AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

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BULLETIN

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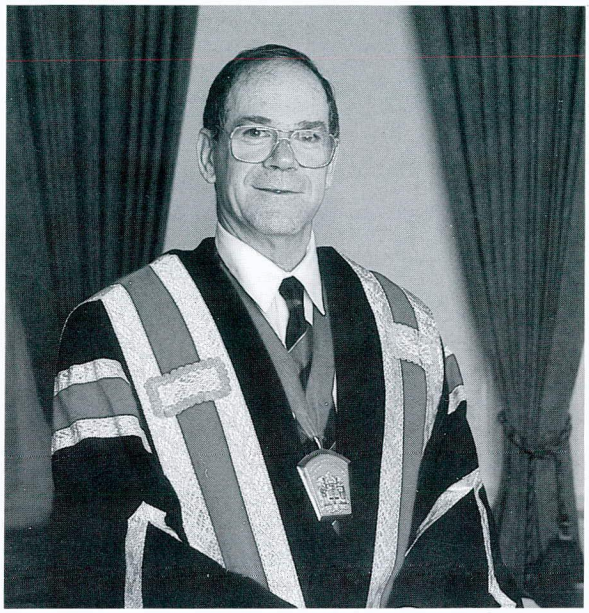
PRESIDENT'S MESSAGE



I am pleased to be able to announce that this year again there were a large number of excellent applications for Research grants from the College Foundation and although there was approximately $150,000 available, the applications totalled several times that figure. This is a good indication of the increasing interest in research in our specialty. Dr Tony Quail from the University of Newcastle has been awarded the Harry Daly Research Fellowship and I heartily congratulate him. Details of the other grants are elsewhere in this *Bulletin.*

I must congratulate Dr Geoff Clarke, the Dean of the Faculty of Intensive Care for the enormous achievement in coming to agreement with all parties to have a single stream for intensive care qualifications which will enable physician intensive care trainees to attain the FFICANZCA, and bring them into the Faculty of Intensive Care.

For some time, the Council has been concerned with the difficulties in assessment of overseas trained doctors and the potential of a two-tiered system of registration. Any new applications for College support for specialist recognition as anaesthetists as from January 1, 1996, will be supported only by the awarding of the FANZCA. This will normally require a successful Final Examination of the College and 12 months residential period spent in a post acceptable to Council after having passed the Examination. Additional training may be required including a successful Primary Examination.

A new post has been created by the Trustees of the Wood Library-Museum of the American Society of Anesthetists – that of the Wood Library-Museum Laureate. It has recently been announced that the WLM Inaugural Laureate of the History of Anesthesia is Dr Gwen Wilson, MD. This award is an enormous honour to Dr Wilson and we heartily congratulate her on this outstanding recognition of her many contributions to our specialty. Gwen's intensive history entitled *"One Grand Chain"* is near publication.

I am very pleased to be able to announce that the College will bestow its highest honour, that of Honorary Fellowship, on Dr Emanuel Papper. Dr Papper is a giant in the field of anaesthesia. This Fellowship will be conferred during the forthcoming World Congress.

Finally, I must report that as expected, the College Library is being much more widely used than previously and the introduction of new technology has enabled greater access for more Fellows and trainees outside Melbourne.

At this time, I would like to wish you and your families all the very best for the Festive Season.

Neville Davis

N.J. DAVIS

The GMC

Education Division

GENERAL MEDICAL COUNCIL

178-202 Great Portland Street London W1N 6JE
Tel: 0171 580 7642 Fax: 0171 436 1383

10 July 1995

Registrar
Australian and New Zealand College of Anaesthetists
630 St Kilda Road
Melbourne Victoria 3004 Australia

Dear Registrar,

Recognition of additional qualifications for registration purposes

The Fellowship awarded by the Australian and New Zealand College of Anaesthetists is presently registrable with the GMC. In May 1995 Council accepted the advice of its Education Committee that postgraduate qualifications granted outside the United Kingdom should no longer be registrable if awarded after 31 December 1996. I am writing to explain the reasons for this decision, and the effects upon the holders of the qualification mentioned above.

As part of a strategic review, the GMC has been looking critically at all areas of its work. It had been clear for some time that a new policy with regard to the recognition of postgraduate qualifications was required, since many anomalies could be identified in the list of those presently registrable. Although these could be explained in terms of the GMC's historical legacy, it was agreed that past events should not determine future policy. Starting from first principles, in particular the Education Committee's statutory duty to promote high standards of medical education, the GMC has decided to limit the postgraduate qualifications which may be registrable to those granted in the United Kingdom because, once recognised, the Committee has no statutory power to monitor the standards of qualifications granted elsewhere.

In order to further simplify register entries, in the interests of the public for whose benefit the register is maintained, the Committee also has plans to reduce significantly the number and range of postgraduate qualifications granted in the United Kingdom that will be recognised in future. The fine detail has, however, yet to be agreed.

I have been asked to emphasise that at no stage in the GMC's deliberations have questions been raised about the standards achieved by holders of your qualifications. Doctors awarded these qualifications on or before 31 December 1996 will not be affected by the GMC's decision, and may apply to have them registered in the normal way. Doctors awarded these qualifications in and after 1997 will not be permitted to include them in their register entries, but may still refer to them in their curricula vitae. They may also include them in, for example, their entries in the Medical Directory published in the United Kingdom.

I am sending a copy of this letter to the Australian Medical Council.

Yours sincerely,

Miss H M Burke
Secretary to the Education Committee

AN AUSTRALIAN GREATLY HONOURED

At a recent meeting of the American Society of Anesthesiologists, a most important announcement was made.

The inaugural Laureate of the History of Anesthesia was bestowed upon an Australian – Dr Gwen Wilson, Emeritus Historian of the College.

This accolade is the most prestigious ever created in the history of our specialty and is an international award with Dr Wilson being the successful recipient from a field of seventeen international anaesthetic historians of note.

It is based upon published monographs and articles in peer-reviewed journals, and was instituted by the Trustees of the Wood Library-Museum of Anesthesiology in Chicago, affiliated with the American Society of Anesthesiologists.

This is a great personal recognition for Dr Wilson's prodigious work of over thirty years but also is of great significance and importance for Australian anaesthesia in particular. Due to Gwen's scholarship, the origins and developments of anaesthesia in Australia have been better researched and documented than any other country in the world.

Apart from her many presentations at meetings and published papers, she has written *Fifty Years — The Australian Society of Anaesthetists 1934-1984* (published by the ASA) and also *A Bibliography of References to Anaesthesia in Australian Medical Journals 1846-1962* (published by the then Faculty of Anaesthetists, RACS) which is an invaluable book for medical historians and anyone researching a particular development in Australian anaesthesia.

Early this year Dr Wilson's scholarship was recognised by the conferring of her MD by the University of Sydney, and the College is currently publishing volume one of her *magnum opus* which will be released in early 1996.

This magnificent narrative is entitled *One Grand Chain. A History of Anaesthesia in Australia 1846-1962,* with volume 1 covering the period 1846-1934, with volume 2 to be published by the College in the near future.

This story of anaesthesia in Australia is eloquently told, intermingled with all the developments of the day – social, political, medical and scientific. It is not just 'a history of anaesthesia', but a reflection of the place of anaesthesia as medicine in Australia developed, and as Australia developed as a country both nationally and internationally – sometimes the resemblance of the present to the past is indeed strong.

The historical importance of this book is reflected by the Foreword being written by none other than the noted historian Professor Geoffrey Blainey of Melbourne.

Michael G Cooper
Hon. Historian

Honours and Appointments

Professor M J Cousins, NSW – Member of the Order of Australia (AM), Queen's Birthday Honours.
Dr G E Knoblauche, NSW – Clinical Associate Professor, University of Sydney.
Associate Professor N J Davis, WA – Honorary Membership, Academy of Medicine of Malaysia.
Professor J M Gibbs, NZ – Emeritus Professor of Anaesthesia, University of Otago.
Professor T Gin, HK – Professor of Anaesthesia, Christchurch School of Medicine, University of Otago.
Dr G C M Wilson, MD, NSW – Inaugural Laureate, Wood Library Museum, USA.

HIGHLIGHTS OF THE OCTOBER 1995 ANZCA COUNCIL MEETING

EDUCATION

Accreditation of Pain Management Units for the Certificate in Pain Management

Council resolved:

1. As from the commencement of the 1996 Hospital Year, the following Units will be accredited for training positions for a Certificate in Pain Management for a maximum period of twelve months:

Auckland Regional Pain Services, NZ	1 post
Flinders Medical Centre, SA	1 post
Sir Charles Gairdner Hospital, WA	1 post
Royal North Shore Hospital, NSW	3 posts

2. This recognition will be subject to a review after one year.
3. Trainees must be in posts at Provisional Fellowship Year level or above.

Sub Specialty — Pain Management

Council resolved that Pain Management be included as an area of desired exposure during the first four years of approved vocational training in order to assist trainees in gaining appropriate knowledge in this field. The mechanism for this decision has been referred back to the Education Committee.

Syllabus for the basic sciences in anaesthesia and intensive care

Council accepted the draft document which will be circulated in the near future to Trainees intending to study for the Primary Examination and Supervisors of Training.

Rural Anaesthesia

Council accepted the following recommendations from the Special Interest Group — Rural Anaesthesia:

1. A rural rotation could be approved to take trainees from any rotation with the only requirement being that the trainee is recognised as "belonging" to an approved rotation;
2. That trainees in rural rotations should be required to keep a log book of experience and supervision in rural centres.

   Council noted that because of differences in the organisation of services in various States, solutions developed in one State are unlikely to be applicable to others.

EMST Course

Council restated its support for the proposal that when trainees register with the College, they are informed that they should apply immediately to undertake an EMST Course during their training, indicating that they are an ANZCA trainee.

FACULTY OF INTENSIVE CARE

Conjoint Committee on Training and Certification

The Dean reported that a proposal for a Conjoint Training Programme with the Royal Australasian College of Physicians had been forwarded to the RACP Council for approval.

This proposal provides for all intensive care trainees to be accredited and assessed through the Conjoint Training Committee which has nine Members, comprising of four members nominated by the Faculty of Intensive Care, four members nominated by the Royal Australasian College of Physicians and one member nominated by the Australian and New Zealand Intensive Care Society who may hold either FFICANZCA, FRACP or both qualifications.

Maintenance of Standards

A programme based on the College format continues to be formulated. It is anticipated a document will be available in 1996, however participants will be requested to maintain records as from the beginning of 1996.

Intensive Care Rotations

Views are being obtained regarding the possibility of rotations between major teaching hospitals and smaller specialist units for the purposes of training.

Academic Intensive Care

The Board resolved that:

1. Persons being appointed to an academic post in intensive care should be formally trained and certified in intensive care.
2. Persons being appointed to any combined academic post involving intensive care should be formally trained and certified in intensive care.

FINANCE

Fees

The Annual Subscription for 1997 due and payable on the 1st February 1996 will remain at A$840 for all Fellows and payable to the Melbourne Office.

The Daily Living Allowance for 1996 will be increased to $190 per day.

The Examination Entry Fee for 1996 will be increased to A$1550 and must be remitted to the Melbourne Office.

The Register of Training Fee for 1996 for all Trainees will be A$500 paid to the Melbourne Office.

The Annual Training Fees for 1996 will be as follows:

Australia and Hong Kong	*A$700*
New Zealand	*NZD700 + GST payable in New Zealand*
Singapore and Malaysia	*$700 (local currency converted into Australian Dollars)*

The Maintenance of Standards Fee payable by Non-Fellows to participate in the MOS Programme will remain at $200 for 1996.

ANNUAL TRAINING FEE CONCESSIONS

As from the commencement of the 1996 Hospital Year, the following will not be required to pay the training fee:

1. Trainees who have successfully completed the Final Examination and who have less than six months training to complete as at 1 January.
2. If an overseas post is held for six months or less outside Australia or New Zealand, Hong Kong, Singapore or Malaysia, during any single continuous year of AVT (e.g. exchange rotations approved by the Assessor) the full Annual Training Fee is payable. If an overseas post is held for more than six months in any one continuous year of AVT, half the Annual Training Fee is payable.
3. Trainees who have not commenced AVT or who have interrupted training for more than six months must pay half the Annual Training Fee to receive normal College mailings to trainees.
4. Persons deemed by the Council to be exempt in part or in whole from paying registration or training fees.

SUBSCRIPTION CONCESSION - RESEARCH FELLOWS

As from 1 February 1996, Fellows in full time College funded or College approved research who are working towards a Research degree will be granted a 50% concession on their annual subscription during the time they are in full time research. Applications must be made to the Registrar for such concession.

ANZCA Foundation — Dr Nerida Dilworth Prize

Council resolved that:

An account will be established within the ANZCA Foundation entitled the *"Dr Nerida Dilworth Prize"*.

These funds will be invested with other College funds and interest apportioned at the end of the financial year and credited to the fund.

The Prize will be supported and administered by a Joint Committee of the Western Australian Section of ANZCA and the ASA. The Prize will be awarded in accordance with an agreement between the Western Australian Section of the College and Society.

CONTINUING EDUCATION AND QUALITY ASSURANCE

Annual Scientific Meetings — Delegate List

Council resolved that a List of Delegates and an Accompanying Persons List with Name and State/Country be distributed to registrants at each Annual Scientific Meeting.

1997 ASM — Christchurch

Dr Jerrold Lerman from Canada has accepted the invitation to be the Foundation Visitor and deliver the Ellis Gillespie Lecture at the 1997 ASM.

Clinical Indicators

Council approved five clinical indicators in anaesthesia for pilot study by the ACHS which are published elsewhere in this *Bulletin.*

INTERNAL AFFAIRS

Library

It was agreed that the Chairman of the Library Committee will write to all Regional Committees seeking:

(i) Input as to how the College Library may better serve the needs of Fellows and Trainees of the College;

(ii) Suggestions regarding purchase of both texts and journals.

It was also agreed:

1. That the College establish a collection of Australian and New Zealand Standards pertaining to the practice of anaesthesia and intensive care.
2. That a Library information pamphlet be produced for mailing to all Fellows and Trainees.
3. That the Library establish a second workstation (including two CD ROM drives) and purchase Medline on CD ROM.
4. That the Library Committee co-opt a trainee to membership of the Committee for a trial period of one year.
5. That a representative of the Faculty of Intensive Care be included in the membership of the Library Committee.

Academic Anaesthesia Review Sub-Committee

The Academic Anaesthesia Review Sub-Committee has been asked to consider the whole question of research awards including applications, review and ranking of submissions.

College Policy on Overseas Trained Doctors

As from 1st January 1996, to be supported for specialist recognition in anaesthesia, overseas trained doctors will be required to be successful at the College's Final Examination and where necessary, to complete the College's Primary Examination, carry out supplementary training and complete a Provisional Fellowship Year. Following completion of these requirements, they will be eligible for admission to Fellowship of the College by Examination.

College Relations with Asia

Council requested a Sub-Committee to develop a medium to long term strategic plan for College relations with Asia Pacific countries. These countries include Malaysia, Singapore, Indonesia, Thailand, Philippines, Vietnam, Cambodia and Laos, Hong Kong, Taiwan, South Korea, Japan and China.

Career Medical Officers — Concept

Council resolved that:

1. The College opposes the concept of Career Medical Officers in a specialist medical practice role.
2. The College supports the high standards of anaesthesia to which it contributes but does not support a two-tiered service for patients as suggested by Career Medical Officers.

3. The College is already involved in training people destined for other non-anaesthetic specialist areas of activity and will continue to play a part in the teaching of other trainees progressing through hospitals destined for other specialised areas of medical practice.

PROFESSIONAL

Policy Documents

Council reviewed the following documents which have been updated and published elsewhere in the *Bulletin.*

E6 *Duties of an Anaesthetist*

P18 *Monitoring During Anaesthesia*

P19 *Monitored Care by an Anaesthetist*

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

T3 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities*

T5 *Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries*

T6 *Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites*

Clinical Indicators

Five clinical indicators have been approved for pilot study by the Australian Council on Healthcare Standards.

Indicator Area 1: **PRE-ANAESTHETIC ASSESSMENT**
Indicator Topic: *Documented pre-anaesthetic patient assessment.*

Indicator Area 2: **ANAESTHESIA RECORDS**
Indicator Topic: *Compliance of anaesthesia records with ANZCA Minimum Requirements for intra anaesthetic information.*

Indicator Area 3: **PATIENT RECOVERY PERIOD**
Indicator Topic: *Occurrence of defined clinical events during the recovery period.*

Indicator Area 4: **UNPLANNED ADMISSION TO INTENSIVE CARE UNIT**
Indicator Topic: *Unplanned patient admission to an Intensive Care Unit within 24 hours of a procedure.*

Indicator Area 5: **POST ANAESTHETIC VISIT**
Indicator Topic: *Patient visit by the anaesthetist/member of the anaesthetic department, within 48 hours post-anaesthesia.*

NB: This Indicator to be introduced in 1996.

RESEARCH AWARDS

Applications totalling $572,202 were received with $158,739 available for grants.

SCHOLARSHIPS

Dr John A Loadsman, NSW
Perioperative Sleep and Breathing
$30,000
In addition, a grant of $7,000 was awarded for this Project.

