

# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852



'ULIMAROA' 630 ST KILDA ROAD, MELBOURNE, VICTORIA 3004

# BULLETIN

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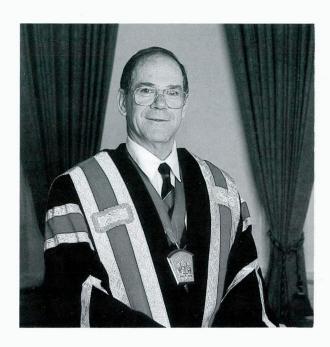
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## PRESIDENT'S MESSAGE



I am honoured to be elected President of your College. This is a good time to be President with the College now very well settled in the headquarters at Ulimaroa.

I am also fortunate in having a very able Vice-President, Professor Garry Phillips and a strong Council with enormous strength having been added with the recent election of Professor Michael Cousins, Professor Teik Oh and Dr Rod Westhorpe.

The College is moving forward. The recent ASM in Townsville was indicative of the way the College is progressing – this was not a success just because we had the largest registration we have ever had, but due to the high calibre of the Scientific Programme which continues to improve each year. Vic and Doreen Callanan should be warmly congratulated for the organisation of this meeting. They also deserve our thanks for the giant task they carried out as a team. It is clear that our independent meetings have been a great success and will continue to be so.

Next year our meeting is to be a combined meeting with the ASA, to be held in Perth in October. It is also planned that we should have a combined meeting with the surgeons in five years time and perhaps this should be repeated approximately every five years.

The Council recently approved the introduction of a Certificate in Pain Management. This programme will involve a balance of chronic and acute pain and will be available to Fellows and trainees who have passed the Final Fellowship examination in the first instance. The development of the Certificate in Pain Management is yet another milestone for the College.

Fellows and Trainees outside Melbourne are encouraged to utilise the College Library which is now connected to the WEB and provides additional communication with the librarian Miss Shanti Nadaraja.

Finally, I would like to extend my thanks to Dr Michael Davies who gave great service to the College as President and had much to do with important decisions on the move into Ulimaroa.

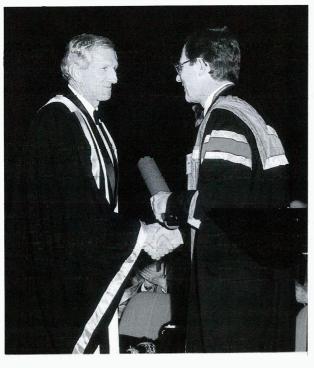
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N.J. DAVIS

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## HONORARY FELLOW CITATION - DAVID EGMONT THEILE

"The Council of the Australian and New Zealand College of Anaesthetists admits from time to time distinguished persons who have made a notable contribution to the advancement of the science and practice of anaesthesia and/or intensive care, who are not practising anaesthesia or intensive care in Australia or New Zealand".



Mr President, I have the honour to present to you **David Egmont Theile.** 

David Egmont Theile is currently the President of the Royal Australasian College of Surgeons, an office he has held with distinction.

He is a Queensland graduate (with Honours 1962) and holds Fellowship of the Royal College of Surgeons in England as well as the Royal Australasian College of Surgeons. He also holds a Master of Surgery from the University of Queensland.

David is a Senior Visiting Surgeon to the Princess Alexandra Hospital, Brisbane and has been awarded the title of Clinical Professor of Surgery within the University of Queensland. He is a well respected general and colorectal surgeon and has written widely on several aspects of surgery but in particular, colorectal surgery and combined surgical procedures for the treatment of oesophageal cancer.

David has made a great contribution in a totally different field—gold medals in back to back Olympic Games in the 100 metre backstroke and in 1956 he broke the world record at the Melbourne Olympics. He is one of the greats of Australian swimming in an era when Australian swimming was dominant. How often have we heard comments by sportsmen that they had to abandon their studies to concentrate on sport, and equally the claims that sports performance was impeded by the need to study.

David Theile managed to be the best in the world at his sport and at the same time not only was he a medical student but he graduated with Honours and was awarded the Prize in Surgery and the Prize for All-Round Achievement. He has managed to keep up his swimming, in spite of a busy surgical life and in 1988 broke the world record for backstroke in the 50 years age group. He is an Honoree of the International Swimming Hall of Fame and the Australian Sports Hall of Fame.

Despite these impressive achievements we are honouring David Theile for another reason this evening, that is, his notable contribution to the affairs of the Australian and New Zealand College of Anaesthetists, and the former Faculty of Anaesthetists, Royal Australasian College of Surgeons.

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From an early stage in his time as a Councillor of the Royal Australasian College of Surgeons, David became involved with the Faculty of Anaesthetists. One of the many offices which he held on the RACS Council was Convenor of the GSM in Brisbane in 1988 where he was responsible for appointing Anaesthetists to pivotal roles within the Organising Committee. He was anxious to ensure that the Faculty of Anaesthetists played an integral part in the proceedings of the meeting, and was most helpful to and supportive of the Faculty Convenor. As a result of this gesture, in what was a most successful meeting, Anaesthetists continued to play a vital role in the organisation of subsequent GSMs of the College and Faculty to the mutual benefit of both the Royal Australasian College of Surgeons and the Faculty of Anaesthetists.

More recently, David Theile has presided over the Royal Australasian College of Surgeons at a most memorable time in the history of our specialty; the changing of the Articles of Association of the RACS to eliminate "Faculty of Anaesthetists" and the move of the Australian and New Zealand College of Anaesthetists from Spring Street to Ulimaroa. We are proud of our headquarters and (I know David Theile is very envious of them!)

David was in no small way responsible for the move being amicable and carried out in an orderly fashion enabling the two Colleges to remain in close co-operation.

Finally, David was largely responsible for the decision by the Royal Australasian College of Surgeons to present our College with the gift of our magnificent ceremonial mace.

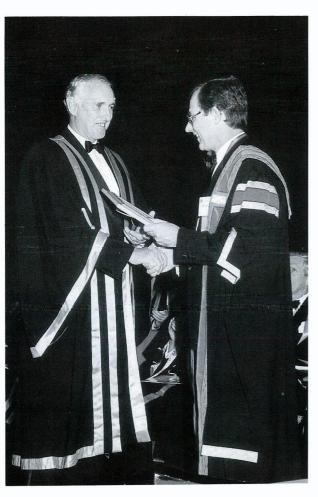
Mr President, it is indeed fitting that in his home state, I have the honour to present David Egmont Theile for conferment of Honorary Fellowship.

Neville J Davis



## ROBERT ORTON MEDAL CITATION - BENEDICT JOHN BARRY

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



Mr President, may I present **Dr Benedict John Barry** for the award of the Robert Orton Medal?

Dr Barry is well known to anaesthetists in Australia, New Zealand and beyond as the founding editor of *Anaesthesia and Intensive Care*, the journal of the Australian Society of Anaesthetists.

In undertaking to establish the journal (in 1970 when he was the Honorary Federal Secretary of the ASA) Ben Barry was acting against the firm advice of quite a few senior members of the specialty in Australasia. Eighteen months passed between his being appointed editor and

the publication of the first issue. This was a most arduous period for the fledgling editor, singlehandedly soliciting manuscripts, approaching advertisers and announcing his intentions to the editors of other journals in the field abroad, and not always being met with encouragement.

I look back with admiration on the day in June 1972 when as a young resident at St Vincent's, I witnessed the discussion of the members of the Department of Anaesthetics as they thumbed the first edition of their new journal and congratulated the editor on his achievement. As Professor Douglas Joseph wrote a decade later in the editorial to mark the end of Dr Barry's editorship, "The foundation and continuity of this journal have been due almost entirely to the dedication and efforts of its first editor".

Nor was the praise confined to his local colleagues. To quote Professor Cedric Prys-Roberts on the occasion of Dr Barry being elected to Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons in 1987, "More than anyone else, Ben established this journal which we now recognise as one of the leading English language journals in the world". The only person whose contribution would come within cooee of Ben's was Sue Butterworth who was the ASA Secretary in 1970 and became manager of the journal during Ben's editorship.

This achievement alone would suffice for the award which you are to bestow on Dr Barry this evening. However, I am sure you would like to know more of this dynamic anaesthetist and something of his other attributes and achievements.

Ben Barry was born in 1936 in Cooma and spent his childhood in the Monaro district of New South Wales. He was educated at the Moonbah Public School, Christian Brothers College, Waverley, and the University of Sydney where he was a resident of St John's College and rowed in the University Eight. He is one of that band of happy doctors who claim Sydney Hospital as their teaching hospital.

After graduation he was a resident and a registrar at St Vincent's and then the Children's Hospital. He won the Cecil Gray Prize at the Final Fellowship Examination in 1965.

With his training completed Ben adopted the life of a private anaesthetist and joined the famous practice at Elizabeth Bay known as General Anaesthetic Services, or "GAS". He attained honorary appointments at Prince of Wales, Repatriation General Hospital, Concord and St Vincent's. When an executive structure was established in the Department at St Vincent's in 1981 he was the inaugural Chairman. He has also been deeply involved in committee work at the other institutions on the St Vincent's campus, namely the private hospital and St Vincent's Clinic.

Ben generously placed his remarkable talents at the disposal of both the Australian Society of Anaesthetists and the Faculty of Anaesthetists of the Royal Australasian College of Surgeons.

Where the ASA is concerned, after a four year spell as Honorary Federal Secretary he was President from 1986 to 1988. Amongst the honours bestowed upon him by the Society are the Gilbert Brown Medal, 1975, and Honorary Life Membership, 1988. Just as he was handing over the editorship of the journal he stepped into the breach to contribute the final chapter of "50 Years, the History of the ASA". His chapter covers the years of fulfilment, 1962-1984.

Perhaps his greatest contribution as President of the ASA was in his presidential address given at the Annual General Meeting in Ballarat in 1988. His topic was "Anaesthesia, Ideals and Reality" and he argued forcefully for the separation of the Faculty of Anaesthetists from the Royal Australasian College of Surgeons and for the foundation of our own College. Once this speech was delivered it was only a matter of time, and a lot of hard work by the Board of Faculty and others, before the prophecy became reality.

Mr President, Ben Barry is no stranger to this College nor its progenitor, the Faculty. He was an Examiner for the Faculty's Final Fellowship Examination from 1972 to 1984. From 1976 to 1981 he was a member of the Board of the Faculty and during that time filled the important offices of General Scientific Meeting Officer and Continuing Medical Education Officer.

Ben's prominence in the Australian Society of Anaesthetists led to ongoing involvement in the World Federation of Societies of Anesthesiologists, including being Vice-President for four years from 1984. He is the Honorary President of the 11th World Congress of Anaesthesiologists to be held in Sydney next year.

Mr President, one might ask how this shy man has managed to do so much for Australasian anaesthesia through his contributions to both this College and the Society. In examining Ben Barry's achievements one finds not one unifying thread but three. The first is his vision. One reason Ben has been a leader is because of his ability to see opportunities. Wedded to his vision is a blend of enthusiasm, application and at times dogged determination which together form the second thread. The third is that he is astute. In Committee or in an executive role he always goes straight to the heart of the matter. He is most dismissive of waffle and woolly thinking.

Over and above all of this, Ben is a family man. He and Colleen have conducted their own trans-Tasman alliance for more than 30 years, a paradigm which this College can but do well to imitate. They are the parents of four adults now making their way in the world.

How does an anaesthetist who has worn so many hats, and many of them concurrently, find time for relaxation? Ben's answer is to spend the weekend at "Banyan", his property at Crookwell in the southern highlands, going about his chores as a farmer and tending his flocks.

Mr President, it is indeed my honour and pleasure to present Dr Benedict John Barry for the award of the Robert Orton Medal.

Brian F. Horan

#### **Honours and Appointments**

Professor Michael J Cousins, NSW – AM, Member of the Order of Australia.

