

The workshop achieved its objective. Participants covered MOS and related aspects of CME, QA, and competence. Some useful issues were raised and recommendations proposed, which will give direction to how MOS should be further developed. The main points and recommendations made are -

- The College MOS Programme should be renamed Maintenance of Professional Standards, MOPS.
- The main role of MOPS is educational, and its main objective is to foster CME and QA activities.
- Participation should remain non compulsory and the duration remain at five years.
- The MOPS Programme should be flexible and cater to the practices and learning needs of individuals. Participants must declare their specific commitments and learning needs, on which their individual MOPS programmes will be based.
- MOPS should encourage self-learning and self-development, with less of a points-accumulating culture.
- Activities currently credited need to be better defined. Restructuring is required in some areas, in terms of commitments required and points allocated.
- Some activities of other medical colleges should be recognised and credited.
- Simulators have a role in MOS, and this should be developed.
- Templates, i.e. guidelines, should be developed on how to implement some activities, especially QA.
- A log book format should be developed for participants, to make record keeping easier. This can be achieved with a Portfolio of Activities, similar to that of the Canadian diary method, whereby participants' activities can be compared with those of peers.
- Feedback to participants, with comparative data of peers should be implemented, to enable self-analysis and self-improvement.
- Data on outcome, or impact on practice as a result of MOS activities, should be an integral part of each participant's Portfolio.
- Verification of returns should be enacted on a random basis.
- MOS, CME and QA educational materials, especially those useful to distance learning, should be developed.
- An evidence based approach should be fostered.

TEIK OH,
QA/MOS Officer

THE AUSTRALIAN INSTITUTE OF HEALTH LAW & ETHICS

Topics for attention

Patients and their doctors

SPECIAL EDITION

ISSUES PAPER 4 WINTER 1997

Professor Louis Waller, AO

Reprinted with approval of The Australian Institute of Health Law & Ethics

I The Fragile Heart

I watched the series, *The Fragile Heart* on ABC TV, some weeks ago, with the kind of concentration ascribed by Dr Johnson to the man about to be hanged in a fortnight. The hero is Mr Edgar Pascoe, a veritable diamond of a man: a cardiovascular surgeon admired and envied by his peers, courted by entrepreneurs, and adored by his patients, whose cardiac arteries he has repaired or replaced. In an early scene, the grateful relative of one such, to whom he announces that all has gone well, kneels and kisses his hand.

But he is a diamond with a deep flaw. Will the flaw yield to the hammer blows of the master cutter, to be fashioned into the stem of a rose, etched into the brilliant, which will render the whole of unique and lasting beauty? Or will the first, or the second, or the third blow from that hammer cause the stone itself to shatter into myriads of fragments, glittering but worthless? The blows are administered in a series of ethical, and even legal, challenges to which Mr Pascoe must respond, ranging from his consultation with a referred patient to his interview with a young Chinese doctor who tells him – shows him – that organs are being harvested from the bodies of executed criminals, and sold for transplantation, to his discovery that his beloved daughter, on her way in his footsteps, is a plagiarist and a liar.

In the first episode, a big, very nervous patient, Mr Sedgley, and his more composed, almost taut wife sit before Mr Pascoe in his consulting room. The surgeon has read the letter of referral from his close friend, the patient's cardiologist, and the accompanying diagnostic reports. He lifts the telephone, and confirms that he now has a vacancy in his operating list the following week. He speaks to Mr Sedgley with his eyes on the papers before him. The patient, nervously and diffidently, asks whether he can stay on his medications, and so avoid surgery. The surgeon responds that his angiogram results show his condition to be very serious. Mr Sedgley says he has been told about alternatives: about herbal remedies, about angiplasty. Mr Pascoe replies: "I'm very aware of your pathology. These herbal remedies - if remedy is the right word - are preventative." "If you doubt", he goes on - making eye contact now, "you should seek a second opinion. Mutual trust, you see, is essential..." Urged by his wife, Mr Sedgley subsides. As they go, she says "Thank you, Dr Pascoe." "Mister: only physicians are doctors", says the scintillating hero. It ends, as the homely saying has it, in tears, bitter tears. Mr Pascoe sends a young assistant to tell Mrs Sedgley the dread news that her husband died on the table, in theatre.

When I watched this television representation of real life, I compared that episode with my own, very recent experience as a patient awaiting surgery, and in particular my conversations with the anaesthetists who came to visit me when I was already in hospital. I was a patient who had elected surgery, and its course had been explained to me, in detail, by the surgeon. The anaesthestists - there were two who came separately, because of my circumstances - each described to me the several courses that might be pursued: a general anaesthetic; a spinal or epidural anaesthetic, which would leave me aware of what was happening to me; an epidural with a light general anaesthetic, from which I could be rapidly awakened. They listed the circumstances and the consequences of each course, and why, in my case, one rather than another was, in their opinions, the preferred choice. I asked a number of questions, and agreed with the proposal of the anaesthetists. Thank God, all went well. My emergence from induced sleep was, if not wholly agreeable, then certainly tolerable. The contrast between my pre-operative experience and Mr Sedgley's was vast.

Of course, one swallow makes no summer, and it would be foolish to draw general conclusions from that one recent episode of mine. But I have also heard, and read, the experiences of many other patients in our

community which match mine, over the past few years. And I discern, in the conversations I have had with doctors, including specialists, in the past five years, that the culture of the profession - to use a convenient phrase - is mostly such as was expressed to me by my anaesthetists. It was not always so.

LAW REFORM IN VICTORIA IN THE 1980s

When the Law Reform Commission of Victoria was established in late I984, the Attorney-General of Victoria gave the new entity a general reference, as it was described, on 'medicine, science and the law'. As the Commission's first Chairperson, l convened a meeting to which medical and other life science personalities were invited, early in I985, together with lawyers, philosophers and social workers, to discuss the selection of one or two specific, important issues upon which we should begin work in the prescribed area. The question of 'informed consent', as it was then denominated, was in the air. The House of Lords, the final appellate tribunal in England, had very recently delivered judgment in a case called *Sidaway v Board of Governors of Bethlem Royal Hospital*[1], which had engendered comments in the English daily papers, as well as in professional journals. That case was not about the peerless proficiency of the neurosurgeon who operated upon the plaintiff's spinal vertebrae. The principal question in it was this: should the surgeon have told Mrs Sidaway that there was a real risk, albeit a small one, that the laminectomy he was to perform could result in damage to the spine, or to nerve roots, and that substantial paralysis could follow? Mrs Sidaway's case failed. Several of the Lords of Appeal, however, said that there may be cases where patients should be given more information than might be given in standard medical practice, because of the kind of risks involved. Then those patients could better decide whether or not to under take the treatment or undergo the operation. One of those judges, Lord Scarman, strongly emphasised the idea of the autonomy of the patient in deciding whether or not to undergo surgery, or indeed any medical procedure.

We invited a person who had recently undergone an operation for coronary artery bypass - which Mr Sedgley, in the TV play, said he heard was called 'cabbage' by the doctors involved - to speak about his experiences to us at that meeting. He told us that he had discovered, almost by chance, that he had been placed by his medical attendants in a trial programme for a new anti-coagulant drug, without receiving from them any information, let alone any discussion about the matter. We heard other anecdotes about patients who had had unhappy experiences, in which choices and risks had not been canvassed - or had been mentioned perfunctorily, and dismissively. We began to discern what sorts of redress those patients, and their sometimes grief-stricken families, really wanted.

There was also a book, published in I984, with the unforgettable title of *The Silent World of the Doctor and Patient.*[2] Written by Professor Jay Katz, a psychiatrist let loose in the Yale Law School, it contained, among many perceptive and many disturbing observations, conclusions and questions, a case. Professor Katz named its central figure Iphigenia. She was a 21 year old woman who found a lump in her breast, which proved to be malignant. Iphigenia agreed to have a mastectomy, its extent to be determined by what her surgeon found as he operated. The surgeon believed that this was not only the right treatment, but the *only* proper treatment.

The surgeon in the case described how he became increasingly concerned about 'having to perform such a mutilating procedure on a person that young and attractive'[3] especially as he had not discussed with her the avail ability of alternative treatments, particularly radiation therapy. 'On the evening prior to the operation', Katz wrote, 'his concerns about having remained silent, concerns that he did not fully understand, became so insistent that he returned to the hospital', and told the patient that although he believed surgery was 'without question the treatment of choice', he wished to inform her of the alternative treatments, and let her decide.[4] She decided to have a lumpectomy as she was about to be married.

"Physicians and writers", wrote John Stone, an American who is both, "draw upon the same source: the human encounter, people and their indelible stories."[5] So do some of us lawyers. Medical technology is of the highest moment, but patients are persons, with spouses, families, friends, and sometimes foes. Iphigenia's decision was a choice influenced by a life-step of vital importance - in her pursuit of happiness. It was an especially moving account, but by no means singular.

So the Commission embarked on a study of informed consent to medical treatment. It conducted extensive consultations in the medical and in allied professions,

and with health issues and particular patient support groups. It successfully invited the Australian and the New South Wales Law Reform Commissions to join with the Victorian Commission in this enterprise, so that its reach would be national. Of course we canvassed and carefully examined the law as we found it in Australia. But a great deal of effort and energy was also devoted to those consultations with doctors and with patients which we undertook, both in preparation for the publication of a Discussion Paper in October I987 and between that time and the publication of our final Report in June I989. We organised a series of symposia in 1986, the papers from which the Commission later published. We undertook empirical studies, including a survey of doctors, asking them about their communications with their patients, on choices in and risks of proposed treatment. The overall purpose of these investigations and consultations was to discern what the Australian community considered the norm or the standard of communication was, and what it should be - and similarly, what were the profession of medicine's practices and protocols.

THE PROVISION OF INFORMATION BY DOCTORS TO PATIENTS

The conclusions of the Commissions were that in Australia, doctors were under a legal duty to conform to a standard of reasonable care in the provision of information about choices and risks, and that adherence to an established practice of revelation in the profession of medicine would not necessarily satisfy that criterion. We endorsed what King CJ had said in *F v R*,[6] the leading South Australian decision on the question in 1983, though we knew that the question had not been determined in the final court of appeal. In that case, King CJ stated:

> In many cases an approved professional practice as to disclosure will be decisive. But professions may adopt unreasonable practices. Practices may develop in professions, particularly as to disclosure, not because they serve the interests of the clients, but because they protect the interests or convenience of the profession... The ultimate question... is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard in question of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.[7]

The more important part of the Report, however, was the recommendation that non-legislative guidelines on the provision of information by doctors to their patients should be formulated and widely circulated. This was a positive proposal designed, if you will, for the purpose of preventing or at least reducing as much as possible the development of those situations which are legally pathological, and which result in litigation of one sort or another, in the courts or in formal complaints to disciplinary bodies or to the Health Services Commissioner or like entity.

We stated in the Report that "[t]he Commissions do not have either the medical expertise or the consumer input to draw general guidelines or the more detailed ones that will be required for particular specialities."[8] We proposed that the National Health and Medical Research Council (NHMRC) should undertake that task, and we secured through discussion and negotiation, the agreement of that federal body to undertake it.

The Report described what the content of such guidelines should be, and proposed emphatically "that doctors should focus on patients' needs in deciding what information should be given."[9] It concluded with a recommendation that the guidelines should be accorded a particular status in the law, "so that in any action for damages for negligence brought against a doctor, the courts will consider the contents of the guidelines in deciding whether a doctor has acted reasonably in relation to the provision of information."[10]

The preparation of the general guidelines was undertaken by a Working Party established by the NHMRC, under the Chairmanship of the Chairman of its Health Care Committee. The Working Party was a large assembly, of 22 members, of whom three were nominees of the Consumers' Health Forum and one the nominee of the Health Issues Centre. There was a range of medical practitioners, including nominees of several of the largest Colleges, the medical protection and defence bodies, the Australian Medical Association and the Australian Health Ministers' Advisory Council. The Royal College of Nursing provided a member, and I was the nominee of the Victorian Law Reform Commission. Ms Kathy Sanders and Mrs (now Associate Professor) Loane Skene, officers of the Commission who had

undertaken the research and analysis leading to the completion of the Report, were also members of the Working Party.

The Guidelines prepared by us postulate four basic principles, all derived from one general principle - that patients are entitled to make their own decisions about medical treatments or procedures and should be given adequate information on which to base those decisions. The principles are:

- Information should be provided in a form and manner which help patients understand the problem and treatment options available, and which are appropriate to the patients' circumstances, personality, expectations, fears, beliefs, values and cultural backgrounds.
- Doctors should give advice. There should be no coercion, and the patient is free to accept or reject the advice.
- Patients should be encouraged to make their own decisions.
- Patients should be frank and honest in giving information about their own health, and doctors should encourage them to do so.

These Guidelines were first canvassed in a preliminary Discussion Paper published in October 1991, circulated to consumer groups, health and law professionals, health organisations and governments, to engender wide consultations and "to promote broad public debate." The Working Party received over 150 written responses, the great majority of them in support of the development of the Guidelines. In light of these, the text was revised, and the final version submitted to the NHMRC in June 1993. The Council adopted them at that meeting, and approved their circulation through out Australia.[11]

THE HIGH COURT STEPS IN

With exquisite timing, the High Court of Australia delivered judgment in the case of *Rogers v Whitaker*[12] on 19 November 1992. Its decision had been eagerly awaited, and is now, justly, known far and wide, and, I opine, understood accordingly. The facts of that case are today well-known among members of both the professions of medicine and of law. The High Court decided, I was glad to read, that in Australia a doctor is under a legal duty to warn her or his patient of a material risk inherent in any proposed treatment. Generally speaking, the Court stated, whether a patient has been given all the relevant information to choose between undergoing or not undergoing treatment proposed by the doctor is not a question which depends on medical standards or practices. On what does it then depend? It depends, the Court held, on a whole congeries of matters, a "complex of factors: the nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient; and the general surrounding circumstances."[13] That last factor encompasses, I consider, the personal, familial and social circumstances of a patient, such as those of Iphigenia in Professor Jay Katz's text.

The High Court reiterated that "except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it. In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality meaningless unless it is made on the basis of relevant information and advice."[14] That encompasses, in my view, relevant information and advice not only about material risks, but also, where appropriate, about choices of procedures or treatments.