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

Dr Christopher Hayes, NSW
Special Project in Pain Management
$20,000

Dr Anthony W Quail, NSW was awarded the Harry Daly Research Fellowship for the project of his grant *Effects of exogenous nitric oxide donors on the distribution of regional coronary blood flow in the anaesthetised dog*
$21,000

GRANTS

Dr Brian M F Lewer, NZ
Late disturbance in ventilation following anaesthesia and surgery
$10,712

Dr Graeme K Hart, VIC
Continuous haemofiltration on the management of severe sepsis and early septic shock
$15,000

Dr Geoffrey A Gutteridge, VIC
Effect of high total volume ventilation on the local and systemic inflammatory response to gram negative pneumonia
$12,960

ADMISSION TO FELLOWSHIP BY EXAMINATION

Michael John AMOS, NSW
John Joseph BARRY, SA
Richard James BURSTAL, NSW
Po Wa CHEUNG, Hong Kong
Yin Choy CHOY, Malaysia
Elizabeth Pak-Yoon CHYE, SA
Alan James COUSINS, Qld
Pamela Anne Kerr EDWARDS, Qld
Jeannette Anne ELSON, WA
Mark Edward FINNIS, SA
Pietro FIORENTINO, NSW
Anthony James FITZPATRICK, NSW
Chiu Fai FUNG, Hong Kong
Robin James LAING, SA
Michael Stuart LAVENDER, Qld
Yasmine Anastasia LAYHER, Vic
Kai Wai LEE, Hong Kong
Brian Michael Furnival LEWER, New Zealand
Wilson LIM, WA
Leong Chow LING, Malaysia
Audrey Theresa LYE, NSW
Phoebe-Anne MAINLAND, Hong Kong
Kwok-Fu Jacobus NG, Hong Kong
Siu-Keung NG, Hong Kong
Jayesh PATEL, New Zealand
Philip John PEYTON, Vic
Andrew Gordon PUDDY, SA
John Charles QUOYLE, NSW
James Bickley SARTAIN, SA
David Chard SIMES, WA
Geoffrey Martin SLAVEN, New Zealand
Richard John SMITH, Qld
Gerard Vincent STAINSBY, Vic
Yuen Heng Peggy TAN, Hong Kong
Vida VILIUNAS, NSW
John Sutherland WALKER, New Zealand
Ket Hiung WONG, Malaysia
Su-Jen YAP, NSW

ADMISSION TO FELLOWSHIP BY ELECTION

UNDER REGULATION 6.3.1 (b)

Stephen Charles BENTLEY, NSW
John BERG, Vic
Imelda Geraldine BOURKE, Qld
Pauline Heather COSH, New Zealand
Andrew Michael HENDERSON, New Zealand
John Stuart HENSHAW, Tas
Michal Theodore KLUGER, SA
Robin Iris LIMB, SA
Noel Francis McMAHON, Qld
Glenys Margaret MILLER, SA
Carl Theodorus MOLLER, Tas
Marjorie Joan PINK, NSW
Gayle Lynley ROBERTON, SA
Tao John SLYKERMAN, Qld

UNDER REGULATION 6.3.1(c)

Cindy Sui Tee AUN, Hong Kong
Seow Koon TAN, Malaysia

UNDER REGULATION 6.3.1(d)

Samuel Walker McVICKER, Vic

UNDER REGULATION 6.3.1(e)

Judith FORBES, New Zealand
Ramani VIJAYAN, Malaysia

Changes in requirements for College support for Specialist Recognition of Overseas Trained Anaesthetists

Procedures for support for specialist registration in anaesthesia of overseas trained doctors have been changed, effective from the start of 1996.

The changes, approved by Council, are designed to avoid a two-tiered system of specialist registration in anaesthesia. As a minimum requirement, all overseas trained doctors will be required to complete the Final Examination and residential year.

They reflect the need for uniformity in the way support for specialist recognition is granted by the College.

Originally, training and examination systems in anaesthesia were similar in Britain, Ireland, Canada, South Africa, Australia and New Zealand. However, over the years, training and examination programmes have changed and it has become impossible for this College to continue routine reciprocity.

In 1992, the Australian Medical Council with the various State Medical Boards in Australia and Specialist Colleges agreed to introduce a mechanism for assessment of overseas trained doctors wishing to practise medicine in Australia.

Under this procedure, medical practitioners recognised as a specialist in their own country were required to apply to the Australian Medical Council for consideration of their training. Following satisfactory completion of general immigration requirements, the Australian Medical Council referred such applicants to the appropriate Specialist College for assessment of their medical training.

However, in view of the knowledge of the training and examination programmes, Fellows of the English, Canadian, and South African Colleges and Irish Faculty and Diplomates of the American Board of Anesthesiology were supported, without interview. However, this was provided documentation confirmed they had fulfilled training and examination requirements which were identical in duration with those required for Fellowship of our College at the time their qualification was granted.

Applicants with qualifications from various other countries were assessed by a panel of three representatives of this College. Usually, they were required to complete both further training and examinations.

Following deliberations by the Australian Medical Council and the Committee of Presidents of Medical Colleges, Council has moved to avoid a two-tiered system of specialist registration in anaesthesia.

At its recent Meeting, Council resolved that, as from **1 January 1996,** the support of this College for specialist recognition in anaesthesia will be contingent upon:

- all overseas trained doctors being successful at the College's Final Examination
- their completion of a residential year in a post approved by Council
- and, where necessary, completion of the College's Primary Examination and supplementary training.

Completion of these requirements would make the applicants eligible for admission to Fellowship of the College by Examination. Such applicants would then be granted restricted specialist registration to Anaesthesia. However, if they held an Australian or New Zealand primary medical degree or been successful at the AMC Examination, full registration would be granted.

Support for specialist recognition in anaesthesia will no longer be available from 1 January 1996, **unless the requirements outlined above are fulfilled.**

Applicants currently in the system of assessment and processing will not be affected by this Council Resolution.

LAW REPORT

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

DIRECTORS' PERSONAL LIABILITY

What do Christopher Skase, Alan Bond, Kerry Packer and Rupert Murdoch have in common with doctors?

They may all be company directors.

The spectacular corporate collapses of the late 1980s focused attention on the role of company directors and their responsibilities. The legal and ethical responsibilities of company directors have, as a consequence, been widely debated.

In the wash of the "entrepreneurs' " failures in recent times, many individuals would be surprised to find out how far our legal system can pursue an individual director for criminal activity, breach of duty, or simple negligence. If one can believe all the allegations made in the media, it would appear that many directors in the late 1980s failed to remember some of the basic obligations placed upon them.

Many doctors are also company directors. They may be directors of private companies, incorporated medical practices, or other private investment entities. The College councillors are all directors of a public company. Many doctors fail to realise that they hold directorships and that there are legal obligations attached to their position.

Common Law Duties

At law, directors occupy a special relationship with their company. It is similar to that of a trustee, and includes duties of loyalty and good faith. In general terms, the duties of directors fall into four over-lapping categories:

1 A duty to act in the best interests of the company.
2 A duty to exercise the powers as a director for the purpose for which those powers are conferred.
3 A duty not to fetter the future exercise of the director's power.
4 A duty to avoid being placed in a position of a conflict of interest.

Clearly, the position of company directors is one in which the exercise of certain skills and discretions is involved. The directors are responsible for the management and affairs of the company and are generally called upon to make commercial decisions. Whilst the courts will not usually interfere with the directors' right to manage the affairs of the company, the courts will intervene if the standard of care or conduct of the directors falls below that expected of a director in accordance with his or her duties.

The courts are not concerned whether the director has made the **best** decision, but rather "whether an intelligent and honest person in the position of a director of the company concerned could, in the circumstances, have reasonably believed that the transactions were for the benefit of the company".

Where a director acts in breach of these general duties, he or she can be personally liable to the company for the loss or damage suffered by it, and for account to the company for any personal gain or benefit which the director may have derived.

Statutory Duties

The personal duties and obligations of a director are modified to some extent by the terms of the company's articles of association (the rules of the company). Some rules expressly allow directors to enter into contracts with the company, and act in respect of the company, even in situations where a conflict of interest may arise. These are more likely to be private or proprietary companies. Directors should therefore always be aware of the provisions of the company's articles of association.

There are also additional statutory obligations imposed by the Corporations Law. Section 232 of the Corporations Law imposes obligations on directors:

1 To act honestly in the exercise of the director's powers and discharge of his or her duties.

2 To exercise a reasonable degree of care and diligence.

3 Not make improper use of information acquired by virtue of their directorship to gain any personal advantage.

4 Not make improper use of the director's position to gain any personal advantage.

A breach of these statutory obligations could leave the director personally liable to the company for any loss or damage suffered, and to account to the company for any profit or gain made as a consequence. In addition, a breach of these particular obligations imposes a criminal sanction of fines and/or imprisonment . . . or, in the alternative, adopt a new life style in sunny Spain.

The Corporations Law includes a broader concept of a "director", and the obligation will include the directors, company secretary, executive officer, and can include any person occupying or acting in the position of director (by whatever name called, and whether or not validly appointed or authorised to act), or any person in accordance with whose directions or instructions the directors of the company are accustomed to act. Thus, simply because a person is not appointed a director, does not mean that, where they occupy a management role, they can escape these obligations.

Personal Liability

Usually a director is protected from personal liability for the actions of a company (other than clear cases of fraud by the director). However, in a number of situations, this protection can be removed.

1 Negligence.

2 Breach of the statutory obligations under the Corporations Law.

3 Breach of the "common law" duties.

In determining whether a director has breached their duties, or acted negligently, the courts will apply the standard based on the following principles:

a The degree of skill that may be expected is no more than may reasonably be expected from a person of that director's knowledge and experience.

b If a director does have special knowledge about the company's business, the director is required to give the company the benefit of that knowledge.

c A director is obliged to obtain at least a general understanding of the business of the company and the effect that the changing economy may have on that business, and directors should bring an informed and independent judgment to bear on the various matters that come to the Board for decision.

d The director must be diligent and, although only acting on an intermittent basis, the director is bound to attend regular meetings when the director is reasonably able to do so.

e Directors are able, in reasonable circumstances, to rely on the skills and honesty of others, but cannot, on a blanket basis, simply refer the management to others.

There are many circumstances where directors can be liable through inactivity. It is not sufficient to hand the affairs of the company over to your personal accountant and let them "work it out". A wife who takes no active part in her husband's business, but is simply the "other director" to make up the numbers, can nonetheless be liable.

Public Companies

Section 232A of the Corporations Law requires that, where a director has a material personal interest in the matter under consideration, the director must not only not vote on the issue, but must take no part in the debate and must physically leave the room. Of course, in the usual manner, notice of their interest must also be declared. The College is, for example, a public company.

How Can I Minimise Risk?

There are many insurance policies available to protect both directors and their companies against claims for negligence, lack of professional duty, etc. Any company of significance, should, prudently, consider taking out such directors' liability insurance.

Directors should be aware of basic management and audit measures for the company, such as control of signatories of company bank accounts, details of who is authorised to incur debts, details of any delegations that have been given to other employees or officers. In appropriate cases, in a company of some significant size, it may be appropriate to establish a separate audit committee.

Other Corporations Law Issues

Under the Corporations Law, there are a number of provisions which will affect the rights and obligations of directors:

1 The Corporations Law imposes a broad prohibition on public companies making loans to directors, or their relatives. Even in respect of some private companies,

special approval may be required before the company enters into any transaction with a director, or any transaction which may benefit a director.

2 The company cannot give financial assistance in connection with the acquisition of shares in itself. A director, or shareholder, proposing to acquire shares in the company, with the finance being provided by the company, or supported by a company guarantee or security, may infringe the Corporations Law, unless special approval has been given as required under the legislation.

3 If a company incurs a debt and, immediately before incurring the debt, the director did not have reasonable grounds to expect that the company would be able to pay its debts as and when they fell due, the director may be personally liable to the company for the amount of that debt. Directors, thus, have an obligation to ensure that their companies do not trade, or incur debts, when they are insolvent.

4 Companies are restricted to paying dividends only out of profits. Clearly, when withdrawing funds from a company, accounting and legal advice should be sought as to whether the funds should be withdrawn as a dividend, loan or return of capital. Various statutory and tax provisions affect these matters, and advice should be obtained.

These are merely a brief survey of some of the issues affecting directors. The issues are, of course, far more complicated than this brief summary. However, it is important that any person acting as a director of the company has, at least, a basic understanding of the various rights and obligations involved.

Certainly, no one should accept the position as a director of a company lightly . . . or you may join the ranks of those various "entrepreneurs" from the 1980s who still loom large in our media!

LETTER TO THE EDITOR

Dear Editor,

I invite all Anaesthetists to comment on the Appendix to the ANZCA "Guidelines on providing information about anaesthesia" P26 (1994). The bald list of risks in the Appendix may achieve savage rectitude, giving an anaesthetist medicolegal protection but compounding patient uncertainty and fear of outcome of surgery. "My anxiety was heightened further when risk factors . . . were explained – a requirement which makes the patients feel worse but experts feel better, because it reduces the possibility of their being sued for not providing information".[1] Furthermore, no list of possible complications can ever be complete.

A preoperative consultation must reassure the patient that every endeavour is made for a safe outcome. It is a disservice to tell patients how an operation can go wrong but ignore how the disease or morbidity would progress in the absence of safe surgery and anaesthesia. The importance of preoperative, oxygenation, monitoring etc. needs to be stressed to the patient, where relevant.

Finally, I venture to say that a patient should not be given a choice in the technique of surgery or anaesthesia after consenting to management. Should a patient be permitted to demand delivery of her infant by caesarean section if no contraindication to vaginal birth exists? Should a patient be permitted to request combined caesarean section and tubal ligation if the delivered infant is male, or caesarean section but no tubal ligation if the infant is female?

In conclusion, I commend the authors' recommendation to provide information prior to anaesthesia, provided its aim is educational, not prophylaxis against litigation.

1. Bayliss J (1994) A psychologist in intensive care. *MJA* **161:** 172.

Yours faithfully,

Rhonda Boyle, FANZCA
Specialist Anaesthetist
Royal Women's Hospital,
Brisbane.

Letters to the Editor *should be no more than 300 words, shorter letters would be preferred.*

All letters must be signed and the author's name and address clearly written.

A letter may be edited for reasons of space or clarity, unless the writer specifies it must be published in full.

MULTI CENTRE AUSTRALIAN TRIAL OF EPIDURAL ANAESTHESIA AND ANALGESIA IN MAJOR SURGERY - THE *MASTER* ANAESTHESIA TRIAL

John Rigg, Perth

The MASTER Anaesthesia Trial was funded by a College Research Grant from February 1995. To the best of our knowledge, it is the first truly national multicentre randomised controlled trial of anaesthesia conducted in Australia.

The purpose of this article is twofold: first, to describe the design features of the trial that are essential for "good science" and secondly, to publicise the study more widely in order that Fellows and other colleagues who may be interested in participation and collaboration can make contact with us to discuss this. We have found that Provisional Fellows and those who have just finished the Provisional Fellow Year often are well suited to join the project as local co-investigators.

Science and Clinical Anaesthesia

This trial asks the question, "Does epidural block improve outcome after surgery"? It is a clinical intervention study, designed to test the worth of particular intervention - epidural block - insofar as it improves outcome after surgery. In such an intervention study there can be much conflict and disagreement among practitioners about many aspects of clinical anaesthetic practice and research design. This study is no exception and the protocol for the trial is the result of numerous consultations and discussions with many colleagues in anaesthesia and intensive care in Perth and Melbourne. The protocol represents a balance between the scientific imperative of maintaining a consistent approach to all aspects of clinical management in both the control and epidural groups and the need to provide flexibility to accommodate widely varying approaches of clinical anaesthetists across the country to important aspects of anaesthetic and post anaesthetic management.

Fortunately, there is much better agreement among knowledgeable clinical investigators and clinical epidemiologists about what constitutes "good clinical science". To elaborate on the matter of "good clinical science" this article poses, and attempts to answer, some fundamental questions about the design and conduct of The MASTER Anaesthesia Trial.

1. Why Randomise?

The randomised controlled trial or RCT is the gold standard of clinical intervention research[1].

Randomisation requires that the allocation of all eligible patients to either the control or the epidural group is determined by a random method completely independent of the investigator and clinicians responsible for patient management. Random allocation is essential to minimise bias, which distorts all non randomised research. There is a long history of non-randomised studies producing demonstrably erroneous results and spurious conclusions[1,2].

Random allocation does not eliminate bias. Its overwhelming advantage in research design is that it balances the control and the epidural groups for both known and unknown confounding variables.

An RCT can be very difficult to design and execute[3] and The MASTER Anaesthesia Trial is no exception. The requirement to randomise may lead to problems of recruitment; these may be logistic due to the constraints of admission and timing and organisation of surgery and the ethical requirements of the informed consent process. Individual anaesthetists may have a personal ethical problem with random allocation of high risk patients. Anaesthetists may have firm convictions about epidural block; there are many colleagues holding strong but widely differing views about the merits of epidural block. The fact is, however, that overall the published evidence does not support a strong conviction one way or the other. Most anaesthetists and intensivists consider the question to be of great clinical importance. From the standpoint of science and the progress of scientific knowledge and understanding, the question can be resolved only by conducting a well designed RCT.