**Dr Peter L Klineberg**, NSW, Associate Professor of Anaesthesia, University of Sydney.

**Dr Brian F Horan,** NSW, Visiting Professor, Prince of Wales Hospital, Chinese University of Hong Kong, April 1995.

**Dr Greg E Knoblanche,** NSW, Clinical Associate Professor of Anaesthesia, University of Sydney.

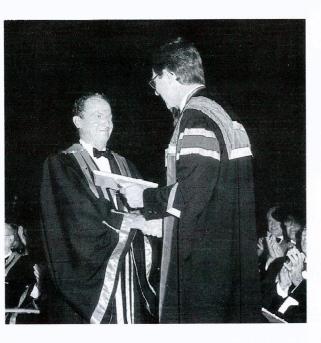
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## ROBERT ORTON MEDAL CITATION - PETER DAVID LIVINGSTONE

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



Mr President, I have the honour to present to you Clinical Associate Professor Peter David Livingstone.

Peter Livingstone graduated in Medicine from the University of Queensland in 1959. He commenced his anaesthetic training at the Royal Brisbane Hospital in 1961 and continued it in Melbourne in 1963. Here he had appointments at the Royal Women's, Royal Children's and Alfred Hospitals and came under the influence of notable anaesthetists such as Gretta McLelland, Kevin McCaul, Bill Crosby and Robert Orton, after whom this award is named.

In 1965 he gained the two part Diploma of Anaesthesia of the University of Melbourne, considered an extremely difficult qualification to obtain at that time, returned to Brisbane and entered specialist anaesthetic practice.

As a result of his Melbourne experience, Peter's activities encompassed obstetric, paediatric and neurosurgical anaesthesia and his first visiting specialist appointment was to the neurosurgical unit at the Royal Brisbane Hospital. However, his great interest has always been

obstctric anaesthesia. Following the teaching of Kevin McCaul he was influential in introducing an obstetric epidural service to Brisbanc, carried out initially virtually by himself, but later due to his example by many members of the practice of which he was a senior associate

In 1970 he was appointed as the first visiting anaesthetist to the Royal Women's Hospital and thus began a teaching commitment to our trainees in obstetric anaesthesia that continues to this day.

In 1989 he was elevated to the status of Scnior Visiting Anaesthetist and in 1991 in recognition of his contribution to teaching, he was awarded the title of Clinical Associate Professor of Anaesthesia within the University of Queensland.

It is a measure of the capacity and determination of this man that in 1973, at the height of his clinical and teaching involvement, he obtained the Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons by Examination.

This capacity and determination spread into the organisational arena. Peter was elected the Secretary of the Queensland Section of the Australian Society of Anaesthetists in 1973, and in 1976 was the Convenor of the AGM of the Society in Surfers Paradise. This meeting with its logo of the Smart Anaesthetist and large reproductions of illustrations of the history of anaesthesia, set the standard by which subsequent AGMs came to be judged. Peter's input into the organisation of this meeting was prodigious.

Finally Peter turned his interest to the affairs of the Faculty of Anaesthetists. He was elected to the Queensland Regional Committee in 1974 and he became its Chairman in 1978, thus starting an illustrious career with our organisation.

Peter was elected to the Board of the Faculty in 1981, where his potential was quickly recognised. He became Treasurer of the Faculty in only his second year as a Board member and immediately proceeded to exert a profound influence on its financial affairs.

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He sought and obtained astute advice on financial investments and was responsible for introducing the College of Surgeons' "subscriptions in advance" scheme to the Faculty. Although this was a somewhat contentious issue at the time, the scheme placed the Faculty Foundation, in particular, in a very strong financial position. Fellows of the College can be extremely grateful to Peter for the sound financial position in which we find ourselves.

Confidants within the Faculty Board assured me that even at this early stage Peter was seen as "Dean material" and so it was to be. After a period as Chairman of the Executive from 1984 and Vice-Dean from 1987, he was elected Dean of the Faculty in 1990.

Arguably his greatest contribution to our specialty was yet to come. During the Deanship of Barry Baker the Faculty was moving progressively towards independence, and the foundation had been laid for establishing the Faculty as a legal entity with its own Articles of Association, but the task of bringing this to fruition Peter took on his own shoulders. As a direct result of his courage and determination, the Faculty acquired collegiate status. The wisdom of the expedience with which this was accomplished was not apparent to some, but the passage of time will continue to reveal Peter's foresight in this manoeuvre and that the Fellowship of this College will be forever in his debt.

And so in February 1992, Peter became the College's first President and the Faculty's last Dean.

In 1994, as a lasting tribute to Peter's capacity for wisdom and sound judgment, the Royal Australasian College of Surgeons elected him to its Court of Honour, so that august body could also avail itself of his wise counsel in the future.

Mr President, I submit that Peter Livingstone has indeed, on a wide spectrum of activities – clinical, organisational and collegiate – satisfied the criterion for the award of this medal – that is, distinguished service to anaesthesia, and so it gives me great personal pleasure to present to you for the award of the Robert Orton Medal, my sometime teacher, mentor, professional associate, fellow Councillor and close personal friend, Peter David Livingstone.

David H. McConnel

## MAINTENANCE OF STANDARDS

Two main issues have arisen since the last *Bulletin*. The first is a concern raised by some Fellows that their clinical practice in anaesthesia is not 30% or more, and they may not be eligible to join the programme.

In view of the fact that non-College agencies may require participation of all medical practitioners in some form of MOS Programme, it is important for Fellows of ANZCA whose practice does not fall within the province of another similar programme (e.g. Faculty of Intensive Care), to register for the ANZCA MOS programme. A comment on the annual return should be made, indicating the nature of clinical practice. A review of the firstyear's Returns will assist in revision of the programme during 1996.

The second item of relevance is a decision by Council that Annual Returns in future will contain a statement to the effect that the Fellow certifies that s/he is free of chemical dependency, and has no condition which would preclude the safe practice of anaesthesia.

GARRY PHILLIPS
Maintenance of Standards Officer

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## 'Ulimaroa'

## Origins of the name of the Headquarters of the Australian and New Zealand College of Anaesthetists

MICHAEL G COOPER, Honorary Historian, ANZCA

In late 1769 Captain James Cook, in the bark *Endeavour*, was heading west across the Pacific after observing the Transit of Venus in Tahiti on the first of his three famous voyages. This was a well planned voyage of scientific discovery and exploration, with Joseph Banks and Dr Daniel Carl Solander aboard – two of the most prominent naturalists of their day. The passage of Venus between the Earth and the Sun was an extremely important phenomenon at the time as this helped towards calculating the distance from the earth to the sun and added greatly to the astronomical knowledge of the day which was essential for navigation. This occurrence was not to recur for over a century until 1874 (the next was in 1882, there were none in the twentieth century, but there are two opportunities from 2000 to 2010).

Cook also carried secret instructions from the Lords of the Admiralty which were to verify the presence or absence of the Great South Land – *Terra Australis Incognita*. Cook had, like other explorers such as Bougainville, long thought such a continent was a myth, and if this failed he was to explore New Zealand which had been discovered in 1642 by Abel Tasman (as was Van Diemen's Land – now Tasmania).

On October 7, 1769, New Zealand was sighted and Cook proceeded north along the east coast of the North Island. On board the *Endeavour* was a Tahitian priest named Tupia whom Banks had brought with them. Banks had become reasonably fluent in the language during their three months in Tahiti and Tupia had developed some skills in English. Tupia had acted as a guide for Cook and Banks in Tahiti and was invaluable on their journey across the Pacific as the *Endeavour* stopped at other islands and also in New Zealand.

By late December, in heavy seas, Cook was rounding North Cape and near a point named by Tasman as Cape Maria van Diemen, Joseph Banks and Tupia spoke with some Maoris. These people, when asked about other lands, provided an unexpected answer stating that some of their people had been to a great land many years previously that was about a month's canoe trip northwest. They called this land 'Ulimaroa'. This extent of exploration is not surprising considering the seafaring skills of the Polynesians and the fact that they visited almost every island east of Australia, including Norfolk Island.

The name *Ulimaroa* was recorded in Banks' or Cook's diary which were edited by John Hawkesworth with his own 'literary' flavour. Hawkesworth was a pompous scholar who was not on the voyage but wrote the official An Account of the Voyages undertaken by the Orders of His Present Majesty for making discoveries in the South Hemisphere (London, 1773). (Joseph Banks made another contribution to anaesthesia – it was an ageing Banks who acted as mentor for Charles Waterton and encouraged him to go to Guiana in 1804 to obtain samples of the deadly blow-pipe poison currare).

The *Endeavour* continued down the west coast of the north island with Cook discovering the strait that now bears his name and was the first to circumnavigate and chart both the north and south islands of New Zealand. He then headed west across the Tasman Sea and his running survey of over three thousand miles of the east coast of Australia was one of the most remarkable feats of mapping and navigation to that date.

Earlier names for Australia included Java-le-Grande and Terra Australis with Cooka and Banks preferring New Holland. The name Ulimaroa was taken up by an eccentric Swedish cartographer, Daniel Djurberg (1744-1834) and was copied only by the Dutch cartographers for a short period from 1780-1818. The first of these was Friedrich G Canzler in 1795 and others who followed were Akerland, von Reilly, Reinecke and Swoboda & Hartl. Some of these early maps showed Tasmania connected to mainland Australia.



Figure 1. A Dutch map showing Australia as 'Ulimaroa' or New Holland -Canzler 1806.

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It was to be Matthew Flinders who provided the final solution about the name. In 1804 he wrote, "I call the whole island *Australia*, or *Terra Australis*" a year after his circumnavigation of the continent proved finally that New Holland and New South Wales were a single landmass and he had circumnavigated Tasmania several years previously. Flinders, on his journey to England, was imprisoned in Mauritius for seven years and did not reach London until 1810. Banks did not like the name Australia nor did the major map publisher of the day, Aaron Arrowsmith and *Australia* did not reach common usage until the early 1820s.

John Traill (1826-1918) was a Scot who had been involved in coastal shipping since his arrival in Australia in 1855. Over the next 35 years several shipping businesses were amalgamated into the Huddart, Parker & Co. – coal importers and shipping merchants who later expanded into the Tasmanian and New Zealand trade, and Traill became company chairman in 1895.

Traill, given his nautical background, also had a particular interest in Pacific history and cartography and so named his home *Ulimaroa* when he moved into the

house not long after its completion in 1890. His family resided in the house until 1946.

Cook's first voyage was paramount in the history of Australia and New Zealand and so it is an appropriate historical connection that it was on this voyage that an early Maori name for Australia should also be the home of the Australian and New Zealand College of Anaesthetists.

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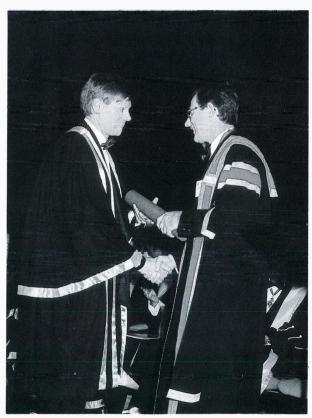
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Foundation Visitors to the Townsville ASM being presented to the President. Left: Dr Chris Eagle. Right: Professor John Sear.

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## LAW REPORT

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

### **EUTHANASIA**



Law reform proposals are now heading into the murky waters of "euthanasia".

Consideration of legislation in the Northern Territory – "The Rights of the Terminally Ill Bill" – has produced much angst in political and medical circles. The recent open letter by seven Melbourne doctors to the Premier of Victoria, declaring that they have helped terminally ill patients to die, has confronted legislators with a very emotional debate. The seven doctors declared:

"Each of us who have signed this letter has personal experience of treating terminally ill people, whose condition has moved them to ask for assistance in suicide, and each of us has, on occasion, after deep thought and lengthy discussion, helped such a patient to die"."

The Premier of Victoria has indicated that he would not propose to change legislation in Victoria, unless there was general community consent and pressure within the medical community for change. Judging by comments from some doctors' groups, including the AMA, this is unlikely.

