

Australian and New Zealand College of Anaesthetists

ACN 055 042 852

and Faculty of Intensive Care

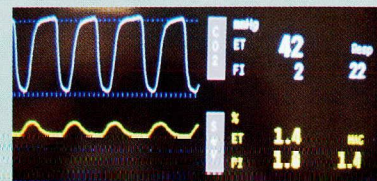
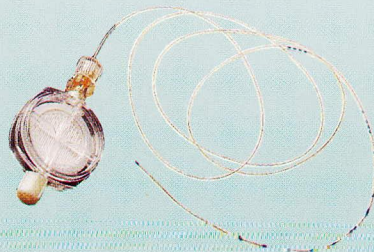
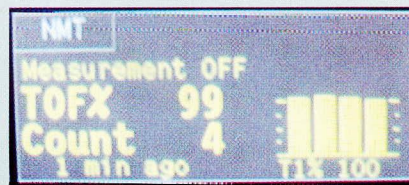


Bulletin

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

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Number 4

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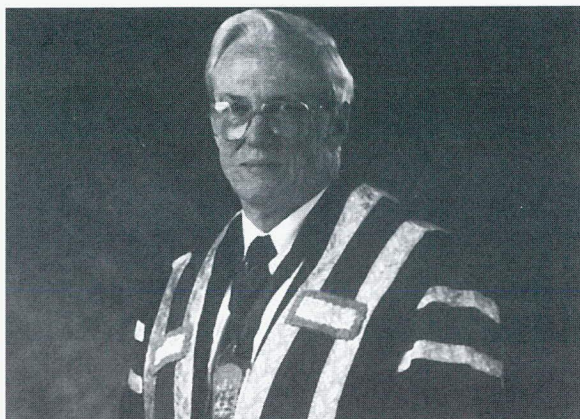
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PRESIDENT'S MESSAGE



The Combined Scientific Meeting held in Perth in October was a great success, even though it followed so soon after the World Congress and the ANZICS meeting. Congratulations to the Convenor, Leigh Coombs, the Scientific Convenors, Neville Gibbs and Stephen Edlin, and the Councillor and Associates' Programme Convenor, Moira Westmore and their Committees. The Younger Fellows' Conference at New Norcia, organised by Dennis Hayward, was also a memorable event.

Pierre Coriat, in his comments at the CSM Dinner, enthused about the commitment of anaesthetists in Australia and New Zealand to developing the image of Anaesthesia. He made the point that this image can only be improved by the collective efforts of individuals, in their attention to detail, in their work, their attitude, their diligence, their behaviour, their dress, and their professionalism. All of this must underpin our efforts to improve our image by formal public relations activities.

National Anaesthesia Day went very well by all accounts, exceeding expectations. The interest in mounting local events in hospitals and public places by anaesthetists raised issues related to anaesthesia in the minds of a wide cross section of the community. Thanks to all those who contributed. Planning for 1997 has already begun.

Asia Pacific matters have taken on a new meaning for me in the last few months, during which I have visited Singapore, Fiji and Papua New Guinea, with plans to visit Malaysia and Hong Kong next year.

The report of the inaugural Diploma of Anaesthesia Examination, Fiji School of Medicine, the result of a long term effort by the Overseas Aid Committee of the Australian Society of Anaesthetists, coordinated by Steve Kinnear, with the assistance of College Examiners, indicated this was

very successful with six candidates out of seven passing. The ANZCA/ASA Prize was awarded to the best candidate, Dr Narko Tuturo, of the Solomon Islands.

The recent Final M. Med. examination in Papua New Guinea, at which I was the External Examiner, passed both candidates. The five year M. Med. training programme, run by the University of Papua New Guinea has now graduated six local anaesthetists. The assistance of Fellows and Training Departments in Australia and New Zealand has contributed substantially to improvements in Anaesthesia in Papua New Guinea.

Fellows raised a number of issues at the Business Meeting in Perth, including:

- The ability of those Fellows undertaking both Anaesthesia and Intensive Care to comply with Maintenance of Standards in both disciplines – College and Faculty will make a statement on this in the new year.
- College views and position on the status of Career Medical Offices in relation to Trainees and Specialists – a Working Party has been established to consider this issue, which is also on the Agenda of the Committee of Presidents of Medical Colleges.
- The need to have more uniform guidelines for Formal Projects, and for their assessment – this matter has been referred to the Education Committee for review.

Best wishes to Fellows, Trainees and their families for a Happy Christmas, both to those who can have time off and those who continue working.

G.D. PHILLIPS

COLLEGE MISSION STATEMENT

The College has approved a Mission Statement *'To Serve the Community by Fostering Safety and Quality Patient Care in Anaesthesia, Intensive Care and Pain Management'*. The purpose of this Statement is to provide meaning to the collective efforts of people within the College and to set its framework.

The objectives of the Mission Statement are:

1. To promote professional standards and patient safety in anaesthesia, intensive care and pain management by:
 - a) conducting professional training programmes in these disciplines;
 - b) conferring professional qualifications in these disciplines to individuals who have attained the appropriate knowledge, skills and attitudes to assume the responsibilities of specialists;
 - c) upholding and advancing professional standards in these disciplines;
 - d) conducting on-going Maintenance of Standards Programmes to foster clinical competency in these disciplines;
 - e) reinforcing quality assurance programmes in these disciplines to improve patient care;
 - f) establishing communications with Fellows and trainees of the College and Faculty.
2. To promote education in anaesthesia, intensive care and pain management by:
 - a) advancing teaching in these disciplines;
 - b) promoting continuing education to Fellows and practitioners in these disciplines;
 - c) advising governments, organisations and public bodies on matters relating to these disciplines;
 - d) educating the public in principles and practice of these disciplines;
3. to advance the science and practice of anaesthesia, intensive care and pain management by:
 - a) promoting basic and clinical research in these disciplines;
 - b) disseminating new knowledge in these disciplines;
 - c) supporting new developments in these disciplines;
 - d) interacting with other professional bodies and the international community, especially the Asia-Pacific region, to share knowledge, skills and development in these disciplines.

In future, this Statement will be published on all College publications.

MARY TAYLOR BURNELL

DEAN 1966-1967

FACULTY OF ANAESTHETISTS

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Australian anaesthetic organisations are unique in the world in their acceptance of women anaesthetists as equal colleagues, and this is due in large part to the work, status and influence of Mary Taylor Burnell.

One of the most distinguished contributors to her field in this country, Mary Burnell was a founding member of the Australian Society of Anaesthetists and Faculty of Anaesthetists, RACS.

Mary Taylor Angel was born in Norwood, South Australia, in 1907. She was educated at St Peter's Collegiate Girls School and studied science at Adelaide University for two years before switching to medicine.

One of the tutors in her medical course was Dr G.H. Burnell, a surgeon. After graduation in 1931, Mary Angel was a resident medical officer at the Adelaide Children's Hospital in 1932 and 1933.

In 1934, the year of her marriage to 'Jimmy' Burnell, she was appointed as assistant honorary anaesthetist to the children's hospital.

By coincidence, 1934 was also the year of foundation of the Australian Society of Anaesthetists, and Dr Angel, now Dr Burnell, in 1935 became its first female member, and the secretary of the South Australian section of the society. Despite the births of three children, with accompanying domestic complications, Dr Burnell with her husband's co-operation, became the sole anaesthetist at the Adelaide Children's Hospital during World War II. Her duties required night, day and weekend work.

She must have welcomed the small break of the first postwar meeting of the society in Sydney, and it was at this meeting that I made a rather overawed acquaintance with this elegant lady, who later became my closet woman friend and fellow traveller to many congresses.



Dr Burnell, who read some of the first papers on paediatric anaesthesia in Australia, was an example to women anaesthetists for many years. She always looked exactly right, whether at meeting sessions, formal dinners or excursions. Her contributions to annual business meetings were succinct and positive, and always carried weight.

She was largely responsible for the inauguration of the society's annual overseas visitor program, an institution with far-reaching results and which has endured from 1953 to the present.

The visitors provided opportunities for new anaesthetists to obtain overseas positions to add to their Australian training; one such new-comer became Australia's first autonomous professor of anaesthesia at Sydney University.

For this international work, in 1968 Dr Burnell was elected as a Fellow of the English Faculty of Anaesthetists, quite a rare honour.

In 1953 she became the first woman president of the Australian Society of Anaesthetists and in 1966, after being elected to the Board of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1955, became the first woman Dean of the Faculty, a world first.

Dr Burnell was renowned for her hospitality, which was frequent and lavish, even after the death of her husband in 1954. In an era when equal numbers of men and women at dinner parties were considered imperative, she had a crisp reply to any comment about uneven numbers. "I ask people to dinner, not to mate", she would say.

Burnell often made the laughing claim that the Faculty of Anaesthetists in the Royal Australasian College of Surgeons was founded in her living room, and most certainly the views exchanged there and correspondence

that followed between Dr Harry Daly, a pioneer anaesthetist in Sydney, and Sir Ivan Jose, President of the RACS, played a major role in the foundation of the Faculty.

It has become the independent Australian and New Zealand College of Anaesthetists.

South Australia recognised Dr Burnell's work with the establishment of the Burnell-Jose professorship at the University of Adelaide in 1975 and in 1976 the RACS elected here to Honorary Fellowship of the College.

Anaesthesia and its organisations were not Dr Burnell's sole interests. In 1949 she joined the central committee of the Mothers and Babies Health Association in South Australia, an organisation responsible for child welfare.

Her work for the association, where she was both Secretary and President, extended over 30 years.

Dr Burnell had other talents, including her extraordinary judgement of wines, for which she was rewarded with the honour of being named Chevalier de Tastevin.

During our travels in France, her discriminating study of the wine lists in restaurants inevitably brought the chief wine steward from his cellars to our table – and the wines chosen were not always the most expensive.

She also had a wide knowledge of world art and its history and, when she retired from anaesthetic work, had the time to attend art classes. The resulting artworks will be a permanent reminder of the contributions of this extraordinary woman.

Dr Burnell is survived by two sons, a daughter, grandchildren and great grandchildren.

GWEN C. WILSON
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ADMISSION TO FELLOWSHIP BY EXAMINATION

George Anthony	CHALKIADIS	WA
Wing Sang	CHAN	Hong Kong
Ian Hugh	CHAPMAN	NZ
Peter Telford	CLARK	NSW
Ka Yi	FUNG	Hong Kong
Marie Jeanne	GOULD	SA
Michael Victor	JONES	WA
Antony Stuart	LEAVER	VIC
Petrus Steenkamp	NEL	NZ
Piers William	ROBERTSON	SA
Kristen Louise	SCHWAGER	NSW
Nigel Ralph	SKJELLERUP	NZ



Dr Rod Westhorpe, Prof. Emanuel Papper and Prof. Garry Phillips.

HONORARY FELLOW CITATION – EMANUEL M. PAPPER

*Conferred by Professor Garry Phillips
on 19 October 1996 in New Orleans, USA*

“THE COUNCIL OF THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS ADMITS TO FELLOWSHIP FROM TIME TO TIME DISTINGUISHED PERSONS WHO HAVE MADE A NOTABLE CONTRIBUTION TO THE ADVANCEMENT OF THE SCIENCE AND PRACTICE OF ANAESTHESIA AND/OR INTENSIVE CARE AND WHO ARE NOT PRACTISING ANAESTHESIA OR INTENSIVE CARE IN AUSTRALIA OR NEW ZEALAND.”

Mr President,

I have the honour to present **Emanuel M. Papper**, MD (New York University) PhD (1990, University of Miami) Honorary Doctorate of Science (University of Vienna, Austria), Honorary MD (University of Turin, Italy), Honorary MD (University of Uppsala, Sweden) Honorary Fellow Royal Society of Medicine of England, Honorary Fellow Royal College of Anaesthetists, Honorary Member of the Society of Anesthesiologists of: Japan, Denmark, Latin America, France, Israel, Finland, Sweden, Honorary Member, Australian Society of Anaesthetists, Honorary Consultant, Royal Prince Alfred Hospital, Sydney.

Following graduation as an MD in 1938 he held the following academic appointments:

Fellow with renowned renal physiologist Homer Smith (1940); Resident in Anesthesiology with E.A. Rovenstine (in 1940-42); Associate Professor at New York University (1949); Professor at Columbia University (1949-69); Vice President for Medical Affairs and Dean, University of Miami (1969-81); Professor of Pharmacology, University of Miami (1974-81); Professor of Anesthesiology, University of Miami (1969-present).

In scientific and professional societies he has been involved in an extraordinarily broad range at the highest level: Co-founder and First President, Association of University Anesthetists of the USA, Life Member American Society for Pharmacology and Experimental Therapeutics; Life Member American Pain Society, President American Society of Anesthesiologists; Chairman, Council of Deans, Association of American Medical Colleges; Vice President World Federation of Societies of Anesthesiologists.

Professor Papper has delivered over 25 eponymous lectures in his career, including:

The first William T. G. Morton Memorial Lecture Harvard Medical School (1982), the Joseph Clover Lecture, Royal College of Surgeons (1964) and the “Living Legend” Lecture, University of Chicago (1990).

He has received many awards and honours, including:

E. M. Papper Day in Dade County, Florida (1985); Outstanding Educator of America (1974); Medal of Honour of the City of Paris, France (1972).

He has served on the Boards of Directors of numerous community organisations including: The National Foundation for the Advancement of the Arts and The National Parkinson Foundation.

His publication list includes over 250 scientific papers published in an extraordinarily wide range of basic science, general medical, surgical, anaesthetic, physiology, pharmacology and other journals. He has also authored four texts and served as editor of a further three texts.

A striking example of Mannie’s continuing energy and breadth of interest is his achievement at age 75 of a PhD degree in English literature, the title of his thesis being **“Pain, Suffering and Anaesthesia in the Romantic Period”**.

Mr President, I have the honour to present Emanuel M. Papper for conferment of Honorary Fellowship of the Australian and New Zealand College of Anaesthetists.

This Citation was prepared by Professor Michael Cousins, AM, and read by Dr Rod Westhorpe.



ROBERT ORTON MEDAL

CITATION

GEOFFREY MALCOLM CLARKE

"THE ROBERT ORTON MEDAL IS THE HIGHEST HONOUR THE COLLEGE CAN AWARD TO ITS FELLOWS IN ANAESTHESIA. THIS AWARD IS MADE AT THE DISCRETION OF THE COUNCIL, THE SOLE CRITERION BEING DISTINGUISHED SERVICE TO ANAESTHESIA."

Mr President, may I present Dr Geoffrey Malcolm Clarke for the award of *The Robert Orton Medal*.