2. Why High Risk? Why Major Surgery? Why Multicentre?

These three questions are interrelated, by the most fundamental issue of an RCT, the **prior determination of sample size**[1,3,4,5].

Unselected surgical patients have very low rates of pre-existing medical morbidity and even lower rates of post surgical morbidity. If one allows all patients in a particular patient group to be eligible for a prospective study of epidural block and outcome, the pre-calculated required sample of patients is huge; the study would be very expensive and unmanageable. In order to have a manageable sample size, it is essential to develop a

screening mechanism to select only patients with identified preoperative morbidity who are at high risk, irrespective of anaesthetic technique, of developing post operative morbidity problems. This principle is also the reason why the study is limited to major surgery of the abdomen and oesophagectomy; to operations that intrinsically have a high risk of post operative morbidity. The power of the trial depends more on the number of endpoints than on the simple numbers of patients participating.

To understand sample size determination and why a multi centre study of high risk patients undergoing major surgery is required, it is necessary to review the concepts of types I and II errors and statistical power[4,5,6].

When a researcher selects a level of significance, of 0.05, this defines the threshold probability of finding a difference in outcome between the epidural and control group being due to chance alone, when none actually exists, as ≤ 0.05. In other words, the probability that of incorrectly concluding that there is a difference of ≤ 0.05; this is the type I error – the false conclusion that there is a difference. The probability of this type of error is designated α.

However, the research may conclude wrongly that there is **no** difference between the epidural and control groups. The probability of the false conclusion that there is **no** difference is designated by the symbol β. For each research study in the literature this probability can be determined. The range of possible values of β is very large, unlike α which is fixed at the value chosen as the level of significance.

Two variables have a major impact on β. They are first, the observed magnitude of the effects on outcome of epidural block (effect size or ES), and secondly sample size (η).

It is customary however, to refer to statistical power rather than β. Power = 1-β, and statistical power is the probability that a true difference between the control treatment and the intervention being tested (epidural blocks) will be detected if it actually exists.

It is desirable to have a modest and manageable sample size with acceptable power. The greater the true difference between the control and the epidural group, the lower will be the sample size required to achieve adequate power. Most epidemiologists and statisticians agree that power >0.80 is acceptable; <0.80 is not acceptable[1,4,6]. In other words, a study is not acceptable unless the sample size is sufficient to ensure at least 80% probability of finding a difference between epidural and control, if such a difference exists.

There are many important features of experimental design which need to be incorporated into the RCT of epidural block to maximise the anticipated difference in outcome between control and epidural groups. Detailed discussion of these issues is beyond the scope of this article, but is canvassed in detail both in general terms[1,3,4,6], and specifically[5], elsewhere.

Sample size can be predetermined from a number of statistical texts and computer programmes via standard tables and graps[4]. The example given here illustrates why high risk patients must be studied, why a comprehensive range of morbidity end points is needed and why a multicentre trial is essential.

To predetermine sample size it is necessary to estimate the anticipated effect size(s). Sometimes there are existing data that permit a precise estimate to be made; in other situations very little information is available. Reference to standard tables or graphs[4] indicates that as ES increases, power increases for a given sample size and sample size decreases for a given level of power. Power also increases with increasing morbidity in the control group. Examples of the number of patients who have to be studied to achieve a power of 0.80, at a significance level of 0.05 is given as follows:

Control rate morbidity	Epidural group morbidity rate	Study size (2 x η)
50%	25%	132
40%	20%	182
30%	15%	260
20%	10%	438
50%	40%	814

If the minimum acceptable power increases from 0.80 to 0.90, the last sample size above increases from 814 to 1076.

The MASTER Anaesthesia Trial

In The MASTER Anaesthesia Trial, we have adopted the strategy of recruiting only the highest risk patients to preselect a sample with a high rate of preoperative morbidity, and an anticipated high rate of post-operative morbidity. Yeager *et al.* (1987)[7] were the only previous group to select a true high risk group for study; in their study, the rate of one or more major complications in the control group was 76%. Allowing for differences in patient populations and improvements generally in medical care, The MASTER Anaesthesia Trial has estimated a 50% morbidity rate in the control group for the purpose of sample size determination. Allowing again for general improvement in care, the trial has sought sufficient statistical power to be able to detect a decline in morbidity from 50% in the control group to 40% in the epidural group. Reference to the table above,

shows that the required sample size is 814, for power = 0.08 and α = 0.05.

An audit in 1991 of major vascular surgery in one large Australian teaching hospital analysed 91 cases. Twenty-one of these had at least one major complication. The numbers confirm why a multicentre trial is necessary and that preselection of high risk patients is also essential to limit sample size and enhance power. The numbers also suggest that, in this group of patients, a single hospital is unlikely to have more than 20 eligible patients per annum. Like Yeager *et al.* The MASTER Anaesthesia Trial is studying major abdominal cases and oesophagectomy in addition to major vascular surgery. Even with this broad range of eligible operations it is unlikely that a participating hospital will be able to randomise more than 50 eligible patients per year. If each participating hospital was able to randomise 100 patients over two years, then 10 participating hospitals would be needed. In practice, many hospitals have lower case loads and smaller numbers of eligible cases.

For example, four participating hospitals in Perth should randomise 60 to 80 patients per annum when the trial is fully operational. Five hospitals in the eastern States have begun to study eligible patients; our estimate is that 10 more hospitals need to be recruited to the study to ensure data collection can be completed within two years.

This brief article has focused upon the two most important facets of experimental design for The MASTER Anaesthesia Trial – randomisation and the prior determination of sample size. The full trial protocol is 21 pages long and covers in detail the protocol for all aspects of anaesthetic and perioperative management, for both control and epidural groups. The protocol also defines precisely nine separate medical risk categories, at least one of which must be present for the patient to be admitted to the trial, and defines precisely eight separate categories of major morbidity endpoints representing a range of defined adverse outcomes. Detailed discussion of these issues is beyond the scope of this article. Fellows who are interested to learn more about the study are requested to contact the author at the Department of Public Health, University of Western Australia, WA 6907, or by telephone (09) 388-2875, fax (09) 381-4362 or page (09) 486-5045.

References

1. Sackett DL, Haynes RB, Guyatt GH, Tugwell P. (1991) *Clinical Epidemiology: A Basic Science for Clinical Medicine.* 2nd ed. Boston, Little Brown. 187-248.
2. Sackett DL (1979). Bias in analytic research. *J. Chron. Dis.* **32:** 51-63.
3. Horwitz RI (1987) Complexity and contradiction in clinical trial research. *Am. J. Med.* **82:** 498-510.
4. Lipsey MW (1990) *Design sensitivity, statistical power for experimental research.* London, Sage Publications. 11-46.
5. Rigg JRA (1991) Does epidural block improve outcome after surgery? *Anaesth. Intens. Care* **19:** 4404-11.
6. Frieman JA, Chalmers TC, Smith H, Keubler RR (1978) The importance of Beta, the type II error and sample size in the design and interpretation of the randomised control trial. Survey of 71 negative trials. *N. Engl. J. Med.* **299:** 690-5.
7. Yeager MP, Glass DD, Neff RK, Brinck-Johnsen T (1987) Epidural anaesthesia and analgesia in high-risk surgical patients. *Anesthesiology* **66:** 729-36.

HOSPITAL ACCREDITATION GROUP

Dates of Meetings

The Hospital Accreditation Group is a subcommittee of the Council, responsible for all matters pertaining to Hospital Accreditation. The process of accreditation is a lengthy one, requiring provision of comprehensive data from the Hospitals for consideration by the Group, often followed by a site review of the hospital's anaesthetic services. The administrative arrangements required for such a review may often take from four to six months.

In the interests of hospitals seeking to apply for recognition of anaesthetic training, or to increase their current establishment of posts, it would be appreciated if applications could be received well in advance of the date the hospital wishes to appoint a trainee, if the application is successful.

For example, hospitals seeking approval for posts for 1997 would be advised to make application **early in 1996** so that the assessment can be made prior to appointments being arranged in August-September.

The following are the dates of meetings of the Hospital Accreditation Group for 1996. In exceptional circumstances, the Group may consider urgent requests outside these dates.

Friday 26 April 1996 **Friday 30 August 1996** **Friday 6 December 1996**

CAN WE COMMUNICATE BETTER?

The need to improve our communication skills has been highlighted in a variety of recent articles. These support the need for the College and individual anaesthetists to address education in the improvement of communication skills. This is required not only to maintain our professional independence and improve our image but also to protect us against litigation and to facilitate better patient care and professional satisfaction.

"All is not well between the public and its doctors"
Richard Smallwood, in the *Medical Journal of Australia*[1], provides a good insight into the current directions of government reform and their basis on the rift between the public and the medical profession. This allows questions such as "Who should set the standards?" to support microeconomic reform of the professions as expressed in the Hilmer Report and the Trade Practices Commission. "Who should control the training?" is leading to pressures for labour market reform including moves to institute competency based education and training into the professions. Should there be an acceptance of minimal standards, rather than the (costly and perhaps non-beneficial pursuit of excellence? Are doctors overskilled? Professor Smallwood concludes that there is a need for the medical profession to persuade the community that the public interest is served by their professional independence. This need is particularly relevant to the College and to anaesthesia and in itself supports the strategic development of the Communications Programme.

"What prompts patients to sue?"
There have been several articles on the basis of decisions to proceed to litigation. Howard Beckman *et al*[2], reviewed 45 completed claims in the period 1985-1987, in Rochester (NY). They conclude that in 71% of cases the decision to proceed to litigation was based on relationship issues. Four themes emerged: in 32% of cases there was a perception of desertion, in 29% devaluing of the patient's and/or family views, in 26% a poor delivery of information and in 13% a failure to understand the perspective of the patient and/or family. They emphasise the need to develop an appropriate relationship with the patient by utilising good communication skills. In Australia, Paul Nisselle[3], Australasian Secretary of the Medical Protection Society, indicates that more than 75% of all complaints stem from a fundamental breakdown in communications.

"Anaesthetists communicating with patients"
Articles in this area are also appearing in the anaesthetic literature. David Learned, in the *American Society of Anesthetists Newsletter*[4], describes the need to improve

the routines we use when we initiate the relationship with a patient and when we continue that relationship as we care for the patient. He emphasises the importance of words and actions and the need to take the development of communications skills seriously. He also describes the appreciation of patients if a closer relationship is attained.

"Communication skills are acquired, not inherited"
An important consideration is that although some people have innately better communication abilities than others, we can all improve our skills with appropriate training. Paul Nisselle, in the *1995 MPS Casebook*[3], describes the Bayer programme which was developed in the United States to help doctors improve their communication skills. The programme is based on four E's: engagement, empathy, education and enlistment. These principles are relevant to anaesthesia and in particular to the pre-anaesthetic consultation. In anaesthesia, a successful progression through to enlistment is extremely important as we require the patients to confidently pass control of their lives into our hands. This can only be achieved by creating a good first impression (engagement), exhibiting empathy, and tailoring information to meet the individual patient needs and expectations (education). Follow-up of doctors after the Bayer programme revealed a lower incidence of patient complaints and improved satisfaction on the part of both doctor and patient. Healthcare outcomes were also improved.

"Good communication is the key"
Regardless of whether the contact is with a patient before an anaesthetic, with a patient's family after an adverse outcome, with a Health Minister or with a

reporter, skilled communication is important. The aim is to develop an appropriate relationship. This is more than just talking or providing information. There must be an understanding of needs and a consideration of the individuality of the particular people and situation. Much is dependent on perceptions. First impressions are extremely important and are based mainly on how you present yourself. Commonly quoted figures indicate that 55% of the first impression is dependent on how you look (dress and body language), 38% on how you sound and only 7% on what you say!

Unfortunately, when I was a trainee, communication skills were not a high priority. Heavy premedication was more the norm. Even now communication skills remain largely untaught and develop by role modelling on mentors. Should the College formalise such training, or are we able as individuals to change our habits and routines and influence current and future anaesthetists?

1 Smallwood RA (1995). The skilled doctor: public asset or liability? *MJA* **163:** 33-5.
2. Beckman HB *et al* (1994) The Doctor-Patient Relationship and Malpractice. *Arch Int Med* **154:** 1365-70.
3. Nisselle P (1995) Consumerism and Medical Care. *Aust & NZ Medical Protection Society Casebook* 5-6.
4. Learned DW (1995) On Communicating With Patients. *Amer Soc Anest News* **59:** 29-31.

Mike Martyn
Communications Officer

This article is based on a paper presented at "The Art of Anaesthesia" Canberra ANZCA/ASA CME Meeting, September 16-17, 1995.
This topic was keenly discussed and feedback from Fellows is encouraged as this is an important strategy within our Communications Programme.

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A Survey on Anaesthetic Registrar Training in a Rural Area

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Tamworth is a rural centre in north-west New South Wales. It has a population of some 35,000 people, but its Hospital services some 180,000 people in the surrounding district. It is noted for its wheat, barley, sheep, cattle and egg production. It is about 400 km north of Sydney.

Tamworth Base Hospital has about 280 beds. Anaesthetics are given for all Specialties except elective Cardiac, Thoracic, and Neurosurgery.

The Anaesthetic Registrar Survey covers an 18 year period from January 1977 to June 1994. During that time 34 Registrars rotated through the Anaesthetic Department. These were all surveyed and 27 replied. These replies form the basis of this report.

Overall, each Registrar stayed for six months, but in 1978 the Registrar stayed for 12 months. In 1977 and 1978 three Registrars were appointed by Tamworth Base Hospital. It was not until January 1979 that a rotational scheme was established with the Anaesthetic Department of Westmead Hospital – a Sydney Teaching Hospital.

Between January 1979 and June 1994 – 31 Registrars rotated from Westmead. All except two stayed six months. These two rotated an additional six months but not in the same year.

Survey Results

The following results were obtained from the 27 replies received.

AGE: The mean age of all registrars was 28 years and there was a range of 25 to 33 years.

GENDER: There were 20 males and seven females. The mean age of each group was also 28 years.

MARITAL STATUS: Ten male registrars were married and six families had their children with them. Five of the wives were employed in Tamworth whilst their husbands were at work.

RESIDENCE: In 1977 the first registrar lived privately. He lived on an outlying farm. The second resided in the RMO's quarters in the hospital grounds. In 1978 the third registrar also lived privately, again on an outlying farm. He did this for 12 months. In 1979, the first registrar who rotated from Westmead resided in newly built units at Calala, some 10 km south from the hospital. These had a rural outlook over the Peel Valley. The units at Calala had several disadvantages:

1. They were not readily accessible to the hospital in an emergency. Initially this did not matter because it was not until 1985 that the Registrar was rostered on Emergency Call.
2. The units were cold in winter and hot in summer. There were no cooling or heating appliances.
3. A Registrar one morning found five mice in his cornflakes. Mice plagues are not uncommon in the country!
4. They were a little cramped, especially with a family.

From January 1979 until June 1990 thirteen Registrars resided at Calala. Two lived privately and another lived in the RMO quarters.

In January 1990 the Registrars were moved closer to the hospital. New units were built on its southern boundary. From July 1990 to June 1994 eight Registrars resided there. Although these units had heating and cooling appliances, some Registrars still found them a little hot in summer. But it was now easier for the Registrars to be on Emergency Call. There was also more room for their families.

When asked if their accommodation in Tamworth was adequate, 26 out of 27 Registrars said "yes".

VACATION OF PRIVATE ACCOMMODATION IN SYDNEY: When asked, 16 out of 27 Registrars said that they had vacated private accommodation in Sydney to rotate to Tamworth. If they could demonstrate that they were paying rent or a mortgage on their Sydney property, then the hospital did not charge them rent on the units, whilst they were in Tamworth.

EASE OF SETTLING IN: All Registrars found that Tamworth was an easy place into which to settle.

WAS IT YOUR CHOICE TO COME TO TAMWORTH?: Yes, said 21 out of 27. One Registrar, who enjoyed the term and found it of great benefit, and who had requested to come, stated that his Director of Anaesthesia thought that he had made an unwise choice!

ROTATION FROM WESTMEAD: Of the 24 Registrars who rotated from Westmead, 22 returned to the scheme after their term in Tamworth. One returned to do research at another hospital, the other returned to the Children's Hospital.

WHAT WERE THE EXPECTATIONS OF YOUR TERM BEFORE YOU ARRIVED? Comments made were:

1. To learn good, basic, safe Anaesthetic practice.
2. To experience Anaesthetic Group Practice in the country.
3. To observe and assess different methods of anaesthetic management and compare them with those of a city Teaching Hospital.
4. To have civilised working hours and conditions.
5. To have a break from the high pressured atmosphere of a major Teaching Hospital.

Other comments made were:

6. I had no idea what to expect!
7. I was a Junior Registrar and thought that I would be left unsupervised especially after hours. This never happened.
8. I had good expectations because I had spoken to previous Registrars and Consultants. They had enjoyed their term and were enthusiastic about it.

WERE THESE EXPECTATIONS ACHIEVED? Yes, said 22 out of 27. No said one. Four said that they "did not know what to expect!"

Another comment made: "I was surprised at the number of interesting general cases and traumatic injuries that I saw".