#### The Northern Territory Legislation

However, the Northern Territory Government clearly intends to lead the pack. "The Rights of the Terminally Ill Bill" permits a patient who has been informed by a medical practitioner that the patient is suffering from a terminal illness and, who is experiencing pain, suffering

and/or distress to an extent unacceptable to the patient to request the medical practitioner to assist the patient to terminate the patient's life (Section 4). A doctor who receives the request may assist the patient to terminate the patient's life (Section 5). "Assistance" includes the prescribing of a substance, the preparation of a substance, and the giving of a substance to the patient for self-administration, and the administration of a substance to the patient (Section 3). These conditions only apply:

- if the patient is over 18 years of age;
- the doctor is satisfied that the patient is likely to die from the illness, there is no reasonable expectation of a cure, and any treatment available is limited to palliative care;
- a second doctor, with psychological qualifications, confirms that opinion;
- the illness is causing severe pain or suffering;
- the doctor has informed the patient of the nature of the illness and its likely course and the treatment that might be available;
- the doctor is satisfied on reasonable grounds that the patient is competent to make the decision and has done so freely and voluntarily, and that the patient has considered the implications of the decision for the patient's family; and
- after due consideration, the patient has signed a certificate of request in a prescribed form witnessed by the doctor.

There are other procedural requirements as well (Section 7).

Under the Bill, it is not permitted to give or promise any reward or advantage, or threaten to cause any disadvantage to a doctor for refusing to assist, or compelling or persuading the doctor to assist or refuse to assist in the termination of a patient's life (penalty \$10,000 – Section 6). Similarly, a person cannot, by deception nor improper influence, procure the signing or witnessing of a certificate of request (penalty \$20,000 or 4 years imprisonment – Section 11).

Under the Bill, all medical records are to be kept. A copy of the "certificate of request" is to be sent as soon as practicable to the Coroner. Immunity is given from criminal sanction which might otherwise apply to the

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doctor's conduct. Wills and policies of insurance are not invalidated by reason of any termination pursuant to the legislation.

Only a patient suffering a terminal illness may request termination of their life. However, "terminal illness" means an illness which, in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient. "Illness" includes injury or degeneration of mental or physical faculties. On a literal construction of these terms, it may seem that merely being elderly qualifies under this provision. The provision applies if death may result "without the application of extraordinary measures", or "of treatment unacceptable to the patient". It would seem contrary to the intention of the legislation that, if a patient chose to refuse treatment (e.g. refusing to take any more heart tablets for heart disease), they could be said to be suffering from a "terminal illness" because of the refusal of the treatment.

The original Bill had stipulated that "terminal illness" would be one where death was likely within the period of 12 months. The removal of this limitation significantly broadens the range of people who may qualify as "terminally ill".

The legislation provides for a 9-day waiting period following request for the euthanasia. This does not seem like an acceptable waiting period, to the extent that the decision is affected by any personal crisis, emotional state, or other treatable psychological condition. It could be strongly argued that a longer waiting period should apply, given the seriousness of the request and consequences.

Sections 7 and 8 also require consideration of palliative care. The certifying doctor is to inform the patient of the nature of the illness, its likely course, the medical treatment, including palliative care, counselling and such psychiatric support and extraordinary measures for keeping the patient alive that may be available. If the doctor has no special qualifications in the field of palliative care, then the information to be provided is to be given by a medical practitioner, who does have such special qualifications (Section 7(3)). A doctor is not to assist a patient under the legislation if, in his or her opinion, there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient (Section 8). Such provisions, of course, remain subjective, and ultimately relate to what is or what is not acceptable to the patient.

News reports confirm the flurry of activity in the Northern Territory Parliament in the dying hours (no pun intended) of the debate on this legislation. It is clear that many of the terms used in the legislation are broad and may be open to interpretation. It would be disappointing if interpretations are permitted, which otherwise seem contrary to the

intention of the legislation. On such an important issue, parliaments have an obligation to ensure that the terms and provisions of the legislation are certain, easily understood and not open to misconstruction or unintended consequences.

No doubt, the Northern Territory legislation has and will provoke intense debate, not only for its essential provisions, but the policy and philosophy on which it is based. Already there has been much controversy generated in the media and journals regarding this subject.

#### **Broad Policy Issues**

At present euthanasia is a crime of murder, and assisting suicide is, in many States, a criminal offence. There is a distinct difference between palliative care, which seeks to address an illness by providing comfort, but which may hasten inevitable death. This contrasts with active intervention to produce termination of a patient. Doctor Brian Pollard, author of *The Challenge of Euthanasia* has defined "euthanasia" as "the intentional taking of the life of another person, whether by action or omission, for compassionate motives. It is voluntary when done at that person's request, and non-voluntary when done without request". Dr Pollard recognises the anguish involved in decisions affecting the terminally ill, but cautions against any rush for change, and seems to conclude that any change is fraught with great danger:

"In calling for euthanasia, what is sought is an apparently simple and compassionate solution to a complex and daunting challenge, without examining possible adverse outcomes as well as the anticipated advantages. To ignore or play down some of those grave consequences would, in my opinion, be a great dereliction by doctors and lawyers. It cannot be claimed that abuses would not occur, because they are already occurring, here and elsewhere."<sup>2</sup>

Dr Pollard cites the experience in the Netherlands, where legislation has operated since 1990. A Government appointed Committee to investigate practices in 1990 (the Remmelink Report) produced some surprising conclusions. It has been suggested that the Remmelink Committee released findings that 129,000 people died in the Netherlands in 1990. Of these, 2,300 (1.8%) were killed by physicians on their patient's request, and a further 400 committed suicide with their doctor's assistance. It has also been suggested that the Remmelink Committee found that, at least 1,000 were terminated without formally requesting euthanasia.<sup>3</sup>

David Oderberg, a commentator in the Australian Financial Review<sup>4</sup>, concluded that:

"What the Dutch exprience shows is that, even with stringent safeguards, once voluntary euthanasia is legalised, the descent down the slippery slope is

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inevitable. Patients will be killed without request, even against their will (as surely must have occurred in at least some of the cases referred to in his article). Doctors will become hired agents of death and some (such as the good Dr Kevorkian in the United States) will specialise in refining and using technology for the one and only purpose of killing others, perhaps whether they request it or not."

In reply, Dr Helga Kuhse, also in the *Australian Financial Review*<sup>5</sup>, suggests that the "slippery slope" arguments are based on a false premise. Evidence of the Netherlands situation does not produce any relevant data for comparison with Australia or other countries. Dr Kuhse suggests that similar figures might be reflected in Australia, if proper research were carried out. Dr Kuhse also suggests:

"There may have been more, or less, unconsented to killings in the Netherlands before voluntary euthanasia became permissible. We simply do not know

Again, there may be more or less (unconsented to) killings in Australia than there are in the Netherlands. We simply do not know . . .

The Northern Territory Bill is concerned with only "euthanasia", in the narrow sense, that is, the administration of a non-therapeutic drug, but... figures from the Netherlands derive from a wide definition of euthanasia and killing.... This means that many more patients were "killed" by non-treatment and palliative care ... than through the administration of a non-therapeutic drug.

In Australia, competent patients have a common law right to refuse medical treatment, and doctors are allowed, and indeed required, to act on such refusals, even if this will result in the patient's death. There is also an emerging legal opinion that doctors may administer potentially life-shortening pain and symptom control."

Dr John Buchanan, a Consulting Psychiatrist, argues against euthanasia legislation<sup>6</sup> –

- It would result in an unreasonable pressure on all terminally ill patients.
- 2. Such legislation would create a change to the role of health care professionals to the detriment of society, and loss of trust in health care professionals.
- It would create unreasonable pressure on all disabled people in society, creating the concept of "a life not worthy to be lived".

Dr Buchanan suggests that euthanasia proposals have been examined by inquiries in Britain and in Victoria, with the conclusion that adequate safeguards are not possible. Dr Brian Pollard also concludes that euthanasia has not been legalised in many countries, because it has not been found possible to remove some of the potent sources of abuse –

"No matter how carefully guidelines were worded, they would be practised through the medium of inequity and bias, which characterise our social services, including health. Those exposed to the greatest risks would be the unwanted, the poor, the elderly, minority groups, and those without access to good care."

Dr Pollard also refers to a "working paper" of the Law Reform Commission of Canada (1982), which comments:

"The principal consideration in terms of legislative policy . . . remains that of possible abuses . . . First of all, there is a real danger that the procedure developed to allow the death of those who are a burden to themselves may be gradually diverted from its original purpose and eventually used as well to eliminate those who are a burden to others or to society . . . There is also the constant danger that the subject's consent to euthanasia may not really be a perfectly free and voluntary act."

The seven doctors in Victoria have publicly declared the very strong and emotive issues involved:

"We respect life. All of our professional training and work deepens that respect. However, the reality is that there are some patients who are beset by physical and mental suffering which is beyond the reach of even our most sophisticated efforts to control. When such patients clearly and repeatedly express a rational plea for help, it is out of respect for them that we have felt compelled to act."

Given these recent Australian developments, the euthanasia debate has certainly taken on "new life". However, the very real legal, philosophical and social issues involved guarantee that the debate will not be easy, and that any resolution is likely to involve lengthy and acrimonious debate.

It is probably a debate that many legislators would wish to avoid.

 $Iam\ indebted\ to\ Dr\ Pollard\ for\ comments\ on\ this\ article.$ 

- 1 Melbourne Age, 25 March, 1995.
- 2 Pollard, "The Fatal Attraction of Euthanasia" delivered to Medico-Legal Seminar, Sydney, 14 February, 1995.
- 3 Oderberg, Australian Financial Review, 22 March, 1995.
- 4 ibid.
- $5\quad \text{Kuhse, } Australian\,Financial\,Review,\,28\,March,\,1995.$
- 6 Melbourne Age, 28 March, 1995.
- 7 Pollard, op cit.
- 8 ibid.
- 9 Melbourne Age, 25 March, 1995.

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## PALLIATIVE CARE IN AUSTRALIA

The first palliative care service in Australia was established by Dr Rosalie Shaw early in 1981 at the Repatriation General Hospital, Perth. At that time, and indeed for several years more, the term 'palliative care' was unknown to most doctors and nurses. The stimulus to commence services in other States came from the occasion of the World Congress of Palliative Care, in Montreal in October 1980. There, about thirty Australians, mostly nurses but including a few doctors, met unexpectedly, being unknown to each other, and resolved to take some joint action on their return.

This was done at a meeting in Adelaide a few months later, where delegates agreed to set up palliative care organisations in each State, as soon as circumstances permitted. This occurred almost at once in some States, while the Northern Territory has yet to make a start.

These services, while having general features in common, have developed in different ways in different places, those differences being determined by levels of government support, patterns of population distribution, degrees of local expertise, enthusiasm, influence and vision, and availability of professionals.

Nurses who saw both personal satisfaction and career opportunities in palliative care have never been in short supply, since it is a logical extension of their caring expertise, but doctors have been more difficult to recruit here, as they have elsewhere. Doctors' training prepares them to act and take responsibility on their own initiative, leaving them often less comfortable with team efforts, especially those shared with, rather than delegated to, nurses. Additionally, doctors were unaccustomed to finding themselves less knowledgeable about what was really needed for patients, because many nurses had trained themselves well in the new methods before doctors became aware of its real benefits.

Dr (now Dame) Cicely Saunders, in turn a social worker, nurse and doctor, had developed her personal philosophy of care for the terminally ill while working at one of London's hospices. When it presented, she took the opportunity to found her own hospice, St Christopher's, where she had free rein to put her practices to the test. She employed a doctor experienced in research method who was able to prove in due course the superiority of the new ideas. New ground was broken in several directions.