Dr Clarke graduated from the Medical School of the University of Western Australia in 1964. After completing his two year residency at Royal Perth Hospital, he took up an appointment as Senior House Officer in Anaesthesia at the Royal East Sussex Hospital and that same year passed the Diploma of Anaesthesia in London. The following year he moved to the Western Infirmary in Glasgow as Registrar in Anaesthesia and in 1968 was appointed ICI Research Fellow in the University Department of Surgery and Anaesthesia. He became a Fellow of the Faculty of Anaesthetists, Royal College of Surgeons of England in 1968 and the following year returned to Royal Perth Hospital as Senior Registrar in the Intensive Care Unit. In 1970 he was appointed as Head of that unit, the post he still holds. In 1975 he was elected to Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, which Fellowship was endorsed in Intensive Care in 1981. He was admitted to Fellowship of the College in 1992 and the Faculty of Intensive Care in 1993.

Dr Clarke's medical career has been dedicated to the development and advancement of intensive care.

When the Australian and New Zealand Intensive Care Society was formed in 1975, Geoff became Chairman of the Western Australian Regional Committee. He was the Inaugural National Vice President from 1975 to 1976, and then followed Dr Matt Spence as the second National President of the Society.

In 1977 a programme of training and certification in intensive care was developed by the Faculty of Anaesthetists with the first examination being held in 1979. Geoff was appointed to the panel of examiners in 1980 and served his full 12 years, the last five as Chairman.

To follow in Geoff's footsteps in this role was truly a daunting task. He was a superb examiner; scrupulously fair but perspicacious. He was able to follow lines of enquiry that could reliably assess the knowledge, experience and safety of the candidate. He demonstrated that with careful preparation it was possible to test many of the attributes that our examination systems are so often criticised for lacking.

Dr Clarke was a member of the Section of Intensive Care from its inception. He was a member of the Faculty's Education Committee from 1980 to 1993. During this time he served as Supervisor of Training at Royal Perth Hospital from 1980 to 1992 and Regional Education Officer from 1984 to 1992. In 1992 he became Secretary of the Section and in 1993 its Chairman. So was to commence a period of remarkable and rapid development of intensive care within the now Australian and New Zealand College of Anaesthetists. The Faculty of Intensive Care was established and when the Interim Board was appointed, Dr Clarke was elected as Inaugural Dean. In 1994 he was elected Dean by the first elected Board of Faculty, which office he continues to occupy.

Geoff's Deanship has been truly outstanding. Under his guidance the Faculty gained a solid foundation and his professional leadership skills were instrumental in the formation of the Joint Specialist Advisory Committee in Intensive Care. Whereas past attempts to rationalise aspects of training and certification for intensive care in the 1970's and 1980's had stumbled, Geoff's tact and diplomacy created a climate of cooperation between the Faculty and the Royal Australasian College of Physicians for the common good of intensive care. Trainees, either from an anaesthetic or physician background can now achieve dual certification in intensive care within seven years of graduation.

Whilst he has continued to work tirelessly for the College and the Faculty, Geoff has also continued to contribute energetically to the Royal Perth Hospital and in particular its Intensive Care Unit. He was recognised by that hospital in 1988 with the Inaugural Outstanding Service Award. He has served on most committees in that hospital, most recently as Chairman of the Division of Critical Care and Chairman of Divisional Directors Forum. To be called on to serve in so many ways is a reflection of the respect of his peers, as well as his management and interpersonal skills. He is a remarkably astute clinician and a superb teacher. His value as a lecturer is attested to by his many invitations to be a speaker, both at home and abroad. Societies and audiences are always guaranteed value for money.

Without wishing this oration to mimic "This is Your Life", the accomplishments of Geoff's Deanship and career are a tribute to this man's personal attributes – his intellect and extraordinary memory, his diplomacy but resoluteness, his humour and his skills as a raconteur. Whilst not seeking the limelight for its own sake, his qualities and achievements ensure that he is never far from the action.

Personally, I value his friendship and wise counsel immensely and like so many of his colleagues continue to learn simply from being in his company.

Without doubt Geoff's achievements would not be so monumental without the support of Sue, his wife and family. Together they have raised four children who are all successful in their chosen fields; and in the midst of this remarkable career, Geoff has somehow managed to find time to enjoy a broad range of interests including gardening, farming, fishing and trekking.

Mr President, Dr Clarke is truly a titan amongst intensivists and with this award, the College is now recognising the enormity of his contribution in the academic arena. The fact that The Robert Orton Medal is to be awarded for distinguished service to an anaesthetist who has spent his career in intensive care is testimony to that fact.

Mr President, it is my great honour and pleasure to present Dr Geoffrey Malcolm Clarke for the award of *The Robert Orton Medal*.

ALAN W. DUNCAN

HONOURS AND APPOINTMENTS

Dr T C Kester Brown, VIC – Gilbert Troup Prize, Australian Society of Anaesthetists

Dr Jack Burkhart, NSW – AMA NSW Branch President's Award

Dr Agnes M Daly, QLD – Member of the Order of Australia (AM)

Dr John N Matheson, NSW – Posthumous Award of the Australian Society of Anaesthetists' President's Medal

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

Dr John G Roberts, SA – Gilbert Troup Prize, Australian Society of Anaesthetists

Dr Walter R Thompson, WA – President, Australian Society of Anaesthetists and Gilbert Troup Prize

Dr Richard G Walsh, NSW – Gilbert Brown Award, Australian Society of Anaesthetists

Dr Rod N Westhorpe, VIC – Vice-President, Australian Society of Anaesthetists and ASA President's Medal

LAW REPORT

Michael Gorton, LL.B., BComm.
Partner, Russell Kennedy, Solicitors
Honorary College Solicitor

THE MEDICAL PROFESSION AND THE TRADE PRACTICES ACT



Which Brand of Shampoo?

So now medical services are just like any other product in a supermarket!

The application of the Trade Practices Act to the medical profession produces a new and unique viewpoint. Doctors are no longer carers, they are simply service providers. Hospitals are no longer charitable institutions, they are purchasing authorities. Medical care no longer has its altruistic and ethical elements, it is simply a professional service. A good bedside manner is now simply a way of distinguishing the type of 'shampoo' on offer.

Application of the Trade Practices Act

The Competition Policy Reform Act 1995 gives effect to certain amendments to the Trade Practices Act (TPA) that will extend the operations of the TPA to the professions, and, in particular, to the medical profession.

The relevant provisions commenced on 21 July, 1996. The penalty provisions in the legislation will take effect one year later, on 21 July, 1997.

The Australian Competition and Consumer Commission (ACCC) has recently issued its 'Guide to the Trade Practices Act for the Health Sector'. It has also recently carried out a number of seminars in the capital cities to discuss the application of the TPA to health professionals and professional organisations in the health sector.

In essence, the relevant provisions of the TPA will prohibit certain anti-competitive practices. These include:

1. Agreements which have the purpose or effect (or likely effect) of substantially lessening competition in a market.
2. Agreements which contain an exclusionary provision (a boycott or restriction on dealing with particular suppliers or customers).
3. Agreements to fix, control or maintain prices.
4. Misuse of market power, by a body or group of people with a substantial degree of power in a market.
5. Exclusive dealing, limiting or restricting the supply or acquisition of goods or services to or from particular customers or suppliers.

Where a professional organisation may potentially breach provisions of the TPA, they can seek authorisation from the ACCC, which would then permit the otherwise prohibited practice, so long as it can be demonstrated to the ACCC that the practice involves some public benefit.

The consequences of a breach of the TPA are substantial. In some cases, it can lead to civil remedies. From July 1997, criminal penalties will apply. Interested parties could seek an injunction preventing the conduct from continuing (unless previously authorised by the ACCC).

Government Responsibilities

By agreement between the Commonwealth and State Governments, all governments must also review their own procedures and departments to determine whether anti-competitive practices exist. Thus, the Federal Government and all State Governments have committed themselves to reviewing their own arrangements for licensing and registration of medical practitioners, dealings with hospitals, health insurance funds, etc.

Thus, some aspects of the legislative changes will also apply to government operations, and will certainly apply in relation to government-owned businesses.

Some Issues for the Health Sector Generally

Some of the practical examples where the new TPA provisions may apply include:

1. Agreements to set fees or prices by health professionals or their professional organisations may breach the provisions of the TPA.
2. Boycotts or group arrangements in dealing with health insurance funds or hospitals, either as to fees or prices, or in relation to other issues in 'managed care' agreements, may potentially infringe the TPA.
3. Agreements between professionals for strict referral arrangements, which would prevent referral of patients outside a particular group, may infringe the TPA.
4. Advertising restrictions imposed by professional bodies, restrictions on the ownership of medical practices, etc, may be restrictive agreements in breach of the TPA.
5. Agreements with pathology services, radiology, blood testing services for restrictive referral arrangements, or requirements that certain patients can only obtain these services from particular groups, may infringe the TPA.
6. Agreements between hospitals to share particular markets, either a geographic area, or some other division, may breach the TPA.

Not all cases of the above will necessarily breach the legislation. However, they are broad examples of the types of conduct that will be examined by the ACCC under the new legislation.

The Medical Market

In general terms, medical practitioners, particularly general practitioners, will operate in the new 'medical market'. Patients or customers will be able to pick and choose in a freely competitive environment. No doubt patients will choose on the basis of convenience, bulk billing, service, hours of practice, as they do at present.

However, general practitioner referral practices will also come under scrutiny, to determine whether any links between the general practitioners and specialists to whom referrals are made have entered into any anti-competitive agreements between them. Also, links to additional services, radiology, blood and other testing, etc, will be closely reviewed to determine whether any of those services are tied, or whether the patient really has a choice as to which of the referred service providers he or she may choose.

Clearly, the new arrangements, whereby health funds contract with doctors, will interrupt the traditional referral pattern between general practitioners and specialists. These arrangements particularly will need special review to determine whether the health funds are engaging in anti-competitive practices, or monopolistic practices, in developing links with their own 'in-house' doctors.

Advertising restrictions have been lessened in most States. The Trade Practices Act requires that any advertising not be false or misleading.

An additional overlay is represented by the hospitals and new health networks, as captive purchasers. Because of the large resources which the hospitals and hospital networks control, they are in a unique position to become dominant players in the market to acquire medical services from medical practitioners.

The ACCC may be kept busy checking out all of these new arrangements from the point of view of competition policy!

Industrial Matters and Representation

Many medical professional societies, including the AMA, have traditionally played an industrial representation role. The ability of doctors to combine to negotiate terms of their services has not been under such threat as is now represented by the changes in this legislation.

There is the potential for the Trade Practices Act to apply where doctors collectively negotiate with a hospital or employer in relation to terms of engagement. However, it must be clear that there has been collusion in negotiation between the doctors, rather than doctors separately negotiating their contracts or terms.

The legislation poses a risk for many of the societies and associations representing specialties, particularly those which generally negotiate terms, fees, etc.

Of most recent interest has been the intervention of the ACCC in a dispute involving the Mildura Base Hospital in Victoria, and the negotiation between the Hospital and its attending doctors in relation to new contracts. In what has been seen by many as a very heavy-handed intervention, the ACCC warned doctors that their actions may constitute a breach of the Trade Practices Act on the basis of their collective negotiation strategy. In its correspondence, the Commission noted:

"The Commission does not claim that an individual refraining to renew a contract for service is necessarily in breach of the Competition Code. However, if such a decision is made collectively between competitors, such conduct is prima facie unjustifiably in the interests of competition".

The ACCC also issued a warning in relation to individuals representing the doctors in the negotiations with the hospital. The Commission alleged that the representatives may also be in breach of the legislation 'by counselling, inducing and being knowingly involved in any breach'.

Following submissions, the ACCC appears to have softened its stance, and withdrawn its threat of action. However, the intervention dramatically displays the potential power of the ACCC and intrusive nature of the new legislation on traditional arrangements.

Issues for Medical Colleges

The new TPA provisions will apply to medical colleges, to the extent that they are involved in:

1. Price setting, or setting recommended fee scales, which are invariably adhered to.
2. Imposing restrictions on advertising by members.
3. Imposing restrictions on the ability of members to associate with other professionals.
4. Imposing any restrictions or obligations in relation to the additional acquisition or supply of goods or services.

However, it is clear that the **major areas** which will apply to the medical colleges are:

1. Disciplinary procedures.
2. Barriers to entry/control of training, and accreditation.

1. Disciplinary Procedures

The ACCC has indicated that it would review the rules and constitutions of medical colleges to the extent that the disciplinary provisions may apply to restrict a member's right to operate professionally in the health sector market. That is not to say that a college cannot discipline a member for any range of legitimate reasons, including professional incompetence, unethical behaviour, etc. However, where the disciplinary procedures are applied to control a member's practice in such matters as fees, advertising, dealings with other professionals, etc, then they may potentially breach the TPA.

Some medical colleges have general provisions which permit the college to deal with members for 'conduct derogatory or contrary to the principles, ethics and dignities of the College'. This is a broad formulation that could apply to unethical behaviour or professional negligence, etc, which would not breach the TPA. However, it could also equally be used to apply to other behaviour which might be regarded as anti-competitive.

Colleges will therefore need to be mindful of the application of the TPA, when applying their disciplinary procedures, so as to ensure that the disciplinary procedures are not being used for anti-competitive reasons.

2. Control of Training and Accreditation

The primary role of most medical colleges is to control training, develop standards and supervise admission to the specialties. In the economist's jargon, these are 'barriers to entry' into the health care 'market'. Clearly, the medical colleges control the opportunity for doctors to become recognised surgeons, anaesthetists, or other specialists in Australia and New Zealand.

Where that control is used by a college to manipulate the numbers of doctors admitted to their specialty, in order to control the numbers in the profession, the ACCC has indicated that it would clearly regard it as an anti-competitive practice contrary to the TPA.

Clearly, the control of training, accreditation of training posts and limitation of admission numbers all have the potential to be seen as anti-competitive. However, in many cases, there are good reasons for limiting numbers of admissions; such as funding restraints, limitations on the ability to supervise training positions, constraints imposed by hospitals or government, the need to maintain professional standards, etc. In most of those cases, the reasons would not be regarded as creating 'anti-competitive' practices.

However, the concern for medical colleges is that Section 45 of the TPA applies in relation to arrangements or agreements **which have the purpose or effect (or likely effect) of substantially lessening competition in the market**. Thus, the **purpose** alone of the conduct of the medical college is not the only factor. If the conduct of the medical college also has the **effect** of substantially lessening competition in the market, it could potentially breach the TPA. This clearly requires further analysis.

The terms '**substantially lessening competition**' and '**market**' in the TPA have developed certain legal and economic meanings. In looking at the elements of Section 45 of the TPA, there must be:

1. 'An agreement, arrangement or understanding between competitors'. The ACCC will regard the rules and constitution of the medical colleges, insofar as they apply to members, as sufficient to constitute a contract, arrangement or understanding between business professionals – the members of the college being the competitors.