Rogers v Whitaker was an action which made its way through the Supreme Court of New South Wales, where Campbell J awarded judgment in the amount of $808,564 against the ophthalmic surgeon who had neglected to tell Mrs Whitaker about the risk of sympathetic opthalmia. An unsuccessful appeal to the Court of Appeal[15] was followed by the final appeal to the High Court. It is to avoid, as far as that may be achieved, or at least to diminish substantially. further litigation of that kind that the Guidelines, and the educational programmes which their circulation has stimulated, are directed.

They are also directed towards another, positive goal - put thus by Professor Richard Smallwood, then Chairman of the Health Care Committee of the NHMRC and Chairman of the Working Party, in the Foreword: "to further better communication between doctor and patient, so that patients are able, with their doctors, to make the best decisions about their medical care."[16]

On reflection I am convinced that the choice of what came, properly to be entitled 'Informed Decisions about Medical Procedures' was the right selection for the initiation of law reform work on medicine, science and the law in those first months of 1985. I consider the impact of that work has been of real significance in the development of the ethics of medicine, and on medical law in this country, and perhaps beyond its borders.

CAPACITY TO CONSENT

Throughout *The Fragile Heart* there is a contrapuntal theme - the ability of the human mind to effect the workings of the human body - exposed in a persistent dream which Edgar Pascoe has, even when he snatches a nap. It is of a young man running through what is clearly the Australian outback, vivid in oranges, browns and yellows, and jumping the rattler, into a goods-carriage on a transcontinental train snaking its way slowly across the desert. He pulls shut the door, and makes himself comfortable - then sees an illuminated sign that he is in a sealed, refrigerated wagon. When the doors are opened at the terminus, the young man is dead - of hypothermia. But the refrigeration was not in operation; the wagon was warm. Late in the play, wide awake, Pascoe by chance reads a scrappy news clipping which describes the case as 'induced hypothermia'. This results in part of the change which affects our hero, and powerfully persuades him of the critical power and importance of the mind-body relationship. All of us understand that, even if we may disagree, sometimes vehemently, about the nature and extent of that force.

Doctors who practise the medicine of the mind, and lawyers who concern themselves with questions of capacity and responsibility, which of course focus on the mind, must be aware of these issues. The matters of informed decision making canvassed already have a particular significance in the cases of people who are diagnosed as mentally ill, or intellectually disabled. The challenges of giving, and receiving, information in those instances have a quality unencountered in even the most anxious of other medical encounters. In the reformative *Mental Health Act* 1986, the Parliament of Victoria enunciated some statutory law on informed consent, as the enactment has it, in relation to highly sensitive operations in the realm of psychiatric medicine. In *Rogers v Whitaker*, Gaudron J wrote, in her separate judgment:

> That duty (to provide information and advice) takes its precise content, in terms of the nature and detail of the information to be provided from the needs, concerns and circumstances of the patient. A patient may have special needs or concerns which, if known to the doctor, will indicate that special or additional information is required.[17]

Form and tone and tenor, as well as content, may be crucial.

Decisions about people who are intellectually disabled throw our subject into a sometimes contorted framework. This is particularly so when what is in prospect is surgery to sterilise a young girl, or older woman, to avoid pregnancies or to manage menstruation or other identified difficulties with reproduction. The establishment of Guardianship Boards by legislation enacted in Australia during the past decade or so means that in some cases decisions about whether or not this should occur are made by a committee of people drawn from the community, who constitute the Board. In the cases of minors, the courts, in England and in Australia, have recognised the nature of this choice by holding that it may only be made when the court grants its imprimatur.[18]

There are English cases of the highest authority which, in effect, hold that that is what should happen not only in the case of teenagers, but also in the case of adult women.[19]

I hope there is a most anxious concern about making these decisions in the councils of Boards, and in our court rooms. Removing "what was widely, and rightly, regarded as one of the fundamental rights of a woman, the right to bear a child", to use the words of Lord Brandon in a recent decision of this sort, is of incalculable significance.[20] We should not forget our own Western civilised history. Compulsory sterilisation of people, men and women, characterised as mental defectives was authorised by statute in some States of the Union, and some provinces in Canada, until the middle of this century, and in a few, even later. In *Buck v Bell*[21] that acclaimed Justice of the US Supreme Court, Oliver Wendell Holmes Jr, wrote these chilling sentences:

> It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those

> who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the fallopian tubes... Three generations of imbeciles are enough.[22]

Nobody would reiterate those words today - would they? I consider that in the list of indicia of what entitles a society to be called civilised its treatment of its intellectually disabled members stands high. Managing informed decision making in respect of, at least, very serious medical and surgical procedures proposed for those members is a crucial element in that calculus. We should make sure it remains one of the focuses of concern in today's realm of health law, and ethics.

CONCLUSION

Why did I begin with Mr Pascoe, with a TV play? It is because I share the view that the art, and the craft, of the writer or dramatist, may illuminate for us with cogent effect those issues of ethics and of law in the realm of medicine which are at the head of today's agendas. Dr John Stone, an American physician who is poet and essayist too, whose words I quoted earlier, illustrates this power and creates that effect throughout his book *In The Country of Hearts*, that country through which Mr Pascoe, and his real-life counter parts, daily walk, or march, or tramp, or tiptoe.

So, finally, what of that hero of *The Fragile Heart*? As the tele-play nears its end, he stands before an assembly of his peers, on whose behalf he has been presented with a high award, which takes the form of a small heart - of gold. His speech of acceptance and of gratitude becomes one in which he declines the honour, on the grounds of what he describes as his unworthiness. The flaw has indeed been transformed into a rose in the diamond's core. Mr Pascoe says this:

> It is not only my patients now who are plagued by uncertainty. But my uncertainty has made me their equal, and I want to build on that. I want to give them the prerogative in the healing process, to ensure that they can make their informed decisions about their own treatment. And I intend to give their emotional, their spiritual needs as much emphasis as the physical things.

His speech may serve as a coda for what I have said on this subject.

ENDNOTES

1. [1985] AC 871.
2. (New York: The Free Press, 1984).
3. Ibid at 91.
4. Id.
5. Stone, J, *In The Country of Hearts: Journeys in the Art of Medicine* (New York: Dell Publishing, 1992) at 68.
6. (1983) 33 SASR 189.
7. Ibid at 194.
8. Law Reform Commission of Victoria (with Australian Law Reform Commission and New South Wales Law Reform Commission), Report No 24, *Informed Decisions about Medical Procedures* (Melbourne: VLRC, June 1989) at 25.
9. Id.
10. Ibid at 30.
11. National Health and Medical Research Council, *General guidelines for medical practitioners on providing information to patients* (Canberra: Commonwealth of Australia, 1993).
12. (1992) 175 CLR 479.
13. Ibid at 632.
14. Ibid at 632-633.
15. (1991) 23 NSWLR 600.
16. Supra, n II at i.
17. (1992) 109 ALR 625 at 636.
18. See, for example, *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (HL); *Secretary, Department of Health and Community Services v JWB and SMB (Marion's Case)* (1992) 175 CLR 218; *P v P* (1994) 68 ALJR 449; 17 Fam LR 457.
19. *Re F (mental patient : sterilisation)* [1990] 2 AC 1; *Re B (a minor) (wardship : sterilisation)* [1988] AC 199.
20. *Re F (mental patient : sterilisation)* [1990] 2 AC 1 at 56.
21. 274 US 200 (1927).
22. Ibid at 207.

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PRIMARY FELLOWSHIP EXAMINATION
August/September 1997

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

The viva examination was held at College Headquarters in Melbourne.

One hundred and eleven (111) candidates presented, eighty (80) candidates were invited and seventy-nine (79) presented for the oral examination in Melbourne. Forty-two (42) were approved.

SUCCESSFUL CANDIDATES

Charles N Bradfield, NZ
Vicki J Browning, NSW
Chan Ka Lai, Anita, HKG
Pearl Cheung, QLD
Grant R Devine, NSW
Robert M Fabian, NSW
Victoria W S Ha, HKG
Anthony J Hackland, NZ
Saskia Hensen, VIC
Terry B B Hercock, NZ
David R Hill, QLD
Penelope J Hodges, NSW
Andrew W Hooton, NSW
Kishore N Jayanthi, ACT
Jennifer M Kaldor, NSW
Cornelis J Kruger, NZ
Jacqueline W-Y Kuh, WA
Lam Wang-Leuk, Desmond, HKG
David R R Lardner, NZ
Mei Lei Lee, HKG
Andy C S Liew, NSW
Thomas Lo, ACT
Eamonn M Mathieson, VIC
Richard J McMahon, VIC
Maria J Middlemiss, NZ
Ian D C Miller, QLD
James A Mitchell, VIC
Phillip J Morrissey, NSW
Ng Huey Ping, S'PORE
Ng Ju Mei, S'PORE
Andrea Nowitz, NZ
Margaret J Perry, NSW
David R Sanford, NSW
Belinda M Schramm, VIC
Toni M Stephen, QLD
Katherine L Taylor, NSW
Christopher J Thomas, QLD
Elizabeth L Trent, NZ
Sally P Troedel, VIC
Anthony W Vulcan, VIC
Bevan Yee, NZ
Sui Cheung Yu, HKG

Front Row (left to right):
Drs Alan McKenzie, Jim Love, Neville Gibbs, Greg Knoblanche.

Back Row:
Drs Terry Loughnan, Steuart Henderson, Richard Morris, Tony Quail (Chairman), Michael Cleary, Prof Tony Gin.

FINAL FELLOWSHIP EXAMINATION
August/September 1997

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

The viva examination in anaesthesia and medicine was held at Royal North Shore Hospital, Sydney.

Eighty-eight (88) candidates presented in Sydney and sixty-eight (68) were approved.

SUCCESSFUL CANDIDATES

Marion I Andrew, SA
David T Andrews, VIC
Stephanie E Armstrong, SA
Allysan Armstrong-Brown, NSW
John W Ausburn, NSW
Sonya Bajenov, NSW
Alan G Bennett, NSW
Dinah J Blunt, QLD
Derek R Browell, VIC
Ian L Cameron, QLD
Ian S Carter, NSW
Yee E Chee, HKG
Noel J Colin-Thome, SA
Ian M Cooper, QLD
David J Daly, VIC
Catherine S Downs, NSW
Mary A Faigan, NZ
Paul E Ferris, NSW
Jennifer J Forester, NZ
Grant J Freear, SA
Julia A Fynn, NSW
Michael D Goldblatt, SA
Alexander C Hancock, SA
Jackson N Harding, SA
Peter W J Harrigan, NSW
Matthew Hayhoe, VIC
David S H Ho, NSW
Ian R Hogarth, VIC
Daryl J Kock, QLD
Peter S Kruger, QLD
Henry W F Lam, NSW
David E Lindholm, VIC
Hendry K Liu, NSW
Mark A Lovell, NSW
David A Lowe, NSW
Benjamin R Ma, NSW
Andrew T Marshall, NZ
Warren P McIntosh, QLD
Marc D McIntyre, NSW
Joanne Melick, VIC
Wayne W Morriss, VIC
Aeneas F O'Leary, NZ
Roberto V Radici, WA
Christopher G Reid, WA
Stephen J Reid, SA
Marc A Russo, NSW
Craig A Schwab, NSW
Ian M Seppelt, NSW
Philip C Soet, WA
Wayne M Sorour, QLD
Jennifer A Stevens, NSW
Penelope C H Stewart, NSW
Paul M Templer, NZ
Melissa A Viney, VIC
Freda Vosdoganis, NSW
Mark J Wardill, NZ
Grant A Waters, NZ
Peter A Watt, QLD
Kathryn E Wearne, NSW
Ashley R Webb, VIC
Ralph S Whiteside, QLD
Paul S Wilkins, NZ
Kerryn L Wilson, NSW
Hiu Y F Yap, HKG
Raymond Yee, NZ
Victor Yeo, HKG
Biing-Lin Yin, NSW
Eric Yip, HKG

Front Row (left to right):
Drs Andy Pybus, Leona Wilson, Penny Briscoe, Peter Klineberg (Chairman), Judy Branch, Kersi Taraporewalla, Roman Kluger, Maggie Bailey.

Centre Row:
Drs Rob Beavis, Sandra Taylor, Richard Willis, Frank Maccioni, Graham Sharpe, Peter Peres, Greg Purcell, Bart McKenzie.

Back Row:
Drs Greg Knoblanche, Ed Loughman, Peter Moran, Tony Weeks, Peter Hales, Pat Farrell, Peter Gibson, Craig Morgan.

CHANGE AND RESTRUCTURE OF THE FINAL EXAMINATION

An Up to Date Means of Assessment

The format for the final examination has not been revised since the May 1972 examination. It established a standard for the then Faculty of Anaesthetists which was deemed to be an appropriate exit examination and which was accepted internationally for its high standard. That format divided the examination into written and oral sections. The written section had 150 multiple choice questions to be completed in two hours (30% marks) and an essay section with two major essays (without choice) to be written in two hours (20% marks). The oral section of the examination had two 30 minute vivas each with two examiners (40% marks). The medical clinical examination had a single long case conducted by an anaesthetic and a medical examiner. The candidate spent 30 minutes with the patient and then was examined for 20 minutes (10% marks).

In 1991, Dr. Barrie McCann the Chairman of the Final Examination Committee and Professor Garry Phillips the Chairman of the General Examinations Committee for the College, together with educationalists and delegates from all the major Colleges, attended the fifth Cambridge Conference on Medical Education. The main purpose of this conference was to discuss the implementation of recent advances in assessment methods.

Formal sumative assessment must be *"reliable"*, *"valid"* and *"practical"*. These terms have very specific significance in relation to assessment as explained below.

Reliability refers to the likelihood that candidates' results in one examination will be the same in a repeat examination. The main cause of unreliability is the "sampling error" or "content specificity" (i.e. if only a few questions are asked these few might be well known or poorly known by a particular candidate leading to a good or poor result). Hence many questions are needed to improve *reliability*. This applies to all methods of assessment whether they are essays, MCQs or vivas.

Validity is the degree to which our examination actually measures what the College requires of a candidate in anaesthesia. Hence the examination must be both relevant and reliable if it is to be *valid*.

The written sections of the examination are reliable, practical and efficient assessment tools for testing factual knowledge. However, they do not demonstrate ability to ***use*** that knowledge. The essay style examination tests the spontaneous reproduction of information and its prioritisation, whereas multiple choice questions test recall. It was considered important to maintain both of these aspects of the examination and with 150 multiple choice questions there is very good *reliability*. The two essay questions, though valid for their goal, were not *reliable* as they offered too few exposures or test points and were subject to *sampling error*. For this reason the number of written assessments was increased to 15 (short answer questions).