First, it had never previously been considered that dying persons required any distinct forms of medical treatment – since there was nothing new about dying, what was new about their treatment? This was a far bigger hurdle to overcome than appears from that simple statement, engendering bemusement and active opposition.

Second, she challenged two of the most entrenched 'basics' of medical treatment, when she claimed that the pain of terminal illness needed different strategies from those traditionally used for acute pain, and that the pursuit of symptom control was now a proper therapeutic aim. The classic line had been that finding the cause of symptoms was the better aim – when that was done, treatment would fix the symptoms. Saunders saw what now seems obvious but was then minor heresy, namely that since the cause of distress in the dying was already known but could not be removed, better and increasingly refined treatment of symptoms must be sought in order to provide consistently high levels of comfort.

Regarding physical pain, she realised that in terminal illness, pain would be either constant or recurrent unless constantly suppressed. Her remedy challenged the concepts that pain should only be treated when it was actually present, and that addiction or dependence were serious risks. Overcoming them has proved an enormous task, not yet by any means complete, with too many doctors and nurses still withholding necessary relief for these spurious reasons. Saunders' regime was to give enough analgesic to suppress pain, totally if possibly, and then to give further doses at regular intervals, to forestall the return of pain, which otherwise would be inevitable. With careful selection of drugs and dosage regulation, a recurrent or constant painful state could usually be converted into a pain-free continuum.

Other major contributions were:

- her insistence on high standards of medical care, so that every medical advance was known about and applied, if it could benefit a particular patient. Thus, palliative care was really the opposite of what it was often accused of being, namely anti-therapeutic
- the confirmation that morphine was effective by mouth, when the vagaries of gastric absorption and first-pass metabolism in the liver were taken into account. This knowledge was crucial to achieving ease of pain control, but also to enabling many patients to be treated out of hospital, freed of dependence on injections
- the importance of effective communication about the illness, its prognosis and treatment options, to facilitate medical decisions by the patients in their own best interests. Such honest dealing, including family members, does not necessarily extend to giving the whole truth, when it is clear that that would not be wanted, though there is no place for dishonesty, even at the prompting of distressed relatives

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- the recognition of the power of the mind/body nexus in those who are seriously ill. Pain, fear and depression are a potent combination, needing to be recognised and understood, as far as possible. Second in importance only to pain control, and intimately linked to it, is the need to address anxiety, anguish and emotional turmoil, so they can be met and replaced with mental calm, confidence and trust. When this can be achieved, over time and with continued support, because one can never be sure what the next day may bring in patients with progressive disease, life can be transformed, to enable relationships to be enjoyed in peace, boosted by the security of knowing that the carers will not desert
- the demonstration of the patient and family benefits to be obtained from respecting the patient's autonomy. In some other medical areas, the requirement for this has moved from being desirable to being legally mandated. Saunders' prescience has been confirmed.

The limitations of palliative care, however, must be acknowledged. While the above description is valid for many, and while its elements remain the goals to be sought for all, they will sometimes be unattainable. The reasons for this may be recalcitrant physical symptoms, such as weakness, anorexia, cachexia, vomiting and some of the most difficult forms of pain, or may be chiefly emotional. Only some of the latter may relate to the illness itself. Many emotional problems are due to the patient's character, to personal relationships or aspects of the social setting. These may be inaccessible to correction by the attendants on account of the individual's limited psychological coping skills. Those who practise palliative care cannot work miracles; they can generally only help patients find and exploit their innate skills in these areas, though it is not uncommon for such therapeutic 'failures' to be laid at the door of palliative care, when the family or the community hold the real key, if indeed one exists.

Because euthanasia is so topical now, and because effective palliative care is intimately concerned with the physical and mental plight of dying persons, the role of palliative care must be examined, vis a vis euthanasia.

Pain control. Even though good care can now abolish or relieve most of the pain of terminal illness, to the extent that those who work in palliative care rarely receive a request for induced death, poorly relieved pain abounds. This is known and feared by the community, but they don't know that much of that pain is unnecessary. Understandably, it is hard to convince them because, if it were true, they reason that surely doctors would relieve it. Less understandably and less to their credit, unrelieved pain is quoted by doctors as the chief reason why they have already practised euthanasia, or would do so if it were

legal. Why is this the case? The reasons are numerous, but they relate to consistently inadequate medical education in this area, right up to the present. This stricture includes self-education, as well as formal.

If euthanasia were to be legalised, the blame would lie, in large measure, at the door of inept educators; individual doctors are required by law to practise at the known standards, and if they cannot do this, to find out or consult with experts. Although doctors who have carried out euthanasia never reveal what actually happened, it is inconceivable that they have regularly consulted with palliative care experts. Whether euthanasia was ever necessary, on medical grounds, can rarely be known.

Mental anguish. The position here is similar, with a couple of added specific factors. One is that, if the anguish were social in origin, taking life for that reason by a doctor or anyone else would clearly be an abuse of the highest order. Doctors cannot be used to rid society of those it does not want. The other factor is the frequent association between the serious wish to die and mental illness, usually depression, with an incidence as high as 95%, according to psychiatrists with expertise in suicide. Depression is difficult for ordinary doctors to diagnose and is often missed in those already under medical care, though expert treatment can abolish such ideation in 70% to 90% of patients.

Currently, however, calls for the legalisation of euthanasia often rest on the claim of a right or entitlement to choose freely the time and manner of one's death. If such a claim were valid, the quality or availability of palliative care would be irrelevant. A full examination of the validity of such a claim is beyond this article, but some points for mention are these: no such right is known in law or ethics, and never has been known; it has long been recognised in law that free choice in individual cases could rarely be guaranteed, because coercion of the vulnerable is already common, and is easily concealed; in the Netherlands, medically managed death has effectively passed into the hands of doctors, who can suggest euthanasia and present it in ways that leave patients thinking it is the only real option, and all done with legal encouragement and protection; the role of the second party (the doctor) is too often disregarded. If a patient asked several doctors, who all refused, for induced death, and then found one to agree, whose choice would have determined the act of euthanasia? It would have come about through the choice of the last doctor, whose ethical position, the criteria used for assessing the value of that life (for which purpose none exist, objectively) and motivation are all exempt from scrutiny, leaving much latitude for abuse.

If improved chemotherapy for a common form of cancer were to be found, and more than ten years later many doctors still knew little about it, or knew about it but failed to call in an expert when necessary, or worse, were taking life on request to solve the problem, the outcry would be deafening. Could it even be imagined that a suggestion that such killing should be legalised would be given credence, rather than oblige every doctor to put the known remedy into practice? Rushing to euthanasia, before ensuring effective care, cannot be justified. It would be a reflection that as a culture we are turning away from efforts to improve our care of the mentally ill, the infirm, and the elderly, and instead, licensing the right to abuse and exploit their fears.

Palliative care, like every solution to every intractable problem, is no panacea. Whatever the position regarding euthanasia, the community deserves appropriate standards of palliative care, from every doctor who treats terminal illness. If, after this had been achieved, it could be shown that there were still some patients for whom euthanasia seemed the only humane solution, it would also be better known what would be needed to achieve this safely, while protecting the lives of all who did not wish to be killed.

BRIAN POLLARD

## HIPPOCRATES AT ULIMAROA

The May issue of the *Bulletin* carried a photo of the sixteenth century edition of the works of Hippocrates generously donated to the College by Professor Bernard Brandstater, formerly Professor of Anesthesia at the American University in Beirut. Elsewhere in the same issue is a photo of Professor Brandstater holding the open volume. No doubt some readers were curious to know more about this book.

The medical writings attributed to Hippocrates of Cos were originally in Greek. The College's edition is the Latin translation of Janus Cornarius, printed in Basel by the house of Joannes Froben (1460-1527). Froben, who established his printing house in about 1491, was friend and printer to Erasmus, the leading scholar of the age. His 1516 printing of the New Testament in Greek was used by Martin Luther for his translation. After Froben's death his work was continued by his son Hieronymus and son-in-law Nicolaus Episcopius who completed many projects conceived and started by Froben senior. The very last paragraph of the College's book tells us that these two were responsible for the edition.

The front and back covers of the book are wooden (pine?) boards with their outer surfaces covered with old velum pages on which lines of music, plainsong, are interspersed with lines of Latin text. The appearance is that of leaves of a monastic psalter which may have been made redundant by the advent of printed versions. The spine is bound in pigskin and carries the date 1563, possibly the date the book was actually published.

On the title page the date of printing is given as MDLVIII, i.e., 1558. Interestingly, an almost identical

edition in the Wallerian Collection of medical manuscripts at the University of Uppsala has the date MDLIIII on its title page, a photo of which is in the catalogue of the collection. On both it is noted that the work was done by the grace and favour of His Imperial Majesty in the fifth year of his reign and of the King of France in the fourth year of his. Copyright on such a work appears to have been vested in the crowned heads of Europe.

Although one would need advanced ability in Latin to translate all that is in the 800 pages, a browse through the index whets the appetite. The oath is there, of course, alongside a brief biography of Hippocrates. There follow writings on the practice of medicine and on the nature of man which lead on to chapters on anatomy and physiology, e.g., "About Skin", "About Teeth", "About the Heart", "About Glands" etc. A more philosophical note is struck with the next group of chapters on aphorisms and predictions. These presumably serve to prepare the reader for the surgical onslaught in the chapters about fractures, ulcers, fistulae and haemorrhoids. However, it is the printer rather than the author who has arranged the topics as we find them and who completed the book with twenty-eight pages of letters to and from Hippocrates.

This is not the only ancient edition of Hippocrates' writings held in Melbourne. The Cowlishaw Collection at the RACS includes a copy of the 1525 edition of the translation by Fabino Calvus of Ravenna, printed by Franciscus Minitius in Rome. It is claimed to be the first printed edition of Hippocrates' writings.

Brian Horan Shanti Nadaraja

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### FINAL FELLOWSHIP EXAMINATION (ANAESTHESIA) APRIL / MAY 1995

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

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

#### SUCCESSFUL CANDIDATES

S C Adamo, Vic R D Allen, Vic JR Awad, NSW JPM Barnard, SA J J Barry, SA R A Bartolacci, NSW A M Bennett, Vic F E Boge, Qld R A Bourne, Vic D A Boyd, NSW J J Bruce, WA G A Chalkiadis, WA Chang Wing Sang, HK S L W Cheung, Qld C J Cokis, WA M E Colson, Vic J M Fabling, NZ M J G Familton, WA JAR Fernandez, NZ C J French, Vic

Fung Ka Yi, HK

M J Gould, SA K Harrison, NSW R J Hayward, NZ M A Higgs, Vic R G Horton, Vic M F Hoskin, Vic D K Hoyle, Vic A J Jeffreys, Vic M V Jones, WA KY Kan, NZ GE Kilminster, Vic DJ Knox, WA A S Leaver, Vic K E Lewis, Vic G C Lindsay, NSW J C Martin, Qld R R Martin. Vic NJD Meares, NSW M A P Mersiades, NSW A J Miller, WA

PS Nel, NZ

BRO'Connell, Qld K D Osborn, SA A J Patrick, Vic J M Reed, NSW L J Roberts, Qld P W Robertson, SA DW Robinson, WA BR Russ, WA DJ Sandeman, NSW CMP Shaw, NZ R E Smiles, NSW BT Spain, Vic D P Stephens, Vic D A Story, Vic R Swainston, Qld H D Swan, WA P D Tobin, NZ P C Tucker, Qld V L S P Vutukuri, NSW

## Examination Prize Winners

The Renton Prize Winner for the half year ended June 30, 1995 was **Dr Catherine** Susan Downs, New South Wales.

The Cecil Gray Prize for the April/May 1995 Final Examination was awarded to **Dr Hilton David Swan,** Western Australia.