2. The conduct or arrangement must have the purpose or effect of 'substantially lessening competition'. This requires an economic analysis of the actual effect in the market place of the relevant conduct. There must be an objective assessment made of the effect on the ability to control pricing, the numbers permitted to enter the market, the ability to conduct business in the market, etc. Clearly, control of the number of admissions to the training programs by the medical colleges could be regarded, in many circumstances, as 'substantially lessening competition'. Clearly, if more trainees were admitted to the programs, competition within the speciality would be increased. Such economic analysis must be reasonably sophisticated in order to conclude that competition has been substantially lessened. However, it is clear that control of admissions will be one matter that the ACCC would review keenly.
3. The relevant conduct or agreement must also take place within a 'market'. The market will not just be all surgeons in Australia, or all anaesthetists in Australia. A 'market' is an area in which the particular goods or services are relatively inter-changeable and competitive with each other. Thus the relevant market may only be anaesthetists in Victoria, or even anaesthetists in Melbourne only. It could be ophthalmologists in Newcastle, if it is clear that most patients do not travel to Sydney for these services and rely on the ophthalmologists in the Newcastle region only. It is probably likely that each of the major capital cities would be regarded as a separate 'market' in their own right, with the potential for sub-markets.
4. It is also potentially the case that 'markets' exist in relation to the separate specialities. For example, intensivists may be regarded as a separate market from the general broader market of anaesthetists. Additionally, orthopaedic surgeons would clearly be a 'market' in their own right, as compared to other surgeons.

Thus, when analysing Section 45 of the TPA, the economic analysis of whether particular conduct or agreements have the effect of substantially lessening competition, must be done in relation to **each** of the relevant markets. Whilst it may be possible to argue that the medical colleges' training schemes does not substantially lessen competition across Australia, it may nonetheless be possible that the conduct of the colleges' training scheme **does** substantially lessen competition in a particular 'market', such as a particular State, or a particular speciality or sub-speciality. Clearly, the analysis can get very detailed and confusing.

Implications for Medical Colleges

There is a significant risk that the training programs, constituting as they do 'barriers to entry', will be regarded as contrary to Section 45 of the TPA, as having the effect, or likely to have the effect, of substantially lessening competition in a 'market'.

Section 45 commenced operation on 21 July, 1996.

From that time, the training programs may be open to attack, not only by the ACCC if it was of a mind to do so, but also by individuals who failed to gain admission to the training program, or other interested parties.

To the extent that the training programs can be demonstrated to have a clear public benefit, and are not structured or intended to operate on any anti-competitive basis (ie, they operate to maintain standards/they are constrained by funding, and the requirement for supervision/they do not operate on the basis of unreasonable standards/there is no assessment of the numbers of entry to the training program which is based on the desire to maintain numbers for the profession generally), then it would be possible for the medical colleges to seek authorisation from the ACCC.

An application for authorisation involves a fee of \$7,500.00, to cover the cost of the ACCC carrying out its review and investigation. An authorisation review by the ACCC involves it closely examining the practices and procedures of the medical college, and invites comment from other interested parties, including government, other professionals, hospitals, insurers, etc. All other sectors will have the opportunity to comment on the college's training program and its potentially anti-competitive effect. They will also be able to comment on the claim by the medical colleges that the training program has clear public benefits.

At the time an application for authorisation is made, the medical colleges can also request immediate interim authorisation pending final review.

Any authorisation granted by the ACCC is likely to be for a limited period of time, say 2-5 years, and would be reviewed at the end of that term.

In relation to such authorisations, the ACCC has said that it could take up to 4 months to complete its review.

The medical colleges therefore have a difficult choice to make. They can decide not to seek authorisation, and attempt to argue that the arrangements in respect of their training program do not lessen competition in any 'market'. This may be subject to challenge by the ACCC (eventually), or by other potential trainees or professionals, who may be

disgruntled for any reason. Alternatively, the colleges can seek authorisation which would involve a substantive analysis by the ACCC, with comments from many other bodies and professionals, as to the public benefit created by the training programs, and would open many of the practices and procedures of the colleges to semi-public scrutiny. If there is any difference between the rhetoric of the colleges in relation to their training programs, compared with the reality, this could be embarrassing.

It is clearly a matter that requires considerable thought by the colleges.

Brave New World

There is no doubt that the changes wrought by the application of the Trade Practices Act have the potential to radically transform traditional arrangements in the health sector – whether for good or bad.

These changes have so far commenced with a whimper – expect the **'bang'** in the not too distant future.

DOUGLAS JOSEPH**PROFESSOR OF ANAESTHETICS, 1997****PROFESSOR BARRY BAKER**

Professor Barry Baker has been appointed the Douglas Joseph Professor of Anaesthetics for 1997.

The Professorship is for \$65,000 to pursue developments in use of low flow and closed circuit anaesthesia which allow for the breath to breath measurement of the patient's oxygen consumption and nitrous oxide uptake, together with computer driven control of the gas inflow to the anaesthetic circuit.

The Douglas Joseph Professorship is the prestigious Research Award of this College, which was established by the Board of Faculty following a bequest to the Faculty of Anaesthetists from the Estate of Professor Joseph to commemorate a Fellowship or grant-in-aid for research into human anaesthesia.

The late Douglas Joseph was a former Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons (1980-1982) and the first incumbent of the Nuffield Chair of Anaesthetics in the University of Sydney. Professor Joseph was appointed to this position in May 1963, an appointment he held until his retirement in 1989.

Professor Baker is the Nuffield Professor of Anaesthetics in the University of Sydney having been appointed to the Chair in December 1992. He is the second incumbent of this Chair previously occupied by Professor Joseph and was also

Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons from 1987-1990.

A graduate of the University of Queensland, he completed his training at the Royal Brisbane Hospital and was admitted to Fellowship of both the Faculty of Anaesthetists, Royal Australasian College of Surgeons and the Faculty of Anaesthetists, Royal College of Surgeons of England in 1968. He was the first Australian Fellow to pursue a Doctorate of Philosophy which was awarded by the University of Oxford in 1971.

Professor Baker then returned to Queensland University where he was appointed Reader in Anaesthesia, Department of Surgery, the first full-time Academic appointment in Anaesthesia in Queensland. He played a key role in the formative stages of the Academic Department in Queensland prior to his appointment as Foundation Professor of Anaesthesia and of Intensive Care at the University of Otago in Dunedin from 1975-1992.

Professor Baker's research and scholarship interests and achievements for the past 25 years have been in the fields of human applied physiology and pharmacology, anaesthesia and intensive care. He has been an invited speaker to many international and national meetings, written chapters in ten books and numerous scientific articles.

ACADEMIC ANAESTHESIA ENHANCEMENT GRANT – 1996

This Grant of \$75,000 was awarded to the Department of Anaesthesia, Christchurch School of Medicine, University of Otago.

NATIONAL DAY SUCCESS

Anaesthetists around Australasia really went out of their way to take the specialty to their communities for National Anaesthesia Day, on 16 October.

The National Day, commemorating the 150th birthday of the specialty, saw Anaesthesia departments and Fellows mount an impressive range of public communication activities.

Many locations reported considerable public interest, and plenty of questions.

It is not possible here to list all that happened, but a truly extraordinary effort was reflected in events that lasted the entire week, or were concentrated on the National Day itself.

Just a few highlights reported so far include:

- demonstrations of anaesthetic procedures in hospitals
- many static displays in hospitals, built around the 150th theme and the immense advances since Morton
- displays in shopping centres
- an exhibition in the New South Wales Parliament Building, organised by Dr Brian Pezzutti, MLC, who also put the significance of the day on the Parliamentary record with a speech in the House
- lectures by anaesthesia department staff at local schools
- schools and other groups organised to visit and tour anaesthesia departments
- specially devised slide programmes at hospital displays
- an ABC State weathercaster using a bronchoscope as a pointer for that night's weather segment, and mentioning the significance of the occasion.
- open days at some hospitals at the weekend
- grand rounds in many hospitals
- arranged media coverage, including newspaper features, radio interviews, and in Dunedin, New Zealand, at least, a special two-part television documentary report.

The ASA held a special ceremony at its Headquarters in Sydney to mark the Day, at which former Federal Health Minister, Graham Richardson, was the guest speaker.



Mr Rob Knowles, Minister for Health at St Vincent's Hospital, Melbourne on National Anaesthesia Day.

Most State Health Ministers supported the Day by way of public statement, or official involvement.

The NSW Health Minister, Dr Andrew Refshauge, officially opened the anaesthesia display in the NSW Parliament, in Sydney; the Victorian Health Minister, Mr Rob Knowles, launched the display at St Vincent's Hospital and in Perth, the West Australian Health Minister, Mr Kevin Prince spent almost an hour touring the display and demonstrations at Sir Charles Gairdner Hospital.

Many participating hospitals reported good use of the 150th anniversary National Anaesthesia Day posters commissioned by the College, along with other information and historical photographs it provided.

The ASA commissioned a special lapel sticker featuring the National Anaesthesia Day logo, and distributed these to its members. Supplies of the ASA's sticker were also included in information packages sent out by the College.

The philosophy of each annual Day is a carefully identified and integral part of the College's on-going community education and public relations programme.

Focus of National Anaesthesia Day for 1996 was to bring anaesthetists closer to their communities, and this they did – handsomely.

The energetic and comprehensive response across Australia and in New Zealand was proof of at least one finding in the survey of Fellows conducted in August, 1994.

There was a significant response rate to that survey, and a massive 72% of respondent Fellows said they would give time to help a particular information programme to improve the image of anaesthesia.

That 72% endorsement clearly translated into effort and delivery on 16 October – providing a very tangible community relations process that has long-term value for the specialty.

Completed questionnaires are still being received from 1996 National Anaesthesia Day participants, and anyone who has not replied is urged to do so.

Responses to the questionnaires will be collated and a comprehensive report published on the ideas and activities deployed in 1996, along with suggestions for future celebrations.

From the experience, and with the support, of Fellows in October, 1996, the College Communications Committee plans to build even better and more noteworthy National Days.

Planning for National Anaesthesia Day, 1997, is already well advanced.

The issue for the Day will be pain, which will provide not only the opportunity to promote the role of anaesthetists in the diagnosis and management of pain, but also will assist in public education about basic pain concepts.

National Anaesthesia Day in 1997 will be in the first half of the year.

Whilst there will be a particular national focus in 1997, grass-roots participation and support will remain an integral part of the overall programme next year.

The Communications Committee welcomes constructive input about National Anaesthesia Day, 1997, and looks forward to co-operating with, and supporting, all participants.

EDDIE DEAN
Communications Consultant

A NEW VIEW OF DRUG LABELS

Dr W. John Russell, Chairman Standards Australia Subcommittee

Standards Australia has recently released **AS/NZS 4375:1996 User-applied labels for use on syringes containing drugs used during anaesthesia**. This standard is a guide to the colour shape and quality of labels for the drugs commonly used during anaesthesia.

Since the publication of the symposium issue of *Anaesthesia & Intensive Care* in 1993, there have been clear data that drug errors are common and that relaxants are particularly involved. It was suggested by the Australian Patient Safety Foundation, the College and the Australian Society of Anaesthetists that a standardized approach to drug labelling may help. A review of the situation showed that several types of label were in use but there was no uniformity. Standards Australia was asked to consider developing a standard. In the enquiry prior to initiating the development of a standard, it was found that South African, Canadian and USA standards were available. These overseas standards had much in common and they were used as the basis of the standards as it was finally developed by the combined Australian and New Zealand Technical Committee.

The standard aims to identify drug groups by their main pharmacological action. It is hoped that this will avoid the major problems which have arisen, eg. giving a relaxant such as suxamethonium when a narcotic such as fentanyl was intended. With this classification, narcotic labels are coloured sky blue, relaxants are coloured strong red and induction agents are coloured yellow.

Suxamethonium and Adrenaline are recognised as potentially of special concern and are reverse coloured on a black background.

Antagonist drugs are coloured for their pharmacological group but identified by white diagonal stripes across the

background. Thus neostigmine has a red label with white diagonal stripes across it.

In addition to colour, the standard also specifies the type of lettering so that it will be as legible as possible. The minimum and maximum sizes of label are also specified and if desired, the label may also include details of the concentration of the drug in use.

Finally, the adhesiveness of the label is controlled so that adequate adhesion on even the smallest syringes is achieved.

For those who require more detail, copies of the standard are available from Standards Australia Offices in all Australian Capitals and from Standards New Zealand in Wellington.

Contact numbers for Standards Australia and New Zealand:

Sydney	Tel: (02) 9746 4700
	Fax: (02) 9746 3333
Melbourne	Tel: (03) 9693 3500
	Fax: (03) 9693 1319
Adelaide	Tel: (08) 8373 4140
	Fax: (08) 8373 4124
Brisbane	Tel: (07) 3831 8605
	Fax: (07) 3832 2140
Perth	Tel: (09) 321 2929
	Fax: (09) 321 8797
Hobart	Tel: (002) 31 5885
	Fax: (002) 31 5886
Canberra	Tel: (06) 249 8990
	Fax: (06) 249 8989
Wellington	Tel: (04) 498 5991
	Fax: (04) 498 5994

EXAMINATION PRIZEWINNERS

Dr Angela G. Playoust of New South Wales was awarded the **Renton Prize** at the September, 1996 Primary Examination and **Dr Stephen J. Bruce** of Queensland was awarded the **Cecil Gray Prize** at the September 1996 Final Examination.

RESEARCH AWARDS FOR 1997

The College had an allocation of \$184,000 available for research in 1997 plus \$30,000 awarded but not taken up in 1996. Applications totalling \$392,631 were received and the following awards made:

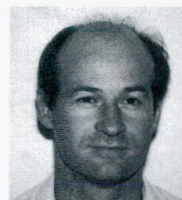
SCHOLARSHIP



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



Dr John Loadsman, NSW
Perioperative Sleep and Breathing \$15,000



Dr Michael Paech, SA
Combined Spinal-Epidural Analgesia (CSEA) During Labour \$15,000

GRANTS



Dr Brian Anderson, VIC
Analgesic Effects of Paracetamol and Diclofenac in Children Using Tonsillectomy as a Pain Model \$9,327



Dr Guy Ludbrook, SA
Co-induction of Anaesthesia - A Pharmacokinetic Study \$25,000



Dr Neil Pollock, NZ
Genetic Test for Malignant Hyperthermia \$25,000



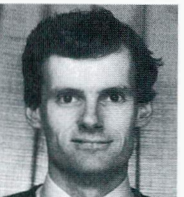
Professor Duncan Blake, VIC
Modification of Autonomic Cardiovascular Control by Alpha 2 Adrenic Agonists \$20,000



Dr Ross MacPherson, NSW
The Effects of Inhalation of Anaesthetic Agents in the Myogenic Response \$3,100



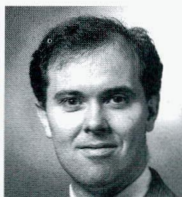
Dr Johan Van der Walt, SA
Treatment of Acute Hypoxic Episodes in Children under Anaesthesia \$12,000



Dr Lawrence Doolan and Dr Philip Peyton, VIC
Randomised Multicentre Trial of Epidural Anaesthesia (Master Anaesthetic Trial) \$20,000



Dr Paul Myles, VIC
Development of a Post-Operative Quality of Recovery Score \$15,000



Dr Adam Tucker, VIC
An Evaluation of the Contributions of Spinal and Supraspinal Action of Drugs to their Overall Analgesic Effects in Man \$25,000

Dr Neil Pollock, of New Zealand was awarded the Harry Daly Award for his project "*Genetic Test for Malignant Hyperthermia*".