In the previous examination format there were four oral examinations in clinical anaesthesia testing the understanding and use of anaesthetic knowledge. In order to improve the reliability of this form of the examination, it was decided that there should be an increase to nine exposures.

The original medical clinical examination comprised one long case. This section has been increased to three medical clinical components, two involving patients and one with investigations. This component of the examination has high "fidelity".

After broad input involving external consultants and using workshops, a recommendation by the Final Examination Committee to adopt the new format was approved by Council in September, 1992. At that time, the Final Examination Committee comprised Drs. Barrie McCann (Chairman), Keith Cronin (Deputy Chairman), Craig Morgan (Statistician), Richard Willis, Ian Rechtman, David Scott, Ed Loughman and Peter

Klineberg. The new structure format for the written examination is 150 multiple choice questions (25% marks) and 15 short answer questions (15% marks). These two components comprise the written examination which is conducted approximately five to six weeks prior to the oral examination.

All candidates present for the oral part of the examination. This consists of a total of 12 vivas each of approximately 19 minutes duration with nine structured oral anaesthetic examinations, two medical clinical examinations involving patients and one medical clinical examination for investigations.

To improve the *reliability* of the viva component there is an increase in the number of exposures to nine, with structured contents of each viva. The marking of each viva is standardised, so that all candidates are now asked similar questions and the marks are awarded according to a calibrated scoring system.

The structured oral questions are prepared by identified groups of examiners and each has a standard introduction and first question. The candidate has two minutes to peruse this information prior to commencement of the viva. Candidates are then asked a series of predetermined questions in which certain elements of the answer are expected to be given. Subsequently, this part of the examination has been refined so that the oral examinations will include a number of "key issues" or "key features" which are regarded as crucial to answering the question. **These key features represent areas of best practice or desired decision making in clinical management.** It is important to emphasise that the oral part of the examination is geared towards assessing the **use** or **synthesis** of factual knowledge and the **application of anaesthetic principles**. It is not intended to be used to test factual knowledge which can be done quite satisfactorily in the written sections of the examination. For this reason the key features represent key responses or management aspects in the application of anaesthetic principles. The allocation of marks is 15% for the medical clinical section and 45% for the vivas.

The new structure of the examination has increased the demands on examiners, but has been well received by the candidates who feel that they are being fairly assessed over a broad range of issues. At the September 1997 examination, there were 88 candidates, each of whom had 12 oral examinations.

The examination will now proceed with an ongoing evolution to encompass changing ideas on assessment. There are a number of issues currently being considered to continue the process of making the examination more *valid* and *reliable* within the constraints of practicality.

In summary, there has been a substantial change in the Final Examination of the College. This change has given the exam increased value as an assessment tool and has generated much interest from other local and overseas colleges. The College believes that the process of change must be ongoing and that, in the future, this assessment must include in-training assessment as part of the overall process to ensure that our candidates are being fairly treated and that College Diplomates are of the highest standard.

A/PROF. PETER L. KLINEBERG
Chairman
Final Examination Committee

1. Fisk, G.C. et al, *The Final FFARACS Examination, Anaesth Intens Care* 1975; 3:227-233
2. Newble, D., Jolly, B., Wakeford, R., *The Certification and Recertification of Doctor's Issues in the Assessment of Clinical Competence*, Cambridge University Press, 1994
3. Phillips, G.D., Willis, R.J., *Specialist Training and Examinations in Anaesthesia and Intensive Care in Australia and New Zealand*, Ann Acad Med Sing, 1994; 23:610-613

SPECIAL INTEREST GROUPS

ANNUAL REPORTS 1997

CARDIOTHORACIC, VASCULAR AND PERFUSION SIG

The Cardiothoracic, Vascular and Perfusion Special Interest Group has been involved with contributions to the scientific programmes for a number of meetings during the past 12 months.

ANZCA/ASA COMBINED SCIENTIFIC MEETING, OCTOBER 1996

A 90 minute session on simulators for cardiopulmonary bypass techniques was held at the Perth ANZCA/ASA Combined Scientific Meeting. This was run by Dr Pybus, Dr Montano and Dr Morris from The St George Hospital, Sydney using a cardiopulmonary bypass model. It was well attended and the feedback very positive. The value of perfusion simulation is similar to that for anaesthesia simulation in that critical events are rare and 'real world' training opportunities therefore infrequent. The opportunity to train perfusionists in a reproducible and controlled manner seems very worthwhile.

ANZCA ANNUAL SCIENTIFIC MEETING, MAY 1997

The ASM was held in Christchurch this year. Two sessions were organised by the CVP SIG. A workshop on 'Problems with Thoracic Epidural Analgesia' was held twice on the Tuesday afternoon and chaired by Dr Alan Merry. Case presentations by Dr Leona Wilson, Dr Robin Holland and Dr David Scott all related to different challenging issues and scenarios. There were full attendances to both sessions and discussion was very active. This format worked well and helped to share a wide range of clinical experiences amongst the participants.

A session on "Fast Track Cardiac Anaesthesia" was held on the Wednesday morning. Despite the Congress dinner on Tuesday night, attendance was good. Chaired by Dr Paul Myles, speakers were Dr Gavin Kenny (Foundation Speaker - Intravenous agents for fast track cardiac anaesthesia), Dr Brendan Silbert (Early outcome with fast track anaesthesia) and Dr Mark Priestly (Epidural analgesia and cardiac surgery). There was considerable interest in the presentations, and especially in the risks versus benefits of epidural placement in cardiac patients.

BIENNIAL CVP SIG MEETING, WIRRINA, OCTOBER 1997

The group's biennial meeting was this year held in two parts. A Friday afternoon session held in conjunction with the International Society for Cardiovascular Surgery, Australian and New Zealand Chapter at the Stamford Grand Hotel, Adelaide. This session focused on aspects of vascular anaesthesia and surgery. The rest of the meeting was held at Wirrina Cove Resort focused on Pulmonary and Cardiac Issues on the Saturday with Perfusion and Echocardiography on the Sunday.

FUTURE MEETINGS

Consideration is being given to the contribution of the CVP SIG to the ANZCA ASM in Newcastle in 1998. College Council has made it clear that not all Special Interest Groups are able to contribute to the scientific programme at each annual meeting, however the CVP SIG has such a wide membership that it is likely that we will usually be able to have some input to the programme of major College meetings.

CVP SIG EXECUTIVE

The Executive of the CVP SIG has a representative from each State and New Zealand who is nominated by their respective Regional Committee. At present the members of the Executive are Dr David Scott (Chairman), Dr Alan Rainbird, Dr Peter Peres, A/Prof Peter Klineberg,

Dr Alan Merry, Dr John Murray and Dr Ken Williams. The Executive meets four to five times per year to deal with issues arising and meeting organisation. A lot of work is performed by members of the Executive to ensure that the main roles of the group are undertaken effectively.

CVP SIG GENERAL MEETINGS

Members can communicate to the SIG at any time through their Executive Member or directly to the Chairman. General meetings are held during many of the College conferences to enable face-to-face discussion of issues amongst members. Unfortunately these sessions often have to be held at the end of the day or at lunchtime and as a result attendance is often reduced to less than twenty people from a membership of 383.

TRANSOESOPHAGEAL ECHOCARDIOGRAPHY

Over the past two years, Dr Roman Kluger and Dr Damon Sutton have met with representatives of the Cardiac Society regarding intraoperative transoesophageal echocardiography (TOE).

At this stage there are no specific guidelines for training, accreditation or certification for TOE, but a list of recommendations is being developed. The main elements of this are that training in TOE by anaesthetists should be formalised to the extent that documentation of case experience should be retained and that a process of case review should be undertaken and continued. It is at present an individual responsibility to develop and maintain these skills. Special aspects of TOE that relate to anaesthetic practice include the use of an imaging modality to provide diagnostic information which is provided to a third party clinician (cardiac surgeon, intensivist) for them to base clinical decisions on. As such, we must be prepared to defend the quality of our practice to both ourselves and outside scrutiny. This is in addition, of course, to the role of TOE for use in anaesthesia decision making. It is also relevant that TOE is an area of clinical practice shared with another, already established, specialist group - namely cardiologists.

MEDICAL PERFUSION

A working group has been formed from College representatives and those from the National Association for Medical Perfusion (NAMPA) to commence discussions regarding standards and training for the practice of Medical Perfusion. Representatives are Dr David Scott, A/Prof Peter Klineberg, Dr Richard Walsh and Dr Ross Wallace. Progress has been slow to date, partly due to the complexity of the issues in that there is a wide range of clinical practice in medical perfusion across Australia. There is general agreement, however, that the role of the Medical Perfusionist should be supported in that it is an integral component of ensuring a high standard of patient care in many centres. In order to establish and maintain standards of practice of medical perfusion, certain minimum standards for training and maintenance of clinical competence are required. Any input or discussion related to such standards should be directed to working group members.

DAVID SCOTT
Chairman

RURAL SIG

The Rural SIG met in Perth in October 1996 at the Combined ASM, via telephone in February 1997 and at the ASM in Christchurch in May 1997. Matters considered at the meetings included overseas trained doctors, formation of a database for rural and remote anaesthetists, the rural workforce, and locums. The group supported the proposed new constitution for Special Interest Groups.

The ANZCA policy document for the training of general practitioner anaesthetists (P1) has been reviewed this year. The College has considered the question of career medical officers, and recommendations regarding the training of these doctors have been made. Various members have participated in continuing medical education for non-specialist anaesthetists. Meetings have been held in New South Wales, Victoria and Queensland.

All regions have been encouraged to include a rural rotation in each training programme. Most training schemes now have this facility. A submission on the desirability of rural rotations being "highly recommended" for vocational trainees was put to the ANZCA Education Committee in July 1997, and was supported by Council at its recent meeting.

At the Christchurch ASM Dr Miller presented his views on running a rural department: "Jack of all Trades"; he also organised sessions on "Inter-hospital transport of critically ill patients". Dr Catt presented a paper in the maintenance of standards session in relation to rural and remote practice; site visits, attendance at metropolitan hospitals, videoconferencing and other mechanisms for CME for the rural specialist were discussed. This subject will be discussed further by ANZCA in October at a special Maintenance of Standards day. Drs Khursandi, Moloney and Catt will attend. Plans for Rural SIG presentations at the Newcastle ASM in May 1998 are under way. The College has indicated that although each SIG will not necessarily be able to have a segment at each ASM, there should not be a problem with fitting in any SIG which wishes to organise a session.

Drs Khursandi, Moloney and Merefield attended the RACS Division Group of Rural Surgery in Coogee in November 1996; Dr Khursandi attended the Provincial Surgeons of Australia meeting in Ballina in March 1997. The Rural SIG continues to liaise with both of these groups. The Rural Workforce issue is a constant topic for discussion, as is the vexed question of who should anaesthetise paediatric patients away from urban centres.

This year has also seen the formation of the Australian College of Rural and Remote Medicine (ACRRM).

I would like to pay tribute again to the executive of the Rural SIG, for their enthusiasm and hard work, and also to Ms Helen Morris of ANZCA for secretarial assistance and support.

DI KHURSANDI, Chair

ACUTE PAIN SIG

1. Acute Pain Continuing Education Meeting: Perth October 1996

This meeting was very successful and well attended. The invited overseas speaker, Associate Professor Brian Ginsberg was greatly received and contributed significantly to all facets of the meeting, particularly the discussion sessions. Other participants in the programme included several noted speakers from Australia and New Zealand.

This meeting occurred as a satellite pre-meeting of the Perth CSM. This was the first time that such timing of a SIG meeting had occurred and this point received strong support from the attendees.

2. Web site

The SIG is undertaking the development of an Acute Pain section for the College Web site. The planned benefits of this include the timely access and provision of continuing education resources to all Fellows regardless of their location. Another aspect, that may be possible, will be a newsgroup service that will aid and assist Fellows with answers to acute pain related questions. It is hoped that this will significantly extend the continuing education role of the SIG and foster further communication amongst Fellows.

3. Financial Status

The October 1996 CME meeting ran at an adequate profit so as to ensure the ongoing financial viability of the SIG.

4. Newcastle 1998 ASM programme participation

The SIG will be participating in the programme of this meeting by running a 90 minute workshop session.

5. 1998 SIG CME meeting

The planning for this meeting is under way. Provisionally the location is to be in NSW, either in the Southern Highlands or the Blue Mountains area. The date is expected to be during June or July.

RICHARD HALLIWELL
Chair

DAY CARE ANAESTHESIA

MEMBERSHIP

During this period the following have been members of the Executive of the Day Care Anaesthesia Special Interest Group:

Professor David Gibb, NSW (Chairman)
Dr Andrew Bacon, NDSC and Victoria
Dr Bruce Burrow, Queensland (resigned Jul 1997)
Dr Michael Claxton, Tasmania (resigned Nov 1996)
Dr Brent Donovan, Western Australia
Dr David Kinchington, ACT (appointed Sep 1996)
Dr Robin Limb, SA (appointed May 1997)
Dr Ruth Matters, Tasmania (appointed May 1997)
Dr Glenda Rudkin, SA (resigned Mar 1997)
Dr Hugh Spencer, New Zealand
Dr Linda Weber, ACT (resigned Sep 1996)
Dr John Zelcer, Victoria (resigned Mar 1997)

MAJOR ITEMS OF BUSINESS

1) PATIENT INFORMATION DOCUMENTS

The following three documents were published in the College Bulletin in March, 1997.

i) Medical History Questionnaire
ii) Preoperative Instructions for Day Surgery Patients
iii) Postoperative Instructions for Day Surgery Patients

2) MANAGEMENT OF COMPLICATIONS ARISING FOLLOWING DISCHARGE FROM A DAY SURGERY UNIT

The SIG submitted recommendations for the management of postoperative complications following day care surgery to the College. These recommendations were published in the College Bulletin in August 1996.

3) RECOMMENDATIONS FOR THE SCHEDULING OF DAY ONLY PATIENTS ON MIXED LISTS

These recommendations were submitted to the College for consideration in September 1996 and published in the May 1997 edition of the College Bulletin.

4) ADVICE TO PATIENTS IN REGARD TO DRIVING A MOTOR VEHICLE FOLLOWING GENERAL ANAESTHESIA OR INTRAVENOUS SEDATION

Recommendations concerning the driving of a motor vehicle following day care surgery were submitted to the College in March 1996. As yet no further communication has been received in regard to these recommendations.