WHAT WERE THE ADVANTAGES OF YOUR TERM? Comments made were:

1. Exposure to a good variety of Anaesthetic cases.
2. The friendly atmosphere and staff.
3. Acquiring good, safe, basic skills.
4. Exposure to Rural Anaesthetic Practice and its social environment.
5. Experiencing Anaesthetic Group Practice.
6. No competition from other Registrars thus allowing a free choice of different surgical lists and interesting cases.
7. Excellent tuition by Consultants who were always available.
8. Some ICU involvement.
9. Working in a well organised department.
10. Less stressful working environment compared to Westmead.
11. Working in a well equipped department.
12. Working sensible hours with time off to study.
13. The opportunity to learn new techniques not available at Westmead, e.g. Fiber Optic Bronchoscopy, Regional Blocks for Chronic Pain.
14. Leaving Westmead for six months.
15. Extra curricular activities – horse riding, chess, windsurfing, sailing, gliding, Bridge, and attending the country music festival.
16. The opportunity to do some retrieval work.
17. Flexible on call arrangements.
18. No worries about peak hour traffic.

WHAT WERE THE DISADVANTAGES OF YOUR TERM? Comments made were:

1. Too much supervision, especially after hours.
2. Isolation from other Registrars and tutorials.
3. The distance from family and friends in Sydney. This led to increased travel and telephone bills.
4. No other Registrar with whom to study.
5. Lack of cinemas and theatres.
6. The cost of relocation. But this was offset by the saving of rent.

WHEN DID YOU PASS THE PRIMARY EXAMINATION? Of the 27:

One passed the Primary during the Term. He was our first Registrar.
Sixteen passed the Primary before the Term. All these were after 1983.
Nine passed the Primary after their Term. Of these, eight passed between 1977 and 1983.
One never passed. He later left the system.

IS IT A BETTER TERM BEFORE OR AFTER PASSING THE PRIMARY?

Four thought that it was a better term before passing the Primary.
Twenty thought that it was a better term after passing the Primary.
Three thought that it did not matter.
Some comments were:

1. It's a better term after because being isolated from other Registrars and tutorials does not matter.
2. It's a better term after because you can enjoy the Anaesthetics rather than be preoccupied with study.
3. I think that it does not matter. Tamworth provides plenty of time to study for the Primary.

WHEN DID YOU PASS THE FINAL EXAMINATION:
None sat the Final during their term.
None sat the Final before their term.
Twenty-three passed the Final after their term.
Three have yet to sit.
One did not sit.

One Registrar came to us with an English Fellowship. He passed the Australasian Fellowship after leaving.

DID YOU CONDUCT ANY RESEARCH WHILST IN TAMWORTH. Only four out of 27 did.

Topics selected were:

1. "A study of factors affecting the life of IV cannulae". This was presented at a Registrars' Scientific Meeting.
2. "End tidal oxygen concentrations in the Recovery Room in patients with laryngeal masks in situ breathing via different circuits".
3. "Peripheral Opioid Analgesia". This was submitted to a journal.
4. "A Review of the Treatment of Postoperative Pain". This was over a period of one month at the hospital.

DID YOU PRESENT ANY SEMINARS WHILST IN TAMWORTH: Fifteen out of 27 did. The presentations included:

1. Fluid replacement.
2. Snake bite.
3. Diabetic ketosis.
4. Halothane hepatitis.
5. Drug pharmacology.
6. Head injuries.
7. Postoperative pain.
8. Epidural blocks in labour.
9. GAs for hip surgery.
10. Regional analgesia update.
11. NSAIDS.
12. Difficult intubation.
13. Airway assessment.
14. Myotonia dystrophica.
15. GAs for obesity.
16. Postop nausea and vomiting.
17. Preop renal protection.
18. Laryngeal mask airways.

WAS YOUR TUITION ADEQUATE: Yes, said 23 out of 27. Some suggested that it was more practical than academic.

WAS THE LIBRARY ADEQUATE: Yes, said 19 out of 27.

WERE THE JOURNALS ADEQUATE: Yes, said 23 out of 27.

DID YOU HAVE ENOUGH LEISURE TIME: All did!

WERE YOUR NIGHTS ON EMERGENCY CALL EXHAUSTING: None found them exhausting. All found them instructional.

From 1977 to 1984 the Registrars were not rostered "on call". They were welcome to attend emergencies with the Consultant, but they were not paid to do so. After 1984 the Registrars were put on a regular "on call" roster.

DID YOU FIND TAMWORTH BASE HOSPITAL WELL EQUIPPED: All said yes.

One thought that the theatres were better equipped than Westmead! Several Registrars suggested improvements that have already been made.

SHOULD THE TERM BE LONGER, SHORTER, AS AS IS: A six month term was supported by 25 out of 27 Registrars. One thought that it should be longer, the other shorter.

WOULD YOU RECOMMEND THE TERM TO OTHER REGISTRARS: All said "definitely yes".

HOW DOD YOU THINK THE TERM COULD BE IMPROVED. The following suggestions were made:

1. Each Consultant should adopt a "pet" topic, which he should teach the Registrar during the term.
2. Registrars should be given more responsibility and less supervision.
3. Registrars should be allocated to his/her own list and "on call" first for emergencies.
4. There should be regular seminars, presentations and tutorials.
5. The Registrar should get more peripheral experience. He/she should go with the Consultant to the private hospital, and to more peripheral hospitals.
6. The Registrar should participate in the continuing education of nurses.
7. The Registrar should be involved in rural retrievals.
8. The Registrar should be given more insight into how the business side of a partnership works.

HAVE YOU ANY OTHER COMMENTS ON THE TERM. These were:

1. An excellent term for the first accredited year.
2. A great term – one of the fondest memories of my career.

3. A thoroughly enjoyable and useful experience. I have recommended it on many occasions to other Registrars and supervisors over the years.
4. The highlight of my training!
5. I loved it so much that I am coming back as a Consultant.

There were no derogatory remarks.

HOW DID THE TERM INFLUENCE YOUR LONG TERM ANAESTHETIC CAREER: All replies stated that the term did influence their choice whether to practice, or not, in the country. Twenty-one said they were very much steered towards rural practice as the result of their country term.

Of 25 replies received (two are not included because they rotated twice) 14 indicated that they are still Registrars, Senior Registrars, or Staff Specialists in Hospital practice. Of the 11 others: three are Consultants in Sydney; one is a GP; seven are Consultants in the country. They are in Tamworth, Orange, Grafton, Albury, Hughes ACT, Newcastle, Southport and Maitland.

Some comments received were:

1. The country is more civilised and pleasant than a Teaching Hospital.
2. The country experience gained showed me a better alternative, or another alternative.
3. Country practice is not suitable for a single girl.
4. Country practice is more suitable for a Consultant with a family.
5. The country term provided me with an insight into rural practice and showed me how challenging it can be.

The results of this survey have convinced me that a country term is an essential part of any Anaesthetic Registrar's training. All should have the opportunity to participate in one. These Registrars are of benefit to the country. They provide the Consultant with a continuous perspective of recent developments in a major Teaching Hospital.

ACKNOWLEDGEMENT

I would like to thank my partners – Drs R Green, R Dennis, C Pearce, R Steele, M Ryan and P Stephens for their help and advice. I would also like to thank the Anaesthetic Department of Westmead Hospital, the ASA, the College of Anaesthetists, and the AMA for their help to find postal addresses.

This survey is dedicated to the late Dr Peter Wake who, with others, initiated this Registrar Rotational Training Programme with the Anaesthetic Department of Westmead Hospital.

SUMMARY

This is a review of surveys received from 27 Anaesthetic Registrars who have worked in a country hospital, at Tamworth, in New South Wales, on rotation from a city Teaching Hospital, at Westmead, in Sydney.

DEATHS

Dr T R Morley, WA Fellow, FFARACS 1956, FANZCA 1992.

Dr M J Sullivan, Vic Fellow, FFARACS 1974, FANZCA 1992

Dr I A Waldie, Vic Fellow, FFARACS 1961, FANZCA 1992.

Dr John Harms presenting Dr Neville Davis, President with a gift of cedar salt and pepper shakers.

Drs Phil Ragg, Kaester Nilsson, Kester Brown, Olli Meretaja, Uta Nilssan, Mrs Veronica Quetglas, Joan Sheales.

MEDICAL MANSLAUGHTER IN NEW ZEALAND

Progress Report on Amendment to NZ Crimes Act

Following the successful application for a discharge under s347 of Hamilton anaesthetist Dr Geoff Long (with the subsequent award of substantial damages), Sir Duncan McMullin, a retired judge of the Court of Appeal, was appointed by the Minister of Justice to review sections 155 and 156 of the NZ Crimes Act 1961. Sir Duncan has concluded that the law needs to be amended. Mr Graham has accepted the report, and announced that he will seek to implement its recommendations.

Sir Duncan heard over 70 submissions, and consulted widely. His in-depth report carries an authority that cannot lightly be put aside. The position of the medical profession in this matter has been endorsed, and a moral and intellectual victory has been won. However, this has still to be translated into an actual amendment of the Crimes Act. There is still a long way to go.

Our College has always stressed the fundamental injustice and inconsistency of the law. There are many other good arguments, which are laid out in Sir Duncan's report, for a reform of this law. However, at the heart of the debate is the simple fact that the law is illogical, inconsistent and unjust. It is simply not good law. For that reason alone, it must be changed.

Sir Duncan's report effectively ends any dispute as to what the law actually says. He makes it very clear that the medical profession's concerns are well justified. The NZ position is out of line with other reputable jurisdictions. The threshold for criminal prosecution for manslaughter in this country is too low. The wording is very wide. It covers virtually any activity. If this section was applied to all activities as it has been to recent medical prosecutions (and, indeed, to a few sporadic non-medical cases of minimal moral culpability), the courts would be flooded with meaningless and counter-productive manslaughter cases.

Furthermore, this harsh and illogical law is not only out of line internationally, it is also anomalous in the context of the law in NZ itself. Other sections (eg 151, 152, 153 and 157) of the Crimes Act even in New Zealand have always operated on a "gross negligence" standard. Since more than one section might apply in a given case, a different threshold for prosecution would pertain depending entirely on which section was chosen. This is clearly inconsistent and undesirable. Interestingly, the change which is currently advocated was first proposed by a strong Criminal Law Committee to the Minister of Justice as long ago as 1976, not with reference to doctors but because the law was considered unjust across the board.

Therefore Sir Duncan McMullin has suggested that the Crimes Act should be amended to ensure a uniform and reasonable threshold before the criminal law is evoked. The required standard of *practice* will not change; it will remain that of *"reasonable knowledge, skill and care"*. Doctors, nurses and anyone else will still face manslaughter charges, but only in the event of a *"major departure"* from this standard. For lesser departures other legislation (such as the Medical Practitioners Act or the Transport Act) would be used.

In seeking change, ANZCA has also supported the *intent* of the new Medical Practitioners Bill which, in combination with the Health and Disability Commissioner's Act 1994, seeks to address perceived problems of medical accountability in NZ. It does seem that the spate of manslaughter prosecutions has been, in part, a reflection of widespread disaffection with the system in recent years. Restoring a sensible and just threshold for manslaughter prosecutions is an important part of developing an effective and acceptable system of medical accountability.

It will probably take about a year for the amendment to go through due parliamentary process and become law, assuming all goes well. This implies further submissions, and, given the uncertainties of the NZ political scene at present, more lobbying. It is our impression that most opposition arises from notions people have of what they think we are saying, and that our best counter to this is to ensure that they know what we are really saying.

The medical profession's push for change has been focused and co-ordinated by the NZ Medical Law Reform Group (NZMLRG). Anaesthetists had a major role in its establishment, and to begin with its finances were largely underwritten by anaesthetists (mainly from an appeal to NZ anaesthetists, but also through ANZCA and NZSA). The group has been chaired by Ross Blair, of RACS. Dennis Pezaro, of the NZMA, and Tony Baird of the Council of Medical Colleges of NZ and RNZCOG have been major contributors, and we have had the full support of the NZ Medical Council. In addition, virtually every major medical organisation has contributed in every way, including financially. RACS and NZMA have been particularly prominent in this regard, but the

Radiologists, the General Practitioners, the Psychiatrists and many others have all made important contributions. The group has also been supported by the various dental organisations, and the NZ Nurses Organisation has made submissions in its own right.

There can be no doubt that the results we are seeing now reflect the degree to which this initiative has been supported by the profession as a whole. Having said that, the role of anaesthetists in general, as individuals, within the NZMLRG, through ANZCA and through NZSA, has been pivotal. This has been widely recognised. We have been convinced that effective contribution to important matters is more to the point than efforts aimed directly at enhancing perceived deficiencies in the image of the specialty. Geoff Long's understated and obviously reasonable television appearances have been a case in point.

Many people have made substantial contributions to this cause. We would, however, like to thank two in particular, Michael Gorton, Honorary Solicitor to ANZCA and RACS, who has twice come to New Zealand from Melbourne to assist with submissions, and Bruce Corkill, Wellington Lawyer and Legal Advisor to the NZMLRG, who has adopted this cause as a personal mission.

Alan Merry FANZCA
Leona Wilson FANZCA

October 1995

1995 COUNCIL

Back Row, left to right:
Dr G F Witherspoon (President ASA), Assoc Prof D H McConnel, Dr R S Henderson, Dr E N Westhorpe, Dr D Jonco (President NZSA), Dr M Martyn.
Middle Row:
Dr Moira Westmore, Dr I Rechtman, Prof T E Oh, Prof M J Cousins, Mrs Joan Sheales (Registrar).
Front Row:
Dr R G Walsh, Dr G M Clarke (Dean, Faculty of Intensive Care), Assoc Prof N J Davis (President), Prof G D Phillips (Vice-President).
Absent: *Prof J M Gibbs, Dr R J Willis.*

GIFTS TO ULIMAROA

Dr Keith Cronin presenting Dr Ashleigh Bishop (left) and Dr Iven Young with Certificates recognising their contribution to the Faculty and College Panel of Examiners.

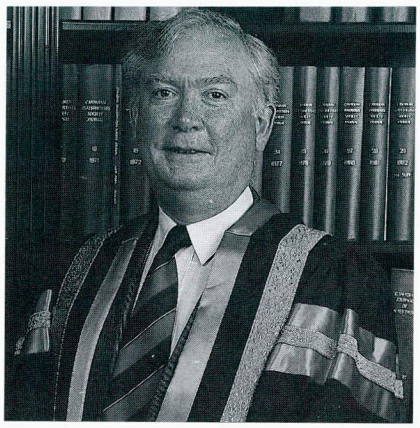
Professor Malcolm Fisher following the presentation of his Certificate Appreciation at the Primary Examination Court Meeting.

Pair of Silver Dragon design chopstick holders presented by Dr Dennis Kerr, Hong Kong.

Cedar salt and pepper shakers crafted by Dr John Hains, Qld.

DEAN'S MESSAGE

THE IMPORTANCE OF KEEPING LINES OF COMMUNICATION OPEN



It seems to happen quite often. A group of people all want the same thing, but they don't talk about it and somehow it never happens.

Well, with respect to conjoint training and certification in intensive care it does look like happening. Prior to the formation of the Faculty of Intensive Care a clear message was evident that Intensivists wanted more commonality in training and certification in their chosen specialty. The Faculty, Specialist Advisory Committee in Intensive Care and other members of the Royal Australasian College of Physicians and the Australian College of Paediatrics, together with ANZICS formed a Conjoint Committee. They talked and have developed a plan which will meet the needs of the separate training bodies and their trainees. It is even possible that in the future a similar model will be used for training and certification in paediatric intensive care. This however, is only in the concept stage and wider consultation is envisaged.

The Medical Liaison Committee (ANZICS, FICANZCA, SAC-IC) is also fulfilling a useful role in keeping all bodies informed of their activities, collaborating on common issues and avoiding where possible unnecessary duplication of activities.

Because the Board of Faculty considers bidirectional communication between the Board and Fellows of the Faculty is essential, Regional Committees have been established in most regions. The strength of the Faculty will depend to a large degree on the involvement of those Committees and all Fellows in the affairs of the Faculty. Regional Committees are in a very good position to recognise opportunities for training posts and possible training rotations. These, of course, must be for the benefit of training our trainees.

This obvious statement is made because financial restraints and restructuring of health services in our countries are designed to limit health care costs. A major danger is that service requirements will be expanded at the cost of training needs. Fellows must resist the introduction of schemes involving our trainees, which will lower standards of supervision and training.

Again Regional Committees must play a watch-dog role. Fellows in the regions are encouraged to communicate with their Regional Committees and the latter should process the ideas and report to the Board.

The Board wishes all Fellows a very Merry Christmas and a Happy 1996.

GEOFFREY M. CLARKE

Board of Faculty 1995

(Left to right) Back row: Drs Neil Matthews, Richard Lee, Bob Whiting, Toby Thomas, Prof. Garry Phillips, Registrar Mrs Joan Sheales. Front row: Drs Jamie Cooper, Ron Trubuhovich, Geoff Clarke, Felicity Hawker, Alan Duncan.

Faculty Fellowship Examination August/September 1995 Successful Candidates

(Left to right) Back row: Drs Chris Joyce, Mark Landy, Rex Smith, Michael Anderson, Andrew Puddy. Front row: Drs Megan Robertson, Anne Whaley, Koo Chi Kwan.

ITEMS OF INTEREST FROM THE SEPTEMBER 1995 BOARD MEETING

EDUCATION

Objectives of Training in Intensive Care

The Objectives of Training in Intensive Care continue to be reviewed in detail and it is anticipated that the document will be promulgated next year.