HIGHLIGHTS OF OCTOBER 1996 COUNCIL MEETING

PAIN MANAGEMENT

Council noted that the NH&MRC Clinical Practice Guidelines will be available for four weeks for comment by the public. The College will distribute a copy to Regional Committees for comment. Any Fellow wishing to peruse this document during the time should either check the WWW or contact the College Headquarters or Regional Committee Office.

INTERNAL AFFAIRS

Communications

Council noted that a large number of Fellows availed themselves of the opportunity to obtain basic or advanced training on the WWW during the Combined Scientific Meeting in Perth.

National Anaesthesia Day

Council noted the great support and involvement of Fellows in the various Regions. Many varied activities were arranged, including Operating Theatre Displays with invitations being extended to Schools and the Community to view. Displays in many Hospitals, involvement of Schools and Members of the Community in various Teaching Hospitals, support from the local Ministers for Health making statements or participating in an activity in a Hospital within their Region and a display in the foyer of the New South Wales Parliament House were planned.

EXAMINATIONS

Examiner Assessors

At the recent Final Examination, a process for internal quality control of the oral examination was introduced.

Assessors are monitoring the general conduct of the oral examinations and specifically the manner in which questions are asked.

The aim of this process is to create an environment in which candidates have the best opportunity to present their knowledge.

This initiative has been welcomed by Examiners as a means to maintain the already high standards of our examinations.

FINANCE

Criteria for Subscription Concession for Fellows undergoing Full Time Research

Following Council's decision to allow a 50% subscription concession to Fellows engaged as Full Time Researchers, it further clarified that such concessions would be available to Fellows undertaking Full Time Research and no more than two clinical sessions per week.

Annual Subscription

Council resolved that:

1. The 1998 Subscription, due and payable on the 1st February 1997 be \$900 for all Fellows and payable to the Melbourne Office. In approving this annual subscription, Council noted that the 1997 subscription had been held to the 1996 subscription and that the current increase reflected CPI increases over the past two years.
2. The Examination Entry fee for 1997 be A\$1650 and remitted to the Melbourne Office.
3. The Register of Training Fee for all Trainees for 1997 be increased to A\$700 and paid to the Melbourne Office.
4. The Annual Training Fee for 1997 be:

Australia and Hong Kong	A\$750
New Zealand	NZD\$750 +GST
Singapore and Malaysia	\$750 (local currency converted into Australian Dollars)

The non-Fellows fee for participation in the Maintenance of Standards Programme **\$200 per annum**

Daily Living Allowance

Council also resolved that the per diem payable to Fellows on College business remain at \$190.

Pugh Sesquicentenary Commemoration

Council considered a request from the William Russ Pugh Sesquicentenary Committee for support to commission a major sculpture by a prominent Australian Artist for installation in Prince's Square, Launceston to mark both the Sesquicentenary of Pugh's first operation using anaesthesia and the fact that this operation was the first surgical use of anaesthesia in the Southern Hemisphere.

Council noted that submission had been made to the Australia Foundation for support for this project and agreed to support the project up to an amount of \$20,000.

Council believed this to be a unique opportunity for anaesthesia to have a statue of William Pugh erected in a parkland which fronts both the former home of Pugh and the Hospital where the anaesthetic was administered.

**CONTINUING EDUCATION -
QUALITY ASSURANCE**

1998 Annual Scientific Meeting

Dr Richard Walsh, Vice President has been appointed the Councillor and Deputy Convenor of this Meeting. Invitations have been extended to Dr David Longnecker, USA and Dr Hugh Van Aken, Germany to be the Foundation Visitors to this Meeting.

The Douglas Joseph Professor, Professor Barry Baker, NSW, will be the Australasian Visitor to this Meeting.

1999 Annual Scientific Meeting – Adelaide

Dr Pam Macintyre has been appointed the Convenor to this Meeting with Dr Guy Ludbrook the Scientific Convenor and Dr Robert Webb, Industry Organiser.

Festival City Conventions has been appointed Professional Conference Organiser to this Meeting.

Younger Fellows' Conference – 1997

Council approved the Theme of *'Looking After Ourselves'* for the Younger Fellows' Conference to be held in conjunction with the 1997 Annual Scientific Meeting in Christchurch. The YFC will be held at Akaroa with an invitation to surgical representatives to participate in this Conference. This Meeting will run from the 8th - 10th May and nominations for two representatives from each Region are sought.

Anaesthesia Simulators Working Party

This party was established when the College was considering the purchase of Simulator. However, on the advice of the Working Party, as this now seems unlikely, the Working Party was disbanded with the responsibility for simulation related issues being transferred to the Education and Continuing Education and Quality Assurance Committees.

INTERNAL AFFAIRS**Mission Statement**

The College has approved a Mission Statement *'To Serve the Community by Fostering Safety and Quality Patient Care in Anaesthesia, Intensive Care and Pain Management'*. The purpose of this Statement is to provide meaning to the collective efforts of people within the College and to set its framework.

The objectives of the Mission Statement are published elsewhere in this Bulletin.

In future, this Statement will be published on all College publications.

Co-Option to Council of ACT Representative

Council considered a request on behalf of the Regional Committee of the Australian Capital Territory for a Co-opted Representative to Council. It was noted that at this stage, the Territory does not have an independent training scheme and limited activities with the small number of Fellows at this time. However, with the increase in training posts in that area, it was believed the number of Fellows will increase. Council agreed to monitor the situation but considered at this stage, it was not appropriate to Co-opt such representation.

Strategic Planning Day

Council has agreed to undergo a Strategic Planning Day on the Thursday prior to the February Council Meeting. The purpose of this day is to review the activities of the College and set goals for the next five years.

College Draft Documents

As there has been confusion with draft documents being circulated for comment, in future all documents will be stamped on every page indicating the date and confirmation that such document is in a draft form for discussion purposes only.

Appointment of College Reviewers

Council has agreed to review the process of appointment of Hospital Reviewers, define the roles and mechanisms in performing Hospital visits and review all documentation associated with such visit.

Asia Pacific Committee

Dr David Mawter has been nominated as the ASA representative to the College Asia Pacific Committee.

Appointment of Assistant Assessor for New Zealand

Council has agreed to the appointment of an Assistant Assessor for New Zealand, such person to be nominated by the New Zealand Regional Committee. The appointee is to be responsible for the assessment and interview of overseas trained doctors seeking registration with the Medical Council of New Zealand. Such appointee will not be involved in assessment of College Trainees.

PROFESSIONAL

National Association of Medical Perfusionists of Australia (NAMPA)

A request from NAMPA for the establishment of a joint Working Party to consider guidelines for accreditation, certification and on-going education of medical perfusionists has been referred to the Cardio-Thoracic, Vascular and Perfusion Special Interest Group.

Career Medical Officers

Council requested the Executive to establish a Working Party to discuss the relationship of Career Medical Officers with regard to trainees in Anaesthesia.

Monitoring of Anaesthetic Agents

In October 1995, the Council approved the revised Policy Document P18 'Monitoring During Anaesthesia'. Clause 3.9 of this document stated that 'Equipment to monitor the concentration of inhaled anaesthetics must be exclusively available for every patient undergoing general anaesthesia' and that this be implemented by the 1st January 1998.

In February 1996 the Council discussed reported incidents following mis-identified inhalational agents and agreed that the interpretation of P18 should be that inhalation agent monitors should automatically identify these agents. A notice to this effect was subsequently published in the College Bulletin, again noting the implementation date as the 1st January 1998. Following further consideration of this aspect, Council has agreed that the requirement for automatic identification of anaesthetic agents is inappropriate for implementation by 1 January 1998 although strongly suggested for future monitor purchases.

In coming to this conclusion, Council believed that monitors which automatically identify agents have been available for only a very limited period and that few monitors offer the ability to set alarms on prescribed levels such as occurs with pulseoximetry and/or capnography monitors.

Council resolved:

1. That the 1995 wording of Policy Document P18 be endorsed.
2. That a mandatory requirement for automatic identification of anaesthetic agents is inappropriate for implementation by the 1st January 1998 but strongly recommended for future purchases of anaesthetic monitors.
3. That a notice in the next College Bulletin be published regarding this matter.

Statement on Euthanasia

Fellows would be aware that an enquiry was received by the College from the Solicitor for the Northern Territory earlier this year with regard to the College assisting in the prescription for the act of euthanasia. Following a response to the Solicitor from the President, the matter was referred to Council.

It is the view of Council that perhaps the College should have an official stance on euthanasia.

Council has debated this matter at length and whilst agreeing that the College should have an official stance on this matter, such stance could well be in conflict with the personal view of Fellows. The College should be able to respond to enquiries in a manner which avoids conflict with the personal views of Fellows. Council has agreed to refer this matter to Regional Committees for their views and placed an invitation in this Bulletin for input from Fellows with regard to a potential statement.

Trade Practices Act – Application to Medical Colleges

The College Honorary Solicitor, Mr Michael Gorton, addressed Council on this matter and it was agreed that the Executive appoint a Working Party to consider the implications of the Trade Practices Act on College activities.

Coding of Anaesthetics

Council agreed to endorse the project initiated by Professor Bill Runciman for the coding of anaesthetics. This submission relates to anaesthesia codes being included in the MBS-Extended Schedule to be introduced in July 1998.

National Day Surgery Committee

The National Day Surgery Committee is a quadripartite Committee of the RACS, ANZCA, AAS and the ASA. In view of the development of this Committee over fifteen years and its involvement with various organisations interested in Day Surgery, Council supported the request that the Committee be renamed the 'National Day Surgery Council'.

The following Policy Documents were reviewed and accepted and are published elsewhere in this Bulletin.

- E1** *Guidelines for Hospitals seeking College Approval of Posts for the first four years of Vocational Training in Anaesthesia*
- E13** *Guidelines for the Provisional Fellowship Year*
- P2** *Privileges in Anaesthesia College Policy*
- P9** *Sedation for Diagnostic and Surgical Procedures*
- T2** *Protocol for Checking the Anaesthetic Machine*

Council agreed to publish Policy Documents in the public domain of the College site on the WWW.

TECHNICAL

RACS New Technology Committee

Dr Chris Thompson was appointed as the ANZCA representative to the RACS New Technology Committee.

RESEARCH

On the advice of the External Reviewers, Council endorsed the Research Awards for 1997. Details are published elsewhere in this Bulletin.

ELECTION TO FELLOWSHIP

The following were elected to Fellowship:

Under Regulation 6.3.1 (b)

- Dr Phillip Thomas, NZ
- Dr Bruce J. McLeod, WA
- Dr Aileen M. Donaghy, WA
- Dr Geoffrey T. Long, NZ
- Dr Frances J. Beswick, NZ
- Dr Colin L. Smith, VIC
- Dr Haydn Perndt, TAS

Under Regulation 6.3.1. (d)

- Dr David J. Foley, SA

Under Regulation 6.3.1. (e)

- Dr Bryan Hodkinson, NZ

SPECIAL INTEREST GROUPS

ANNUAL REPORTS 1995-1996

RURAL

This year has been one of consolidation and continuing progress.

EXECUTIVE MATTERS

Since the successful Rural SIG session in Townsville at the ASM, we have had two teleconference meetings in which our long-serving Executive took part.

At the December meeting, Dr Diana Strange Khursandi (Maryborough, Qld) was elected to the Chair, in succession to Dr Frank Moloney (Orange, NSW) who has served the Rural SIG with dedication and enthusiasm as Chairman for three years.

The other members of the Executive are Dr Mark Radnor (Wangaratta, Vic), Dr Darryl Catt (Alice Springs, SA and NT), Dr Ray Cook (Canberra, ACT), Dr Graham Dale (Bunbury, WA), Dr Simon Fraser (Launceston, Tas), and Dr Mike Miller (Wanganui, NZ).

Dr Dan Connor (Taree, NSW) is maintaining a data base of rural and remote anaesthetists in New South Wales, to facilitate communication and continuing medical education.

RURAL WORKFORCE

Recruitment of specialists to provincial and rural areas of Australia and New Zealand is still inadequate, but there have been some improvements.

This year, as in previous years, political machinations have compounded the problem of the provision of rural anaesthetic services, especially in Queensland, Victoria and New Zealand. Money and resources are being put into rural areas, but often with no noticeable improvement in direct patient care or the clinical workforce.

The decision by College Council to support for specialist registration only those with a FANZCA after January 1996 has compounded the problems of recruitment to rural areas; the SIG Executive is conducting a continuing dialogue with ANZCA Council on this subject.

Designation of rural areas unable to recruit specialists as "areas of need" may allow the employment of non-FANZCA anaesthetists where this is possible. Overseas trained

anaesthetists are at present employed as short and long term locums in such centres.

Long overdue improvements to conditions of service have now been introduced in Queensland. These improvements have been due to several influences, including a direct approach to the Department of Health by ex-President of ANZCA Dr Michael Davies, and continuing action by members of the Rural SIG Executive and the ANZCA Queensland Regional Committee; these improvements have resulted in some reduction of the shortfall in specialist anaesthetic services.

RURAL REGISTRAR ROTATIONS

The rotation of registrars in training to rural centres continues to expand, particularly in New South Wales; the Rural SIG is grateful to the College Council, the Regional Committees, the Regional Education Officers and the Supervisors of Training for this expansion, and to the anaesthetists and management of the hospitals in the provincial centres for their support.

Rural rotations can be across state borders, as long as the trainee remains attached to his/her original teaching hospital training scheme, (eg in Victoria: Melbourne-Launceston, and in South Australia: Adelaide-Darwin/Alice Springs).

Dr Brian Jones' (Tamworth, NSW) paper on registrars' experience of their time in Tamworth, presented in Townsville, was published in the ANZCA Bulletin in November 1995; it validates previously anecdotal views that the experience of working outside the capital city is a positive and rewarding one for the great majority of young anaesthetists in training.

Once a registrar rotation has been established in a peripheral centre, it is important that the parent training hospital maintains a trainee in that position. Both provincial centres and trainees are disadvantaged if the rotation cannot be maintained.

CONTINUING MEDICAL EDUCATION

In April a post World Congress meeting was held in Dubbo NSW, ably organised by Dr Mike Logan and his colleagues.

Overseas speakers from Norway, Canada and Tonga gave us fascinating insights into anaesthetic services and retrievals in their respective countries.

Australian speakers included Dr Frank Moloney (GP training and credentialling), Dr Chris Sparks (The South Pacific Programme), Dr Howard Roby (International Retrievals), Dr Bruce Sanderson (RFDS), Dr Ron Manning (CNSW Air Ambulance) and Dr Bernard Hanrahan (Care flight).