5) DAY CARE ANAESTHESIA QUESTIONNAIRE

This questionnaire, designed by Dr Glenda Rudkin, was circulated to all members of the College in March 1997. The object of this survey was to determine the perceived educational requirements of the ANZCA Fellows. 487 replies were received from 2552 Fellows (19% response rate). Many suggestions were made to improve the quality of our educational programmes. Dr Rudkin's report on this survey is available on request.

6) SPECIAL INTEREST GROUP CONSTITUTION

In response to a request from the College, the Day Care Anaesthesia SIG submitted comments concerning the proposed new constitution in February 1997. In summary the Executive expressed unanimous support for the changes proposed although there was some concern that the method put forward for electing delegates would disadvantage the smaller states. The intention of involving several outside organisations was also questioned.

7) SIG PARTICIPATION IN ANNUAL SCIENTIFIC MEETINGS

The Day Care Anaesthesia Executive expressed some concern at the intention of the College to limit the number of SIG sessions at the Annual Scientific Meetings. It was the view of the Executive that, as Day Surgery now constitutes about 50% of the work of the College Fellows, this SIG should be allocated sessions at every Annual Scientific Meeting.

8) PROPOSAL TO UTILISE THE INTERNET TO COMMUNICATE WITH MEMBERS OF THE SIG

Access to the Internet with E-mail facilities and a Day Care Anaesthesia Home Page is currently being investigated by the SIG Executive.

MEETINGS 1996 - 1997

1) DAY SURGERY 2000, ADELAIDE 31ST AUGUST 1996

This was a general meeting for surgeons, anaesthetists, nurses and administrators. Although anaesthetists were not strongly represented at this meeting, Dr Rudkin reported that it had been well attended and was of good quality.

2) COMBINED ANZCA/ASA MEETING, PERTH 26-30TH OCTOBER 1996

This meeting which was concerned with Quality Care, Economics and Legal Issues was organised by Dr Brent Donovan. Speakers included Dr Donovan, Dr Andrew Bacon, Dr Robin Limb and Mr Dominic Bourke. The Day Care Anaesthesia session was well attended and of a high standard.

3) ANZCA ASM CHRISTCHURCH 10 - 14TH MAY 1997

The Day Care Anaesthesia Programme at Christchurch consisted of three workshop sessions on:

i) Maintenance of Standards (Drs Glenda Rudkin, Di Khursandi, Brian Horan, Richard Halliwell and Daryl Catt).

ii) Laryngeal Mask Airways: What are the Limits? (Prof David Gibb, Drs Alan McKeag, Brian Lewer, Robin Limb and Doug Rigg).

iii) Regional Nerve Blocks in Day Surgery (Drs Hugh Spencer and David Kinchington).

All workshops were well subscribed and well received by those attending.

4) ANZCA ASM NEWCASTLE MAY 1998

As yet no Day Care Anaesthesia Programme has been planned for this meeting.

5) THE 1998 DAY SURGERY CONFERENCE OF AUSTRALASIA, SYDNEY, 13- 15TH NOVEMBER 1998

The Day Care Anaesthesia SIG has been asked to contribute two 90 minute sessions to this programme. In addition there will be a number of plenary sessions featuring distinguished local and overseas clinicians including Professor Paul Jarrett UK, Dr Paul Baskerville UK, and Dr Rebecca Twersky USA.

GENERAL COMMENTS

The last year has been a very busy one for the Day Care Anaesthesia SIG. There has been considerable involvement by the Executive in the organisation of, and participation in, Scientific Meetings. Teleconferences which are held every two months, were very well attended by members of the Executive.

It has also been a year of great changes within the Executive with resignations of Drs Bruce Burrow, Michael Claxton, Glenda Rudkin, Linda Weber and John Zelcer. All of these have made very considerable contributions to the Special Interest Group over a number of years and have been instrumental in the major advances that have occurred in Day Care Anaesthesia in Australia and New Zealand over that period of time. As Chairman, I would however like to make special mention of two of these: John Zelcer and Glenda Rudkin. John proved to be a most forceful, dedicated and effective Chairman who established a sound scientific and business bases for our organisation. Glenda, similarly dedicated has, with tireless good humour, promoted the cause of Day Surgery with crusading zeal. Working with these two dynamos has been a most stimulating, rewarding and humbling experience. I would also like to thank most sincerely our hardworking secretary Helen Morris. Her enthusiasm efficiency and tolerance has greatly contributed to the smooth running of our organisation.

DAVID GIBB
Chairman

WELFARE OF ANAESTHETISTS GROUP

The Groups' activities and membership (now 77) continued to expand in 1996-7.

A pilot registrars' briefing day was organised by Drs Goulding and Swann in Sydney in November 1996. This was a valuable and well-received seminar. A similar day was held in Perth in May 1997. Other regions are planning welfare briefing meetings, including Queensland, South Australia and Auckland. It is hoped that all regions will hold regular sessions for trainees and others, to educate and inform anaesthetists about welfare issues.

A welfare session was held at the Combined ASM in Perth. At the Christchurch ASM, two workshops on "Looking After Ourselves" were conducted by Tom Marshall a psychologist. A similar workshop, "Caring for the Carers", was organised at a non-specialists' CME week in Queensland, followed by a afternoon session, "Dilemmas", on suicide and depression at a combined Qld ASA/ANZCA meeting. Feedback from these activities showed that they were very well received. A combined associates and registrants morning on welfare, financial and practice issues will take place at the ASA in Hobart in October.

A submission to ANZCA for the Welfare Group to become a College Special Interest Group was accepted, although ratification of this decision awaits acceptance of our constitution. (Our constitution was agreed upon at our Christchurch meeting, but minor changes to it continue, in an attempt to satisfy all parties). We are grateful to the College for providing us with secretarial support and mailing assistance. An approach to the ASA has also been made. The possibility of establishing regional and/or national welfare officers has been considered.

In 1996 a Doctors Mental Health Working Group was set up in NSW; Dr G Goulding was one of the members. This Group produced a report, which all WOAG members should read. It made many recommendations, many of which WOAC has already formulated and agreed upon. Some of these recommendations were directed at the specialist Colleges, aimed at improving the welfare of trainees. This report has been brought to the attention of ANZCA.

A draft document by Dr R Large of New Zealand on "Maintaining Doctors' Competence" will be very useful when in final form; it examines many competence issues that can be correlated with our activities.

The Action Plans continue to develop, and the Welfare Brochure is nearer completion. The Substance Abuse Protocol, developed in Auckland is now available from the College and the Welfare Group executive.

Liaison with the Stress Working Party of the Association of Anaesthetists of Great Britain and Ireland has been sought. The World Congress (Montreal 2000) will have a session on "The Anaesthetist's Life Cycle", which will include many welfare issues.

DI KHURSANDI
Chair

LETTERS OF APPRECIATION

Dear Doctor,

Just a note to thank you on your care given to me at the birth of my son.

Having a form of anaesthetic is always nerve-racking, especially when it is a form you have never before heard of ("Spinal").

My previous experience with an epidural was so horrifying. I thank you so much for your insight into the Caesarean anaesthetic and for making what could have been a harrowing experience comprehensive and easy to go through.

Thank you again for your expertise.

Yours Faithfully,
Patient

Dear Doctor,

Please find enclosed "cheques" to cover your account.

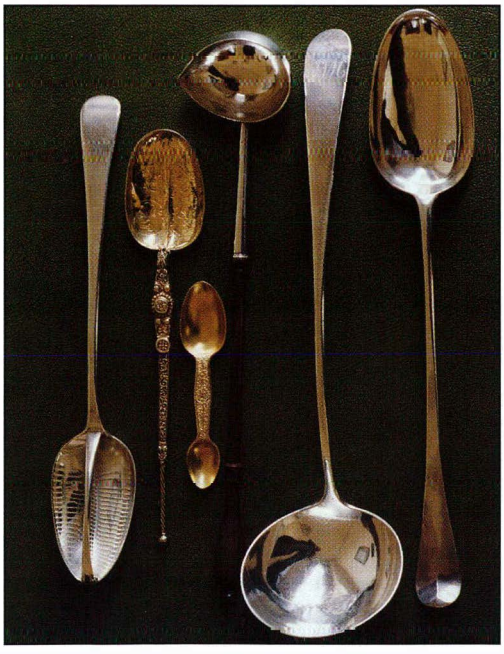
Thank you for your kindness and wonderful professionalism during my recent operation – it was really incredible how easy you made it for me.

God bless you and the work you daily perform.

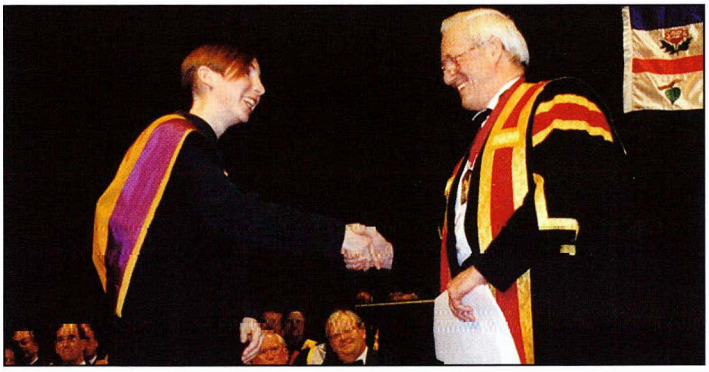
Sincerely,

Patient

GIFT TO THE COLLEGE



A group of magnificent antique silver spoons presented to the College by Dr Terrence Bourke, Western Australia.



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

Dr Loughman presenting Assoc Prof Peter Klineberg, Chairman, Final Examination Committee with Certification of Recognition and gift following completion of his 12 year appointment.

OBITUARIES

DR EUSTACE ALFRED

Eustace Alfred was born to a proudly Greek family in Sydney in 1940.

Educated at Newington College and later Sydney University, he graduated in 1964 the same year he married Katrina.

After residencies at St Vincents and Eastern Suburbs Hospitals he relocated to Royal Newcastle Hospital in 1966 where he completed his residency and registrar years in Anaesthesia and Intensive Care and he successfully completed the F.F.A.R.A.C.S. During a subsequent extended vacation he exhibited the exquisite class of taking delivery of a Maserati Indi at the factory at Modena.

Returning to a Staff Specialist position in Anaesthesia and Intensive Care at Royal Newcastle in 1974 he began to develop the higher technology aspects of the specialty when that development was in its infancy. He was particularly keen to develop a monitoring and recording system which traced trends and successfully completed this project to prototype stage.

A keen and incisive clinician Eustace's contribution to the Anaesthesia and Intensive Care Department at Royal Newcastle Hospital was quite clear and remarkable. Unfortunately he began to develop the signs of a long and debilitating illness in 1982 and relocated to a computer consultancy with Neomedics.

Eustace's personal fortitude during the inexorable progress of the debilitating condition afflicting him was remarkable.

Eustace is survived by his wife Katrina and two children, Christopher and Natasha.

OWEN JAMES

DR HENRY WILLIAMS

Henry Williams was born in Dunedin in 1915. After schooling there and in Christchurch, he returned to the Otago Medical School from which he graduated in 1939. He gained some experience of anaesthetics during hospital service after graduation but in 1940 he was posted to the NZ Forces in the Middle East. He was quickly drafted into anaesthetic practice at No. 1 NZ General Hospital. In 1986, Henry described anaesthesia and equipment during the war as "quite basic". Gas supplies were limited and intravenous barbiturate was guarded like gold. Spinal anaesthesia was widely used as was open ether – not withstanding the heat of the desert. Henry returned to combined anaesthetic and general practice in Dunedin after the war.

He spent 1950 at the Alfred and Royal Melbourne Hospitals and completed the DA while in Australia. In 1956 he became a Fellow of the Faculty of Anaesthetists, RACS. In 1964 he moved to Christchurch and continued in private anaesthetic practice as well as having visiting sessions at Christchurch Hospital. He retired from anaesthetic practice at the age of 65 in 1980 but continued in general practice for a number of years. He was associated with the New Zealand Society of Anaesthetists for many years and was its sixth President from 1962-1964.

Henry was a quietly spoken but invariably polite man. He brought a wealth of clinical experience to anaesthesia at a time when the art of anaesthesia was perhaps a more necessary part of practice than is the case today.

JOHN M. GIBBS

REGINALD ABBOT LEWIS

On Monday 18th August 1997, Reginald (Reg) Abbot Lewis died. So ended an era of anaesthetic history in Tasmania.

Reg Lewis was a Founding Fellow of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, and was the first specialist anaesthetist in Tasmania.

Reg was educated at Melbourne Grammar School and, after matriculating, enrolled in medicine at Melbourne University and resided at Trinity College. He graduated in 1936 and was appointed a Resident Medical Officer at the Launceston General Hospital. In his first year he was put in charge of the polio ward and at this time the polio epidemic was at the most prevalent stage.

The following year, using an Austox Machine, he enabled a woman requiring continuous iron lung respiration to deliver a healthy baby boy. It is believed that this was the first time that such a birth had occurred anywhere in the world.

He later served as Medical Superintendent at the Launceston General Hospital before enlisting as Medical Officer in the 2nd AIF, serving in Darwin and New Guinea. He obtained his Diploma of Anaesthetics from Sydney University in 1947 and commenced private practice in Hobart, the first specialist anaesthetist in Tasmania.

In 1952, he was admitted as a Founding Fellow of the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

Reg worked in all areas of anaesthesia, but his particular skill was in thoracic anaesthesia. In those early days, if there was ever a patient with a serious problem, Reg's involvement was sought.

He served with distinction both the Faculty of Anaesthetists and the Australian Society of Anaesthetists. He was Chairman of the Tasmanian Regional Committee from 1955 to 1965, Chairman of the Tasmanian State Committee of the ASA for several years, President of the ASA in 1960 - 61 and was elected Life Member of the ASA in 1982.

His professional interests were not confined to anaesthesia and he was President of the Tasmanian Branch of the BMA in 1960, Vice President of the Tasmanian Branch of the AMA in 1971 - 1972 and President of the Anaesthetic Section of the First AMA Australian Medical Congress in Adelaide in 1962. For his outstanding service to the AMA he was elected a Fellow of the Association in 1967.

His interests outside medicine were equally great. He was a keen golfer all his life and he built his own short golf course utilising the meticulously maintained garden lawns which surrounded his home.