In-Training Assessment

The Board approved the concept of in-training assessment, and approved Policy Document IC-11 (1995) "In-Training Assessment of Trainees in Intensive Care". This document is published elsewhere in the *Bulletin*.

Commencing in 1996, in-training assessment should be conducted on all Intensive Care Registrars at the completion of each six month training period by the Supervisor of Training in conjunction with other specialists in the Department. A standard form will be used for all Registrars. Registered Intensive Care trainees will have these assessments collated and reviewed (along with the Fellowship Examination) to determine eligibility for Fellowship. Registrars who are not currently Intensive Care trainees should have the same in-training assessments completed. These will be retained at the Faculty Secretariat to enable the assessment to be included for those registrars who decide at a later date to become registered Faculty trainees. Further information regarding In-Training Assessment will be forwarded to Supervisors and Trainees in Accredited Intensive Care Units.

Academic Intensive Care

The Board agreed that the Faculty should seek to establish a database of information relating to academic intensive care, including existing posts at universities, intensivists undertaking postgraduate study, and possible means of intensive care input to undergraduate curricula.

The Board also resolved that:

1. Persons being appointed to an academic post in intensive care should be formally trained and certified in intensive care.
2. Persons being appointed to any combined academic post involving intensive care should be formally trained and certified in intensive care.

Survey of Successful Trainees in Intensive Care

The Board supported the proposal for a survey which will address the perception of Fellows of the quality of the training and examination system, and the extent to which the Fellows remained an intensive care or anaesthetic practice.

ADMISSION TO FELLOWSHIP

The following were admitted by the Board as Fellows of the Faculty:

Dr N A Barnes, NZ
Dr J G L Cockings, SA
Dr C L Cole, NSW
Dr R C Freebairn, HK
Dr P R Hicks, NZ
Dr Tran Yung Van, NSW
Dr P Laussen, USA

PROFESSIONAL

Policy Documents

A draft policy document on Ethics and Patients' Rights and Responsibilities relating to intensive care is currently under consideration by the Board.

The following documents have been reviewed and approved by the Board:

IC-5 *"Duties of Regional Education Officers in Intensive Care"*
IC-6 *"Supervisors of Training in Intensive Care".*

The Board approved the promulgation of the following new Policy Document:

IC-11 *"In-Training Assessment of Trainees in Intensive Care".*

These documents are published elsewhere in this *Bulletin.*

Conjoint Training and Certification in Intensive Care

The Board accepted the proposal for a conjoint training scheme. The scheme is based on the establishment of the Joint Specialist Advisory Committee in Intensive Care (JSAC-IC), involving representatives of the Board of Faculty, the RACP, ANZICS and the Australian College of Paediatrics. Its role will be to supervise training in intensive care of all trainees on behalf of the Faculty and the RACP, and to advise both bodies on matters relating to specialist recognition. Administrative Instruction 2 – Joint Specialist Advisory Committee – Intensive Care was approved.

A fundamental, though optional aspect of the proposal is that the Board will approve that practitioners, who have completed basic physician training as laid down by the RACP and who have passed the written and clinical RACP Examination either prior to or in the first year of advanced training, will be exempt from the ANZCA Primary Examination, provided they are registered Faculty trainees. Subject to such persons meeting all other relevant training requirements, such trainees will be admitted to Fellowship of the Faculty.

These proposals have been referred to the RACP for approval by the RACP members of the Conjoint Committee on Training and Certification. Subject to such approval and following the establishment of the Joint Specialist Advisory Committee in Intensive Care, the joint training programme will commence at the earliest possible time. This could be operative from around the middle of 1996.

It is probable that RACP trainees who have passed the RACP Examination will be able to exercise the option of being exempt from the ANZCA Primary Examination (if they choose to also register as FFICANZCA trainees) from the beginning of 1996.

Training and Certification in Paediatric Intensive Care

A document outlining a draft proposal for a training scheme in paediatric intensive care was considered by the Board and it was agreed that further development of such a scheme was appropriate.

CONTINUING EDUCATION

Annual Scientific Meeting — Perth 1996

A programme of four sessions is proposed for the intensive care component of the 1996 Annual Scientific Meeting, with Dr Norman Swan, Dr Stephen Lewis and Professor Oh as speakers.

Maintenance of Standards

A Maintenance of Standards Programme based on the College format continues to be formulated. A document will be available in 1996 however Fellows will be requested to maintain records as from the beginning of 1996.

INTERNAL AFFAIRS

Appointment of Faculty Administrative Officer

The Board appointed Carol Cunningham-Browne as the Faculty Administrative Officer.

Regulations

The Board revised its Regulations to incorporate the Joint Specialist Advisory Committee in Intensive Care, new regulations for its Regional Committees and in-training assessment.

Administrative Instructions

The Board also revised Administrative Instruction 1 to include reference to the Conjoint Training Scheme, to incorporate exemption from the Primary Examination for eligible physician trainees registered with the Faculty, in-training assessment and other issues. Administrative Instruction 2 – Joint Specialist Advisory Committee – Intensive Care was also promulgated, outlining the processes and functions of this new Committee.

INTENSIVE CARE UNITS ACCREDITED FOR VOCATIONAL INTENSIVE CARE TRAINING BY THE FACULTY OF INTENSIVE CARE

(AS AT 1996)

Below is a list of Hospitals whose Intensive Care Units are approved by the Faculty of Intensive Care, ANZCA, for Vocational Intensive Care Training, under Administrative Instruction 1.5.1.1 [core (compulsory) training] and 1.5.1.2 [elective (optional) training].

Please note that these Units are also recognised for the intensive care component of vocational anaesthesia training under College Regulation 15.4.1.2, with the exception of those Units marked[1] (see footnotes).

New South Wales	
Careflight Ltd	Elective[2]
Gosford Hospital	Elective
John Hunter Hospital	Core
Liverpool Hospital	Core
Nepean Hospital	Core[3]
Prince Henry Hospital	Core
Prince of Wales Hospital Adult ICU and PICU	Core
Repatriation General Hospital, Concord	Elective
Royal Alexandra Hospital for Children	Core
Royal North Shore Hospital	Core
Royal Prince Alfred Hospital	Core
St George Hospital	Core
St Vincent's Public and Private Hospital	Core
Westmead Hospital	Core
Victoria	
Alfred Hospital	Core
Austin & Repatriation Medical Centre	Core
Box Hill Hospital	Elective
Epworth Hospital	Core[2]
Geelong Hospital	Elective
Monash Medical Centre	Core[3]
Royal Children's Hospital	Core
Royal Melbourne Hospital	Core
St Vincent's Hospital	Core
Western Hospital	Elective
Queensland	
Gold Coast Hospital	Core
Mater Misericordiae Adult Hospital	Elective
Mater Misericordiae Children's Hospital	Elective
Prince Charles Hospital	Core[2]
Princess Alexandra Hospital	Core
Greenslopes Private Hospital	Elective
Royal Brisbane Hospital	Core
Royal Children's Hospital	Elective[2]
Townsville General Hospital	Elective
Western Australia	
Princess Margaret Hospital for Children	Elective[3]
Royal Perth Hospital	Core
Sir Charles Gairdner Hospital	Core
South Australia	
Adelaide Children's Hospital	Core
Ashford Community Hospital	Elective[1,2]
Flinders Medical Centre	Core
Queen Elizabeth Hospital	Core
Royal Adelaide Hospital	Core
Wakefield Hospital	Elective[1,2]
Tasmania	
Launceston General Hospital	Elective
Royal Hobart Hospital	Core
Australian Capital Territory	
Woden Valley Hospital	Core
New Zealand	
Auckland Hospital	Core
Christchurch Hospital	Core
Dunedin Hospital	Elective
Middlemore Hospital	Core
Palmerston North Hospital	Elective
Starship Children's Hospital	Elective[3]
Waikato Hospital	Core
Wellington Hospital	Core
Hong Kong	
Prince of Wales Hospital	Core
Queen Elizabeth Hospital	Elective

[1] Not accredited for the 3 months compulsory intensive care training for anaesthesia trainees

[2] Accredited for a maximum of 6 months only

[3] Accredited for a maximum of 12 months only

MAINTENANCE OF STANDARDS PROGRAMME FACULTY OF INTENSIVE CARE

A Maintenance of Standards Programme will be made available to Fellows of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists in 1996. Although some matters of detail will not be finalised until the February Meeting of the Board of Faculty, Fellows are advised to start documenting activities that will attract credit points. The Programme is voluntary, but highly recommended.

As outlined previously, the Programme will be very similar to the Anaesthesia Programme, and there will be a minimum requirement for involvement in clinical intensive care practice (probably 30%), and a need to provide the Faculty with evidence of current registration and accreditation at an institution of practice. In addition, a total of 500 credit points gained from Quality Assurance activities, continuing medical education, teaching and research and other activities will need to be accumulated over a five year period before a Certificate of Participation in the Maintenance of Standards Programme is issued.

Certificates will be issued every five years but Fellows will complete forms annually. Activities specific to intensive care, such as participation in the ANZICS database project and/or the Intensive Care 'AIMS' Incident Monitoring Study will be included. However, other activities such as participation in hospital morbidity and mortality meetings, and attendance at scientific meetings and accredited workshops eg. EMST, will potentially attract points for both the College and Faculty Maintenance of Standards Programmes.

It is anticipated that Fellows practising in both specialties will be able to have at least a major portion of these credit points allocated to both programmes. However, the FICANZCA Certificate of Participation will not be issued unless the minimum requirement for clinical involvement is met.

Full details of the Programme will be available following the February 1996 Board Meeting. In the meantime I would be grateful to receive any comments from Fellows of the Faculty of Intensive Care.

Felicity Hawker
Faculty Education Officer

October 1995

POLICY DOCUMENTS *IC-6 (1995)*

FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

SUPERVISORS OF TRAINING IN INTENSIVE CARE

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

1. APPOINTMENT AND TENURE

1.1 The Supervisor of Training in Intensive Care will be nominated by the Hospital Administration on the recommendation of the Department. The Hospital Administration will be responsible for notifying the Board of the recommendation for appointment. The appointment will be ratified by the Board of Faculty.

1.2 The appointee will hold the Diploma of FFICANZCA or an equivalent qualification acceptable to the Board and should not be a candidate for any Faculty examination.

1.3 It is preferable but not mandatory that the Supervisor of Training be an intensive care specialist other than the Director of the Unit, and has held the Diploma of FFICANZCA or equivalent for at least three years.

1.4 The Board, at its discretion and after consultation with the relevant Regional Education Officer, may not approve of the Supervisor recommended by a Hospital. In that case, the Faculty Administrative Officer will notify the Hospital and request the recommendation of a different Supervisor.

2. DUTIES OF SUPERVISORS

2.1 Within the Hospital

2.1.1 To be familiar with the Faculty's Administrative Instructions on Training, Examinations and Registration of Trainees.

2.1.2 To provide a list (on Form R2) to the Regional Education Officer of the names of all trainees in Faculty approved posts. This list is to be forwarded to the Regional Education Officer within two months of the start of the hospital employment year. Form R2 will be provided by the Regional Education Officer.

2.1.3 To notify the Regional Education Officer of any changes to the list referred to in 2.1.2 created by trainees joining or leaving training posts during the hospital employment year. It is particularly important that the date of such changes are noted to allow independent verification of training by the Censor.

2.1.4 To notify the Regional Education Officer of any senior staffing changes likely to impact on training.

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

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

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

2.1.8 To complete and despatch promptly trainees' training certificates to the Board with particular emphasis on the accuracy of the dates of specialty attachments.

2.1.9 To complete in-training assessments on Faculty trainees in collaboration with senior intensivists in the Department at six monthly intervals or at the completion of a shorter attachment. The completed form FITA should be forwarded to the Regional Education Officer, via the Regional Committee Secretariat. Refer Faculty Policy Document IC-11 *'In-Training Assessment of Trainees in Intensive Care'.*

2.2 Outside the Hospital

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

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

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

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

2.2.5 To attend, when possible, any regional meetings of the Supervisors of Training.

Related Documents:

IC-3"Guidelines for Hospitals seeking Faculty Approval of Training Posts in Intensive Care"

IC-4"The Supervision of Vocational Trainees in Intensive Care".

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

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

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

Promulgated: February 1994

Reviewed: 1995

Date of current document: September 1995

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IC-11 (1995)

FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

IN-TRAINING ASSESSMENT OF TRAINEES IN INTENSIVE CARE

1. INTRODUCTION

1.1 In-training assessment is an essential part of the training of specialists in Intensive Care. It allows information concerning highly desirable but non-examinable attributes to form part of the Faculty's assessment processes.

1.2 In-training assessment of trainees will have two components.

1.2.1 Assessment by training departments.

1.2.2 Certification from the Censor stating satisfactory in-training assessment prior to awarding Fellowship.

2. GUIDELINES FOR IN-TRAINING ASSESSMENT

2.1 Assessments will be carried out for all registered Faculty trainees at six monthly intervals or in the case of a shorter attachment, at the conclusion of that attachment. Assessments should be undertaken by the Supervisor of Training in collaboration with the senior specialists in the department with whom the trainee has worked during the assessment period. Staff must award a score with which they are comfortable using the Form *FITA*. They must have personal knowledge of the trainee. If there is any doubt about an assessment, it is appropriate to use the 'insufficient knowledge to comment' category.

2.2 During non-intensive care training, assessments should be completed by the Head of the relevant Department, in collaboration with other senior specialists with whom the trainee has worked within the Department.

2.3 The assessment must be formally discussed with the trainee. The trainee and Supervisor must then sign the form *FITA*. Information sharing between senior staff and trainee is an essential part of the process. It is normally appropriate for a third person to be present at the interview. Two copies of form *FITA* must be signed. One copy is retained by the trainee. Opportunity must be given for correction of problems and where appropriate, a special additional assessment arranged.

2.4 Form *FITA* should be sent by the Supervisor of Training to the Regional Education Officer, care of the Regional Committee Secretariat. The original (for registered trainees) must then be forwarded to the Censor and a copy retained by the Regional Committee Secretariat.

Original and copy signed. Copy retained by trainee.

Copy of *FITA* of all Registrars retained by Regional Committee Secretariat.

Original *FITA* of registered trainees to Censor via Faculty Administrative Officer.

3. RESPONSIBILITIES OF THE REGIONAL EDUCATION OFFICER

3.1 To ensure in-training assessment forms are circulated to registered trainees and Supervisors of Training bi-annually at six monthly intervals, at the commencement of each assessment period.

3.2 To ensure assessments are completed and returned to the Regional Committee Secretariat and the original forwarded to the Censor at the Central Office, at the end of each assessment period.

3.3 In the event of an unsatisfactory assessment, the Regional Education Officer should contact the trainee and Supervisor in an attempt to assess and understand the reasons behind the unsatisfactory report, and to offer appropriate advice to both Supervisor and trainee.

3.4 To notify the Faculty Administrative Officer of trainee movements between regions.

4. RESPONSIBILITIES OF THE CENSOR

To keep copies of form FITA in each trainee's central record file.

4.1 Annually and prior to awarding Fellowship, the Censor will review all assessments made in respect of each trainee.

4.2 Following the review of assessments, the Censor shall inform the Board of any unsatisfactory assessment where it is considered that a trainee should not be awarded Fellowship:

4.2.1 The Censor will then inform these trainees that they will not be awarded Fellowship.

4.2.2 Inform trainees that they will only be awarded Fellowship after undertaking further specified training.

4.2.3 In the case of an unsatisfactory assessment, the trainee may appeal to the Censor. If the matter is not resolved to the satisfaction of the trainee it will be referred to the Board of Faculty. The decision of the Board of Faculty is subject to appeal according to the Appeal Procedure of the College.

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

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

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

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IC-5 (1995)

FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

DUTIES OF REGIONAL EDUCATION OFFICERS IN INTENSIVE CARE

1. Regional Education Officers occupy an important position in the Faculty's educational network. They have responsibilities to provide liaison between trainees, Supervisors of Training, their Regional Committee where relevant and the central administration of the Faculty. Specific duties include:
   - 1.1 Maintaining a list of approved hospitals in each region. Notifying the Regional Committee and the Board of any changes in senior intensive care staffing which have the potential to affect the training programmes.
   - 1.2 Obtaining a list, (on Form R2) from Supervisors of Training of all trainees in Faculty approved posts.

     This list should be forwarded to the Faculty within two months of the commencement of the hospital employment year in each region.
   - 1.3 Requiring notification from Supervisors of Training of any changes in the list referred to in 1.2 created by trainees joining or leaving training posts during the hospital employment year. It is particularly important that the date of such changes are noted to allow independent verification of training by the Censor.
2. Informing the Faculty of changes in personnel occupying the following positions in each approved hospital:
   - 2.1 Chief Executive Officer or equivalent.
   - 2.2 Chief Medical Officer or equivalent.
   - 2.3 Director of Intensive Care and deputy.
   - 2.4 Supervisors of Training in Intensive Care (see Faculty Policy Document IC-6 *'Supervisors of Training in Intensive Care'*).
3. Assisting Supervisors of Training with monitoring of staffing and trainee supervision in each approved hospital.
4. Understanding Faculty Administrative Instructions related to training and examinations.
5. Maintaining a calendar of dates relevant to Faculty examinations.
6. Maintaining contact with Supervisors of Training with advice as appropriate on matters related to training and examinations. At least one meeting each year of Supervisors in each region is recommended.
7. Advising trainees of relevant educational activities.
8. Keeping the Faculty Education Officer informed of regional activities and problems. Providing a report to the Board by 1st July each year.
9. Attending or nominating a representative to attend the annual meeting of Regional Education Officers with the Faculty Education Officer held during the ASM.
10. Ensuring that in-training assessments are conducted on all Faculty trainees in accordance with Faculty Policy Document IC-11 *'In-Training Assessment of Trainees in Intensive Care'.*
11. Providing advice as appropriate to trainees and prospective trainees.