There was a Rural SIG session at the combined ANZCA/ASA meeting in Perth, chaired by Dr Graham Dale. The speakers were:

Dr Alan McKenzie (Palmerston North, NZ) "The Crash of Ansett Flight 703"

Dr Wal Grimmett (Roma, Qld) "Flying Anaesthetic Services in Queensland"

Dr Mark Radnor (Vic) "An Acute Pain Service in a rural hospital"

At the Perth CSM there was a Rural Special Interest Group Meeting on Sunday 27 October, to which all interested delegates were welcome; the Executive met with Council representatives on Monday 28 October to discuss recruitment, specialist registration and educational issues.

Plans for Rural SIG input to the 1997 College meeting in Christchurch are developing well – a workshop is planned on Aero-Medical Retrievals; in addition members will participate in sessions on "Maintenance of Standards" and "Running a department".

Agreement has been reached that CME conference activities should be videotaped, and recordings made available to isolated anaesthetists; the cost of such taping has however made this venture uneconomic at some meetings. There is a need to provide resources for this service at all major State and national meetings.

Rural specialist anaesthetists continue to provide training for non-specialist anaesthetists, and to cooperate with organisations providing training and continuing medical education for these practitioners.

I would like to thank the Executive and Ms Helen Morris of the College for their help and support over the last year.

DIANA STRANGE KHURSANDI
Chair
Rural Special Interest Group
October 1996

CARDIO-THORACIC VASCULAR PERFUSION

Following the successful CVP SIG meeting in Wanaka, New Zealand last year, activities of the CVP group have focused on support or programme contributions to other major meetings, and issues. The Cardiovascular Anaesthesia Symposium in Melbourne was a satellite pre-congress meeting to the World Congress of Anaesthesiologists (WCA). Dr Michael Davies and Dr David Scott organised a stimulating international program which was attended by over 200 registrants. The CVP SIG co-supported the meeting with the Society of Cardiovascular Anesthesiologists, U.S.A., and the European Association of Cardiovascular Anaesthesiologists. The WCA programme was organised independently of the CVP Group, although we assisted the scientific programme organisers wherever required.

The Group presented a 90 minute session at the Perth ANZCA/ASA Combined Scientific Meeting. The theme for that session was computer enhanced simulations in training which was run by the team from St George Hospital, Sydney, using a cardiopulmonary bypass model.

Over 1996 the CVP group has been in the in-between year for our biennial CME meeting. Organisation for the fourth CME meeting is underway and it will be held from October 17 to 19, 1997. The meeting will commence as a joint session with the Australian and New Zealand Chapter of the International Society for Cardiovascular Surgery, in Adelaide, and continue at the Wirrina Cove resort, to the south of Adelaide.

The increasing profile of intraoperative Trans-Oesophageal Echocardiography has meant that discussions with relevant bodies regarding training, and accreditation have been required. Drs Roman Kluger and Damon Sutton have been representing the CVP SIG in ongoing discussions with the Cardiac Society. Likewise, similar discussions are commencing regarding standards and training for Medical Perfusion with the CVP Group and the National Association of Medical Perfusionists of Australia (NAMPA).

Finally, the Executive extends its thanks to Dr Alan Rainbird who has stepped down as Chairman of the CVP SIG. Alan has made an enormous contribution in that role over the last three years. Dr David Scott was unanimously elected by the Executive as the new Chairman. I am pleased to note that Alan will be remaining on the Executive.

DAVID A. SCOTT
Chairman
CVP SIG

DAY CARE ANAESTHESIA

MAJOR ITEMS OF BUSINESS

1) PATIENT INFORMATION DOCUMENTS

Three patient information documents were forwarded to the College for approval in August 1995,

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

It was hoped that these documents would be made widely available by publication in the College Bulletin but as yet no action has been taken in this regard.

2) GUIDELINES FOR THE MANAGEMENT OF PATIENTS LIVING AT A CONSIDERABLE DISTANCE FROM A DAY CARE FACILITY.

This topic was discussed at some length by the Executive and several versions were submitted to the College for approval. Recommendations were finally submitted under the more general title of "Management of Complications Arising Following Discharge from a Day Surgery Unit" (revised statement: March 1996).

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

A revised version of this recommendation was submitted in March 1996.

4) STATEMENT CONCERNING THE SCHEDULING OF DAY SURGERY PATIENTS.

A recommendation concerning scheduling of Day Surgery Patients was submitted to the Executive for discussion, by Dr Glenda Rudkin in March 1996. This is currently being revised and it is anticipated that an updated version will be presented to the Council in the near future.

MEETINGS 1995 – 1996

1) CHRISTCHURCH: JULY 1995

This very successful meeting on "Controversial Issues in Day Care Anaesthesia" was reviewed in the 1995 Report. However since that time further information arising from that meeting has become available,

i) Comprehensive proceedings of the meeting has been published mainly as a result of the work of Dr John Zelcer and an educational grant from ICI Pharmaceuticals.

ii) A financial report of the meeting that after paying all teleconference expenses relating to the meeting there was a profit to the College of \$5,790.24.

2) SATELLITE SYMPOSIUM: "ECONOMICS AND QUALITY IN AMBULATORY ANAESTHESIA".

This meeting was held on Saturday 13th April 1996 and has been fully reported elsewhere by Dr Glenda Rudkin. It was a combined meeting of the College, the Australian Society of Anaesthetists and the Society of Ambulatory Anesthesia of North America. The Scientific Programme consisted of four sessions:

- i) Pushing the Limits.
- ii) Continuous Quality Improvement.
- iii) Factors affecting Recovery and Discharge.
- iv) Panel Discussion: "Cost and Quality".

168 clinicians from 13 countries attended the meeting which was an outstanding success. Special thanks is extended to the convenors Dr Glenda Rudkin and Professor Paul White, and to Dr John Marshman and Ms Helen Morris for their involvement in the organisation of the meeting. On the night of the meeting and excellent dinner was provided for the speakers by Roche Products, with Mr John Collins, Product Manager, being our host for the evening.

3) WORLD CONGRESS

Day Care Anaesthesia was well represented on the programme during the World Congress.

i) Monday 15th April, 1996: This was an all day session which dealt with a wide range of topics including the establishment of Day Care Units, preoperative assessment, paediatric management, local anaesthetic techniques, sedation and postoperative care. The session was very well attended and the standard of presentation of papers excellent.

ii) Tuesday 16th April 1996: This was a Poster Session Consisting of 30 posters ten of which were open for discussion. The organisers were very pleased at the standard of the presentations.

4) DAY SURGERY 2000, ADELAIDE

This meeting held on 31 August in Adelaide preceded the RACS Annual Scientific Congress. The meeting was hosted by the Australian Day Surgery Association and the National Day Surgery Committee. Although the SIG had little input into the meeting there was considerable participation by Anaesthetists.

5) COMBINED ANZCA AND ASA MEETING, PERTH 26-30 OCTOBER 1996.

The day Surgery SIG session at the Perth Meeting was organised by Dr Brent Donovan. The Scientific Programme consisted of four 15 minute presentations followed by a half hour panel discussion.

6) ANZCA – ASM, CHRISTCHURCH 10-14 MAY 1997.

Dr Glenda Rudkin has proposed that the theme for the Day Surgery session be "Education in Day Surgery". A document requesting suggestions for suitable topics for discussion has been circulated. Involvement of a New Zealand representative is required to ensure the successful organisation of the session.

GENERAL COMMENTS

The last year has been a very busy one for the Day Surgery SIG. There have been a large number of meetings and all those on the Executive Panel have had a major involvement in the administrative and academic aspects of the group. There has been general disappointment with the College's pronouncement that it would not be possible for all SIGs to have sessions at each College Meeting, and Dr Rudkin has written to the College Executive indicating that the Day Surgery SIG was keen to present at each meeting if that was at all possible. The Executive has also expressed to the College its view that meeting fees should be waived for invited speakers. This is currently against the policy of the College.

During the last year Dr Mark Chapman retired from his position on the Executive. Dr Chapman made major contributions to our work over a number of years and was largely responsible for the organisation of our Christchurch Meeting in 1995, which was an outstanding success. He has been replaced by another New Zealand representative, Dr Hugh Spencer. Thanks is due also to Dr Glenda Rudkin who took on the role of Acting Chairman in the absence of Professor Gibb who was on three months overseas study leave.

DAVID GIBB
Chairman

Day Care Anaesthesia SIG

DEATHS

Dr Mary Burnell, South Australia, FFARACS 25/8/52, FANZCA 2/3/92

Dr Preston Calvert, New Zealand, FFARACS 23/5/61, FANZCA 30/6/92

Dr Rosemary Faull, New Zealand, FFARACS 23/5/61, FANZCA 2/3/92

Dr Gordon Houseman, Victoria, FFARACS 25/6/55, FANZCA 24/2/92

Dr John Matheson, New South Wales, FFARACS 30/10/70, FANZCA 27/4/92

Dr Ian Miller, Western Australia, FFARACS 17/10/68, FANZCA 2/3/92

LAW REFORM

MEDICAL MANSLAUGHTER UPDATE

(Reprinted from NZMA Newsletter)

On 18 July, the Crimes Amendment Bill (no. 5) was introduced into the Parliament of New Zealand (NZ). The Bill implements the recommendations of Sir Duncan McMullin, retired judge of the Court of Appeal, in a report to the Minister of Justice on s155 and 156 of the Crimes Act 1961 (which relate to the duties expected of people doing or using 'dangerous' things). On 27 August, the last day of sitting of the current Parliament, the Bill (with several other Government Bills) was given its second reading and was referred to the Justice and Law Reform Select Committee, to be reported back to Parliament by 30/6/97. Under current standing orders, all Bills referred to select committee must be returned to Parliament. In practice, this means that a newly constituted Committee will receive submissions and consider the Bill after the election.

It is appropriate that doctors have a clear understanding of what the Bill says. Section 1 gives the title of the proposed Act. Section 3 simply corrects a previous unrelated drafting error.

Section 2 says:

Standard of care required of persons under legal duties – (1) The principal Act is hereby amended by inserting in Part VIII, immediately before section 151, the following section:

150A(1) This section applies in respect of the legal duties specified in any of sections 151, 152, 153, 155, 156 and 157 of this Act.

(2) For the purposes of this Part of this Act, a person is criminally responsible for –

- (a) Omitting to discharge or perform a legal duty to which this applies, or
- (b) Neglecting a legal duty to which this section applies – only if, in the circumstances of the particular case, the omission or neglect is a major departure from the standard of care expected of a reasonable person to whom that legal duty applies in those circumstances.

(3) Nothing in this section applies in respect of any act or omission that occurred before the commencement of this Act.

We have always held, and continue to do so, that the proposed amendment is no more than common sense, that it will be in the interests of the public of New Zealand as a whole, and that it will restore justice, balance and consistency to this section of the Crimes Act. It is particularly gratifying that the explanatory notes accept without dispute that the standard of negligence applying to s155 and s156 has been out of step with comparable jurisdictions and with common law in New Zealand itself. For example, I quote: "The standard of gross negligence that currently applies with respect to the legal duties imposed by sections 151, 152, 153 and 157 of that Act will now also apply with respect to the legal duties imposed by sections 155 and 156 of that Act".

The Justice and Law Reform Select Committee will be reconstituted after the election. It will receive submissions and consider the Bill. It will, of course, have its own views on the issue, and the Bill will have to pass a third reading in Parliament itself before it becomes law. It may not be passed, or it may be altered. Nevertheless the fact that this Bill has been introduced to Parliament and referred to a Select Committee is a major step forward in addressing the concerns of health professionals about the current standard of negligence pertaining to sections 155 and 156 of the Crimes Act 1961. The presentation to the Social Services Select Committee on the Medical Practitioners' Bill was probably the first time that the facts of the problem were clearly and authoritatively stated in an influential public forum. The judgement of Justice Hammond of the High Court in the section 137 hearing in Dr Long's case contributed to the decision of the Minister of Justice to appoint Sir Duncan McMullin to consider sections 155 and 156 of the Crimes Act. His report has led to the current Bill.

The debate is, at heart, a legal one. While there is no doubt that a huge contribution has been made by a large number of medical and nursing practitioners, it is worth reflecting on the help which has come in one form or another from members of the legal profession. Michael Gorton from Melbourne, Honorary Solicitor to ANZCA and RACS, and Sandy McCall Smith, now Professor of Medical Law in Edinburgh, both came to New Zealand (Michael Gorton twice) with no thought of a fee to support what they saw as a simple matter of justice. Don Mathieson, QC, Julian Miles, QC and Bruce Corkill have all made vital

contributions, all at considerably reduced fees, again because of their assessment of the underlying injustice of the existing law. The high quality of the defence mounted in Dr Long's case by Chris Hodson and John Haigh, QC, is also worth noting, both to acknowledge it, and to recognise the importance of defence counsel in any future cases.

Finally, Justice Minister, Doug Graham, with many matters far weightier to worry about, has dealt with the problem fairly and with good faith. Faced with conflicting advice, and accepting the real concern of the medical profession, he appointed a suitable impartial expert to look into the matter in depth. He has accepted the recommendations of that expert, and he has done all that could be asked in seeing that they are implemented if possible. Whatever the outcome of his Bill, the medical profession should be very grateful to him.

ALAN MERRY
 Executive member, NZ Medical Law Reform Group
 Chairman, NZ Regional Committee, ANZCA
 September 1996



Professor Gary Phillips (ANZCA President) with Ms Christine Spaul, Prescription Marketing Manager, The Boots Company and Dr David Crankshaw, Australasian Visitor.

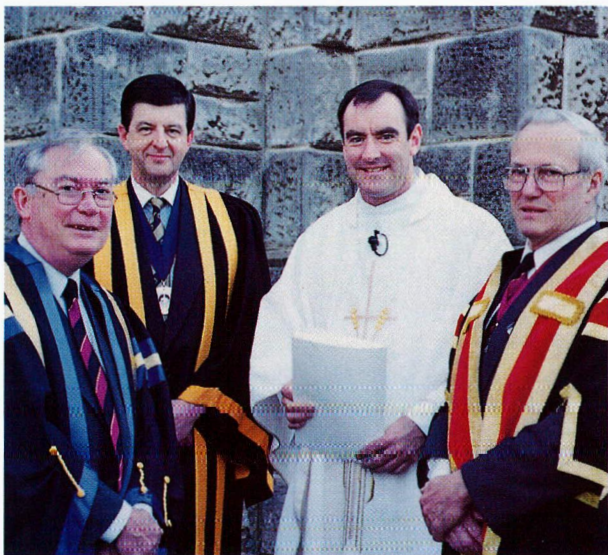
CSM PERTH 1996



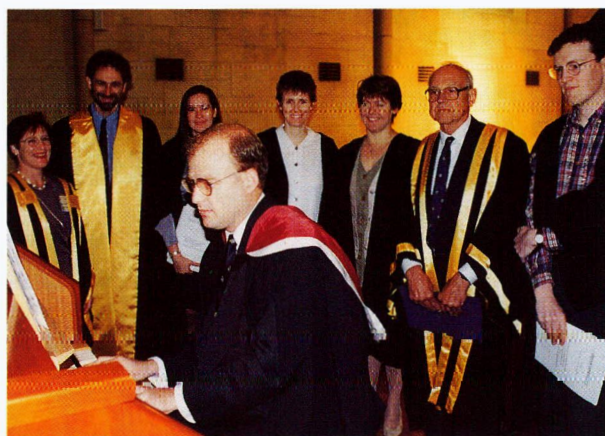
His Excellency, Major General Michael Jeffery, AO MC, Governor of State of Western Australia during the College Ceremony.