Reg served with distinction the National Trust in Tasmania being Foundation Chairman of the Southern Regional Committee from 1962 - 1972 and was still an active participating member of the Southern Region Classification Committee at the time of his death.

He was involved in many battles to preserve historic buildings and was in no small way responsible for the preservation of the warehouses in Salamanca Place, Runneymede House and many other well recognised landmarks. His service to the Trust was recognised with his being made Honorary Life Member.

Reg married Judy in 1941, and they lived most of their married life in the historic home "Mawhera" in Sandy Bay. It is a beautiful home with an equally beautiful garden which won the first Australia-wide "Garden of the Year Contest" conducted by the Australian Home Beautiful magazine. They had six children, two of whom died in tragic circumstances. Reg bore these tragedies with great dignity, feeling but not showing his great anguish.

Reg himself was a quiet unassuming man who had great humility. He had strong views on what he believed was right. He was immensely helpful to more people than know it through his quiet word or quiet action.

The contribution Reg made to anaesthesia was not through presenting papers at meetings, nor through publishing in journals, but through his teaching of the principles of good sound anaesthetic practice. He was meticulous and maintained notes of every anaesthetic he ever gave in personal diaries.

He will be greatly missed.

M. J. HODGSON

DONALD JOHN TAYLOR

Donald was strong, steadfast, sometimes immobile, a man of immense stature in the community and in his own chosen profession; a fine athlete, friend and a passionate supporter of his family and true friends.

His contributions to the community at large, his skills to patients, generosity, support for others, humour and humility characterised his career.

Born in Adelaide on 1st June 1932, his early childhood was spent in that city. He later moved to Melbourne with the family and was educated at Scotch College. He was an active participant in sports; an outstanding gymnast and team player. Later he was awarded a University Blue in table tennis and had a life-long enthusiastic association with tennis and golf.

He completed his medical training at Melbourne University in 1956. A hospital residency followed in Launceston, Tasmania, general practice in Shepparton and consultant anaesthetist in that city and finally in Melbourne.

His skills in anaesthesia were honed at Shepparton where he was the only specialist anaesthetist. He would work tirelessly in the care of accident trauma victims brought in from the highway, involving himself with all surgical disciplines and obstetrical anaesthesia when required.

His fine career involved devotion to St Vincentís Public Hospital as an anaesthetist to the Plastic Surgical Unit, as Chairman of the Anaesthetic Department at St Vincentís Private Hospital and to a substantial and busy private practice – an outstanding medical contribution.

He took an active interest in the operations and many a time I have thought that if I was unable to finish my task, Don would step up and do so.

For approximately 25 years he graced the tennis court almost every Saturday afternoon but 'fly-fishing' was his passion. The chase and the skills of the catch, the master fisherman's constant challenge to obtain the best catch and the competition with his great mate, Rodney McAuliffe - a competition between them that had gone on from time immemorial.

However, with the taking of the fly he became the complete angler and it has always been a privilege to watch him play the trout and to land it. More often than not he would throw the fish back as eating the catch was not part of his make-up. Stories of trout fishing were his forte and it is a pity that he was unable to write that book that we wished him to do over many years. A raconteur of great depth whether after tennis or around the table on a fishing trip, whilst tying the flies or in discussion of the anticipated catch the next day, he could not be equaled or beaten.

Donald was a leader amongst men, his quiet dedication and meticulousness would have made him equipped to lead a battalion into action if his earlier life had been timed differently. He would never give up. "Come along Geoffrey. Let's get this show on the road."

He has been dedicated to youth training and spent much of his time whilst in Shepparton with the scouting movement.

A Rotarian always was another valued way he served the community in concert with his peers and no matter where he was he joined in the affairs of Rotary. He worked with others and for others and gave freely of his leisure time.

Over the last three years, his strength of purpose, his extraordinary ability to come to terms with matters, have stood him in good stead. He has been a giant amongst men and throughout his whole life he has been devoted to his family, intensely proud of them all.

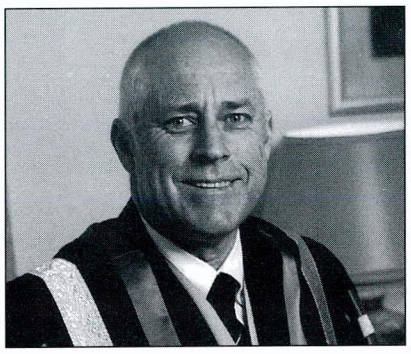
I said finally to him at our recent last meeting "Give it your best shot, Don. If you don't make it, I'll see you shortly at the big river on the other side and I will bring the rods with me." A great smile engulfed his face.

We shall all miss him in our own ways. Brave, kindly man with high principles, immense stature, quiet achiever and a true and constant friend.

G. J. BISHOP, FRACS

FACULTY OF INTENSIVE CARE

DEAN'S MESSAGE



The October Board Meeting realised a number of important milestones and developments.

The first of these was the completion of the document "The Objectives of Training in Intensive Care". Whilst many contributed to this monumental achievement, special recognition is appropriate for the tireless work of Felicity Hawker. The document will be circulated shortly and it is the hope of the Board that it will prove valuable to trainees in helping shape their future careers in Intensive Care. Fellows are also encouraged to utilise the document that defines the knowledge, skills and attitudes which should be maintained and enhanced through professional life.

After much discussion the Fellowship Examination is to undergo a major overhaul during 1998, the most significant for many years. The Board has agreed to the introduction of an Objective Structured Clinical Examination (OSCE) to replace (and incorporate) the Investigation Section of the examination. It is also proposed to replace the current vivas with six "structured" cross-table vivas of 10 minutes duration, each with one examiner. The Clinical Section of the examination will be split into two sections, ICU long cases and "cold" cases with separate sets of examiners. It is proposed to mount this revised examination from 1999. These changes are designed to improve the reliability and validity of the examination and to cater for the increasing number of candidates. Trainees and Supervisors of Training will be given specific details of the changes through individual mailings and via the Bulletin.

A number of Fellows have written to the Faculty expressing concerns regarding recent appointments of practitioners to tertiary and secondary hospital intensive care units who have not been trained and certified in intensive care. In some cases these appointments have occurred in preference to appropriately trained specialists. The Board agrees that this is unacceptable and will be seeking the support of Fellows, Regional Committees and the Joint Specialist Advisory Committee to address the problem. The Board believes that Hospital Appointments Committees should seek the advice of intensive care specialists when making such appointments. The problem is likely to recur until the current manpower shortage in intensive care is solved.

Further debate regarding the recognition of training posts and intensive care units occurred at the October Board Meeting and a number of options are beginning to crystallise. A discussion document detailing the issues and these options will be circulated widely for consideration and feedback prior to the February Board Meeting.

Of special note is the College Council's agreement to support a National Intensive Care Day on July 1 1998. This will provide a unique opportunity for Intensive Care Units and Societies to publicise to the community the important work that we do and to dispel myths. The project seeks to involve all members of the intensive care unit team and has the support of the ASA, NZSA, ANZICS and the CACCN and the Intensive Therapy Section of the New Zealand Nurses Organisation.

Finally, I would take this opportunity of wishing the Fellowship a very Merry Christmas. I hope that the Faculty will continue to grow and strengthen in 1998.

Alan Duncan

A W DUNCAN, DEAN

ADMISSION TO FELLOWSHIP BY EXAMINATION

Ashoke Banerjee, QLD

Dorothy Margaret Breen, NSW

John Stuart Martin Evans, QLD

Craig John French, VIC

Ho Kwok Ming, HK

Catherine Grace Hill, NZ

Janet Liang, NZ

Paul Anthony MacDonald, NSW

Rachakonda Kanaka Sundaram, ACT

ITEMS OF INTEREST FROM THE OCTOBER 1997 BOARD MEETING

HONOURS AND APPOINTMENTS

The Board noted the following appointments:

- Prof Teik E Oh, HK –
  Chairman of the Health Services Research Committee of Hong Kong
- Professor Garry D Phillips, SA –
  Fellow of the Academy of Medicine of Malaysia
- Mr Michael Gorton
  Honorary Fellow, Australian and New Zealand College of Anaesthetists

EDUCATION

Accreditation of Training

A series of recommendations relating to a revision of the process for accrediting Intensive Care Units were considered. The main principle of the proposal would be continued accreditation of Units. However, the number of training posts in Units would no longer be restricted, depending upon the level of the post. Units will be graded as unrestricted, or restricted for periods of one year, six months or three months. In effect this would remove the ceiling on numbers of training posts and withdraw the category of elective training. Also under consideration is a modification to the training programme to 30 months of core intensive care training, six months of anaesthesia and six months of medicine.

Comments will be sought from Regional Committees and the Joint Specialist Advisory Committee in Intensive Care, however views of individual Fellows are welcomed.

Objectives of Training in Intensive Care

The Board approved the Objectives of Training in Intensive Care for promulgation.

Manual on Training

A Manual on Training for trainees was approved and will be circulated.

EXAMINATIONS

Changes to the Fellowship Examination format

The Board resolved that the Faculty Fellowship Examination format will change from 1999. The Investigations Section of the Exam will be replaced by an Objective Structured Clinical Examination (OSCE), which will include stations for assessment of procedures, techniques and ethical/management problems. The Clinical Section of the Examination will be divided into 'Cold Cases' and ICU long cases, with separate examiners for each section. The Cross Table Vivas will

be reorganised to increase the number of encounters to six encounters of 10 minutes, each with one examiner and structured questions.

The G.A. (Don) Harrison Medal 1997

The Board announced the Winner of the G.A. (Don) Harrison Medal for 1997 is Dr Janet Liang, of North Shore Hospital, Auckland.

FINANCE

The following fees relating to training will apply from 1st February 1998:

Faculty Registration Fee	$850
Faculty Training Fee (for dual FANZCA/FICANZCA and FICANZCA/RACP trainees)	$900
Faculty Annual Training Fee (for trainees undertaking training with the Faculty only)	$900
Faculty Assessment of Overseas Training Fee	$950
Faculty Examination Fee	$1850

The Board also resolved that for trainees undertaking dual certification, the Faculty Training Fee will be payable by 31st October in the second year of core training.

Daily Living Allowance

In line with College policy, the daily living allowance has been increased to $200 per diem, effective from 1st February 1998.

PROFESSIONAL

Policy Document

The Board approved the Policy Document IC-9 "Statement on Ethics and Patients' Rights and Responsibilities". The document is reproduced elsewhere in this edition of the Bulletin.

Australian Medical Workforce Advisory Committee

The Faculty is represented on this Committee's Intensive Care Working Party, which is currently gathering data on workforce requirements in Intensive Care.

CONTINUING EDUCATION

Annual Scientific Meeting, Newcastle 1998

The programme for the Faculty component of the 1998 Annual Scientific Meeting in Newcastle was ratified. The Faculty Foundation Speaker Dr Gordon Doig, and Mr John McClenahan will present various topics relating to evidence based medicine.

ASM, 2000

The Faculty Scientific Convenor for 2000 in Melbourne will be Dr Megan Robertson.

Younger Fellows Conference

The Board resolved that a Board Member in Residence will attend the Younger Fellows Conference. Dr Neil Matthews was nominated as the Board representative for 1998.

INTERNAL AFFAIRS

Changes to Faculty Regulations

The Regulations were amended to allow Regional Committees to have the power to co-opt an intensive care specialist representative of the Royal Australasian College of Physicians. This representative will be recommended by the local ANZICS Committee. In New Zealand, the co-opted member will be nominated by the New Zealand Specialist Advisory Committee in Intensive Care.

Faculty Ties

A design for a Faculty Tie was approved and will be available in due course.

National Intensive Care Day

A proposal for activities for National Intensive Care Day on 1st July 1998 was supported by the Board. This initiative will be sponsored conjointly by the College and Faculty, with the support of ANZICS, the ASA and the NZSA, CACCN and the Intensive Therapy Section of the New Zealand Nursing Organisation.

NATIONAL INTENSIVE CARE DAY 1998

1st JULY

Over the last three years, the Australian and New Zealand College of Anaesthetists has promoted anaesthesia and its related disciplines through National Anaesthesia Day. The Council and Board of Faculty have agreed that the theme in 1998 will be the work of intensive care staff. This incentive has the support of ANZICS, the ASA and the NZSA, the the CACCN and the Intensive Therapy Section of the NZNO.

"National Intensive Care Day" in 1998 will provide an opportunity for intensive care teams to share their challenges and achievements with the public in a nationwide education project to further improve community recognition and understanding.

Units are encouraged to start considering ways to mark the Day, which will be 1st July 1998. The media and community involvement are key factors in the formula for a successful National Intensive Care Day. Some ideas include a reunion of former patients, an 'open day', news releases or speaking engagements within the community.

Resource materials in the form of posters and pamphlets will be available from College Headquarters in May 1998, however the success of the Day relies heavily on participation of individual units. Meanwhile, background information and a questionnaire has been circulated to Intensive Care Units.

All Fellows and Trainees are encouraged to participate in the event to make the Day a success.

For further information, contact the Faculty Administrative Officer:

Carol Cunningham-Browne
Faculty of Intensive Care, ANZCA
'Ulimaroa'
630 St Kilda Road
MELBOURNE VIC 3004

Tel: (03) 9530 2861
Fax: (03) 9530 2862
Email: ficanzca@anzca.edu.au

The G.A. (Don) Harrison Medal Winner 1997

Dr Janet Liang of Auckland has been awarded the G.A. (Don) Harrison Medal for 1997. The Medal is awarded annually to the candidate who achieves the highest mark in the Faculty Fellowship Examination in each calendar year.

WHAT NAME FOR OUR SPECIALTY?

With the imminent recognition by the Medical Council of New Zealand that the practice of intensive care receive specialty status (the final details of our application were forwarded to the MCNZ in September) a re-think has taken place over the best term for describing our specialty. All the intensive care specialists practising in New Zealand, 21 of whom are qualified from the Faculty of Intensive Care and 7 from the Royal Australasian College of Physicians - Specialist Advisory Care (Intensive Care), were polled for their order of preference in five choices offered. These were:

1. Intensive Care
2. Intensive Care Medicine
3. Critical Care
4. Critical Care Medicine
5. Intensive Care/Critical Care Medicine.

On a world wide basis all if these terms are in use, which one depends on local preference.

A 100% return in the New Zealand poll showed that as their first choice,

(1) 25 of the 28 preferred "Intensive Care Medicine",

(2) only 2 opted for "Intensive Care" unspecified and

(3) a lone voice requested "Critical Care Medicine".