Related Documents:

IC-2 "The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts"
IC-3 "Guidelines for Hospitals seeking Faculty Approval of Training Posts in Intensive Care"
IC-4 "The Supervision of Vocational Trainees in Intensive Care"
IC-6 "Supervisors of Training in Intensive Care"
IC-11 "In-Training Assessment of Trainees in Intensive Care".

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

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

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

Promulgated: February 1994
Reviewed: 1995
Date of current document: September 1995

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POLICY DOCUMENTS *Review T1 (1995)*

RECOMMENDED MINIMUM FACILITIES FOR SAFE ANAESTHETIC PRACTICE IN OPERATING SUITES

The safe provision of anaesthesia requires appropriate staff, facilities and equipment for proper patient safety. These are specified in this Document.

1. PRINCIPLES OF ANAESTHETIC CARE

1.1 Anaesthesia should be administered only by medical practitioners with appropriate training in anaesthesia or by trainees supervised according to College Policy Documents *'The Supervision of Trainees in Anaesthesia'* (E3) and *'Privileges in Anaesthesia'* (P2).

1.2 Every patient presenting for anaesthesia should have a pre-anaesthetic consultation by a medical practitioner who has appropriate training in anaesthesia. See College Policy Document *'Pre-anaesthetic Consultation'* (P7).

1.3 Appropriate monitoring of physiological variables must occur during anaesthesia. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

2. STAFFING

2.1 In addition to the nursing staff required by those carrying out the operative procedure, there must be:

2.1.1 An assistant to the anaesthetist. See College Policy Document *'Minimum Assistance for the Safe Conduct of Anaesthesia'* (P8).

2.1.2 Adequate assistance in positioning the patient.

2.1.3 Adequate technical assistance to ensure proper servicing of all equipment used.

3. OPERATING SUITES

3.1 ***Anaesthetic Equipment***

3.1.1 Essential requirements are listed below. Where a range of equipment is recommended, the hospital is expected to provide the type most suitable to its needs.

3.1.2 Each hospital must designate:

3.1.2.1 One (or more) specialists to advise on the choice and maintenance of anaesthetic equipment.

3.1.2.2 One (or more) of its nursing or technical staff to be responsible for the organisation of cleaning, maintenance and servicing of anaesthetic equipment.

3.1.3 There must be an anaesthetic machine for each anaesthetising location which is capable of delivering oxygen and nitrous oxide as well as other anaesthetic agents which are in common use. Essential equipment includes:

3.1.3.1 Suitable calibrated vaporisers for the delivery of inhalational anaesthetic agents.

3.1.3.2 A range of suitable breathing systems.

3.1.3.3 Breathing systems suitable for paediatric use if children are to be anaesthetised.

3.1.3.4 Medical air where this is clinically necessary.

3.1.4 Safety devices which must be present on every machine include:

3.1.4.1 An indexed gas connection system.

3.1.4.2 A reserve supply of oxygen.

3.1.4.3 An oxygen supply failure warning device. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.4.4 A breathing system high pressure relief valve.

3.1.4.5 An oxygen concentration analyser with appropriate alarm limits. See College Policy

Document *'Monitoring During Anaesthesia'* (P18).

3.1.4.6 Every anaesthetic machine purchased after 1 January 1996 shall have a device to prevent the supply of a hypoxic gas mixture whenever nitrous oxide is administered.

3.1.4.7 Every anaesthetic machine purchased after 1 January 1996 shall have an approved non-slip connection for the common gas outlet whenever a circle system is in use.

3.1.5 A separate means of inflating the lungs with oxygen must be provided in each anaesthetising location. This apparatus should comply with the current requirements of the relevant national Standards. Its oxygen supply should be independent of the anaesthetic machine.

3.1.6 Suction apparatus must be available for the exclusive use of the anaesthetist at all times together with appropriate hand pieces and endotracheal suction catheters. This apparatus should comply with the current requirements of the relevant national Standards. Provision must be made for an alternative suction system in the event of primary suction failure.

3.1.7 In every anaesthetising location there must be:

3.1.7.1 Appropriate protection for the anaesthesia team against biological contaminants. This shall include disposable gloves and eye shields.

3.1.7.2 A stethoscope

3.1.7.3 A sphygmomanometer

3.1.7.4 Monitoring equipment complying with College Policy Document *'Monitoring During Anaesthesia'* (P18).

Special problems are encountered in magnetic resonance imaging facilities. See College Policy Document *'Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Units'* (T3).

3.1.7.5 An appropriate range of face masks.

3.1.7.6 An appropriate range of oropharyngeal, nasopharyngeal and laryngeal mask airways.

3.1.7.7 Two laryngoscopes with a range of suitable blades.

3.1.7.8 An appropriate range of endotracheal tubes and connectors.

3.1.7.9 A range of endotracheal tube introducers.

3.1.7.10 Inflating syringe and clamps.

3.1.7.11 Magill's forceps.

3.1.7.12 A suitable range of adhesive and other tapes.

3.1.7.13 Scissors.

3.1.7.14 Sterile endotracheal lubricant.

3.1.7.15 Vascular tourniquets.

3.1.7.16 Intravenous infusion equipment with an appropriate range of cannulae and solutions.

3.1.7.17 Means for the safe disposal of items contaminated with biological fluids as well as of "sharps" and waste glass.

3.1.7.18 Equipment suitable for the establishment of sub-arachnoid, epidural or regional nerve blocks.

3.1.8 In each anaesthetising location there should be available:

3.1.8.1 Equipment for managing difficult intubations.

3.1.8.2 Equipment for automatic ventilation of the lungs incorporating alarms as specified in College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.8.3 Equipment for the direct measurement of arterial and venous pressures.

3.1.8.4 Equipment for the rapid infusion of fluids.

3.1.8.5 Equipment to minimise patient heat loss by warming of infused fluids and the body surface.

3.1.8.6 Equipment to warm and humidify gases administered during anaesthesia.

3.1.8.7 Provision for scavenging of anaesthetic gases and vapours with interface equipment which precludes over-pressurisation of the anaesthesia breathing circuit.

3.1.8.8 Interpleural drainage sets.

3.1.8.9 A cardiac defibrillator with capacity for synchronised cardioversion.

3.1.9 Other requirements for safe anaesthesia include:

3.1.9.1 Appropriate lighting for the clinical observation of patients which complies with the current requirements of the relevant national Standards.

3.1.9.2 Emergency lighting.

3.1.9.3 Telephone/Intercom to communicate with persons outside the anaesthetising location.

3.1.9.4 Refrigeration facilities for the storage of drugs and biological products.

3.1.9.5 The means to maintain room temperature in the anaesthetising location within the range of 18–28°C.

3.1.9.6 Patient transfer trolleys/beds as specified in College Policy Document *'Guidelines for the Care of Patients Recovering from Anaesthesia'* (P4).

3.2 ***Drugs***

3.2.1 In addition to the drugs and agents commonly used in anaesthesia, drugs necessary for the management of conditions which may complicate or co-exist with anaesthesia must also be available:

Anaphylaxis
Cardiac arrhythmias
Cardiac arrest
Pulmonary oedema
Hypotension
Hypertension
Bronchospasm
Respiratory depression
Hypoglycaemia
Hyperglycaemia
Adrenal dysfunction
Raised intracranial pressure
Uterine atony
Blood coagulopathy
Malignant hyperpyrexia

3.2.2 In making an appropriate selection of drugs for the management of these conditions, advice should be sought as in 3.1.2.1.

3.2.3 Appropriate mechanisms must exist for the regular replacement of these drugs after use and/or their expiry date has been reached.

3.2.4 A basic supply of dantrolene should be rapidly available to all anaesthetising locations with further doses being available on request.

3.3 ***Routines for Checking, Cleaning and Servicing Equipment***

3.3.1 Regular sterilising, cleaning and housekeeping routines for the care of equipment should be established.

3.3.2 Documented servicing of the anaesthetic machine and medical gas equipment by an appropriate organisation must be carried out at least twice a year. After any modification to the gas distribution system, gas analysis and flow measurement must be carried out and documented before use.

3.3.3 A copy of the College Policy Document *'Protocol for Checking an Anaesthetic Machine Before Use'* (T2) or a similar document should be available on each anaesthetic machine.

3.4 ***Recovery Area***

3.4.1 Recovery from anaesthesia should take place under appropriate supervision in a designated area which conforms with College Policy Document *'Guidelines for the Care of Patients Recovering from Anaesthesia'* (P4).

3.4.2 Contingency plans should exist which would allow rapid patient transfer in an emergency from the operating suite or recovery areas under adequate medical supervision.

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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FINAL FELLOWSHIP EXAMINATION

AUGUST/SEPTEMBER 1995

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

The Viva Examination in anaesthesia and medicine was held at Westmead Hospital, Sydney.

Seventy-four (74) candidates presented and fifty-one (51) were approved.

SUCCESSFUL CANDIDATES

Names of successful candidates who have not completed training:

C. ARALI	NSW	M.L. HARTY	NZ	A. PURDON	NSW
D.L. BAIN	VIC	W.C.T. HUI	HKG	M.C. REDDY	NZ
K.C. BAKER	NSW	A.M. LILLEY	VIC	G.M. ROPER	NZ
H.K.T. BEH	HKG	G.C.B. LLOYD	NSW	D.A. SIDEBOTHAM	NZ
A.M. BRENNAN	VIC	S.M. LOCKLEY	NSW	A.J. SILVERS	VIC
G. BURGIN	VIC	I. LOMAS	QLD	N.R. SKJELLERUP	NZ
A.CAVDARSKI	QLD	W.C. MACAULAY	NZ	M.G. STEWART	NSW
T.V. CHAN	HKG	S.C. MACLAURIN	NZ	P. TALBUTT	QLD
CHEW TSONG HUEY SOPHIA	S'PRE	G.J. MCHUGH	NZ	K.H. TAN	NSW
P.T. CLARK	NSW	A.D. MCKEE	NZ	N.M. VANDEN DRIESEN	WA
J.G.L. COCKINGS	SA	C.M. MCKENZIE	VIC	E.J. VISSER	WA
B.T. COOK	NSW	S.D. NEWELL	QLD	D.C. WILKINSON	SA
F.J. DADAY	QLD	NGOH IVAN HON SENG	M'SIA	I.R. WILLIAMS	NZ
A.B. EVANS	VIC	S.R. NICOLL	NZ	P.A. WILSON	NZ
M.A. FEATHERSTON	NZ	N.B.T. NOR	M'SIA	WONG HO SHAN STEVEN	HKG
S.C. FORTEY	NSW	T.E.A. PALMER	QLD	C.M.L. WONG	HKG
GOH MENG HUAT	S'PRE	S.B. PARKES	QLD	D.W. WRATHALL	NZ

Review T3 (1995)

RECOMMENDED MINIMUM FACILITIES FOR SAFE ANAESTHETIC PRACTICE IN ORGAN IMAGING FACILITIES

The safe provision of anaesthesia requires appropriate staff, facilities and equipment for proper patient safety. These are specified in this Document.

1. PRINCIPLES OF ANAESTHETIC CARE

1.1 Anaesthesia should be administered only by medical practitioners with appropriate training in anaesthesia or by trainees supervised according to College Policy Documents *'The Supervision of Trainees in Anaesthesia'* (E3) and *'Privileges in Anaesthesia'* (P2).

1.2 Every patient presenting for anaesthesia should have a pre-anaesthetic consultation by a medical practitioner who has appropriate training in anaesthesia. See College Policy Document *'Pre-anaesthetic Consultation'* (P7).

1.3 Appropriate monitoring of physiological variables must occur during anaesthesia. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

2. STAFFING

2.1 In addition to the nursing staff required by those carrying out the operative or diagnostic procedure, there must be:

2.1.1 An assistant to the anaesthetist. See College Policy Document *'Minimum Assistance for the Safe Conduct of Anaesthesia'* (P8).

2.1.2 Adequate assistance in positioning the patient.

2.1.3 Adequate technical assistance to ensure proper servicing of all equipment used.

3. ORGAN IMAGING UNITS

3.1 *Anaesthetic Equipment*

3.1.1 Essential requirements are listed below. Where a range of equipment is recommended, the hospital is expected to provide the type most suitable to its needs.

3.1.2 Each hospital must designate:

3.1.2.1 One (or more) specialists to advise on the choice and maintenance of anaesthetic equipment.

3.1.2.2 One (or more) of its nursing or technical staff to be responsible for the organisation of cleaning, maintenance and servicing of anaesthetic equipment.

3.1.3 There must be an anaesthetic machine for each anaesthetising location which is capable of delivering air, oxygen, nitrous oxide as well as other anaesthetic agents which are in common use. Essential equipment includes:

3.1.3.1 Suitable calibrated vaporisers for the delivery of inhalational anaesthetic agents.

3.1.3.2 A range of suitable breathing systems. Those for use in magnetic resonance imaging units may require modification to make them suitable for use.

3.1.3.3 Breathing systems suitable for paediatric use if children are to be anaesthetised.

3.1.3.4 Medical air where this is clinically necessary.

3.1.4 Safety devices which must be present on every machine include:

3.1.4.1 An indexed gas connection system.

3.1.4.2 A reserve supply of oxygen.

3.1.4.3 An oxygen supply failure warning device. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.4.4 A breathing system high pressure relief valve.

3.1.4.5 An oxygen concentration analyser with appropriate alarm limits. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.4.6 Every anaesthetic machine purchased after 1 January 1996 shall have a device to prevent the supply of a hypoxic gas mixture whenever nitrous oxide is administered.

3.1.4.7 Every anaesthetic machine purchased after 1 January 1996 shall have an approved non-slip connection for the common gas outlet whenever a circle system is in use.

3.1.5 A separate means of inflating the lungs with oxygen must be provided in each anaesthetising location. This apparatus should comply with the current requirements of the relevant national Standards. Its oxygen supply should be independent of the anaesthetic machine.

3.1.6 Suction apparatus must be available for the exclusive use of the anaesthetist at all times together with appropriate hand pieces and endotracheal suction catheters. This apparatus should comply with the current requirements of the relevant national Standards. Provision must be made for an alternative suction system in the event of primary suction failure.

3.1.7 In every anaesthetising location there should be:

3.1.7.1 Appropriate protection for the anaesthesia team against biological contaminants. This shall include disposable gloves and eye shields. Protection against ionizing radiation and appropriate monitoring of that radiation is also mandatory.

3.1.7.2 A stethoscope

3.1.7.3 A sphygmomanometer

3.1.7.4 Monitoring equipment complying with College Policy Document *'Monitoring During Anaesthesia'* (P18).

Although special problems are encountered in magnetic resonance imaging facilities, equipment which allows compliance with College Policy Document P18 *'Monitoring During Anaesthesia'* is available.

3.1.7.5 An appropriate range of face masks.

3.1.7.6 An appropriate range of oropharyngeal, nasopharyngeal and laryngeal mask airways.

3.1.7.7 Two laryngoscopes with a range of suitable blades.

3.1.7.8 An appropriate range of endotracheal tubes and connectors.

3.1.7.9 A range of endotracheal tube introducers.

3.1.7.10 Inflating syringe and clamps.

3.1.7.11 Magill's forceps.

3.1.7.12 A suitable range of adhesive and other tapes.

3.1.7.13 Scissors.

3.1.7.14 Sterile endotracheal lubricant.

3.1.7.15 Vascular tourniquets.

3.1.7.16 Intravenous infusion equipment with an appropriate range of cannulae and solutions.

3.1.7.17 Means for the safe disposal of items contaminated with biological fluids as well as of "sharps" and waste glass.

3.1.8 In each anaesthetising location there should be available:

3.1.8.1 Equipment for managing difficult intubations.

3.1.8.2 Equipment for automatic ventilation of the lungs incorporating alarms as specified in College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.8.3 Equipment for the direct measurement of arterial and venous pressures.

3.1.8.4 Equipment for the rapid infusion of fluids.

3.1.8.5 Equipment to minimise patient heat loss by warming of infused fluids and the body surface.

3.1.8.6 Equipment to warm and humidify gases administered during anaesthesia.

3.1.8.7 Provision for scavenging of anaesthetic gases and vapours with interface equipment which precludes overpressurisation of the anaesthesia breathing circuit.

3.1.8.8 Interpleural drainage sets.

3.1.8.9 Equipment suitable for the establishment of sub-arachnoid, epidural or regional nerve blocks.

3.1.8.10 A cardiac defibrillator with capacity for synchronised cardioversion.

3.1.9 Other requirements for safe anaesthesia include:

3.1.9.1 Appropriate lighting for the clinical observation of patients which complies with the current requirements of the relevant national Standards.