The Honourable Fred Chaney, Chancellor, Murdoch University, WA delivered the Oration 'Individual Excellence and the Common Good'.



Dr Geoffrey Clarke (Dean, Faculty of Intensive Care), Dr Gregory Wotherspoon (President ASA), Father Vincent Glynn and Professor Garry Phillips (College President).



Choir of local anaesthetists under the direction of Dr Andrew Gardner at the Church Service.



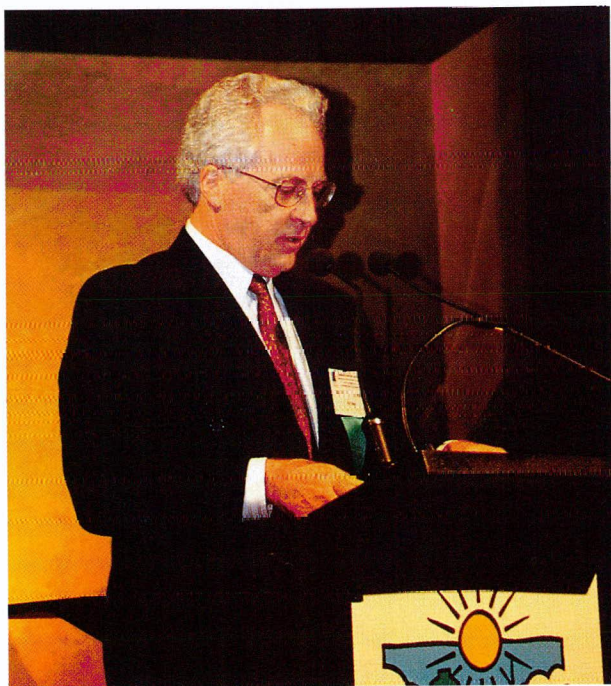
Presentation of Gilbert Brown Prize to Dr Paul Myles (Vic.) by College President.



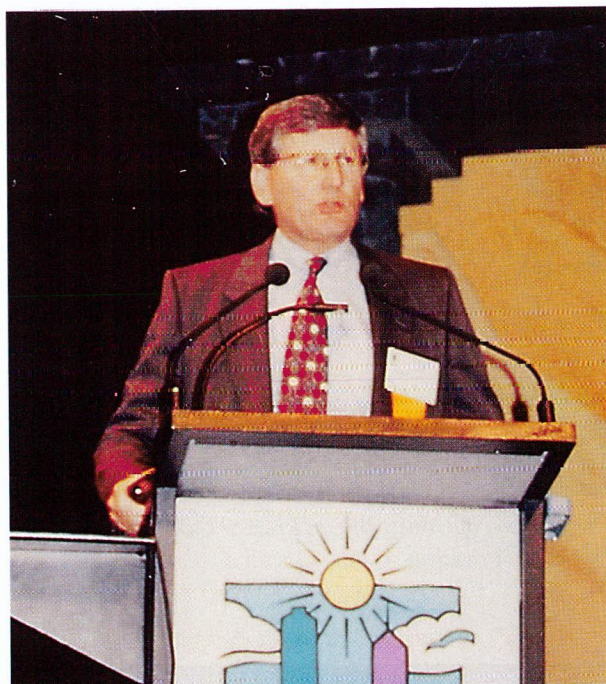
Presentation of Formal Project Prize to Dr Deborah Wilson by Prof. Phillips.



Dr Leigh Coombs, Convenor of Meeting and Master of Ceremonies at CSM Dinner.



Dr David Crankshaw, Australasian Visitor.



Professor Bruce Cullen, Foundation Visitor.



Dr Neville Gibbs, Scientific Convenor (Anaesthesia).



College President with Professor Pierre Coriat, Foundation Visitor.

BOARD OF FACULTY 1996-97



The workshop on Septic Shock involved Geoff Clarke, Teik Oh and Andrew Bersten.

At rear: Carol Cunningham-Browne (Administrative Officer), Drs Neil Matthews, Bob Whiting, Jamie Cooper, Richard Walsh (College Vice President), Toby Thomas and Richard Lee.

Centre: Mrs Joan Sheales (College Registrar), Dr Gillian Bishop [Co-opted Representative].

Front: Drs Alan Duncan, Geoff Clarke (Dean), Ron Trubuhovich (Vice Dean), Felicity Hawker.

FELLOWSHIP EXAMINATION IN INTENSIVE CARE

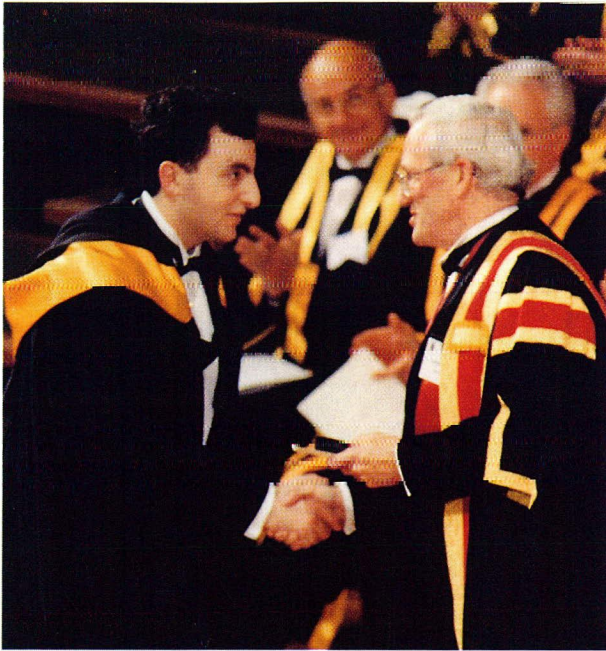


Successful Candidates of the Faculty Fellowship Examination August 1996: Drs David Simes, Craig French, Shane Townsend, Carl Scott and Ian Webb.

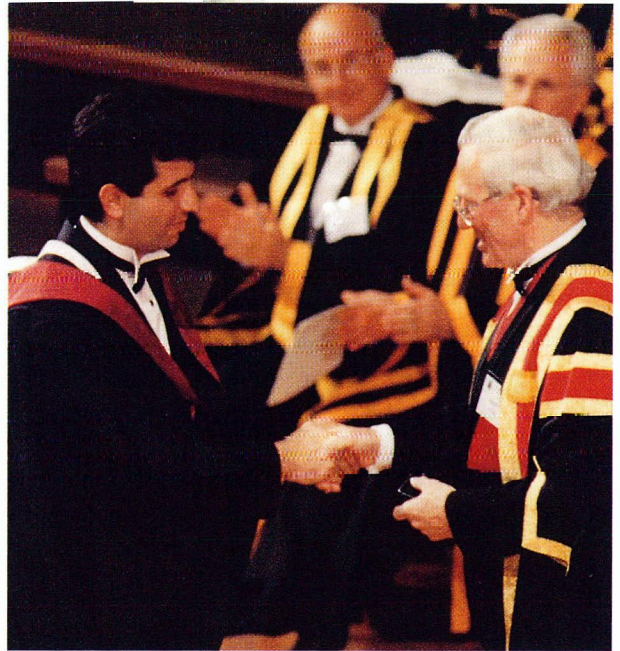


The Court of Examiners and Successful Candidates August/September, 1996.

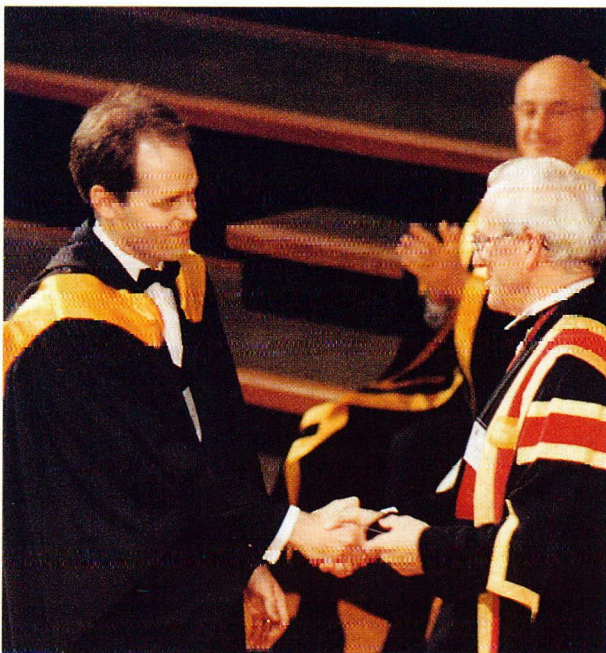
PRESENTATION OF EXAMINATION PRIZE WINNERS



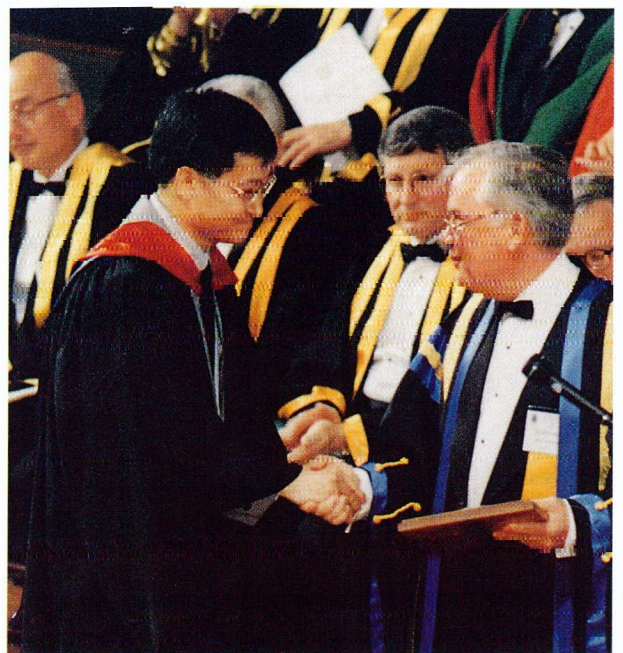
Dr Anthony Coorey, QLD, Renton Prize, May 1996.



Dr Cyrus Edibam, WA, Cecil Gray Prize, May 1996.



Dr Stephen Bruce, QLD, Cecil Gray Prize, May 1996.



Dr Ho Kwok Ming, Hong Kong, The G. A. (Don) Harrison Award, 1995.

GIFT TO ULIMAROA



Professor Garry Phillips receiving a lithograph of St Kilda Road, Melbourne from Dr John Roberts, SA.

YOUNGER FELLOWS' CONFERENCE

NEW NORCIA 23-25 OCTOBER 1996



BACK ROW: David Hilton (WA), Bill O'Regan (NSW), Vida Viliunas (ACT), Michelle Mulligan (NSW), Craig Sims (WA).
MIDDLE ROW: Dennis Hayward (WA), Glen Downey (VIC), Mary-Ann Fox (SA), Clement Goh (VIC), Stephanie Davies (WA), Vernon Van Heerden (WA).
FRONT ROW: Trevor Shum (VIC), Maurice Vialle (TAS), Lisa McEwin (SA), Megan Robertson (VIC), Wilson Lim (WA).
ABSENT: Mike Martyn (TAS), Lyndall Patterson (QLD), Bill Myles (QLD), Chris Johnson (WA).

Accompanied by unseasonable heavy rain our group of seventeen Younger Fellows and three 'Faculty' (Convenors Dennis Hayward, David Hillman and Councillor Mike Martyn) left Perth on Wednesday 23 October for the two hour drive to New Norcia, venue for the 1996 Younger Fellows' Conference. Ahead were two days of intensive discussion, planning, exploration, competition and final consensus, all created within a semi structured format involving maximum participation from each delegate.

For those not familiar with New Norcia, it is a Benedictine Community founded, along with anaesthesia, 150 years ago. Until recently this community provided both boys and girls schools as well as the full range of monastic functions. Gracious and magnificent Spanish structures steeped in the rich Benedictine tradition rise rather surprisingly from the dry fields of the Australian outback, resting amongst sheep, cattle, olive trees and vineyards. Despite financial obstacles which led to the closing of the schools in 1991 and to lack of upkeep for the buildings this monastic town still retains the rich feel of its heritage. This provided a marvellous and appropriate backdrop for two days of concentrated mental activity, although I am not sure that all Fellows enjoyed making their own beds!

The programme for this Younger Fellows' Meeting was titled Improving Communication. Firstly, we explored the subject

of conflict resolution. In a reasonably structured programme under the control of the Australian Institute of Management we discussed conflict and then reviewed our own techniques of managing discord. We then considered the subject of communication between patients and anaesthetists. It was the firm belief of all delegates that we as a group can communicate better with our patients. It was also strongly felt that ANZCA has an important part to play in teaching us to improve our communication skills. Delegates then developed a Communication Package which addresses the problem of teaching communication. This package has been presented to College Council for consideration and follows to this report for all Fellows to read.

As with all Younger Fellows' Meetings both delegates and convenors gained from the close affiliation with new and unknown colleagues and also from the formal and informal discussions which are the main contract of these meetings. It is always a pleasure to be involved in such an intensive workshop environment, particularly when every person present puts so much into the affairs at hand. In making my final comments I would urge all young anaesthetists to strive to attend a Younger Fellows' Meeting and reassure 'Older Fellows' that they can be well pleased with the calibre of our younger colleagues.

DENNIS HAYWARD

Submission of the Younger Fellows' Conference

We recognise that excellence in communication with colleagues, the public and with patients is an essential component of good anaesthetic practice. The enhancement of these skills should be a focus of College training and continuing education.

Specifically, this area could be addressed with respect to:

1. Anaesthesia and Intensive Care Trainees
2. Fellows – Continuing Education
3. Others – including patients, colleagues and the public.

1. TRAINEES

- 1.1 Objectives of training should specify communication skills.
- 1.2 In-training assessment of communication skills.
- 1.3 Training programme to include workshops and modules on communication skills. This should be a compulsory component of training. These activities should be reinforced by departmental and regional CME activities. Areas to be covered should include:
 - Communication with patients and colleagues
 - Conflict resolution and negotiation
 - Communication under difficult or stressful conditions, e.g. patient death, brain death, organ donation and withdrawal of therapy
 - Crisis management and debriefing skills.
- 1.4 Log books to document the training process and workshop attendance. There should be observation of a prescribed number of pre- and post-anaesthetic consultations and ICU situations in the presence of a consultant.
- 1.5 Guidelines for the selection of Trainees should include reference to communication skills. This is currently an informal process.

2. FELLOWS – CONTINUING EDUCATION

- 2.1 The College should actively promote the improvement of Communication skills amongst Fellows. Specifically:
 - Drawing attention to existing resources such as books, videos and courses that may be available from the College, ASA or other sources.
 - Resource packages made available by the College to Departments or groups e.g. videos and pamphlets on subjects such as conflict resolution.