This demonstrates fairly conclusively the clear opinion of these specialists. The Medical Council of New Zealand has been advised accordingly and we all look forward to Intensive Care Medicine becoming, in the new nomenclature, a ***Branch*** (previously: Principal Specialty) of medicine, and not a Sub-Branch (previously ***sub-specialty***, of either anaesthesia or internal medicine).

On allocating points on the basis of the order of preference for the various titles (five for 1st choice, one for 5th) the following scores were obtained (five of the responders would not give some of the options any mark at all):

Intensive Care Medicine:	136
Intensive Care:	86
Critical Care Medicine:	67
Intensive Care/Critical Care Medicine:	51
Critical Care:	38

One of the two replies which favoured "Intensive Care" noted two points re "Intensive Care Medicine":

(1) Our Faculty is called the "Faculty of Intensive Care"

(2) The term "Medicine" may imply physicians rather than surgeons re importance (ie not sufficiently impartial).

In comment (for whatever it is worth), the New Zealand pioneer of Intensive Care, Matt Spence, always resisted the term "Intensive Care" for his Acute Respiratory Unit as "That was something nurses did, what doctors did was intensive therapy". He upgraded his department's name to "Department of Critical Care", however (which became the Department of Critical Care Medicine after his retirement). "Critical Care" seems to be of more common usage in North America. "Intensive Therapy" was not offered as an option in the poll – possibly an error?

Of curiosity and possibly of historical interest I can advise that I first requested the Medical Council of New Zealand to consider recognition of "Critical Care Medicine" in 1974, at that time not really so new a specialty.

RONALD V TRUBUHOVICH,
Chairman and Secretary
New Zealand Regional Committee,
Faculty of Intensive Care

ANNUAL SCIENTIFIC MEETING

2-4 MAY, 1998 – NEWCASTLE

Improving the performance of ICUs using quality management and evidence-based decision making.

Are you bored with the format and content of the conferences you attend? Are there too many intensive care meetings in Australasia? What is the purpose of these meetings anyway? Are they really contributing to your ongoing education and professional development? Are you going offshore to find what you want?

The Scientific Committee for the 1998 Faculty meeting does not pretend to know the answers to all these questions; but know we are not the only people asking them! Newcastle is well recognised for its capacity to be innovative and creative in medical education. This programme has been developed in this tradition focussing on the theme of change and improving the performance of units using "evidence" to do so. Many of us may think quality management is something nurses are involved in; but is your unit paying sufficient attention to structural and process issues to meet your corporate vision for the unit in the year 2000? How many of us are using information from our own databases or the ANZICS database to improve aspects of patient care? Can we demonstrate an improvement in the process of care or the outcome as a result? Can the use of clinical practice guidelines in units be used to improve the process of care and/or patient outcomes? Are they being developed and implemented in ways where the probability of better outcomes is enhanced?

This meeting will attempt to answer some of these questions using a combination of overseas experts in management and evidence based medicine along with invited Australasian intensivists. The culture and medical attendance of recent Faculty meetings encourages us to believe the sessions will be highly interactive; the programme allows for workshops and journal clubs conducted by the Foundation Visitor and the invited overseas speaker.

The Faculty meeting is immediately preceded by a two day workshop of ICU teams entitled Effective Management for ICU teams - leadership, strategy and the use of evidence, organised by the Centre for Leadership and Learning and supported by the Faculty. Both overseas guests will join a team of five facilitators for this workshop.

These two back to back meetings provide a tremendous opportunity for intensivists to meet with colleagues and teams of managers from our own and other units to

- understand the complex issues that relate to quality of intensive care services and their improvement
- learn more about managing change in our units - leadership, team work, strategic direction, planning for the future
- facilitate a team building approach to the development, implementation and evaluation of evidence based clinical practice guidelines - as well as identification of areas where CPG development might improve efficiency and efficacy of care.

Bring your team to Newcastle for an exciting double header.

(April 30 - May 1 CLL Workshop, May 2 - 4 Faculty Meeting)

Further information is available from Phil Byth.

Phone: (02) 4921 4240
Fax: (02) 4921 4799
Email: mdpby@cc.newcastle.edu.au

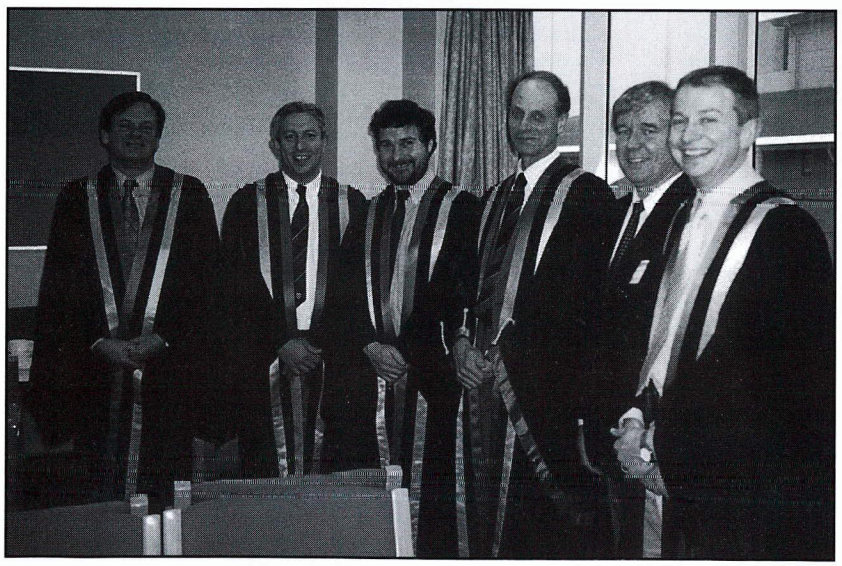
INTENSIVE CARE FELLOWSHIP EXAMINATION

SEPTEMBER 1997

Front Row *(left to right)* Drs Rachakonda Sundaram, Helen Opdam, Ashoke Banerjee

Middle Row *(left to right)* Drs Janet Liang, Cathie Hill, Peggy Yuen-heng Tan, John Evans, Mary Pinder, Catherine Motherway

Back Row *(left to right)* Drs Tony Williams, Christian Boehringer, Charles Gomersall, Gerry O'Callaghan, Daniel Mullany, Cyrus Edibam



COURT OF EXAMINERS:

Professor Ken Hillman, Drs Steve Edlin, Peter Morley, Ron Trubuhovich, Al Vedig and Chairman Richard Lee

FACULTY REGIONAL COMMITTEES

1997 / 98

NEW SOUTH WALES

Chairman	P.L. Byth
Vice-Chairman	T.C. Jacques
Regional Education Officer	G.F. Bishop
Honorary Secretary	F.G. Eruini-Bennett
Ex-officio Board member	R.P. Lee
Co-opted representative for ACT	T. Dobbinson
Co-opted Younger Fellow	E.R. Stachowski

VICTORIAN REGIONAL COMMITTEE

Chairman	P.T. Morley
Regional Education Officer	G.J. Duke
Honorary Secretary	J.V. Green
Ex-officio Board members	D.J. Cooper
	F.H. Hawker

WESTERN AUSTRALIAN REGIONAL COMMITTEE

Chairman	J.W.N. Weekes
Honorary Secretary	P.V. van Heerden
	F.X. Breheny
Regioinal Education Officer (co-opted)	S.A. Edlin
Ex-officio Board members	G.M. Clarke
	A.W. Duncan

SOUTH AUSTRALIAN REGIONAL COMMITTEE

Chairman	N.T. Matthews
	M.O'Fathartaigh
Regional Education Officer	J.A. Myburgh
	A. Bersten
Ex-officio Board member	P.D. Thomas

QUEENSLAND REGIONAL COMMITTEE

Chairman	M.J. Cleary
Honorary Secretary	B.G. Lister
Regional Education Officer	R.J. Barnett
Ex-offico Board member	R.F. Whiting

NEW ZEALAND REGIONAL COMMITTEE

	F.E. Bennett
	J.H. Havill
	J. Judson
Ex-officio Board member	R.V. Trubuhovich
Faculty Regional Education Officer in Hong Kong	T.E. Oh

POLICY DOCUMENT

Review IC-9 (1997)

FACULTY OF INTENSIVE CARE

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

STATEMENT ON ETHICS AND PATIENTS' RIGHTS AND RESPONSIBILITIES

Professional codes and guidelines impose ethical responsibilities on intensivists. In addition intensivists must be aware that they also have legal responsibilities arising from relevant legislation(s) or general rulings at law. This Statement on Ethics is not intended to replace or supersede those responsibilities and liabilities. It is the responsibility of each intensivist to be aware of other ethical and legal requirements imposed by other professional and regulatory bodies. This document is intended to set professional standards of practice at the highest level and to educate intensivists on ethical and professional responsibilities, rather than be intended to inform intensivists of their legal obligations.

The Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists, aims to maintain the highest standards of practice, teaching and research in intensive care. The intensivist must recognise that the overall welfare of the patient is the principal goal of intensive care management, and that there is a professional responsibility to maintain and if possible improve patient health.

The relationship between the intensivist and the patient must have regard to the following concepts:

- patient autonomy, meaning the patients have the right to decide their own treatment, with intensivists respecting the principles of truthful disclosure and informed consent;
- the principle of beneficence, or the obligation to do good;
- the principle of non-maleficence, or the duty to do no harm; and the principle of social justice, as it applies to the fair distribution of resources.

Many intensive care patients, as the result of illness, injury or the side effects of medication, may not be mentally competent. Management must then fully involve the patient's legally recognised representative unless precluded by nature of an emergency.

1. Patients' Rights

Patients themselves (or through their legally recognised representatives) have the right to:

1.1 Expect that the services provided are of optimal quality and that they will receive the most appropriate care available.

1.2 Be treated with care, consideration and dignity including the respect for personal, religious, cultural and social beliefs.

1.3 When realistically possible, know the identity and professional status of all attending medical and other staff.

1.4 When realistically possible, be informed, with a clear, concise and understandable explanation of the proposed care and procedures, including the relevant alternatives and known side effects and risks,

unless precluded by the nature of an emergency.

1.5 Give verbal or written consent for a procedure, after explanation and before treatment, unless this is precluded by the nature of an emergency.

1.6 Know what services are available in the hospital.

1.7 Receive a second opinion when requested, without prejudice to any aspect of future treatment.

1.8 Be provided with appropriate information and give consent whenever considered appropriate (according to NH&MRC and hospital ethics committee requirements) for involvement in teaching or research activities, and to understand that non-involvement will not prejudice treatment.

1.9 Refuse treatment, and to be informed of the effects of such refusal.

1.10 Expect that all aspects of care will remain confidential, including personal privacy in conversations and physical examinations.

1.11 Know the financial implications to themselves of therapy.

2. Patients' Responsibilities

Patients themselves (or through their legally recognised representatives) have a responsibility to:

2.1 Inform the intensivist fully of all relevant medical history.

2.2 Comply with the agreed prescribed treatment or inform the intensivist of the intention not to comply.

3. Clinical Research

The NH&MRC recognises that unconscious, semiconscious or critically ill patients from whom or on behalf of whom consent cannot be obtained for treatment or other interventions, because of the urgency of their condition, merit special attention.

When intensive care patients are to be involved in research, the intensivist must recognise:

3.1 The need for further medical knowledge through research, but respect that the well being of the patient takes precedence over the interests of society and research.

4. Clinical Teaching

The requirement for providing appropriate information and obtaining consent, whenever considered appropriate by NH&MRC and hospital ethics committees, before patient participation.

4.1 The intensivist has an obligation to pass on professional knowledge to junior and other colleagues.

4.2 Whenever teaching involves elective situations or conscious patients, consent should be obtained from the patients themselves (or through their legally recognised representatives) .

5. Professional Conduct

Intensivists should:

5.1 Conduct themselves with integrity and honesty.

5.2 Accept responsibility for their own physical and mental health, especially when impairment of health affects patient care and professional conduct.

5.3 Participate in continuing medical education, and recognise the need for ongoing professional development.

5.4 Participate in the establishment and updating of appropriate professional standards.

5.5 Not undertake procedures and treatment which he/she knows to be of no benefit to the patient.

5.6 Understand that the decision to withhold or withdraw treatment does not imply

termination of care. Implicit in these decisions is an understanding of the ethical principles involved in "not for resuscitation" orders, orders related to foregoing life sustaining treatment, and care of the dying patient.

Reference:

NH&MRC Statement on Human Experimentation and Supplementary Notes 1992, National Health and Medical Research Council.

Promulgated: October 1997

POLICY DOCUMENTS

Review PS-12 (1997)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ACN 055 042 852

STATEMENT ON SMOKING AS RELATED TO THE PERIOPERATIVE PERIOD

The Australian and New Zealand College of Anaesthetists recognises that tobacco smoking is addictive and can damage both the health of smokers and those passively exposed to tobacco smoke. The College supports all measures to decrease tobacco consumption and involuntary exposure to tobacco smoke (i.e. passive smoking).

Some adverse effects of smoking are considerably lessened following cessation of smoking (1,2). These benefits are particularly relevant in the perioperative period.

1. Smoking increases the blood concentration of carboxyhaemoglobin, which has an average elimination half-life of four hours (3). An abstinence of only 12 hours will greatly reduce carboxyhaemoglobin concentrations, improve oxygen content and availability, and reverse negative inotropic and arrhythmic effects. Smokers' polycythaemia and increased blood viscosity take a few days to reverse (4).
2. Nicotine increases heart rate, blood pressure and peripheral vasoconstriction (5). These adverse effects generally improve following 12 - 24 hours of abstinence (6).
3. In the respiratory system, smoking causes hypersecretion of mucus, impairment of tracheobronchial clearance, and small airways narrowing. Smokers have a greater tendency to develop hypoxia in the postoperative recovery period (10). If smoking is stopped, sputum production declines over a six week period, half of which occurs in the first two weeks (1). Small airways function improves after one month, with further improvements up to six months (7). The high incidence of chest infection in smokers following coronary artery surgery is reduced if smoking is stopped two months preoperatively, six months of preoperative abstinence will reduce the incidence to that of non-smokers (8,9).
4. Smoking may adversely affect immune mechanisms (11-15). Decreased levels of immunoglobulins and cells involved in the immune response in smokers apparently return to normal following a six month period of abstinence (1).
5. Perioperative analgesic requirements are increased in smokers (16,17). This may be due to increased enzyme induction (16) or withdrawal of endogenous opioid stimulation. Improvement is seen 6 - 8 weeks after cessation of smoking (18).
6. Postoperative complication rates are higher in smokers (19), particularly following plastic and reconstructive surgery (22). Smoking has adverse effects on the microcirculation (21) which may impair wound healing (20).