### **Deaths**

L M Watterson, NSW

DH Williams, NZ

**Dr A J Carroll,** Victorian Fellow, MFARACS 1952, FANZCA 1993.

**Dr J Woodley,** Victorian Fellow, FFARACS 1952, FANZCA 1992.

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### PRIMARY FELLOWSHIP EXAMINATION MARCH / APRIL 1995

The written section of the Examination was held in all capital cities in Australia, Australian Capital Territory, Northern Territory, Auckland, Christchurch, Wellington, Hong Kong, Malaysia and Singapore. The oral Examination was conducted in Melbourne and Hong Kong.

#### SUCCESSFUL CANDIDATES

C J Andrews, Qld
D T Andrews, Vic
A Armstrong-Brown, NSW
S Bajenov, NSW
M E Brooker, NZ
G Caponas, NSW
I StJ Carter, NSW
Y E Chee, HK
M R Daley, NSW
A S Davies, Vic
C S Downs, NSW
C G Fowler, NZ
J E Fov. NZ

M J Gillham, NZ

B H Graham, NSW

C F Hanavan, WA
P W Howe, NT
J K James, Qld
G T Joyce, Vic
C P King, NZ
D J Koch, Qld
A H Konstantatos, Vic
P P K Lam, HK
B S L Lim, WA
D E Lindholm, Vic
D R Matthews, NZ
W W Morriss, NZ
S I Mullender, NZ

A P Padley, NSW

A J Gray, NZ

H C Platt, Vic
L M Power, WA
A N Purcell, Vic
R V Radici, WA
K Rees, Vic
S J Reid, SA
P C Soet, WA
P C Stewart, NSW
G Sue, Vic
T Theodorou, NSW
F Vosdoganis, NSW
D A Vote, Vic
M D Wilson, SA
M Y M Wong, Vic



Final Fellowship Examination, May 1995 — Court of Examiners

Back row, left: Drs Geoff Mullins, Rob Beavis, Tony Weeks, Ken Sleeman, Craig Morgan, David Scott, Andy Pybus, Peter Moran, Ed Loughman, John Madden, Doug Rigg, Dick Willis, Tony Gin, Peter Hales, Tony White, David Sage, Kersi Taraporewalla, John Russell. Front row: Peter Dawson, Roman Kluger, Brian Trainer, Nick Radford, Leona Wilson, Glenda Rudkin, Ian Rechtman, Peter Klineberg (Deputy Chairman), Penny Briscoe, Judy Branch, Keith Cronin (Chairman), Bart McKenzie.

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## HIGHLIGHTS OF THE JUNE 1995 ANZCA COUNCIL MEETINGS

ELECTION OF COLLEGE OFFICE BEARERS AND OFFICERS President N.J. Davis

Vice-President G.D. Phillips

Honorary Treasurer R.G. Walsh

Assessor J.M. Gibbs

Education Officer R.S. Henderson

Chairman of Examinations R.J. Willis

Chairman Hospital Accreditation Group I. Rechtman

CE & QA Officer R.N. Westhorpe

MOS Officer G.D. Phillips

#### EDUCATION

#### Stress Management Education

A Working Party has been established to examine the issue of stress management to identify further strategies and to produce a discussion document for Council.

#### Sub-Specialty Training

Council approved a statement on sub-specialty experience for trainees indicating the importance of anaesthetic experience in the areas of neurosurgical, thoracic, cardiac and paediatric anaesthesia and obstetric analgesia anaesthesia. This Statement is published elsewhere in this *Bulletin*.

#### Certificate in Pain Management

The Council resolved to establish a Certificate in Pain Management.

It is hoped that it will be possible to offer Certification for posts occupied for a twelve month period in Pain Management Units complying with College Policy Document P25 Minimum Standards for Pain Management Units. If the necessary preliminaries can be completed, this will have effect from the commencement of the 1996 Hospital Year.

The Certificate in Pain Management will be designed primarily for anaesthetists. It will be open to Provisional Fellows and to holders of the Diploma of Fellowship. Other medical practitioners who wish to enrol will be considered by the Assessor in respect of the equivalence of their training to that of ANZCA trainees and Fellows. Council will be advised by a Committee who will be examining the potential for further development.

#### **EXAMINATIONS**

#### Primary Examination Observers

Council resolved that Observers to the Primary Examination be Fellows who are three years post Primary Examination.

#### Final Examination Observers

Council resolved that unless in exceptional circumstances, Fellows eligible to observe the Final Examination must be three years post Fellowship.

#### Primary Examiners Workshop

Council approved a Workshop for Primary Examiners to be held during August next.

#### FINANCE

#### Financial Assistance for Developing Countries

Council resolved to support actively the development of anaesthesia and intensive care services in developing nations of the South Pacific and Asian regions.

Council further resolved to approach the Australian Society of Anaesthetists and the New Zealand Society of Anaesthetists regarding the potential role of the College in providing aid and advice with regard to examination systems in those regions. In the event that the Societies welcome such involvement, the College would seek consideration by all three bodies regarding the establishment of a combined ANZCA/ASA/NZSA Developing Nations Aid Committee together with the roles, regulations and membership of such a combined committee.

#### **Credit Card Facilities**

Council approved the establishment of credit card facilities for all College activities processed through the College Headquarters. These financial activities include subscriptions, Examination fees, annual training fees, CME, Special Interest Group and ASM registrations.

#### CONTINUING EDUCATION AND QUALITY ASSURANCE

#### Australasian Anaesthesia

Dr John Keneally, NSW, was re-appointed the Editor of Australasian Anaesthesia for 1996.

#### Annual Scientific Meeting, Christchurch, May 1997

Dr Jerrold Lerman (Canada) has accepted an invitation to be a Foundation Visitor at this Meeting. Dr Lerman will deliver the Mary Burnell Lecture. The Australasian Visitor to this Meeting will be Dr Brian F. Horan, NSW.

#### Free Paper Sessions at Annual Scientific Meetings

Council resolved that in future every effort should be made to ensure that free papers are presented as oral presentations at Annual Scientific Meetings.

#### INTERNAL AFFAIRS

#### Community Education and Communications Committee

Council approved the establishment of a Communications Committee to pursue a Community Education and Fellows Communication Programme.

#### Chemical Dependency and Illness

Council resolved to include the following statement on all Register of Training and Examination application forms:

#### "I certify that:

- (i) I am free of chemical dependency
- (ii) I have no condition which would preclude the safe practice of anaesthesia.

I acknowledge that any drug or chemical dependence by me or any condition which precludes the safe practice of anaesthesia may result in the suspension or termination of my training at any time and may prevent my admission to Fellowship'.

The Maintenance of Standards Annual Return Form will include the following statement:

#### "I certify that:

- (i) I am free of chemical dependency
- (ii) I have no condition which would preclude the safe practice of anaesthesia.

I acknowledge that any drug or chemical dependence by me or any condition which precludes the safe practice of anaesthesia may prevent a Certificate of Participation in the Maintenance of Standards Programme being issued to me".

#### ANZCA Medal

The Regulation relating to the award of the College Medal were amended and are published elsewhere in this *Bulletin*.

#### Lennard Travers Professorship

The Regulation relating to the award of the Lennard Travers Professorship was amended and is published elsewhere in this Bulletin.

#### The History of Anaesthesia

Dr Gwen Wilson, MD, the College Emeritus Historian has agreed that the College publish *One Grand Chain* — *The History of Anaesthesia in Australia* 1846-1962. Volume 1 will be available for distribution later in the year. Full details will appear in the *Bulletin*.

#### **PROFESSIONAL**

#### **Policy Documents**

P4 Guidelines for the Care of Patients Recovering from Anaesthesia.

P15 Guidelines for the Peri-Operative Care of Patients Selected for Day Care Surgery.

Council reviewed and approved these documents which are published elsewhere in this Bulletin.

*AIDS and Hepatitis* — *College Statement*. The Council reviewed and approved the Statement published in this *Bulletin*.

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## NEW ERA FOR MEDIA RELATIONS

The Townsville Annual Scientific Meeting marked a new era in media relations for the College. Fellows may be interested in the process and outcome of this important initiative which is part of the wider "Community Education and Public Relations Programme" of the College.

The ASM was preceded by a pilot "National Anaesthesia Day" (reported in the last *Bulletin*). This enhanced the credibility of the College and made a "grass-roots" network of key contacts in the media and in government.

The main process in the ASM media programme was to select at least one newsworthy topic each day and distribute a media release to a wide range of local and national media outlets. Most of these newsworthy topics were chosen before the meeting with some of the releases written and approved prior to the meeting. Other topics were selected during the meeting. In most cases they related to particular papers being presented with approval of the presenter, who was then organised to be available for follow-up contact with the media. This tactic created a very positive reaction from all reporters.

The interest from the media was very encouraging. Considering the timing and location of the meeting we still attracted considerable national coverage. Several media outlets regularly followed up all releases with interviews over the phone and there were also ad hoc interviews and general stories. Brisbane ABC radio, Courier Mail and AAP followed the meeting closely and there were media contacts from Sydney, Melbourne and Radio New Zealand. As a result various stories associated with the meeting were reported widely throughout Australia and New Zealand.

#### **Main ASM Media Stories**

- "ASM Background": Mike Martyn.
- "Intensive Care Costs under Scrutiny": Bob Barnett.
- "Anaesthetic Procedure Better for Patients and Budgets": Michael Davies.
- "Old Hygiene Rules Still Essential": Ross Kerridge.
- "Outdated Equipment Concern": John Russell.
- "Mystery Confirmed": Guy Orlay.
- "Call to Improve Private Health Care": Chris Eagle.
- "Call for Incentives to Attract Specialists": Di Strange Khursandi.

The interest from the local Townsville media was relatively disappointing. Two TV channels attended on one day with interviews with the President, Michael Davies, appearing on the evening news. Despite thorough advance briefing on the ASM and its significance, the

Townsville Courier displayed a less than enthusiasti attitude to our stories. However, persistence did resul in some coverage, although not as good as was receive in Launceston in 1994. The local ABC radio was supportive and in fact complimented the organisation of our media liaison at the end of the ASM.

More than ten different Fellows were involved it speaking with the media during the ASM and there were no instances of negative reporting. Some reporters were very supportive and in fact commented on the news worthy nature of the stories that we were distributing. They left little doubt that their perception and knowledg of anaesthesia and intensive care was improved by the process.

The wider aim of improving our image was achieved by bringing various anaesthetists, and their stories, into the media light in a proactive, strategic and positive fashion Many people who had not attended the meeting reported the positive nature of the stories. One Director of Anaesthesia has used the media coverage of John Russell' story ("Outdated Equipment Concern") and subsequent enquiries from up to 20 patients in his submission to his hospital to upgrade the outdated ventilators in his department!

Our Communications Consultant, Eddie Dean, attender the ASM and was the key factor in our media liaison success. His experience, knowledge of the media, writing skills and follow-up with reporters paved the way. He also met many Fellows and gained a good insight into the scientific and social aspects of anaesthesia.

There were many lessons learned which have been collated and presented to College Council in order to improve the media coverage of future meetings. All CME organisers are encouraged to contact the Registrar or the Communications Officer well before any meetings. The ultimate success of any media liaison, as with most othe things, is dependent on appropriate planning well before the event.

MIKE MARTYN
Communications Office:

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 $Representatives of National \ University \ of Singapore, Jonathan \ Siew, Prof. \ S.S.\ Ratnam, Dr N.J.\ Davis \ (ANZCA\ President) \ and \ Dr \ C.H.\ Chew.$ 



Australasian Visitor Dr John Russell with his wife Jan.



 $President, Dr\,Neville\,Davis\,presenting\,Dr\,Hilton\,Swan\,with\\ the\,Cecil\,Gray\,Prize\,following\,the\,May\,1995\,Examination.$ 

August 1995

## Report from the President to Fellows of the Australian and New Zealand College of Anaesthetists as at June 2, 1995

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

#### AWARDS, HONOURS AND APPOINTMENTS

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

Or Gwen C M Wilson (NSW) was awarded a Doctorate of Medicine, University of Sydney.