3.1.9.2 Emergency lighting.

3.1.9.3 Telephone/Intercom to communicate with persons outside the anaesthetising location.

3.1.9.4 Refrigeration facilities for the storage of drugs and biological products.

3.1.9.5 The means to maintain room temperature in the anaesthetising location within the range of 18–28°C.

3.1.9.6 Patient transfer trolleys/beds as specified in College Policy Document *'Guidelines for the Care of Patients Recovering from Anaesthesia'* (P4).

3.2 ***Drugs***

3.2.1 In addition to the drugs and agents commonly used in anaesthesia, drugs necessary for management of conditions which may complicate or co-exist with anaesthesia must also be available:

Anaphylaxis
Cardiac arrhythmias
Cardiac arrest
Pulmonary oedema
Hypotension
Hypertension
Bronchospasm
Respiratory depression
Hypoglycaemia
Hyperglycaemia
Adrenal dysfunction
Raised intracranial pressure
Uterine atony
Blood coagulopathy
Malignant hyperpyrexia

3.2.2 In making an appropriate selection of drugs for the management of these conditions, advice should be sought as in 3.1.2.1.

3.2.3 Appropriate mechanisms must exist for the regular replacement of these drugs after use and/or their expiry date has been reached.

3.2.4 A basic supply of dantrolene should be rapidly available to all anaesthetising locations with further doses being available on request.

3.3 ***Routines for Checking, Cleaning and Servicing Equipment***

3.3.1 Regular sterilising, cleaning and housekeeping routines for the care of equipment should be established.

3.3.2 Documented servicing of the anaesthetic machine and medical gas equipment by an appropriate organisation must be carried out at least twice a year. After any modification to the gas distribution system, gas analysis and flow measurement must be carried out and documented before use.

3.3.3 A copy of the College Policy Document *'Protocol for Checking an Anaesthetic Machine Before Use'* (T2) or a similar document should be available on each anaesthetic machine.

3.4 ***Recovery Area***

3.4.1 Recovery from anaesthesia should take place under appropriate supervision in a designated area which conforms with College Policy Document *'Guidelines for the Care of Patients Recovering from Anaesthesia'* (P4).

3.4.2 Contingency plans should exist which would allow rapid patient transfer in an emergency from the organ imaging or recovery areas under adequate medical supervision.

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

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PRIMARY FELLOWSHIP EXAMINATION

AUGUST/SEPTEMBER 1995

The Written Section was held in all capital cities in Australia, Canberra, Darwin, Newcastle, Auckland, Christchurch, Dunedin, Hamilton, Wellington, Hong Kong, Kuala Lumpur and Singapore.

One hundred and fifty-four candidates (154) presented for the Written Section and one hundred and twenty-four (124) candidates were invited to the Viva Examination in Melbourne where eighty-one candidates were approved.

SUCCESSFUL CANDIDATES

T.M. ALLEN, WA
C. AYNSLEY, NSW
K.J. BENFIELD, VIC
S.J. BIGNELL, QLD
P.G. BLUM, NSW
M.A. BOQUEST, NZ
S.M. BOTTRELL, NSW
A.W. BOWIE, SA
J.R. BRADSHAW, ACT
S.M. BROWNE, NSW
N.D. BURGESS, NSW
A.C. BURKE, SA
B.T. BURKE, QLD
D.J. CASTANELLI, VIC
A.M.H CHAN, HKG
G.W.M. CHANG, NSW
J.P. CLARKE, NZ
J.V. CLARKE, VIC
E.I. COHEN, VIC
N.J. COLIN-THOME, SA
B.J. CREATI, VIC
H.M. CRILLY, QLD
A.C. DUFFIELD, NSW
M.K. DUNCAN, QLD
J.G. ELLINGHAM, ACT
D.J. EVANS, SA
G.M. FALCONE, VIC
M.P. FANSHAWE, QLD
SAI YAN FONG, WA
R.W. FOREMAN, NSW
J.J. FORESTER, NZ
P.W. FOUND, NSW
A.I. GARDNER, WA
D. GERBER, QLD
M.D. GOLDBLATT, QLD
P.D. GRAY, QLD
S.C. HAMS, VIC
A.C. HANCOCK, SA
B. HENNESSY, VIC
F.J. JOHNSON, VIC
M.D. KIRTON, VIC
H. KOCENT, ACT
A. KUMAR, NSW
KWOK WING HONG, HKG
M.Y.H. LAI, QLD
M.S.M. LEE, NSW
M.P. LEVESTAM, NZ
B.R. MA, NSW
M.F. MAHER, QLD
G.C. MAR FAN, QLD
A.T. MARSHALL, NZ
A.J. MATTHEWS, NZ
A.D. McGEORGE, NZ
W.P. McINTOSH, QLD
M.D. McINTYRE, NSW
B. McKINNEY, QLD
M. MOYLE, NSW
E.J. MURPHY, NSW
T.J.B. O'BRIEN, QLD
C.B. O'SULLIVAN, NSW
G.S. OBEROI, SA
B.R. PAIX, SA
S.G. PEARCE, NZ
A.B. POON, VIC
L.B.Y.C. POON, VIC
D. RAMASAMY, TAS
M.D.S. REEVES, VIC
J.M. RILEY, NSW
M.N. SCHUITEMAKER, NZ
P.H. SCOTT, QLD
I.M. SEPPELT, NSW
F.C. SHARP, WA
R.S. SIMPSON, SA
A.P. TUCKER, VIC
J.J. WALLACE, TAS
M.J. WARDILL, NZ
W.R. WATSON, VIC
T.G. WEBB, VIC
J.R. WHITTLE, QLD
D.L. WILLIAMS, VIC
BIING-LIN YIN, NSW

Review P19 (1995)

MONITORED CARE BY AN ANAESTHETIST

INTRODUCTION

The Australian and New Zealand College of Anaesthetists endorses the concept of monitored care provided by an anaesthetist for a procedure performed under local anaesthesia or sedation. Monitored care may also be required in special situations such as the intravascular administration of contrast medium in a suspected susceptible patient.

Monitored care may be requested by a surgeon, dentist, obstetrician, physician, endoscopist, radiologist, radio therapist, or other proceduralist.

Because of the general condition of the patient and, in some cases poor access, the provision of monitored care may be exacting and time consuming.

GENERAL PRINCIPLES

1. Monitored care shall include:
   - 1.1 Performance of a pre-anaesthetic consultation in accordance with College Policy Document *'The Pre-Anaesthetic Consultation'* (P7).
   - 1.2 Monitoring of the patient, as appropriate, in accordance with College Policy Document *'Monitoring During Anaesthesia'* (P18).
   - 1.3 Administration of intravenous sedation, if required, in accordance with College Policy Document *'Sedation for Diagnostic and Minor Surgical Procedures'* (P9).
   - 1.4 Other therapeutic measures as required.
   - 1.5 Transfer of the patient, if required, to an appropriate Recovery Area College Policy Document *'Guidelines for the Care of Patients Recovering from Anaesthesia'* (P4).
2. A record of clinical observations and of drugs administered shall be kept.
3. 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 Document regarding recommended Minimum Facilities for Safe Anaesthetic Practice in:

Operating Suites	T1
Organ Imaging Facilities	T3
Dental Surgeries	T5
Delivery Suites	T6

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

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

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Review T6 (1995)

RECOMMENDED MINIMUM GUIDELINES FOR SAFE ANAESTHETIC PRACTICE IN DELIVERY SUITES

The safe provision of anaesthesia requires appropriate staff, facilities and equipment for proper patient safety. These are specified in this Document.

1. PRINCIPLES OF ANAESTHETIC CARE

1.1 Anaesthesia should be administered only by medical practitioners with appropriate training in anaesthesia or by trainees supervised according to College Policy Documents *'The Supervision of Trainees in Anaesthesia'* (E3) and *'Privileges in Anaesthesia'* (P2).

1.2 Every patient presenting for anaesthesia should have a pre-anaesthetic consultation by a medical practitioner who has appropriate training in anaesthesia. See College Policy Document *'Pre-anaesthetic Consultation'* (P7).

1.3 Appropriate monitoring of physiological variables must occur during anaesthesia. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

2. STAFFING

2.1 In addition to the nursing staff required by those carrying out the obstetric or the operative procedure, there must be:

2.1.1 An assistant to the anaesthetist. See College Policy Document *'Minimum Assistance for the Safe Conduct of Anaesthesia'* (P8).

For the establishment and management of epidural blockade for analgesia in labour, the presence of a midwife trained and competent in obstetric epidural management is required.

2.1.2 Adequate assistance in positioning the patient.

2.1.3 Adequate technical assistance to ensure proper servicing of all equipment used.

2.1.4 At the time of delivery, there must be a medical practitioner with appropriate training in the resuscitation and care of the neonate with sole responsibility for that task.

3. DELIVERY SUITES

3.1 *Anaesthetic Equipment*

3.1.1 Where general anaesthesia, sedation or major regional blockade are utilised, equipment must comply with the requirements set out below as well as with College Policy Document *'Sedation for Diagnostic and Minor Surgical Procedures'* (P9). Where a range of equipment is recommended, the hospital is expected to provide the type most suitable to its needs. Where patients are transferred to another facility for operative delivery, anaesthetic and resuscitative equipment is still essential for the management of complications of epidural and other major regional blockade.

3.1.2 Each hospital must designate:

3.1.2.1 One (or more) specialists to advise on the choice and maintenance of anaesthetic equipment.

3.1.2.2 One (or more) of its nursing or technical staff to be responsible for the organisation of cleaning, maintenance and servicing of anaesthetic equipment.

3.1.3 There must be an anaesthetic machine for each anaesthetising location which is capable of delivering air, oxygen, nitrous oxide as well as other anaesthetic agents which are in common use. Essential equipment includes:

3.1.3.1 Suitable calibrated vaporisers for the delivery of inhalational anaesthetic agents.

3.1.3.2 A range of suitable breathing systems.

3.1.3.3 Medical air where this is clinically necessary.

3.1.4 Safety devices which must be present on every machine include:

3.1.4.1 An indexed gas connection system.

3.1.4.2 A reserve supply of oxygen.

3.1.4.3 An oxygen supply failure warning device. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.4.4 A breathing system high pressure relief valve.

3.1.4.5 An oxygen concentration analyser with appropriate alarm limits. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.4.6 Every anaesthetic machine purchased after 1 January 1996 shall have a device to prevent the supply of a hypoxic gas mixture whenever nitrous oxide is administered.

3.1.4.7 Every anaesthetic machine purchased after 1 January 1996 shall have an approved non-slip connection for the common gas outlet whenever a circle system is in use.

3.1.5 A separate means of inflating the lungs with oxygen must be provided in each anaesthetising location. This apparatus should comply with the current requirements of the relevant national Standards. Its oxygen supply should be independent of the anaesthetic machine.

3.1.6 Suction apparatus must be available for the exclusive use of the anaesthetist at all times together with appropriate hand pieces and endotracheal suction catheters. This apparatus should comply with the current requirements of the relevant national Standards. Provision must be made for an alternative suction system in the event of primary suction failure.

3.1.7 In every anaesthetising location there should be:

3.1.7.1 Appropriate protection for the anaesthesia team against biological contaminants. This shall include disposable gloves and eye shields.

3.1.7.2 A stethoscope

3.1.7.3 A sphygmomanometer

3.1.7.4 Monitoring equipment complying with College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.7.5 An appropriate range of face masks.

3.1.7.6 An appropriate range of oropharyngeal, nasopharyngeal and laryngeal mask airways.

3.1.7.7 Two laryngoscopes with a range of suitable blades.

3.1.7.8 An appropriate range of endotracheal tubes and connectors.

3.1.7.9 A range of endotracheal tube introducers.

3.1.7.10 Inflating syringe and clamps.

3.1.7.11 Magill's forceps.

3.1.7.12 A suitable range of adhesive and other tapes.

3.1.7.13 Scissors.

3.1.7.14 Sterile endotracheal lubricant.

3.1.7.15 Vascular tourniquets.

3.1.7.16 Intravenous infusion equipment with an appropriate range of cannulae and solutions.

3.1.7.17 Means for the safe disposal of items contaminated with biological fluids as well as of 'sharps' and waste glass.

3.1.7.18 Equipment suitable for the establishment of sub-arachnoid, epidural or regional nerve blocks.

3.1.7.19 Provision for scavenging of anaesthetic gases and vapours with interface equipment which precludes over-pressurisation of the anaesthesia breathing circuit.

3.1.7.20 A cardiac defibrillator with capacity for synchronised cardioversion.

3.1.8 In every anaesthetising location there should be available:

3.1.8.1 Equipment for managing difficult intubations.

3.1.8.2 Equipment for automatic ventilation of the lungs incorporating alarms as specified in College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.8.3 Equipment for the direct measurement of arterial and venous pressures.

3.1.8.4 Equipment for the rapid infusion of fluids.

3.1.8.5 Equipment to minimise patient heat loss by warming of infused fluids and the body surface.

3.1.8.6 Equipment to warm and humidify gases administered during anaesthesia.

3.1.8.7 Interpleural drainage sets.

3.1.9 Other requirements for safe anaesthesia include:

3.1.9.1 Appropriate lighting for the clinical observation of patients which complies with the current requirements of the relevant national Standards.

3.1.9.2 Emergency lighting.

3.1.9.3 Telephone/Intercom to communicate with persons outside the anaesthetising location.

3.1.9.4 Refrigeration facilities for the storage of drugs and biological products.

3.1.9.5 The means to maintain room temperature in the anaesthetising location within the range of 18–28°C.

3.1.9.6 Patient transfer trolleys/beds as specified in College Policy Document *'Guidelines for the Care of Patients Recovering from Anaesthesia'* (P4).

3.1.10 In each delivery room there must be:

3.1.10.1 Apparatus for the administration of inhalational analgesia with a minimum of 30% oxygen.

3.1.10.2 Suction apparatus for the exclusive use of the anaesthetist which is separate from that required for the resuscitation of the neonate.

3.1.10.3 Separate oxygen outlets and suitable attachments for administering oxygen to the mother and to the neonate.

3.2 ***Drugs***

3.2.1 In addition to the drugs and agents commonly used in anaesthesia, drugs necessary for management of conditions which may complicate or coexist with anaesthesia must also be available:

Anaphylaxis
Cardiac arrhythmias
Cardiac arrest
Pulmonary oedema
Hypotension
Hypertension
Bronchospasm
Respiratory depression
Hypoglycaemia
Hyperglycaemia
Adrenal dysfunction
Raised intracranial pressure
Uterine atony
Blood coagulopathy
Malignant hyperpyrexia

3.2.2 In making an appropriate selection of drugs for the management of these conditions, advice should be sought as in 3.1.2.1.

3.2.3 Appropriate mechanisms must exist for the regular replacement of these drugs after use and/or their expiry date has been reached.

3.2.4 A basic supply of dantrolene should be rapidly available to all anaesthetising locations with further doses being available on request.

3.3 ***Routines for Checking, Cleaning and Servicing Equipment***

3.3.1 Regular sterilising, cleaning and housekeeping routines for the care of equipment should be established.

3.3.2 Documented servicing of the anaesthetic machine and medical gas equipment by an appropriate organisation must be carried out at least twice a year. After any modification to the gas distribution system, gas analysis and flow measurement must be carried out and documented before use.

3.3.3 A copy of the College Policy Document *'Protocol for Checking an Anaesthetic Machine Before Use'* (T2) or a similar document should be available on each anaesthetic machine.

3.4 ***Recovery Area***

3.4.1 Recovery from anaesthesia should take place under appropriate supervision in a designated area which conforms with College Policy Document *'Guidelines for the Care of Patients Recovering from Anaesthesia'* (P4).

3.4.2 Contingency plans should exist which would allow rapid patient transfer in an emergency from the delivery suite or recovery areas to another appropriate area under adequate medical supervision.

3.5 ***Neonatal Resuscitation Equipment***

3.5.1 A suitable range of equipment must be available for:

3.5.1.1 Administration of oxygen to the neonate.

3.5.1.2 Intubation and ventilation of the neonate.

3.5.1.3 Clearing of the airway of the neonate.

3.5.1.4 Administration of intravenous fluids and drugs.

3.5.1.5 Maintenance of the neonate's temperature.

3.5.2 An appropriate range of drugs must be available.

3.5.3 It is recommended that each hospital designate:

3.5.3.1 One (or more) medical practitioners with appropriate training and qualifications to advise on the choice and maintenance of equipment and drugs required for the resuscitation and care of the neonate.

3.5.3.2 One (or more) of its nursing or technical staff to be responsible for the organisation of cleaning, servicing and maintenance of this equipment.

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Review T5 (1995)

RECOMMENDED MINIMUM FACILITIES FOR SAFE ANAESTHETIC PRACTICE IN DENTAL SURGERIES

The safe provision of anaesthesia in Dental Surgeries requires appropriate staff, facilities and equipment for proper patient safety. These are specified in this Document.

1. PRINCIPLES OF ANAESTHETIC CARE

1.1 Anaesthesia in Dental Surgeries should be administered only by medical practitioners with appropriate training in anaesthesia or by trainees supervised according to College Policy Documents *'The Supervision of Trainees in Anaesthesia'* (E3) and *'Privileges in Anaesthesia'* (P2).