CONCLUSION

Tobacco smoking is an identifiable major risk factor relating to surgery and the perioperative period.

Patients who smoke should be encouraged to stop smoking at least six to eight weeks before surgery. In the

short term, smoking should not be permitted 12 hours before surgery.

The College supports all reasonable measures to reduce tobacco use in the community.

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Promulgated: *1986*
Reviewed: *1991*
Date of current document: *Oct 1996*

Review PS-17 (1997)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ACN 055 042 852

ENDOSCOPY OF THE AIRWAYS

1. INTRODUCTION

1.1 Assessment and care of the airways is an important part of the practice of anaesthesia and intensive care.

1.2 Laryngoscopy or bronchoscopy, rigid or fibreoptic, may be required to assess and/or aid in management of problems with the airways or lungs.

1.3 Although laryngoscopy and bronchoscopy are safe procedures when appropriate precautions are taken, serious complications can occur during or after the procedure, including hypoxia, cardiac arrhythmias, hypertension, airway obstruction, haemorrhage.

2. PRINCIPLES

2.1 Laryngoscopy and bronchoscopy should be performed by or under the direct supervision of a person with appropriate experience.

2.2 The patient should be thoroughly assessed before the procedure, with particular attention to the presence of problems which may increase the difficulty of carrying out the procedure safely. This assessment may indicate the necessity for a second appropriately trained medical practitioner, in addition to the endoscopist's assistant, to monitor the patient during the procedure and manage any necessary therapy.

2.3 Informed consent for the procedure should be obtained.

2.4 All equipment to be used for the procedure must be thoroughly checked before use to ensure that all items are operating correctly and are compatible with each other.

2.5 General anaesthesia, local anaesthesia or intravenous sedation may be required. General anaesthesia or sedation may be inappropriate or even dangerous under certain circumstances. If used, sedation should be under the control of an appropriately trained medical practitioner other than the endoscopist.

2.6 Patients undergoing endoscopy of the airways must be monitored continually with pulse oximetry. This equipment must alarm when certain set limitations are exceeded. Other monitoring should be used as indicated in accordance with College Policy Document P18 *Monitoring During Anaesthesia.*

2.7 Reliable venous access should be in place for all endoscopies.

2.8 Supplemental oxygen therapy should be administered in an appropriate manner as indicated before, during and after the procedure.

2.9 Close observation of the patient must continue until full recovery from the procedure and any sedation is deemed to be complete. A medical practitioner must be readily available during this time.

2.10 A written record of drug dose and time of administration must be kept as part of the patient's records.

3. FACILITIES

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

3.1 Adequate space to enable safe access to the patient by all involved staff and to perform resuscitation on the patient should this prove necessary.

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

3.3 Adequate suction and room lighting.

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

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

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

3.7 A pulse oximeter.

3.8 Ready access to an ECG monitor and defibrillator.

3.9 Drugs for reversal of benzodiazapines and opiates.

3.10 Equipment suitable for measurement of B.P.

4. DISCHARGE

The patient should be discharged only after an appropriate period of recovery and observation in the procedure room or in an adjacent area which is adequately equipped and staffed. Discharge of patients should be authorised by the practitioner who administered the drugs, or another qualified person. The patient should be discharged into the care of a responsible adult to whom written instructions should be given. Written instructions should also include prohibition of driving and the operation of machinery until the next day, and eating and drinking instructions. A list of symptoms, (e.g. bleeding, severe pain, etc) requiring the need for medical attention should be provided.

5. To ensure that standards of patient care are satisfactory, equipment and staffing of areas in which the patient is being managed should satisfy the requirements in the appropriate College Policy Documents regarding:

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

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

P9 *Sedation for Diagnostic and Surgical Procedures*

P18 *Monitoring During Anaesthesia*

P19 *Monitored Care by an Anaesthetist*

APPENDIX

Emergency drugs should include at least the following:

adrenaline
atropine
dextrose 50%
flumazenil
naloxone

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

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

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

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ACN 055 042 852

ANAESTHESIA CARE OF CHILDREN IN HEALTHCARE FACILITIES WITHOUT DEDICATED PAEDIATRIC FACILITIES

1. INTRODUCTION

Anaesthesia for children is an area of practice in which the College strongly recommends specific training and experience. The College therefore recommends that a healthcare facility which is not dedicated to paediatric care but which proposes to manage children for anaesthesia and surgery should develop a policy which details criteria for management of anaesthesia, surgery and nursing care.

This policy should be developed and documented jointly by representatives of the anaesthesia, surgical and nursing staffs and should be reviewed at intervals of not more than five years.

It must always be recognised that the initial treatment of paediatric emergencies may be necessary in facilities and under circumstances where paediatric care is not normally provided. In this situation the child should be transferred to a specialist paediatric centre at the earliest opportunity.

2. FACTORS TO BE CONSIDERED WHEN DEVELOPING A POLICY INCLUDE:

2.1 **Age**. There should be a specified age at which any restrictions on management and referral policies come into effect. Children of less than 12 months of age are classified as infants and when less than 28 days as neonates. Risks associated with anaesthesia are greater in smaller children thus the policies are more likely to apply to infants and neonates.

2.2 **Staff training and experience**. Specialist anaesthetists are expected to have training in the care of infants and children. However individual anaesthetists may have varying recent experience in managing anaesthesia for children. They should not be required to provided anaesthesia care without regular clinical exposure to an extent necessary to maintain and be comfortable with their competence.

It will often be of benefit for two anaesthetists to be present for the care of infants and children classified as ASA 3 or greater.

Anaesthesia assistants and nursing staff providing care in the perioperative period must be trained in the care of children. Regular experience and tuition is essential if care of appropriate standard is to be provided. Sufficient numbers of staff must be available whenever children are managed in the facility.

A liaison should be established with a specialist paediatric facility so that authoritative advice is available at all times.

2.3 **Equipment and facilities**. Anaesthesia equipment must comply with College Policy Document T1 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites*. Specific requirements will include:

2.3.1 Appropriate equipment for the needs of infants and children.

2.3.2 Climate control and equipment designed to meet the special needs of small children so that body temperature is maintained throughout the perioperative period.

2.3.3 Monitoring equipment which complies with College Policy Document P18 *Monitoring During Anaesthesia* and is suitable for use with infants and children.

2.3.4 A separate ward area in the facility.

2.4 Criteria for transfer to a Specialist Children's Hospital or Facility. The distance to the nearest appropriate centres will be an important factor in determining the need for transfer. The following groups of patients should be considered for transfer:

2.4.1 Neonates

2.4.2 Infants born at less than 37 weeks gestation and with a post-conceptual age of less than 52 weeks.

2.4.3 Infants with a history of opnoeic episodes.

2.4.4 Infants and children with unusual and/or complex medical or surgical problems classified as ASA3 or greater.

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ACN 055 042 852

PROTOCOL FOR CHECKING THE ANAESTHETIC MACHINE

1. INTRODUCTION

1.1 The regulated supply of gases and vapours for anaesthesia and the provision of controlled ventilation for the patient are the main functions of the anaesthetic machine or workstation. Because oxygenation and ventilation are essential for every patient and because even a brief failure to maintain them may cause irreparable harm, every machine must be regularly and thoroughly checked to ensure that all functions are correctly maintained.

1.2 There must be a reserve facility to maintain oxygenation and ventilation of a patient should failure of the primary systems occur.

1.3 To ensure early detection of any failure in the anaesthetic machine, it is essential that appropriate alarms are present in the machine and that there is monitoring of the state of the patient as specified in College Policy Document P18 *Monitoring During Anaesthesia*.

1.4 This protocol incorporates three components:

1.4.1 **Level One check**. This is very detailed and is required on a) any new machine and b) on all machines after the required regular servicing. This check will usually be performed by the service person – whether from the equipment provider, or from the Bio Engineering Department.

1.4.2 **Level Two check**. This should be performed at the start of each anaesthetic session.

1.4.3 **Level Three check**. This should be performed immediately before commencing each subsequent anaesthetic.

Each check must be derived specifically for the machine under test and the Anaesthesia Department (on behalf of the hospital administration) is responsible for the training and accreditation of the personnel involved with each test.

1.5 Accreditation for checking the anaesthetic machine requires:

1.5.1 **Level One**. Attendance at a manufacturer's course or a programme developed by the hospital's Anaesthesia Department in consultation with a qualified Biomedical Engineer.

1.5.2 **Levels Two and Three**. Checks must follow protocols specifically developed for the machine under test. All personnel must be trained in correct procedures and accredited to perform them by the Anaesthesia Department. The specific protocols should be attached to the machine.

2. PROTOCOLS

2.1 **Level One check**. This must be performed on anaesthetic machines a) before they enter service and b) following all service inspections, which must be performed at regular and specified intervals.

2.1.1 The Hospital, Anaesthesia Department or body responsible for the equipment shall keep a detailed record of the equipment and the checking procedures. This process requires that a checklist be maintained. The checklist will be based on manufacturer's guidelines, and on Biomedical Engineering and Anaesthesia Department recommendations. The protocols shall describe checking and calibration protocols and the intervals at which these must be performed.

2.1.2 The anaesthetic machine must have a prominent label to advise of past service(s) and to indicate when the next check is due. This label must be visible to the anaesthetist.

2.1.3 **Gas Delivery System**. The check shall include:

2.1.3.1 Quantifying and minimising leaks

2.1.3.2 Excluding crossed pipelines within the machine

2.1.3.3 Ascertaining the correct functioning of non-return valves throughout the system

2.1.3.4 Ascertaining the integrity of oxygen failure prevention and warning devices

2.1.4 **Anaesthetic Vapour Delivery System**. The check shall include the accuracy of vapour output and delivery devices.

2.1.5 It is essential to ascertain that the machine as supplied complies with the relevant Australian or New Zealand Standard.

2.1.6 The check specified above must be undertaken by a suitably qualified person, usually the service provider. The check must be recorded with inclusion of information as to what was checked, and by whom. After servicing, the particular checklist will relate to the actual service performed.

2.2 **Level Two check**. This check must be undertaken by a suitably qualified person (such as an anaesthetist, technician or nurse) in accordance with a protocol specific for the particular machine. Thus several different protocols may be required in a single hospital. These will serve to verify the correct functioning of the anaesthesia machine before it is used for patient care. Equipment required for the tests must be available on each machine.

2.2.1 **High Pressure System**.

2.2.1.1 Check oxygen cylinder supply. Ensure that cylinder content is sufficient for its intended purpose.

2.2.1.2 Check that piped gas supplies (where present) are at the specified pressures and that following high pressure system checks, the cylinders are turned off.

2.2.1.3 Confirm correct pipeline supply by using an oxygen analyser or multigas analyser distal to the common gas outlet.

2.2.2 **Low Pressure System**.

2.2.2.1 Check control valves and flow meters. Turn on each gas and observe the appropriate operation of the corresponding flow meter. Check the functioning of any interactive anti-hypoxic device.

2.2.2.2 Check that any required vapouriser is present:

2.2.2.2.1 Check that ade-quate anaesthetic liquid is present.

2.2.2.2.2 Ensure that the vapouriser filling ports are closed.

2.2.2.2.3 Check correct seating and lock-ing of a detachable vapouriser.

2.2.2.2.4 Test for circuit leaks for each vapouriser in both on and off positions.

2.2.2.2.5 Ensure power is available for elec-trically operated vapourisers.

2.2.2.3 Check for pre-circuit leaks using a method sensitive to 100ml/minute and appro-priate for the specific machine.

2.2.2.4 **Breathing systems**. Check the general status to ensure correct assembly and absence of leaks. The precise protocol will depend on the anaes-thesia circuit to be used.

2.2.2.4.1 Perform leak test on the breathing system by occlud-ing the patient connection, applying a fresh gas flow of 300 ml/min and ensur-ing that a pressure of >30 cm H_2O is sustained.

2.2.2.4.2 In the circle system check its integrity and the functioning of uni-directional valves.

This can be accomplished with a breathing bag on the patient limb of the Y-piece. Ventilate the system manually using an appro-priate fresh gas flow. Observe in-flation and de-flation of the attached breathing bag and check for normal system resistance and compliance. Observe movement of unidirectional valves. Check function of adjust-able pressure limiting (APL) valve by ensuring easy gas spill through APL when the two breathing bags are squeezed.

2.2.3 **Automatic Ventilation System**. This should be checked according to the manufacturer's recommendations. This test protocol must be present on the machine. A test lung (such as a suitably compliant bag) may be used to check the function of the ventilator. Where practicable, gas flow should be reduced to check for leaks. The functioning of disconnection and high pressure alarms should be checked at this time.

2.2.4 **Scavenging System**. This should be checked after connection to APL valve and ensuring a free gas flow. If there is negative pressure in any part of the system, ensure that this does not lead to emptying of the breathing system. With the patient outlet occluded, a full breathing system should not empty with the APL valve open.

2.2.5 **Emergency Ventilation System**. Verify the presence and functioning of an alternative method of providing oxygen and of controlled ventilation (such as a self-inflating bag).

2.2.6 **Other apparatus to be used**. This should be checked according to specified protocols. Attention should be given to:

2.2.6.1 Equipment used for airway maintenance and intubation of the trachea.

2.2.6.2 Suction apparatus.

2.2.6.3 Gas analysis devices.

2.2.6.4 Monitoring equipment. Special attention should be paid to alarm limits and any necessary calibration.

2.2.6.5 Intravenous infusion devices.

2.2.6.6 Devices to reduce hypo-thermia during anaesthesia.

2.2.6.7 Breathing circuit humidifiers.

2.2.6.8 Breathing circuit filters.

2.2.7 **Final check**. Ensure vapourisers are turned off and that the breathing system is purged with air or oxygen as appropriate.