Or Peter L Klineberg (NSW) was appointed Associate Professor of Anaesthesia at the University of Sydney at Westmead Hospital, and Dr David H McConnel (Qld) was appointed Clinical Associate Professor in the Department of Surgery at the University of Queensland.

Or Ian Steven (SA) was invested as an Officer of the Order of Australia (AO), and Dr Aldo V Dreosti (SA) was invested as a Member of the Order of Australia (AM).

Professor Malcolm M Fisher was elected to Fellowship of the Royal College of Anaesthetists. Dr Ronald V Crubuhovich was awarded Honorary Membership of the Australian and New Zealand Intensive Care Society.

Or Greg P Wotherspoon (NSW) was elected President of the Australian Society of Anaesthetists and Dr David Jones New Zealand) President of the New Zealand Society of Anaesthetists.

Other appointments include **Dr Ben J Barry** (NSW) who was appointed Honorary President of the 1996 World Congress of Anaesthesiologists, and **Dr Richard G Walsh** NSW) the College Honorary Treasurer, President of the Congress.

Professor Lucien Morris (USA) was elected President of the Anesthesiology and History Association, and Professor Michael D A Vickers (UK) was conferred with Honorary Fellowship of the Hong Kong College of Anaesthesiologists.

#### DEATHS

t is with regret that I report the death of the following fellows:

Dr J C D Callander, WA Professor D G Lampard, Honorary Fellow, Vic Dr S G Seruvatu, Fiji (formerly New Zealand)

Dr A J Carroll, Vic.

#### RESEARCH GRANTS FOR 1995

In the past year the College received applications for Research Scholarships and Grants totalling \$484,815. College funds available for distribution and awarded in 1995 were in excess of \$300,000.

Scholarships were awarded to:

- **Dr Robin A Youngson, NZ.** Vocal Cord Force Transducer. \$8,350.
- **Dr Brendan S Silbert, Vic.** The Recovery Characteristics of Combined Regional and General Anaesthesia **vs** General Anaesthesia in Major Surgery. \$8,977.
- Dr John A Loadsman, NSW. Post-operative Respiratory Function and the Effects of Anaesthesia/Analgesia for Major Surgery on Breathing, especially during Sleep. \$7,325.
- Dr Kate Leslie, Vic. (1) Spinal Block Height and Core Temperature Triggering Shivering. (2) Thermoregulatory Thresholds in Normal Pregnant Women. \$11,625.
- Dr Peter J Dawson, Vic. The Cardiovascular Actions of Propofol in Cardiac Surgery. \$13,830.
- **Dr Neil A Pollock, NZ.** To Develop a Genetic Test for the Diagnosis of Malignant Hyperthermia (for one year). \$23,280.
- Dr Peter T Morley, Vic. Pathophysiology of Ventilator Dependence in the Critically Ill. \$10,387.
- Dr John R A Rigg, WA. A Randomised Controlled Trial of Epidural Anaesthesia and Analgesia in High-Risk Patients Undergoing Major Surgery. (Research Nurses). \$34,219.
- Dr Paul S Myles, Vic. Haemodynamic Effects, Myocardiac Ischaemia and Timing of Extubation with Propofol-based Anaesthesia for Cardiac Surgery. (Research Assistant half time). \$17,476.
- Dr Martin E Lum, NSW. Anaesthetic Outcome Study. (Research Assistant 1 Year). \$30,340.
- Professor Tess R Cramond, Qld. The Clinical Efficacy and Pharmocokinetics of Oxycodone Administered as Subcutaneous Infusion or as Oral Syrup. \$23,046.

#### 1994 Establishment Grant

The 1994 Establishment Grant of \$75,000 was awarded to the Department of Anaesthesia and Intensive Care, University of Newcastle at the John Hunter Hospital.

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#### **Lennard Travers Professorship**

Dr David Crankshaw, Vic. was appointed the Lennard Travers Professor for 1995. Dr Crankshaw's project is titled Variability of Anaesthetic Agents. Dr Crankshaw's emolument was \$30,000.

#### Harry Daly Research Fellowship

On the recommendation of the adjudicators, the Harry Daly Research Fellowship was not awarded.

#### The John Boyd Craig Award

The John Boyd Craig Annual Award for 1995 of \$10,879 was awarded to Dr Stephanie Delfos for her project Assessment of outcome in the treatment of posterior element back pain: a randomised controlled comparison of percutaneous radio frequency lesions and percutaneous cyroprobe lesions.

#### COUNCIL 1995-1996

Membership of the Council to take office after the Annual General Meeting, its Office Bearers and Committees will be published as an addendum to this Report.

#### ADMISSION TO FELLOWSHIP BY ELECTION

The Council elected to Fellowship under Regulation 6.2 Dr Christopher Eagle, Canada and Dr John Sear, UK. These Fellows were Foundation Visitors at the Annual Scientific Meeting in Townsville.

#### Under Regulation 6.3.1 (b)

Dr Nanette Crimmins, Old

Dr John Streeter Male, WA

Dr Douglas Baldwin Welch, Tas

Dr Jennifer Mary Weller, SA

#### Under Regulation 6.3.1 (c)

Dr Roberta Kay Deam, Vic

Dr Philip Neil Ogden, Tas

Dr James Wallace Sleigh, New Zealand

Dr Thomas Garth Watson, New Zealand

#### Admission to Fellowship Under Regulation 6.3.15

Dr Tat Yan Au, Hong Kong

Dr Che Ling Kwok, Hong Kong

Dr Yi Cheung Sit, Hong Kong

Dr Choong-Howe Wong, Malaysia.

#### PRIMARY EXAMINATIONS

The Renton Prize was awarded to Dr Ai Yu Cheng of Hong Kong for the half year ended December 31, 1994 and to Dr Catherine Susan Downs of New South Wales for the half year ended June 30, 1995.

Examinations were held in Melbourne and Hong Kong.

August/Septe	ember 1994		
	Total No. Candidates	Invited to Oral	Approve
Melbourne	119	87	57
March/April	1995		
Melbourne	88	59	42
Hong Kong	9	5	2
Total	97	64	44

#### FINAL EXAMINATIONS

#### August/September 1994

The Examinations were held in Melbourne. Eighty-seven (87) candidates presented and fifty-five (55) were approved

Successful Candidate who has completed training: Dr J C Scroope, NSW.

#### Successful Candidates who had not completed training

Successful Candidates who ha	id not completed training
Dr B A Ager, NSW	Dr J Liang, NZ
Dr D S Barker, NSW	Dr W Lim, WA
Dr C M Bolton, Vic	Dr G R Martin, Qld
Dr D C Borshoff, WA	Dr P T McAleer, SA
Dr W J Buchanan, NZ	Dr R B McCrossin, Qld
Dr R M Calcroft, NSW	Dr W H Miles, Qld
Dr Chan Tsz Yeung, HK	Dr V Moo, Qld
Dr I H Chapman, NZ	Dr D V Mullany, Qld
Dr D K P Chua, HK	Dr Ng Kwee Peng, SA
Dr E Pak-Yoon Chye, ACT	Dr W J O'Regan, NSW
Dr P E Cordato, NSW	Dr M S Oliver, NZ
Dr I R Cox, NSW	Dr G R Orlay, NSW
Dr J Cudis, Vic	Dr C J Peady, SA
Dr G B Downey, NSW	Dr W J Pederick, Vic
Dr J A Elson, WA	Dr O J Perks, SA
Dr A Frankl, Vic	Dr A G Puddy, SA
Dr J L Gibson, NSW	Dr A P Richards, Vic
Dr C Goh, NZ	Dr M S Robertson, Vic
Dr M J Goldberg, Vic	Dr K W Russell, NSW
Dr P D Good, NSW	Dr W R Saunders, Vic
Dr S R Green, Qld	Dr C Schneider, NZ
Dr W G Grimmett, NSW	Dr O C Y Shaw, NSW
Dr S N Hocking, WA	Dr E R Stachowski, NSW
Dr W Hong, NSW	Dr Tan Yuen Heng, HK
Dr S A Kanagasundaram, NZ	Dr J S Walker, NZ
Dr Bee Beng Lee, HK	Dr P W Y Wong, NSW
Dr B M F Lewer, NZ	Dr T A W Wong, Qld

The Cecil Gray Prize for the half year ended December 31 1994 was awarded to Dr Daniel V Mullany of Queensland

#### April/May 1995

The Examination was held in Melbourne. Eighty-one (81 candidates presented and sixty-three (63) were approved.

Successful Candidate who has completed training: Dr J J Barry, SA.

#### 26

#### Successful Candidates who had not completed training:

Dr S C Adamo, Vic Dr D J Knox, WA Dr R D Allen, Vic Dr A S Leaver, Vic Dr J R Awad, NSW Dr K E Lewis, Vic Dr J P M Barnard, SA Dr G C Lindsay, NSW Dr R A Bartolacci, NSW Dr J C Martin, Qld Dr A M Bennett, Vic Dr R R Martin, Vic Dr F E Boge, Qld Dr N J D Meares, NSW Dr R A Bourne, Vic Dr M Mersiades, NSW Dr D A Boyd, NSW Dr A J Miller, WA Dr J J Bruce, WA Dr P S Nel, NZ Dr G A Chalkiadis, WA Dr B R O'Connell, Qld Dr K D Osborn, SA Dr Chan Wing Sang, HK Dr S L W Cheung, Qld Dr A J Patrick, Vic Dr C J Cokis, WA Dr J M Reed, NSW Dr M E Colson, Vic Dr L J Roberts, Qld Dr J M Fabling, NZ Dr P W Robertson, SA Dr M J G Familton, WA Dr D W Robinson, WA Dr J A R Fernandez, NZ Dr B R Russ, WA Dr D J Sandeman, NSW Dr C J French, Vic Dr C Shaw, NZ Dr Fung Ka Yi, HK Dr M J Gould, SA Dr R E Smiles, NSW Dr K Harrison, NSW Dr B T Spain, Vic Dr R J Hayward, NZ Dr D P Stephens, Vic Dr M A Higgs, Vic Dr D A Story, Vic Dr R G Horton, Vic Dr R Swainston, Qld Dr M F Hoskin, Vic Dr H D Swan, WA Dr D K Hoyle, Vic Dr P D Tobin, NZ Dr A J Jeffreys, Vic Dr P C Tucker, Qld Dr M V Jones, WA Dr VLSP Vutukuri, NSW Dr K Y Kan, NZ Dr L Watterson, NSW Dr G E Kilminster, Vic Dr D H Williams, NZ

The **Cecil Gray Prize** for the half year ended June 30, 1995 was awarded to **Dr Hilton D Swan** of Western Australia.

#### ANNUAL SCIENTIFIC MEETING

The Annual Scientific Meeting was held at the Townsville Entertainment Centre from May 6-10, 1995. This Meeting attracted the largest registration of any College/Faculty Meeting and our sincere thanks go to Vic Callanan and Rob Whiting for a magnificent Scientific Programme, and to Mrs Doreen Callanan and her Committee for the varied and most enjoyable accompanying persons programme.

During the College Ceremony it gave me great pleasure to confer Honorary Fellowship on Clinical Professor David Theile (Qld), President of the Royal Australasian College of Surgeons and to present Dr Ben Barry (NSW) and the Inaugural President of the College, Associate Professor Peter Livingstone (Qld) with the Robert Orton Medal.

Our Foundation Visitors were **Associate Professor** Christopher Eagle from Canada and Dr John Sear and Dr Charles Hinds from the United Kingdom.

The Ellis Gillespie Lecture entitled *Health Care Reforms – Changing the Face of Anaesthesia* was delivered by Professor Eagle.

Dr Sear delivered the Inaugural Mary Burnell Lecture entitled Steroid Anaesthesia Revisited: Old Compounds, New Drugs.

**Dr John Russell** delivered the Australasian Visitor's Lecture, Safety in Anaesthesia.

All Visitors provided excellent presentations which stimulated great interest and discussion from the floor.