1.2 Every patient presenting for anaesthesia in Dental Surgeries should have a pre-anaesthetic consultation by a medical practitioner who has appropriate training in anaesthesia. College Policy Document *'Pre-anaesthetic Consultation'* (P7).

1.3 Appropriate monitoring of physiological variables must occur during anaesthesia. College Policy Document *'Monitoring During Anaesthesia'* (P18).

1.4 On occasion the anaesthetist may decide that the condition of the patient (having regard to the facilities available and/or the patient's health status) does not permit of safe care in the dental surgery.

2. STAFFING

2.1 In addition to the nursing staff required by the person carrying out the procedure, there must be:

2.1.1 An assistant to the anaesthetist. See College Policy Document *'Minimum Assistance for the Safe Conduct of Anaesthesia'* (P8).

2.1.2 Adequate assistance in positioning the patient.

2.1.3 Adequate technical assistance to ensure proper servicing of all equipment used.

3. DENTAL SURGERIES

3.1 ***Anaesthetic Equipment***

3.1.1 Essential requirements are listed below. Where a range of equipment is available, the dental surgery is expected to provide the type most suitable to its needs.

3.1.2 Anaesthetic equipment, agents and drugs in dental surgeries may be provided by the dentist or brought by the anaesthetist to the dental surgery. In the former case, it is essential that the dentist seek advice from an anaesthetist who is experienced in anaesthesia in the dental environment.

3.1.3 There must be an anaesthetic machine for each anaesthetising location which is capable of delivering oxygen and nitrous oxide as well as other anaesthetic agents which are in common use. Essential equipment includes:

3.1.3.1 Suitable calibrated vaporisers for the delivery of inhalational anaesthetic agents.

3.1.3.2 A range of suitable breathing systems.

3.1.3.3 Breathing systems suitable for paediatric use if children are to be anaesthetised.

3.1.4 Safety devices which must be present on every machine include:

3.1.4.1 An indexed gas connection system.

3.1.4.2 A reserve supply of oxygen.

3.1.4.3 An oxygen supply failure warning device. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.4.4 A breathing system high pressure relief valve.

3.1.4.5 An oxygen concentration analyser with appropriate alarm limits. See College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.4.6 Every anaesthetic machine purchased after 1 January 1996 shall have a device to prevent the supply of a hypoxic gas mixture whenever nitrous oxide is administered.

3.1.4.7 Every anaesthetic machine purchased after 1 January 1996 shall have an approved non-slip connection for the common gas outlet whenever a circle system is in use.

3.1.5 A separate means of inflating the lungs with oxygen must be provided in each anaesthetising location. This apparatus should comply with the current requirements of the relevant national Standards. Its oxygen supply should be independent of the anaesthetic machine.

3.1.6 Suction apparatus must be available for the exclusive use of the anaesthetist at all times together with appropriate hand pieces and endotracheal suction catheters. This apparatus should comply with the current requirements of the relevant national Standards. Provision must be made for an alternative suction system in the event of primary suction failure.

3.1.7 In every anaesthetising location there should be:

3.1.7.1 Appropriate protection for the anaesthesia team against biological contaminants which shall include disposable gloves and eye shields.

3.1.7.2 A stethoscope

3.1.7.3 A sphygmomanometer

3.1.7.4 Monitoring equipment complying with College Policy Document *'Monitoring During Anaesthesia'* (P18).

3.1.7.5 An appropriate range of face masks.

3.1.7.6 An appropriate range of airways.

3.1.7.7 Two laryngoscopes with a range of suitable blades.

3.1.7.8 An appropriate range of endotracheal tubes and connectors.

3.1.7.9 A range of endotracheal tube introducers.

3.1.7.10 Inflating syringe and clamps.

3.1.7.11 Magill's forceps.

3.1.7.12 A suitable range of adhesive and other tapes.

3.1.7.13 Scissors.

3.1.7.14 Sterile endotracheal lubricant.

3.1.7.15 Vascular tourniquets.

3.1.7.16 Intravenous infusion equipment with an appropriate range of cannulae and solutions.

3.1.7.17 Means for the safe disposal of items contaminated with biological fluids as well as of "sharps" and waste glass.

3.1.7.18 Equipment suitable for the establishment of regional anaesthetic nerve blocks.

3.1.7.19 Throat packs.

3.1.7.20 Provision for scavenging of anaesthetic gases and vapours with interface equipment which precludes overpressurisation of the anaesthesia breathing circuit.

3.1.7.21 A cardiac defibrillator.

3.1.8 Other requirements for safe anaesthesia include:

3.1.8.1 Appropriate lighting for the clinical observation of patients which comply with the current requirements of the relevant national Standards.

3.1.8.2 Emergency lighting.

3.1.8.3 Telephone/Intercom to communicate with persons outside the anaesthetising location.

3.1.8.4 Refrigeration facilities for the storage of drugs and biological products.

3.1.8.5 The means to maintain room temperature in the anaesthetising location within the range of 18–28°C.

3.1.8.6 A dental operating chair which will allow the patient to be rapidly placed in the horizontal or head-down position.

3.2 ***Drugs***

3.2.1 In addition to the drugs and agents commonly used in anaesthesia, drugs necessary for initial management of conditions which may complicate or co-exist with anaesthesia must also be available:

Anaphylaxis
Cardiac arrhythmias
Cardiac arrest
Pulmonary oedema
Hypotension
Hypertension
Bronchospasm
Respiratory depression
Hypoglycaemia
Hyperglycaemia
Adrenal dysfunction
Malignant hyperpyrexia
Blood coagulopathy

3.2.2 In ensuring the availability of drugs for the treatment of these conditions, the processes outlined in 3.1.2 should be followed.

3.2.3 Appropriate mechanisms must exist for the regular replacement of these drugs after use and/or their expiry date has been reached.

3.2.4 Dantrolene (used in the management of malignant hyperpyrexia) should be rapidly available from a nearby hospital which holds adequate supplies of this drug.

3.3 ***Routines for Checking, Cleaning and Servicing Equipment***

3.3.1 Regular sterilising, cleaning and housekeeping routines for the care of equipment should be established.

3.3.2 Documented servicing of the anaesthetic machine and medical gas equipment by an appropriate organisation must be carried out at least twice a year. After any modification to the gas distribution system, gas analysis and flow measurement must be carried out and documented before use.

3.3.3 A copy of the College Policy Document *'Protocol for Checking an Anaesthetic Machine Before Use'* (T2) or a similar document should be available on each anaesthetic machine.

3.4 ***Recovery Area***

3.4.1 Recovery from anaesthesia should take place under appropriate supervision in a designated area which conforms with College Policy Document *'Guidelines for the Care of Patients Recovering from Anaesthesia'* (P4).

3.4.2 Contingency plans should exist which would allow rapid patient transfer in an emergency from the dental surgery to hospital care under adequate medical supervision.

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Review P18 (1995)

MONITORING DURING ANAESTHESIA

INTRODUCTION

Monitoring of certain fundamental physiological variables during anaesthesia is essential. Clinical judgement will determine how long this monitoring should be continued following completion of anaesthesia.

The Health Care Facility in which the procedure is being performed is responsible for provision of equipment for anaesthesia and monitoring on the advice of one or more designated specialist anaesthetists, and for effective maintenance of this equipment (see College Policy Document *'Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites'* (T1)).

Some or all of the recommendations in this document may need to be exceeded depending on the physical status of the patient, the type and complexity of the surgery to be performed as well as the requirements of anaesthesia.

The described monitoring must always be used in conjunction with careful clinical observation by the anaesthetist as there are circumstances in which equipment may not detect unfavourable clinical developments.

The following recommendations refer to patients undergoing general anaesthesia or major regional anaesthesia for diagnostic or therapeutic procedures and should be interpreted in conjunction with other Policy Documents published by the Australian and New Zealand College of Anaesthetists.

1. PERSONNEL

Clinical monitoring by a vigilant anaesthetist is the basis of safe patient care during anaesthesia. This should be supplemented by appropriate devices to assist the anaesthetist.

A medical practitioner whose sole responsibility is the provision of anaesthetic care for that patient must be constantly present from induction of anaesthesia until safe transfer to Recovery Room staff or Intensive Care Unit has been accomplished. This medical practitioner must be appropriately trained in Anaesthesia, or be a Trainee Anaesthetist supervised in accordance with College Policy Document *'The Supervision of Trainees in Anaesthesia'* (E3).

In exceptional circumstances brief absences of the person primarily responsible for the anaesthetic may be unavoidable. In such circumstances that person may temporarily delegate observation of the patient to an appropriately qualified person who is judged to be competent for the task. Permanent handover of responsibility must be to an anaesthetist who is able to accept continued responsibility for the care of the patient (see College Policy Document *'Handover of Responsibility during an Anaesthetic'* (P10)).

The individual anaesthetist is responsible for monitoring the patient and should ensure that appropriate monitoring equipment is available. Some procedures necessitate special monitoring (e.g. MRI scanning) or remote monitoring to reduce hazard to staff (e.g. radiological procedures) (see College Policy Document *'Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities'* (T3)).

2. PATIENT MONITORING

2.1 *Circulation*

The circulation must be monitored at frequent and clinically appropriate intervals by detection of the arterial pulse and measurement of arterial blood pressure by indirect or direct means.

2.2 *Ventilation*

Ventilation must be monitored continuously by both direct and indirect means.

2.3 *Oxygenation*

Oximetric values must be interpreted in conjunction with clinical observation of the patient. Adequate lighting must be available to aid with assessment of patient colour.

3. EQUIPMENT

3.1 *Oxygen Supply Failure Alarm*

An automatically activated device to monitor oxygen supply pressure and to warn of low pressure must be fitted to the anaesthetic machine. This device should shut off the nitrous oxide supply and be capable of maintaining oxygen flow for a limited period (see College Policy Document *'Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites'* (T1)).

3.2 ***Oxygen Analyser***

A device incorporating an audible signal to warn of low oxygen concentrations, correctly fitted in the breathing system, must be in continuous operation for every patient when an anaesthetic machine is in use.

3.3 ***Pulse Oximeter***

Pulse oximetry provides evidence of the level of oxygen saturation of the haemoglobin of arterial blood and identifies arterial pulsation at the site of application. A pulse oximeter must be in use for every anaesthetised patient.

3.4 ***Breathing System Disconnection or Ventilator Failure Alarm***

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

3.5 ***Electrocardiograph***

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

3.6 ***Temperature Monitor***

Equipment to monitor temperature continuously must be available for every anaesthetised patient.

3.7 ***Carbon Dioxide Monitor***

A monitor of carbon dioxide level in inhaled and exhaled gases must be exclusively available for every patient.

3.8 ***Neuromuscular Function Monitor***

Equipment to monitor neuromuscular function must be available for every patient in whom neuromuscular blockade has been induced.

3.9 ***Volatile Anaesthetic Agent Monitor***

Equipment to monitor the concentration of inhaled anaesthetics must be exclusively available for every patient undergoing general anaesthesia. This recommendation should be implemented as soon as possible but in any case no later than 1 January 1998.

3.10 ***Other Equipment***

When clinically indicated, equipment to monitor other physiological variables such as cardiac output should be available.

RELATED DOCUMENTS

T1 Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites

T3 Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Facilities

E3 The Supervision of Trainees in Anaesthesia

P10 Handover of Responsibility During an Anaesthetic

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Review E6 (1995)

THE DUTIES OF AN ANAESTHETIST

1. PREAMBLE

These guidelines represent the views of the Australian and New Zealand College of Anaesthetists as to the duties of an anaesthetist. In hospitals with College approved training posts, specialist staff have additional educational duties. It is accepted that not all of these duties will be carried out by every anaesthetist.

2. CLINICAL DUTIES

2.1 Providing anaesthesia and other appropriate consultative services.

2.2 Carrying out pre-operative assessment and continuing management of patients (see College Policy Documents *'The Pre-Anaesthetic Consultation'* (P7) and *'Responsibilities of Anaesthetists in the Post-Operative Period'* (P20)).

2.3 Supervising anaesthesia trainees and other staff as appropriate.

2.4 Supervising the Recovery Area.

2.5 Supervising the anaesthesia component of the work of the Day Care Surgery Unit (see College Policy Document *'Guidelines for the Care of Patients Recovering from Anaesthesia Related to Day Surgery'* (P15)).

2.6 Organising and managing an acute pain service.

2.7 Associating with a Pain Management Unit where appropriate (see College Policy Document *'Minimum Standards for Pain Management Units'* (P25)).

2.8 Providing an acute resuscitation service for medical, surgical and trauma emergencies.

2.9 Supervising and/or assisting with managing patients in the Intensive Care Unit.

2.10 Providing a consultative service in respect of pre-operative assessment and management.

2.11 Supervising or managing cardiopulmonary bypass as appropriate.

2.12 Such other clinical services as may be necessary and appropriate to the specialty.

3. OTHER PROFESSIONAL DUTIES

3.1 Assisting with administrative duties relating to the proper functioning of the Department and the Hospital.

3.2 Providing and participating in appropriate educational activities for

- 3.2.1 anaesthetic trainees
- 3.2.2 intern and resident medical staff
- 3.2.3 medical students
- 3.2.4 trainee and postgraduate nurses
- 3.2.5 anaesthetic nurses and/or technicians
- 3.2.6 recovery area nurses
- 3.2.7 operating room nurses
- 3.2.8 other health professionals
- 3.2.9 interested community groups in subjects such as "basic life support".

3.3 Supervising the preparation of teaching material.

3.4 Participating in peer review and quality improvement activities to ensure and review the quality of patient care (see College Policy Document *'Quality Assurance'* (E9)).

3.5 Participating in continuing medical education to maintain personal knowledge and skills as established in the College's Maintenance of Standards Programme. Amongst objectives of this education, it is necessary to ensure that practice of anaesthesia is consistent with personal safety.

3.6 Contributing to activities of professional associations.

3.7 Participating in research and reviews on drugs, equipment, clinical management and techniques, physiological, pharmacological and other matters relevant to anaesthesia, pain relief, resuscitation and intensive care. These activities may include assistance to trainees with their formal project.

3.9 Contributing to advisory services as a member of Hospital Committees, Health Commissions and other organisations.

3.10 Contributing to professional anaesthesia related organisations.

3.11 Participating in activities to safeguard the wellbeing of colleagues.

4. THE APPORTIONMENT OF TIME BETWEEN CLINICAL AND OTHER PROFESSIONAL DUTIES

All anaesthetists should have a commitment to the continuing medical education of themselves and their colleagues. On average 10% of the normal working week should be allowed for this activity to ensure that personal professional standards are maintained. All anaesthetists also have commitments to administration, quality assurance and other educational duties. Time must be set aside for these duties which may be distributed throughout the staff of a department or practice group to allow for expertise to be effectively utilised.

4.1 *The Director of Anaesthesia*

4.1.1 The Director has a prime responsibility to ensure that the Department of Anaesthesia functions safely and effectively. Consequently administration comprises a significant part of the workload. In order to maintain a high personal standard of patient care, a minimum of 40% of the normal working week should be devoted to the activities outlined in sections 2.1–2.12 inclusive. This allows up to 60% of the normal working week to be scheduled for duties outlined in sections 3.1–3.11.

4.1.2 If the Director is not a full time appointee, appropriate time must be provided for clinical and administrative duties and personal continuing education needs.

4.2 *The Deputy Director of Anaesthesia*

4.2.1 In large Departments, a Deputy Director should be appointed to assist the Director with the administration of the Department.

4.2.2 Under these circumstances the Director and Deputy Director will between them ensure that a minimum of 40% of their joint working week is devoted to activities outlined in sections 2.1–2.12, and up to 60% to activities outlined in sections 3.1–3.11.

4.3 *The Whole Time or Staff Anaesthetist*

As well as responsibilities for clinical duties, the whole time or staff anaesthetist must have a commitment to teaching, to personal continuing medical education, to administration, quality assurance and other activities. In order to ensure a high quality of patient care, a minimum of 30% of a normal working week should be devoted to other professional activities as outlined in sections 3.1–3.11 inclusive.

4.4 *The Visiting Anaesthetist*

Provision should be made for the administrative and educational duties and responsibilities of visiting anaesthetists.

4.5 *The Trainee Anaesthetist*

The trainee is not a specialist — the trainee is a specialist-in-training. The supervision of the trainee is an essential component of the training experience (see College Policy Document *'The Supervision of Trainees in Anaesthesia'* (E3)). They should be assigned educational and administrative responsibilities appropriate to their level of training.

5. CONCLUSION

All staff must have sufficient exposure to clinical duties to maintain their skills. They must also have sufficient time set aside for other professional duties as defined in this document to ensure a high standard of practice both at a departmental or group level as well as on an individual basis.

RELATED DOCUMENTS

P7 The Pre-Anaesthetic Consultation
P15 Guidelines for the Care of Patients Recovering from Anaesthesia
P20 Responsibilities of Anaesthetists in the Post-Operative Period
P25 Minimum Standards for Pain Management Units
E3 The Supervision of Trainees in Anaesthesia
E9 Quality Assurance

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AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

ACN 055 042 852

AND

FACULTY OF INTENSIVE CARE

POLICY DOCUMENTS

E = educational. P = professional. T = technical. EX = examinations. IC = Intensive Care.

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E5 (1992) Supervisors of Training in Anaesthesia and Intensive Care *Bulletin Nov 92, pg 45*
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