- Special Interest group to be established.
 - Education linked to CME and MOS programmes.
- 2.2 Expanded role of the Communications Committee.
 - 2.3 Optimally, a communication resource person to be appointed in each Department.
 - 2.4 Suggestions for improving communication in the area of anaesthetic consultations. These should strongly recommend:
 - Early referral
 - Anaesthetic consultation prior to admission to hospital
 - Post-Anaesthetic consultation as a routine.
 - 2.5 Feedback from Fellows on the relevance and usefulness of any implemented programme.
 - 2.6 Healthy doctor equals healthy communicator. The College should encourage balance and perspective within the individual.
 - 2.7 The College should provide a process for dealing with major communication breakdowns within Departments or groups or between individuals. The aim is to prevent the escalation of damaging conflicts.
 - 2.8 Improved communication and co-operation between professional bodies representing Fellows. Significant conflict exists in the workplace between Fellows from different Colleges, e.g. in ICU.

3. OTHERS

- 3.1 The College should promote clear identification of Anaesthetists. Name badges and business cards to make it clear to the public that anaesthetists are doctors and specialists.
- 3.2 Patient education programme:
 - For elective surgery, emergency admissions, brain death, etc.
 - Tours, information pamphlets and videos.
 - Anaesthetists conducting ante-natal classes.
- 3.3 Surveys to assess patient needs in areas of information and communication.
- 3.4 Education of medical colleagues, specialists, students, RMOs, administrators and nurses. Liaison with other Colleges.
- 3.5 Community education programme.
 - Pamphlets etc.

PRIMARY FELLOWSHIP EXAMINATION

AUGUST/SEPTEMBER 1996

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

The Viva Examination was held at College Headquarters in Melbourne.

One hundred and two (102) candidates presented in Melbourne and seventy-four (74) were approved.

SUCCESSFUL CANDIDATES

R J Ayer	NSW	C R James	VIC	L B Ong	SA
A Aziz	NSW	B S Jan	NSW	G M Palmer	VIC
E J Bennett	QLD	S J Jones	VIC	B A Pearce	VIC
F M Bennett	NSW	C P Kalinowski	NZ	K Pedersen	NZ
T Bui	NSW	S J Kelly	NZ	O U Petring	VIC
S G Buntain	QLD	Y Kontrobarsky	VIC	A G Playoust	NSW
T K Chow	VIC	H W Lam	NSW	J H Poh	QLD
D K Clarke	VIC	Lam Tung-ching, Doris	HKG	M C Poon	HKG
G R Clery	NSW	R A Lang	ACT	D J Provan	QLD
P J Clunies-Ross	NSW	S M Lindsay	QLD	A S Robinson	VIC
J P Cooper	VIC	M R Lorimer	NZ	A C Schneider	VIC
M J Davis	NSW	N D Lovelock	NSW	R J Scolaro	WA
L C De Gabriele	NSW	H W Lui	NSW	A U See	NSW
L T Fan	NSW	J Z Malczewski	QLD	V M Shearer	QLD
P M Fien	NSW	A Mann	VIC	C A Smith	WA
S R Gopal	ACT	G P Mann	QLD	S Tavakol	QLD
R P Grauer	VIC	C L McCalman	NZ	D E Terry	NSW
K N Gray	NSW	P P McConkey	NSW	J M Thomas	NZ
T S Hampton	NZ	A J McDonald	NSW	M G Veltman	WA
G P Henderson	NSW	R J McLean	QLD	G P Willemsen	NZ
J S Hill	NZ	T Mohler	TAS	J S Wong	NSW
S Ho	VIC	A R Molnar	VIC	Wong Chui-Wah, Wendy	HKG
M M Hosny	NSW	S J Morphett	TAS	J C Yap	HKG
J J Hunt-Smith	VIC	A F O'Leary	NZ	Yee Chia Shao	MAL
A L Illingsworth	NZ	D J Olive	VIC		

EXAMINERS' RETIREMENT



Dr Keith Cronin (VIC), Dr Ken Sleeman (VIC), Dr Rupert Edwards (NSW), Dr Karl Alexander (VIC), Dr Richard Willis (SA), Chairman of Examinations.



Left: Dr Keith Cronin with Dr Jeremy Hammond (VIC) following presentation to Dr Hammond of a Certificate of Recognition.



Dr Ed Loughman, presenting Dr Keith Cronin, Chairman of Final Examination Committee with a gift from the Court of Examinations upon his retirement.



Dr Peter Roessler (VIC), Chairman, Primary Examination Committee at the completion of his 12 years appointment with Dr Tony Quail.

FINAL FELLOWSHIP FELLOWSHIP EXAMINATION (ANAESTHESIA)

AUGUST/SEPTEMBER 1996

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

The Viva Examination in anaesthesia and medicine was held at Royal North Shore Hospital, Sydney.

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

SUCCESSFUL CANDIDATES

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

Court of Final Fellowship Examiners, September 1996 at Royal North Shore Hospital, Sydney



Front Row: Drs Graham Sharpe, Keith Cronin, (Chairman), Ken Sleeman, Judy Branch, Penny Briscoe, Bart McKenzie.

2nd Row: Drs Andy Pybus, Tony Weeks, Karl Alexander, Dick Willis, Leona Wilson, Dough Rigg, Sandra Taylor, Peter Klineberg, Phillipa Hore, Maggie Bailey.

Back Row: Drs Peter Gibson, Patrick See, Vic Callanan, David Jones, Craig Morgan, Frank Maccioni, Patrick Moran, Ed Loughman, Greg Conner, Rupert Edwards.

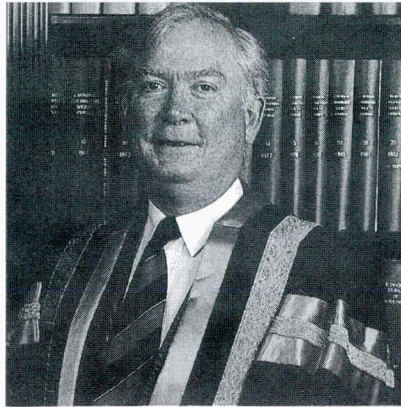
EUTHANASIA

Earlier this year the Solicitor for the Northern Territory wrote to the College seeking advice on the most appropriate drugs and doses to use for euthanasia. The College responded by stating that it had no expertise in the choice of drugs and doses for this purpose. At the June Council Meeting, some Councillors expressed the view that the College should have a policy on euthanasia, so that it could respond to enquiries. At the October Council Meeting, the issue of euthanasia was discussed informally, and it was decided that before considering the matter further, Regional Committees and Fellows should be asked to comment on:

- a) What stand they consider the College should have on the matter.
- b) How the College might develop a stand which also accepts that individual Fellows will have personal views with a range probably similar to those held by the general community.

Your views on this matter are important, and all input will be considered prior to further consideration by Council.

DEAN'S MESSAGE



Whose Faculty is it anyway?

The strength of any organisation can be measured by the degree of participation of its membership.

The Faculty of Intensive Care has a lot going for it. It is new and its Fellowship is still relatively small. There are plenty of highly worthwhile tasks to be done, which if undertaken properly, could involve a large number of our Fellows.

The training programme under the Joint Specialist Advisory Committee in Intensive Care is now well underway. New initiatives for our trainees such as in-training assessment and the soon to be introduced Formal Project need overseeing. Supervisors of Training and Regional Education Officers are encouraged to enlist the help of other Fellows in carrying out their tasks. The Regional Committee system is working well and the Board is receiving excellent feedback on a number of issues.

It is the enthusiasm of the younger Fellows that we should strive to incorporate into the Faculty system. Every opportunity and encouragement should be given to them to get involved in teaching trainees and generally involving themselves in Faculty affairs. Having visited the Younger Fellows Conference at New Norcia recently I was impressed by the talent and positive attitudes of those attending.

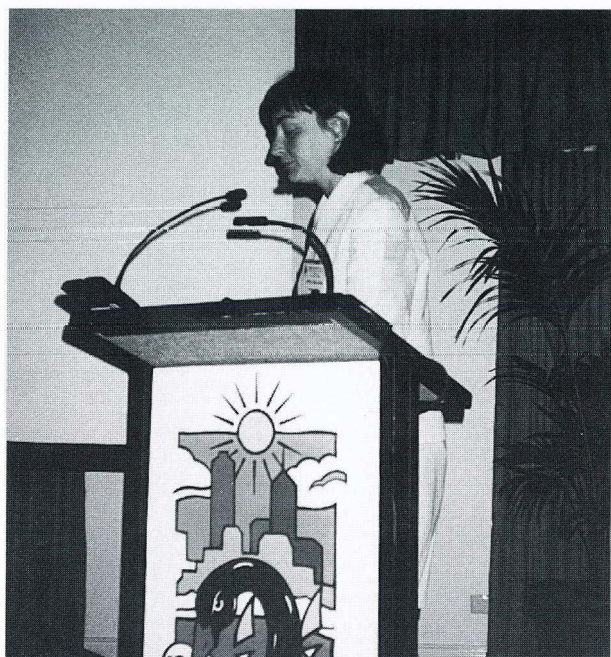
The Faculty component of the recent ASM held in Perth was a great success. Steve Edlin and his crew organised a superb programme which was extremely well attended. The first session on neurotrauma and imaging attracted over 120 doctors and attendances remained extremely high throughout the whole programme. The Faculty meeting is a high quality, well attended meeting and it may well expand in the future. From Launceston to Townsville and now Perth, the Faculty meeting has continued to grow in numbers and in its overall success. Fellows and their trainees are encouraged to attend and to participate.

Whose Faculty is it anyway?

It is your Faculty!

G. M. CLARKE
Dean

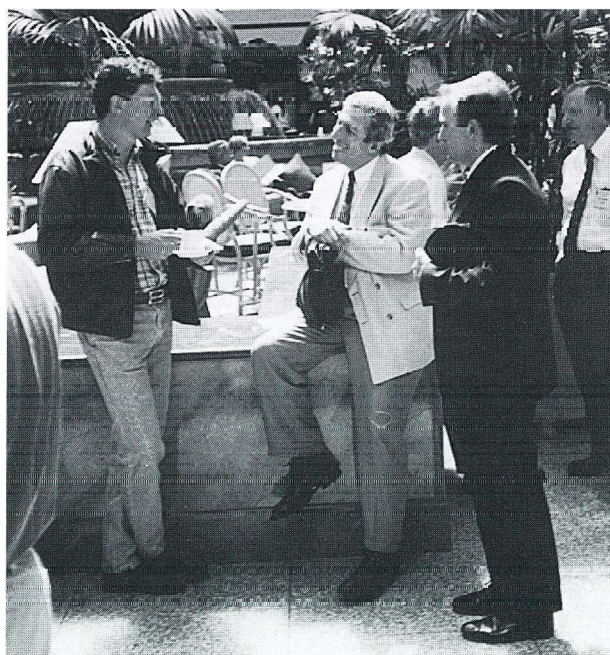
CSM PERTH 1996



Angela McLuckie presented 'Ecstasy Poisoning: A London Experience'.



John Weekes spoke on 'Problems and traps in the treatment of envenomation'.



Dr Steve Edlin (centre), Scientific Convenor (Intensive Care) discussing a presentation.

ITEMS OF INTEREST FROM THE OCTOBER 1996 BOARD MEETING

EDUCATION

Formal Project

Following its decision in June to introduce a Formal Project for intensive care trainees, the Board approved a document outlining the details of this requirement. All intensive care trainees supervised by the Joint Specialist Advisory Committee in Intensive Care (JSAC-IC) commencing training in 1997 will be required to complete a research project. The project may be undertaken at any stage during approved vocational training. Those trainees who have completed projects during anaesthesia or physician training may choose to submit that project for approval.

Completed projects must be forwarded to the Censor or Co-ordinator of Advanced Training. Final approval will be considered by the JSAC-IC. The Supervisor of Training will be required to confirm to the Censor that the trainee has presented the project at an appropriate forum and has been a major contributor to the preparation of the report.

Certificate of Training for Overseas Personnel

The suggestion for a certificate of training for overseas doctors undertaking intensive care training in Australia for a limited period has been discussed and following views from Regional Committees, the Board resolved that such a certificate will not be pursued at this time.

Trainee Logbooks

The Board supported the principle of logbooks for trainees and the matter will be further discussed by the JSAC-IC.

Short Course in Intensive Care

The Short Course conducted by Dr Worthley in Adelaide was noted as scheduled for 1 - 4 April 1997.

EXAMINATIONS

August/September Fellowship Examination

11 candidates presented at the August/September Fellowship Examination. Successful candidates are listed elsewhere in the Bulletin.

The G.A. (Don) Harrison Medal, 1996

The Board awarded the G.A. (Don) Harrison Medal for 1996 to Dr Ed Stachowski based on his performance in the September Examination.

**HOSPITAL
ACCREDITATION**

A working party has been created to consider accreditation of training. A number of specific issues have been identified, such as a limit on the number of training posts that can be approved for one unit, the possibility of approving a trainee's proposed training programme prospectively, and the nature of elective training.

FINANCE

The budget for 1996 was reviewed and a budget for 1997 and 1998 approved. A number of fees relating to training and examinations have been approved and will apply from 1997:

Registration Fee	\$700
Faculty Training Fee	\$750
Faculty Examination Fee	\$1650
Assessment of overseas training	\$950

PROFESSIONAL

The College Honorary Solicitor, Mr Michael Gorton, briefed the Board on the implications of the Trade Practices Act and its possible impact for Medical Colleges.

A number of submissions from the NH&MRC on organ donation and transplantation were considered and commented upon, along with a proposed definition of continuous mechanical ventilation for the National Health Data Dictionary.

Faculty Policy Documents will soon be available on the Internet as part of a decision by the Board to join the World Wide Web.

The issue of euthanasia was discussed and the Board agreed prepare a statement from the Faculty on this controversial issue.

ADMISSION TO FELLOWSHIP BY EXAMINATION

Athanasios FLABOURIS, NSW

Ian James WEBB, QLD

Carl Brian SCOTT, QLD

Bernice Yuen Yee NG, WA

ADMISSION TO FELLOWSHIP BY ELECTION

The Board elected the following to Fellowship under Regulation 5.3:

Robert Francis SALAMONSEN, VIC

John William STOKES, QLD

ANZCA POLICY DOCUMENTS

Review E1 (1996)

GUIDELINES FOR HOSPITALS SEEKING COLLEGE APPROVAL OF POSTS FOR THE FIRST FOUR YEARS OF VOCATIONAL TRAINING IN ANAESTHESIA

1. GENERAL

- 1.1 A training post in anaesthesia is one that has been approved by the College as appropriate to be occupied by a trainee anaesthetist who is registered as such with the College.
- 1.2 Training posts will only be approved by the College if they comply with its educational requirements and are part of a recognised training programme.
- 1.3 A training programme is a scheme of rotation between two or more hospitals such that the programme can provide an appropriate range of experience of anaesthesia and its sub-specialties including a significant period (at least three months but not more than fifteen months) of Intensive Care.
- 1.4 It would be unusual for a single hospital to provide up to four years of the designated five years of training from its own resources. Trainees will not normally be permitted to spend all of their training in one hospital.
- 1.5 Training programmes will be regularly reviewed at intervals determined by Council. Hospitals will be visited by the College. Accreditation of Intensive Care training posts will normally be carried out by the Faculty.
- 1.6 The number of posts approved within a training programme will be specified with regard to the size of the host departments. Additional posts will not be recognised without the prior knowledge and consent of Council. This will generally require the inspection of the hospital and consideration of the effect of the increase on the training programme.