The Gilbert Brown Prize was awarded to Dr Kate Leslie, Victoria, for her presentation *The Effect of Spinal Block Heights on the Core Temperature Triggering Shivering.* 

The Inaugural Formal Project Prize was awarded to Dr Matthew Chan, Hong Kong, for his presentation Mac of Isoflurane in the Post Partum Period.

#### COLLEGE AFFAIRS

#### Maintenance of Standards Programme

The College's Maintenance of Standards Programme was established in June 1994 and designed to enable Fellows to demonstrate their participation in a programme aimed at maintaining clinical standards. Participation by Fellows is voluntary and the programme is flexible to allow Fellows to tailor it to their particular practice.

In October 1994 Council resolved to offer the Maintenance of Standards Programme to non-Fellows and at the February 1995 Council Meeting the fee of A\$200 for 1995 was agreed. In line with College policy, this fee will be reviewed annually.

I wish to acknowledge the input of the Working Party, especially the tremendous contribution by Professor Garry Phillips, in establishing the Programme.

#### Changes to the Fellowship Examinations

Extensive changes to the College Examinations have occurred over the past two years in the Final Examination format. At present educational research suggests that the ultimate overall assessment is achieved by multiple short topics in both written and oral examinations, the long essay questions are being phased out. Multiple choice questions (MCQs) will continue to be used in the Final Examination and it is intended to introduce MCQs to the Primary Examination early in 1996. Short answer questions (SAQs) are mini-essays of 10 minutes duration and have already replaced the long essays in the Final Examination. SAQs were introduced into the Primary Examination this year.

The written examinations will continue to be held biannually in all major centres as at present. The Primary Oral

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Examination will be held twice yearly at the College Headquarters in Melbourne and may be held annually in Hong Kong. The Final Oral Examination will be held twice yearly, once at the College Headquarters and once in Sydney, usually at one of the major teaching Hospitals.

Development of an improved system for the selection, training and assessment of Examiners is currently under consideration and continuing involvement of ANZCA Examination Committee Members in College joint examination workshops will be encouraged.

I wish to thank those many Fellows who have devoted countless hours of their own time to develop an examination process of the highest standard.

#### Library

With the appointment of Ms Shanti Nadaraja as College Librarian, the Library Catalogue Database was established and the complete catalogue successfully downloaded from the RACS Library.

The Library has on-line access to the Australian Bibliographic Network which enables access to the collections of other participating Libraries. Access to Medline is also available through the National Library of Australia with requests for searches carried out by the College Librarian.

New editions of text books have been purchased and added to the Library collection and each edition of the College *Bulletin* will provide a list of new additions to the Library.

#### **Community Education and Communication**

As a result of concern by the Council at the lack of knowledge and status of anaesthesia and anaesthetists in the community, discussion occurred with a public relations company. Subsequently a questionnaire was distributed to all Fellows and following analysis of their replies, a strategic programme to improve communications with Fellows, colleagues and the community at large was embarked upon.

Contact has been made with representatives of all national media organisations and a National Anaesthesia Day was established just prior to the Annual Scientific Meeting. The theme for this Day was "Safety". This Day was launched by a Press Release in conjunction with a Press Statement on behalf of the College and supported by State Ministers for Health in the Australian Capital Territory, Western Australia and South Australia. The launch of this Day was supported by the Federal Minister for Health and Community Services.

#### **Policy Documents**

The Council completed the promulgation of six new Policy Documents:

- E14 Guidelines for the In-Training Assessment of Trainees in Anaesthesia
- P10 Handover of Responsibility During an Anaesthetic
- P16 Standards of Practice of a Specialist Anaesthetist
- P26 Guidelines on Providing Information about Anaesthesia
- P27 Standards of Practice for Major Extracorporeal Perfusion
- P28 Policy on Infection Control.

Seven Policy Documents were revised after consultation with our Regional Committees.

#### Workforce

A review of specialist anaesthetist requirements fo Australia and New Zealand was undertaken and it was considered that the total number of specialist anaesthetist was covered but there was a maldistribution in rural area and public hospitals. The Council has requested Regiona Committees to increase training positions by 15-20% and to reassess suitable training positions in rural areas.

We have also requested the Australian Medical Association Australian Society of Anaesthetists and the Australian Salaried Medical Officers Federation to address the problems of remuneration and conditions of service for Staf Anaesthetists to ensure that the chronic shortage of anaesthetists in some public hospitals is addressed.

#### **Continuing Education**

This continues to be a great success story for the College. In 1995 there are 21 major meetings which are available to our Fellows for their continuing education. This represents a 100% increase over the past decade.

Australasian Anaesthesia was again published under the editorship of Dr John Keneally. This publication is continually improving and remains an important contribution to our anaesthetic literature.

#### Council

In accordance with the provisions of the Articles of Association, nominations were called for nine vacancies on Council This large number was occasioned by the requirement of the Australian Securities Commission for Councillors to be reelected every three years, with some Councillors completing the balance of their aggregate of 12 years on the Faculty Board and Council.

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t was very pleasing indeed to see so many Fellows seeking nomination and being prepared to contribute to the College welfare in this way.

The following is the result of the Ballot:

Votes Received Less Informal	$\frac{1020}{\frac{9}{1011}}$	
	x9	9099
N J Davis	748	
R G Walsh	717	
R N Westhorpe	630	
M J Cousins	617	
R J Willis	614	
T E Oh	611	
R S Henderson	608	
D H McConnel	587	
I Rechtman	543	
D R Kerr	541	
M Martyn	515	
D C S Khursandi	427	
J P Keneally	414	
P Roessler	367	
P L Klineberg	360	
G B Donnan	303	
R D M Jones	300	
P J Christie	197	

#### Retiring Councillor

Or Brian Horan resigned from Council at the completion of two years service. During this short time Dr Horan has made a great contribution to the deliberations and debate at Council, particularly with regard to the Infection Control document.

#### College Administration

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

Miss Vivienne Lillis replaced Mr Julian Miller as College Accountant following his resignation.

Miss Karen Monette, Administrative Secretary, Examinations joined the staff in June 1994 and has proved to be a valuable contributor to the College administration, and in particular the Examinations and Training area.

Ms Shanti Nadaraja was appointed Librarian in August 1994 and her duties also include management of the Archives and maintenance of the Museum Catalogue. Shanti is already known to many Fellows, providing a most

efficient search and communication service. The Library now has an E-mail address which will prove to be convenient to Fellows.

Ms Helen Morris is the most recent addition to the College staff, following Mrs Allison Burger's resignation in February 1995 to pursue her career with ANZICS. Helen is providing the secretariat for the MOS Programme, CE & QA Committee and the numerous Special Interest Groups.

Allison Burger joined the Faculty staff as Administrative Assistant in October 1988 during which time she provided the secretariat for the Victorian Regional Committee, CME, VCAF Appeal, CE & QA Committee and the Special Interest Groups. Allison's dedication to her tasks and efficiency in dealing with a broad spectrum of activities including the administration of the VCAF Appeal and establishment of the various Special Interest Groups and their associated Meetings have been greatly appreciated. On behalf of the Fellows I wish to acknowledge and thank her most sincerely for her work on behalf of the Faculty and College during her appointment.

Following re-organisation of the staff in our Queensland Office, Mrs Joyce Holland was appointed in November 1994 to manage the College Office in that Region, and provide a secretariat for the College Regional Committee and its Faculty of Intensive Care and the ASA in Queensland. Mrs Holland has re-established the office administration in that Region and has been of great assistance to the Fellows there.

I wish to convey our thanks to Miss Jill McCartney for her assistance over the years in providing the secretariat for the local Fellows and ASA Members, and her most efficient management of the building.

I wish to express my sincere thanks to all Fellows and their families who continually devote so much time to the welfare of the College by their involvement in Committees, in the education and examination of our trainees and Hospital Inspections.

I would also like to record my thanks and appreciation to the Councillors for their support and contributions over the past two years which have seen the establishment of our new Headquarters and changing times in our specialty.

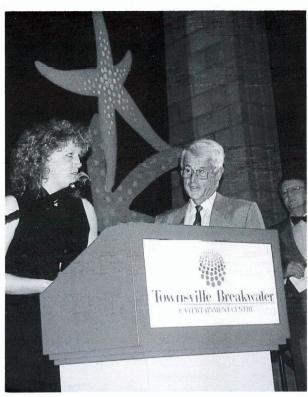
Finally, to the administrative staff both in Melbourne and all the Regions who continue to contribute so willingly and tirelessly to ensure the efficient running of the College, my sincere thanks.

MICHAEL J DAVIES

President



Professor Don Harrison presenting Dr Andrew Belessis, ISW, with the Inaugural G A (Don) Harrison Award.



$$\label{eq:continuous} \begin{split} Dr\,Kate\,Leslie,\,Vic,\,recipient\,of\,the\,Gilbert\,Brown\,Prize\,with\\ Professor\,John\,Gibbs.\,Dr\,David\,McConnel\,in\,background. \end{split}$$



Or Pamela Edwards with Dr Daniel Mullany, Qld, Cecil Tray Prize Winners in the respective 1994 Final Examinations.



 $Dr\,Matthew\,Chan\,from\,Hong\,Kong,\,the\,Inaugural\,Formal\\Project\,Prize\,Winner.$ 

## HONORARY TREASURER'S REPORT

The Annual Financial Statements of the College for the ear ending 31 January 1995 are presented in the pages revious to this Report. It is very important that Fellows hould have an understanding of the financial status of heir College. I acknowledge that many Fellows find the equired format of the Statements difficult to ppreciate. I therefore offer the following interpretation f the salient features of the Statements and Statutory Report, as do the accompanying diagrams.

The previous two Annual Financial Statements were complicated by the formation of the College and the najor purchase of the College Headquarters. The urrent report is therefore relatively straightforward lthough comparisons with 1994 figures are not all elevant. One important change is the establishment of the Project Fund formed by combination of the previous development Fund and Fellows' Fund (both now bolished.)

## EVENUE AND EXPENDITURE STATEMENT This statement summarises the total revenue and

xpenditure of the College during the year ending 1 January 1995. On the basis of these figures, revenue acreased by 5% while expenditure decreased by 6%, esulting in an overall operating surplus of \$1,230,807. While this figure is high, it may be broken down to reveal nat over \$360,000 was derived as interest from deposits rith financial institutions and as such was redirected ack into the corpus of the funds (particularly the NZCA Foundation). Just over \$400,000 of the perating surplus was derived from the Subscription count and nearly \$160,000 from the Trainees Fund. n other words, less than half of the effective operating urplus came from subscriptions of Fellows and fees of rainees. Further reading will reveal that the operating urplus does not reflect the actual gain to the very nportant total cash reserves of the College.

#### ALANCE SHEET AS AT 31 JANUARY 1995

his part of the Statement presents the overall annetary value of the College as at the above date. The et assets of the College are determined by the total seets (including properties, equipment and other such ems) minus the total liabilities – the majority of which re subscriptions and trainees' fees held in advance until ne following year. Such advance payments are invested ntil needed and the interest earned mostly placed in the

ANZCA Foundation for later distribution as research and similar grants.

Net assets of the College are shown in the Equity section of the Balance Sheet as held by the three funds of the College – the Project Fund (incorporating the old Development Fund and the Fellows Fund), the Trainees Fund and the Foundation Fund (the ANZCA Foundation). It should be explained that the Subscription Account is not a Fund but represents the use of Fellows' subscriptions on general College expenditure during the whole Financial year. Any surplus or deficit at the end of the year is transferred to the Project Fund.

Of total net assets (\$6.5 million), it can be noted that College properties, equipment and the like account for nearly \$2.6 million, while nearly \$2.5 million is held by the ANZCA Foundation. Expenditure of the Foundation is limited to that on research and continuing education. This leaves just over \$1.4 million as the true cash reserves of the College, a non-profit organisation which has an annual expenditure of about \$2 million. I believe that it is good financial sense to ensure that the College can match its total liabilities (currently \$2.2 million) with its current cash reserves. It is apparent that despite our enormous gains since purchase of the College head-quarters in Melbourne, we still have some way to go to meet this aim.