2.3 **Level Three check**. Immediately before commencement of each anaesthetic, the anaesthetist should:

2.3.1 Check a changed vapouriser using the protocol outlined in 2.2.2.2.

2.3.2 Check a changed breathing circuit using the protocol outlined in 2.2.2.4.

2.3.3 Check that equipment as specified in 2.2.6 is ready for the next case.

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ACN 055 042 852

DUTIES OF REGIONAL EDUCATION OFFICERS IN ANAESTHESIA

1. Regional Education Officers occupy an important position in the College's educational network. They have responsibilities to provide liaison between trainees, Supervisors of Training, their Regional Committee and the central administration of the College. Specific duties include:

   1.1 Maintaining a list of approved hospitals in each region. Notifying the Regional Committee and the College Council of any changes in senior Anaesthesia staffing or department workload which have the potential to affect the training programmes.

   1.2 Obtaining a list (on Form R1 or R2) from Supervisors of Training with:

      1.2.1 The names of all trainees in College approved posts.

      1.2.2 The numbers of occupied service posts which are not approved by the College for training purposes.

      These lists should be forwarded to the College within two months of the commencement of the hospital employment year in each region.

   1.3 Obtaining notification from Supervisors of Training of any changes in the list referred to in 1.2.1 caused by trainees joining or leaving a rotational training scheme during the hospital employment year. It is particularly important that the dates of such changes are noted to allow independent verification of training by the Assessor.

   1.4 Co-ordinating In-Training Assessments.

   1.5 Assisting Supervisors of Training with monitoring of staffing and trainee supervision in each approved hospital. When considered necessary by Council or the Regional Committee, a survey of staffing and workload (using Form HA-2) should be conducted. Results should be forwarded – with any relevant recommendations – to the Hospital Accreditation Committee of the College.

   1.6 Understanding College Regulations relating to training and examinations.

   1.7 Maintaining a calendar of dates relevant to College examinations.

   1.8 Maintaining contact with Supervisors of Training with advice as appropriate on matters related to training and examinations.

   1.9 Ensuring that courses for Primary and Final Examinations are held on a regional basis.

   1.10 Keeping the College Education Officer informed of regional activities and problems. Providing a report to the Education Committee by 1st July each year.

   1.11 Attending or nominating a representative to attend the annual meeting of Regional Education Officers with College Education Officers held during the ASM.

   1.12 Providing advice as appropriate to trainees and prospective trainees.

2. REGIONAL EDUCATION SUB-COMMITTEE

2.1 This sub-committee will include the Regional Education Officer, the Regional Education Officer of the Faculty of Intensive Care, the Regional Committee Chairman, and the Supervisors of Training within the region.

2.2 The Regional Education Officer will convene and chair the sub-committee.

2.3 The sub-committee will assist the Education Officer with all matters related to educational activities within the region and will report to the Regional Committee.

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ACN 055 042 852

SUPERVISORS OF TRAINING IN ANAESTHESIA

Supervisors of Training are the College's representatives on training in its approved hospitals. They have an important role and must have a broad understanding and experience in College affairs. They provide liaison between trainees and Hospital authorities (in respect of matters related to training) as well as with Regional Education Officers and the central administration of the College.

1. APPOINTMENT AND TENURE

1.1 The Supervisor of Training in Anaesthesia shall be nominated by the relevant Department. The appointment shall be ratified by the College Council.

1.2 The Supervisor shall not be the Director of the Department or administratively responsible for its functioning unless the circumstances are exceptional.

1.3 The appointee shall hold the Diploma of FANZCA or an equivalent qualification acceptable to the College Council and should not be a candidate for any College examination.

1.4 The Department shall be responsible for notifying the Registrar of the College of the recommendation for appointment.

1.5 The College Council, at its discretion and after consultation with the relevant Regional Education Officer, may not approve of the Supervisor recommended by a Hospital. In that case, the Registrar shall notify the Hospital and request the recommendation of a different Supervisor.

1.6 The appointment of a Supervisor of Training shall be for an initial term of five years with a review by the Regional Committee after two years. Supervisors will be eligible for reappointment by the Council after advice from the Regional Committee.

2. DUTIES OF SUPERVISORS

2.1 Within the Hospital

2.1.1 To be familiar with the College's Regulations on Training, Examinations and Registration of Trainees.

2.1.2 To provide a list (on Forms R1 and R2) to the Regional Education Officer with:

2.1.2.1 The names of all trainees in College approved posts.

2.1.2.2 The numbers of occupied service posts which are not approved by the College for training purposes.

These lists are to be forwarded to the Regional Education Officer within two months of the start of the hospital employment year. Forms R1 and R2 will be provided by the Regional Education Officer.

2.1.3 To notify the Regional Education Officer of any changes to the list referred to in 2.1.2.1 created by trainees joining or leaving the rotational training scheme during the hospital employment year. It is particularly important that the date of such changes is noted to allow independent verification of training by the Assessor.

2.1.4 To notify the Regional Education Officer of any senior staffing or workload changes likely to impact on training programmes. To provide information when requested for a Hospital Data Sheet or for a Trainee Workload Survey.

2.1.5 To advise potential and current trainees on their training, registration requirements, fee payments and examination preparation.

2.1.6 To monitor supervision, experience and fair allocation of duties for trainees and to facilitate such changes as may be necessary.

2.1.7 To liaise with the Director of the Department in respect of trainee duties, supervision, rest and study time and release for approved courses.

2.1.8 To oversee the Department's compliance with the College's requirements for In-Training Assessment.

2.1.9 To complete and despatch promptly trainees' training certificates to the College with particular emphasis on the accuracy of the dates of specific training experiences or specialty attachments.

2.2 Outside the Hospital

2.2.1 To establish and maintain liaison with the Regional Education Officer and with other Supervisors of Training.

2.2.2 To participate as a member of the Regional Education Sub-committee.

2.2.3 To refer any difficulties in respect of training programmes or trainees to the Regional Education Officer.

2.2.4 To be aware of appropriate training courses and to see that trainees receive this information.

2.2.5 To maintain a calendar of examination dates, and dates of closure for entries.

3. RESOURCES

The Supervisor of Training shall be provided by the Department with the resources needed to fulfil his or her responsibilities. In larger Departments this will require a time allocation of approximately one session per week.

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

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

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

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
ACN 055 042 852

GUIDELINES FOR COMPLETION OF A FORMAL PROJECT

1. INTRODUCTION

Every trainee will be required to complete a formal project **during the period of approved vocational training**. This project is not a prerequisite for presenting for either the Primary or the Final examinations and may be undertaken at any time. To avoid delay in the award of the Diploma of FANZCA, the trainee must ensure that the project is submitted well before the completion of approved vocational training.

A trainee must prospectively register the project with his or her Regional Committee (or Training Committee in South East Asia) Formal Projects Officer and seek advice **prior to commencing work on their project**. This requirement will apply to all trainees registering with the College after 31 December 1997.

2. PROJECT

A project must include a written critical review of the work undertaken. This will include an evidence based approach to the specific area. It is expected that the trainee will produce evidence of having assessed background data relating to the project and objectively weighed up the validity of relevant information obtained from the scientific literature and from other sources. The format for publication in the journal *Anaesthesia and Intensive Care* will generally be appropriate.

Suitable activities may include:

2.1 A dissertation on appropriate case reports or other clinical material.

2.2 Documentation of activity resulting from a period of research prospectively approved by the Assessor. In general this will require a period of not less than three months full-time research. The trainee must have an appropriate supervisor.

2.3 Any other project which has value from a clinical, scientific or educational perspective.

3. ASSESSMENT OF PROJECTS

Regional Committees and, in South East Asia, Training Committees, will be responsible for certifying to the Assessor that each trainee has completed a Formal Project to an appropriate standard. Each Committee will nominate a Formal Projects Officer to be responsible for this task and may delegate its authority to him or her. All projects must be assessed by at least two people one of whom will be the Formal Projects Officer.

The project must be of satisfactory standard. The Formal Projects Officer may accept a project, may require it to be revised or may reject it.

Where the Formal Projects Officer has problems with any project, the Assessor should be consulted in the first instance. Normal College Appeals mechanisms apply to Formal Projects.

In assessing Formal Projects, the following matters will be noted:

3.1 The project must be conducted in major part by the trainee. In the case of a project with multiple participants there must be a

statement from the trainee (ratified by the senior team member) as to his or her contribution to the project.

3.2 Presentation of a paper at a scientific meeting approved by the College's Maintenance of Standards Officer (at which abstracts are subject to review and selection) is to be encouraged. Such a presentation should be made after approval of the entire project by the Formal Projects Officer who will take into account its acceptance for presentation.

3.3 Publication of a paper based on the Formal Project in a journal which referees all manuscripts is to be encouraged. Acceptance of such a manuscript will be taken into account by the Formal Projects Officer.

3.4 Where the Formal Project involves research activities approved as in 2.2, the outcome **must** include a paper, a publication or a dissertation. In each case there must be a statement of support from the trainee's supervisor.

4. CERTIFICATION

Upon compliance with the above, the Formal Projects Officer will certify to the Assessor that the trainee has completed an appropriate Formal Project. The College will notify the trainee of its acceptance.

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

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

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
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SEDATION FOR REGIONAL ANAESTHESIA FOR OPHTHALMIC SURGERY

1. INTRODUCTION

Ophthalmic surgery may be carried out under general anaesthesia, regional anaesthesia with or without sedation, local infiltration with or without sedation, or topical anaesthesia with or without sedation.

The technique used will depend upon the type of surgery and the choice of the surgeon after discussion with the patient, whose co-operation is essential.

Many patients undergoing ophthalmic surgery are elderly, and have associated conditions such as diabetes, cardiovascular disease, lung disease or arthritis. They may be anxious, or have difficulty lying still for the duration of surgery.

Sedation for ophthalmic surgery includes the administration by any route or technique of all forms of drugs which result in depression of the central nervous system. The objective of these techniques is to produce a degree of sedation of the patient, without loss of consciousness.

These techniques are not without risk because of:

1.1 The depression of protective reflexes.

1.2 The depression of respiration.

1.3 The depression of the cardiovascular system.

1.4 The wide variety of drugs and combinations of drugs which may be used.

1.5 The difficulty in predicting absorption, distribution and efficacy of drugs when administered orally or rectally.

1.6 The possibility of excessive amounts of these drugs being used to compensate for inadequate local analgesia.

1.7 The individual variations in response to the drugs used particularly in the elderly or infirm.

1.8 The wide variety of procedures performed.

1.9 The differing standards of equipment and staffing at the locations where these procedures are performed.

Thus it is important to understand the variability of effects which may occur with sedative drugs, however administered, and that over-sedation or airway obstruction may occur at any time. To ensure that standards of patient care are satisfactory, equipment and staffing of the area in which the patient is being managed should satisfy the requirements in the appropriate College Policy Documents.

2. GENERAL PRINCIPLES

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

2.1.1 A concise medical history and examination and must include blood pressure measurement.

2.1.2 Informed consent.

2.1.3 Any instructions for preparation for the procedure (including the

importance of fasting), the recovery period, and discharge of the patient (which may include avoidance of driving, other dangerous activities, undertaking responsible business).

2.2 If the patient has any serious medical condition (such as significant cardiac or respiratory disease), or danger of airway compromise, or is being sedated, then an anaesthetist should be present to monitor the patient during the procedure.

Risk assessment is aided by the American Society of Anesthesiologists' classification system (Appendix 1).

Reliable intravenous access should be in place prior to anaesthesia or sedation.

2.3 Systemic complications of retrobulbar or peribulbar block may be cardiac (usually vasovagal) or due to central nervous system toxicity of local anaesthetics, resulting in coma, convulsions, hypertension, cardio-pulmonary arrest. The practitioner administering these drugs requires sufficient basic knowledge to be able to:

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

2.3.2 Detect and manage appropriately any complications arising from these actions. *In particular doctors administering sedation must be skilled in airway management and cardiovascular resuscitation.*

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

2.4 Oxygenation. Degrees of hypoxia are not uncommon in the elderly and infirm. If sedation is used, oxygen should be administered.

2.5 A written record of the dosages of drugs and the timing of their administration must be kept as a part of the patient's records. Such entries should be made as near the time of administration of the drugs as possible. This record should also note the readings from the monitored variables, and should contain other information as indicated in the College Policy Document P6 – *Minimum Requirements for the Anaesthetic Record.*

2.6 Staffing

2.6.1 If sedation is to be used as part of the procedure, an appropriately trained anaesthetist must be present to care exclusively for the patient.

2.6.2 If sedation is not to be used as part of the procedure, there must be an assistant present during the procedure appropriately trained in resuscitative measures who shall monitor the level of consciousness and cardiorespiratory function of the patient. If the patient has risk factors identified in the preoperative assessment, an anaesthetist should be present.

3. FACILITIES

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

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

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

3.3 Adequate suction and room lighting.

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

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

3.6 Appropriate drugs for cardiopulmonary resuscitation and a range of intravenous equipment. (See Appendix II).

3.7 A pulse oximeter which must be used when sedation is employed.

3.8 Ready access to a defibrillator.

4 MONITORING

Patients undergoing intravenous sedation must be monitored continuously with pulse oximetry. This equipment must alarm when certain set limits are exceeded.

5. DISCHARGE

The patient should be discharged only after an appropriate period of recovery and observation in the procedure room or in an adjacent area which is adequately equipped and staffed.

Discharge of the patient should be authorised by the practitioner who administered the drugs, or another appropriately qualified practitioner. The patient should be discharged into the care of a responsible adult to whom written instructions should be given.

Adequate facilities must be available in the Recovery Area for managing patients who have become unconscious or who have suffered some medical mishap. These facilities should be similar to those listed under 3 and 4 above.

Should the need arise the patient must be transferred to appropriate medical care.

Supporting ANZCA Policy Documents:

P4 Guidelines for the Care of Patients Recovering From Anaesthesia

P7 The Pre-Anaesthetic Consultation

P9 Sedation for Diagnostic and Surgical Procedures

P15 Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery

P18 Monitoring During Anaesthesia

P19 Monitored Care by an Anaesthetist

APPENDIX I

The American Society of Anesthesiologists' classification of physical status:

Class I: A normal, healthy patient.

Class II: A patient with mild systemic disease.

Class III: A patient with a severe systemic disease that limits activity but is not incapacitating.

Class IV: A patient with an incapacitating systemic disease that is a constant threat to life.

Class V: A moribund patient not expected to survive 24 hours.

APPENDIX II

Emergency drugs should include at least the following:

adrenaline
atropine
dextrose 50%
lignocaine
naloxone
flumazenil

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

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

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

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

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POLICY DOCUMENTS INDEX

E = educational. P = professional. T = technical. EX = examinations.
PS = professional standards. TE = training examinations