2. THE HOSPITAL

- 2.1 A recognised hospital must have a Department of Anaesthesia under the direction of a suitably qualified anaesthetist who is responsible for the organisation, teaching and service requirements of that Department.
- 2.2 Training posts may be full or part time but must include normal, emergency and out-of-hours duties. Part time posts are subject to the requirements of the relevant College regulations.
- 2.3 There must be adequate supervision of trainees by specialist anaesthesia staff who hold the FANZCA or another qualification acceptable to Council (see College Policy Document E3 The Supervision of Vocational Trainees in Anaesthesia). Specialist anaesthesia staff must be familiar with the College's training programme.
- 2.4 Job descriptions for the specialist anaesthesia staff must be acceptable to the College (see College Policy Document E6 The Duties of an Anaesthetist).
- 2.5 When specialist anaesthesia staff are appointed, the advice of a properly constituted committee capable of evaluating the applicants must be sought. College nominees for appointments committees may only assist with advice on the qualifications of applicants.
- 2.6 A Supervisor of Training in Anaesthesia must be appointed by the hospital on the advice of the Department of Anaesthesia. This appointment requires ratification by Council. The duties of the Supervisor of Training are specified in College Policy Document E5 Supervisors of Training in Anaesthesia and Intensive Care.

- 2.7 The hospital (and other hospitals forming part of the training programme) must agree to inspection by representatives of the Council.
- 2.8 Posts approved for training in anaesthesia by the College must be advertised with that approval being noted. Where the number of training posts is less than the number of posts being advertised, the number of training posts should be specifically indicated.
- 2.9 The hospital must agree to notify Council (through the Supervisor of Training) of any changes that might affect training. Importance is placed on changes such as alterations in workload and increases or decreases in the number of senior staff working in the Department.
- 2.10 The Department of Anaesthesia must have:
- 2.10.1 A minimum of two full time equivalent (FTE) specialist anaesthesia staff with qualifications acceptable to Council.
- 2.10.2 No more than two FTE non-specialist anaesthesia staff (either trainees or other medical officers) for each FTE specialist.
- 2.10.3 At least one FTE anaesthesia specialist for each trainee.
- 2.10.4 Adequate secretarial staff. Most departments will require at least one full-time secretary with several being needed in larger hospitals (see College Policy Document E7 Secretarial Services to Departments of Anaesthesia).
- 2.10.5 Adequate office space for the specialist staff.
- 2.10.6 A suitable room for trainees to study.
- 2.10.7 Access to a suitable conference room for quality assurance, clinical review and educational activities.
- 2.10.8 Regular programmes of quality assurance and teaching appropriate to the size of the department (see College Policy Document E9 Quality Assurance)
- 2.10.9 Adequate library facilities with information sources appropriate to anaesthesia and its sub-specialities.

- 2.10.10 Ready access to appropriate computer facilities.
- 2.10.11 Access to clinical support services appropriate to the role of the hospital.
- 2.10.12 Anaesthesia specialists participating in the College's Maintenance of Standards Programme or its equivalent.
- 2.11 In addition to matters noted above, the hospital and department will take note of and comply with all College Policy documents and in particular:
- P4 Guidelines for the Care of Patients recovering from Anaesthesia
- P6 Minimum requirements for the Anaesthetic Record
- P7 The Pre-Anaesthetic Consultation
- P8 Minimum Assistance Required for the Safe conduct of Anaesthesia
- P18 Monitoring During Anaesthesia
- T1 Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites

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Promulgated: 1985

Reviewed: 1991

Date of current document: Oct 1996

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Review E13 (1996)**GUIDELINES FOR THE PROVISIONAL FELLOWSHIP YEAR****1. INTRODUCTION**

- 1.1 Trainees in anaesthesia must complete a four year training programme, pass the primary and final examinations of the College, complete other specified training requirements and undertake a further year of experience – the Provisional Fellowship Year – to be eligible for admission to the Fellowship of the College.
- 1.2 Trainees must seek approval from the College before commencing their Provisional Fellowship Year. The trainee is responsible for making application to the College with the written support of the appropriate Departmental head.
- 1.3 Trainees in this year are known as Provisional Fellows. They must be registered with the College and pay the annual training fee.
- 1.4 The Provisional Fellow:
 - 1.4.1 Is not a specialist anaesthetist
 - 1.4.2 Must be supervised appropriately
 - 1.4.3 Must work in posts approved by the College
 - 1.4.4 Should achieve widened experience and maturity

2. DETAILS

- 2.1 The Provisional Fellowship Year will allow for the development of:
 - 2.1.1 A consultant approach
 - 2.1.2 An interest in continuing education
 - 2.1.3 An interest in teaching and teaching skills
 - 2.1.4 An understanding of research methods and techniques
 - 2.1.5 Responsibility and commitment to the training of other staff
- 2.2 Provisional Fellowship posts must satisfy the above requirements and must be either:
 - 2.2.1 Specifically approved by the College as part of its training programmes; or
 - 2.2.2 Specially approved by the College on prospective application to the Assessor
- 2.3 Approved Provisional Fellowship posts may allow:

- 2.3.1 Recognition for intensive care training
- 2.3.2 Training for the College's qualification in pain management
- 2.3.3 Experience in a field of special interest
- 2.3.4 Experience in a deficient area of training
- 2.4 Provisional Fellows should be involved in teaching and supervision of other trainees provided that the clinical situation is appropriate and that supervision as specified in College Policy Document E3 The Supervision of Trainees in Anaesthesia is available.
- 2.5 Provisional Fellows should ordinarily work only in situations where work is supervised as noted above. Distance supervision will not ordinarily be permitted for more than three months.
- 2.6 The Assessor (on behalf of Council) has discretionary powers to approve specific proposals for the Provisional Fellowship Year and will be flexible in considering a proposal. Any such programme must have prior approval. Training outside Australia and New Zealand is to be encouraged.

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Promulgated: 1988

Reviewed: 1991

Date of current document: Oct 1996

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Review T2 (1996)

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 any new machine and on all machines after the required regular servicing.
 - 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 by attendance at a programme developed jointly by the hospital's Bioengineering and Anaesthesia Departments.

- 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 new anaesthetic machines before they enter service and 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 Engineers 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:
- 2.1.4.1 The method and accuracy of vapour output and delivery devices
- 2.1.4.2 The calibration of vapour output devices and monitors
- 2.1.5 A formal check of compliance of all components of the machine or part of the machine (after servicing of that part in accordance with AS3551) with the relevant Australian or New Zealand Standard is essential.
- 2.1.6 The check specified above must be undertaken by a suitably qualified person. The check must be recorded with inclusion of information as to what was checked, and by whom.
- 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 Check gas pipeline connections.
Confirm correct pipeline supply using an oxygen analyser or multigas analyser.
- 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 vaporiser is present:
- 2.2.2.2.1 Check that adequate anaesthetic liquid is present
- 2.2.2.2.2 Ensure that the vaporiser filling ports are closed.
- 2.2.2.2.3 Check correct seating and locking of a detachable vaporiser.
- 2.2.2.2.4 Test for circuit leaks for each vaporiser in both on and off positions.
- 2.2.2.2.5 Ensure power is available for electrically operated vaporisers
- 2.2.2.3 Check for pre-circuit leaks using a method sensitive to 100ml/minute and appropriate 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 anaesthesia circuit to be used.
- 2.2.2.4.1 In the circle system check its integrity and the functioning of unidirectional valves.

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

- 2.2.2.4.2 Perform leak test on circle with breathing bag attached to Y-piece and fresh gas flow of 300ml/min. Pressure of more than 30cm. of water is necessary to exclude significant leaks but requires the presence of a machine pressure relief valve set to 50 - 60 cm. of water and an incircuit pressure gauge.
- 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 hypothermia during anaesthesia
 - 2.2.6.7 Breathing circuit humidifiers
 - 2.2.6.8 Breathing circuit filters
- 2.2.7 Final check. Ensure vaporisers 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 vaporiser 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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Promulgated: 1984

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*Review EX1 (1996)***EXAMINATION CANDIDATES SUFFERING FROM ILLNESS,
ACCIDENT OR DISABILITY****1. INTRODUCTION**

- 1.1 Candidates should not be disadvantaged as a result of events outside their control. Nevertheless, in seeking to redress any disadvantage, no action should be taken which might be held to be unfair to other candidates.
- 1.2 Guidelines can be formulated for procedures to be followed in some cases of illness in relation to the examinations. However, it is impossible to foresee every eventuality.
- 1.3 Where a problem arises which is not covered in the Regulations, instructions to examiners, or these guidelines, advice is to be immediately sought from the Registrar in discussion with the Chairman of Examinations.

2. ACUTE ILLNESS OCCURRING AT THE TIME OF EXAMINATION

- 2.1 In the event that an examiner becomes aware that a candidate is ill, he/she should notify the Chairman of the Court who will:
 - 2.1.1 determine whether, in his/her opinion, the illness is incapacitating.
 - 2.1.2 if appropriate, advise the candidate to withdraw.
 - 2.1.3 notify the Registrar in writing of his/her action.
- 2.2 In the event of illness or disability occurring prior to or during any part of the examination, no special consideration will be given to a candidate who elects to continue with the examination.
- 2.3 Sudden illness which precludes a candidate from attending all or part of an examination, may provide grounds for remission of the examination entry fee.

- 2.4 Application for this consideration must be made by the candidate and supported by a medical certificate. Such a medical certificate may be provided by a member of the Court of Examiners, but not by the candidate.
- 2.5 Further action is at the discretion of the Council on the advice of the Chairman of Examinations.

3. ACUTE ILLNESS, ACCIDENT OR DISABILITY WHICH IMMOBILISES, BUT DOES NOT INCAPACITATE THE CANDIDATE

- 3.1 A candidate who is otherwise fit to participate in the written examination may be precluded from attending the venue for the written examination by an illness, accident or disability.
- 3.2 Under these circumstances, the Chairman of the Court of Examiners and the Chairman of Examinations should consider the possibility that the written examination could be taken at some other appropriate place at the same time as other candidates in the region. An appropriate invigilator must then be appointed for this purpose.
- 3.3 No such concession is possible for the oral examination, so that if the action under 3.2 is contemplated, it must be anticipated the candidate will be fit to attend the vivas.

4. CHRONIC ILLNESS OR DISABILITY

Candidates with a chronic illness or disability will not normally be granted any concession with respect to any part of an examination. If a candidate believes that extraordinary consideration should be given to particular circumstances, a fully documented application should be submitted to the Chairman of Examinations at least four (4) calendar months prior to the advised examination closing date. Further action is at the discretion of the Council, on advice from the Chairman of Examinations.

5. OTHER CONCESSIONS

- 5.1 A candidate who has been prevented from completing an examination by illness, accident or disability will not be exempt from any part of a future examination.
- 5.2 A candidate who has been prevented from completing an examination by illness, accident or disability will remain eligible for awards and prizes at a future examination.

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Promulgated: 1984

Reviewed: 1991

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Review P2 (1996)**PRIVILEGES IN ANAESTHESIA
COLLEGE POLICY**

1. Privileges in anaesthesia may be granted to a medical practitioner by an institution, thus enabling that practitioner to practise in the specialty of anaesthesia at that institution.
2. The College policy is that anaesthesia should be administered by fully trained specialists except in areas where specialists are unavailable or in insufficient numbers to provide a complete service. The definition of a specialist for these purposes is possession of the FANZCA or equivalent qualification acceptable to the Council.
3. The Committee structure for the determination of privileges in anaesthesia should include a representative of the College who, where possible, does not hold an appointment at the institution.
4. Privileges granted in anaesthesia, irrespective of qualification, should be:
 - 4.1 Unique to the granting institution, and not transferable.
 - 4.2 Subject to review at regular intervals, of not more than 5 years. Such privileges may exclude certain sub-specialty areas.
5. Criteria on which privileges are granted should include:
 - 5.1 Review of competence, with evaluation from peers and/or supervisors, sub-committee recommendations or peer review. An interview with a supervisor or Department Head may be appropriate.
 - 5.2 A satisfactory record of continuing education, sufficient to make the practitioner aware of major advances, complications and other significant events in the specialty. This may include satisfactory completion of annual returns to the Maintenance of Standards Programme.
 - 5.3 Qualifications in accordance with 2 above.
 - 5.3.1 In the absence of such qualifications:
 - 5.3.1.1 Evidence of training consistent with College Policy Document P1 "Essential Training for General Practitioners Proposing to Administer Anaesthesia".
 - 5.3.1.2 Evidence of clinical experience since training sufficient to maintain skills, in accordance with College Policy Document P1.

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*Review P9 (1996)***SEDATION FOR DIAGNOSTIC AND SURGICAL PROCEDURES****1. INTRODUCTION**

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

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 assessment 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 (including avoidance of driving, other dangerous activities, undertaking responsible business).
- 2.2 If the patient has any serious medical condition or danger of airway compromise, or is a young child or is elderly, then an anaesthetist should be present to monitor the patient during the procedure.
- 2.3 The practitioner administering these drugs requires sufficient basic knowledge to be able to:
 - 2.3.1 Understand the 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 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.

2.5 Staffing

There must be an assistant present during the procedure appropriately trained in resuscitative measures who shall monitor the level of consciousness and cardio-respiratory function of the patient.

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

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

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

2.6 Techniques which compensate for anxiety or pain by means of heavy sedation must not be used unless an anaesthetist is 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 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 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.

All College Policy Documents will be complied with and in particular:

- P2 Privileges in Anaesthesia
- P4 Guidelines for the Care of Patients Recovering From Anaesthesia
- P6 Minimum Requirements for the Anaesthetic Record
- P7 The Pre-Anaesthetic Consultation
- P15 Guidelines for the Use of Patients Recovering from Anaesthesia Related to Day Surgery
- P18 Monitoring During Anaesthesia
- P19 Monitored Care by an Anaesthetist

APPENDIX

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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POLICY DOCUMENTS – UNDER REVIEW

In line with College policy the following policy documents are due for review in 1997

- E4 – Duties of Regional Education Officers
- E5 – Supervisors of Training in Anaesthesia and Intensive Care
- E11 – Formal Project
- P7 – The Pre-Anaesthetic Consultation
- P13 – Protocol for The Use of Autologous Blood
- P17 – Endoscopy of the Airways
- P24 – Sedation for Endoscopy

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

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

POLICY DOCUMENTS INDEX

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

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