#### ACCOUNTS AND FUNDS

As outlined above the Subscription Account shows distribution of funds received from Fellows as their payment for the daily running of the College, with any eventual surplus or deficit going to the Project Fund. The net assets of the College are held by three Funds, the Project Fund, the Foundation Fund (ANZCA Foundation) and the Trainees Fund. The Development Fund is now defunct and its previous assets are shown as transferred to the Project Fund.

#### Subscription Account

Expenditure in this account increased only marginally over the previous year while revenue increased by nearly 19%. The latter resulted from increased new Fellow numbers and a subscription rate planned to significantly contribute to building cash reserves. As with previous years, 10% of Subscription revenue was allocated to the ANZCA Foundation for research purposes and 10% was

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allocated to the Project Fund (noted as the old Development Fund) for major building or other related projects of the future. A contribution of \$778,860 from the Trainees Fund is noted for general administration of the College on behalf of trainees.

The effective surplus of the Subscription Account was \$409,486 and this was transferred to the Project Fund referred to as the old Fellows Fund). Although not specifically recorded, the balance of the Subscription Account at 31 January 1995 was zero.

#### Project Fund

This fund was formed by amalgamation of the previously named Fellows' Fund and the Development Fund, and represents the Fellows' share in net assets of the College. Revenue is mainly interest on investments, a 'development' allocation from subscriptions (for use on tuture building or other special projects) and any surplus from the Subscription Account. The interest shown as emanating from subscriptions "in advance" is, as always in the past, eventually allocated to the ANZCA

#### **Foundation Fund**

Foundation for research purposes.

This Fund represents the financial activities of the ANZCA Foundation, the balance of which has reached hearly \$2.5 million. It is pleasing to note the improvement in general donations to the Foundation. It should be explained that the fall in research grant allocations results from significant annual variations in timing of such payments and the year ending 31 January 1995 was a slow one for these. The Foundation continues to be used extensively for both research and continuing education purposes, and average annual expenditure over the last few years demonstrates the importance and

#### **Trainees Fund**

alue of this Fund.

xamination system, aiming to run at a minimal but safe urplus in terms of projected expenditure. Revenue acreased by 7% over the previous year, accounted for y a much higher than expected number of registered rainees. Direct expenditure was also unexpectedly ecreased although costs involved in the new format of the Final Examination (Anaesthesia) are expected to ise in coming years. The gain for the year was \$164,530 marginally above that for the previous year) and rovided an end of year balance of the Trainees Fund of 332,066. Prior to the purchase of the College

This Fund provides for the College training and

Headquarters, the Trainees Fund balance approached \$500,000 and I regard such a figure as an appropriate reserve to ensure further development of the training system of the College.

#### CONCLUSION

As Honorary Treasurer, I am pleased to report that a healthy surplus for the year ending 31 January 1995 has resulted in a significant increase in the financial reserves of the College. These reserves were severely depleted with recent purchases, particularly that of "Ulimaroa" in Melbourne. Although the reserves are not yes sufficient, the major purchases and costs of formation of the College were achieved without imposition of any levy or special fee on Fellows and Trainees.

Fellows' Subscriptions and Trainees' fees are acknow-

ledged as unwelcome by all of us, and it is pleasing that compliance with payment requests, is and always has been, extremely high. The annual increase in subscription has been falling over each of the last three years, and Fellows should note that the increase in the 1996 subscription approximates the predicted CPI increase (in Australia) for the next twelve months. The surplus generated by the current and other recent financial years has enabled the College to almost reach a period when our fiscal policies will once again stabilise.

1994 and early 1995 saw major administration changes with respect to managing the College financial affairs. A great tribute is deserving of our new College Accountant, Ms Vivienne Lillis, who with our locum consultant, Mr Ross Blain, was able to take on our accounts and deliver the Auditors' and the Council's requirements over the last six or so months. They were of course assisted by the many other College staff (headed by the Registrar, Mrs Joan Sheales) both in Melbourne and in all College Regions. One must also note the important responsibilities accepted by Fellows who become Honorary Treasurers in each College Region. Without all these people, our College finances would not be in such a healthy state.

Finally, I would welcome any queries from Fellows and trainees regarding this Report and accompanying Financial Statement. I request that such inquiries be in writing.

#### RICHARD G WALSH

Honorary Treasurer

### Report of the College Golf Day at the 1995 Annual Scientific Meeting, Townsville

A very successful Golf Competition was held at the Townsville Golf Club during the recent Annual Scientific Meeting. Approximately 40 golfers including Fellows, Trade and associates joined us at this rather superb Golf Course.

The Golf Day was organised by Dr Damon Sutton who did an excellent job to ensure that players had an enjoyable day. The competition was an individual par and a four-ball, best-ball par competition. The result of the pairs competition was quite unusual in that five

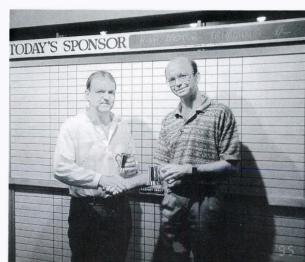
groups were equal at +5. A rather complex countback was undertaken and Dr Gabriel Myburgh and Dr David Earl were the winners. The runners-up were Dr Peter Moran and Dr Brian Duffy.

The individual winner was Dr John Rigg who was on +2 and he was presented with the ANZCA Golf Trophy. Dr John Rigg now has the distinguished record of winning both the RACS Golf Trophy and the ANZCA Golf Trophy in the same year. Runner-up for the individual competition was Dr Tony Sutherland.





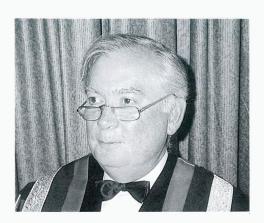




ulletin

## DEAN'S MESSAGE

### TRAINING OF INTENSIVISTS - THE IMPORTANCE OF TEACHERS



he Faculty training programme in Intensive Care is really a package. This consists of core and elective training components in specified approved posts and application of methods of assessment of the trainee.

To date the methods of assessment have mainly been

confined to the examination system. Unfortunately this s limited in what it can properly assess. Examinations can certainly adequately test knowledge, but we all know that this is just one attribute of a competent Intensivist. Other attributes include skills such as history taking, physical examination, technical skills, communicating and 'team building' skills, problem solving skills and mportant correct attitudes toward patients, their elatives and the staff with whom we work. So although able to test knowledge, history taking, physical examination, problem solving, communicating and to an extremely limited extent technical skills, there are other very important aspects which cannot be tested by the examination system. Included here are attitudes, the najority of technical skills and 'team building' skills. It s hoped that properly carried out 'in-training assessnent' will fill this gap and improve both the scope and quality of our current efforts at fair and proper

Adequate training depends upon a balance of self lirected learning, informal and formal teaching, broad anging clinical experience, an increasing acceptance of clinical responsibility with decreasing levels of upervision as training progresses. Hopefully there is also exposure to good role models.

Role models help shape the attitudes of others toward patients and their relatives, how they interact with other staff, what attitudes and interests are developed in teaching, research, and in quality assurance and improvement.

Teaching is an activity we all need to promote. It not only helps trainees and other members of the Unit, but it also forms an important part of the teacher's personal maintenance of standards. Unfortunately many people with latent teaching ability do not allow this to develop because of reasons such as shyness or feelings of not 'knowing enough'.

A most important aspect of teaching is asking questions and getting everyone (including oneself) thinking and searching for answers. In many instances it is the 'catalyst' teacher who ropes in able colleagues and from there teaching in a hospital or region can blossom. Lindsay Worthley is clearly such a catalyst in Adelaide and his long-standing Intensive Care course is hailed as one of life's really worthwhile experiences by all who have attended it. Melbourne also has an excellent course and it is equally exciting to see people such as Peter Cranswick, Charlie Corke and Jamie Cooper making excellent use of local fine Intensivists and teachers just as Dr Worthley has done in Adelaide. Both of these courses are highly recommended! They are complementary rather than competitive.

Apart from local hospital Intensive Care teaching and regional training courses, the regional and federal ANZICS meetings and the Faculty of Intensive Care component of the ANZCA provide excellent 'state of the art' knowledge not only for trainees but for all practising Intensivists.

Fellows of the Faculty who are not already involved in teaching should seriously consider becoming 'active'. It is a commendable and worthwhile pursuit. It helps others as well as oneself and it certainly puts something back into the teaching pool which we have all benefited from during training.

GEOFFREY M. CLARKE

ssessment of our trainees.

# FACULTY OF INTENSIVE CARE DEAN'S REPORT TO FELLOWS AS AT MAY 4, 1995

#### Election

There was no requirement for an election of the Board.

#### **Establishment of Regional Committees**

These have been established in all regions with the exception of the Australian Capital Territory, Northern Territory and Tasmania. A pathway for the flow of information between the Board and the Regional Committees and vice versa is thus established.

It is hoped that the activities of the Regional Committee will continue to grow and the Board will gain an increasing response from Fellows regarding Faculty affairs.

#### **Policy Documents**

Those already printed include:

IC-1 (1994) Minimum Standards for Intensive Care Units (This is soon to be reviewed in light of input from Regional Committees and the ANZICS Liaison Committee.)

IC-2 (1994) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts

IC-3 (1994) Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Intensive Care

IC-4 (1994) The Supervision of Vocational Trainees in Intensive Care

IC-5 (1994) Duties of Regional Education Officers in Intensive Care

IC-6 (1994) Supervisors of Training in Intensive Care

IC-7 (1994) Secretarial Services to Intensive Care Units

IC-8 (1995) Ensuring Quality Care

Documents currently being considered in draft form include:

- Minimum Standards for Transport of the Critically Ill
- Statement on Ethics and Patient's Rights and Responsibilities

#### Education

Objectives of Training in Intensive Care

Work is progressing on review of the Objectives of Training document. It is hoped that a draft document will be sent to Regional Committees and other bodies for comment by the end of 1995.

#### Accreditation of Units

There has been considerable debate on the subject of units suitable for training. Several issues are involved, including the changing health care scene. Discussion on these important topics will continue.

#### Short Course in Intensive Care

Dr Worthley continues to organise this highly successful course which was last held in April this year.

## Maintenance of Standards in Intensive Care

This matter is under consideration. It is still in draft form

#### **Examinations**

Chairman of Examinations

Dr R.P. Lee was appointed Chairman of the Fellowship Examination Committee for 1995.

#### Fellowship Examinations

At the Fellowship Examination held in Sydney on 13th May 1994, a total of six candidates presented and two were approved.

The names of the successful candidates who had not completed training are:

Dr D.H.F. Buckley, Victoria Dr J.G.L. Cockings, SA

At the Fellowship Examination held in Melbourne on 22nd and 23rd September 1994, a total of seven candidates presented and five were approved.

The names of the successful candidates who had completed training are:

Dr A. Belessis, NSW Dr J.V. Green, SA The names of the successful candidates who had not completed training are:

Dr D.A. Cook, Qld Dr R.C. Freebairn, HK Dr Yung Tran, NSW

The Inaugural G.A. (Don) Harrison Medal for 1994 was awarded to Dr Andrew Belessis, (NSW).

#### Admission to Fellowship

By Examination:

William John O'REGAN, NSW Stephen Frederick WOODFORD, QLD Geoffrey Mark SHAW, SA Ian, Kee Seng TAN, HK Andrew BELESSIS, NSW John Victor GREEN, SA Anthony John MULLENS, NSW Robert John YOUNG, SA

By Election:

Valerie M.J. MUIR, QLD

## Conjoint Committee on Training and Certification

This Committee has agreed in principle that:

- (a) There should be a Joint Specialist Advisory Committee in Intensive Care to supervise training of intensive care trainees from both the RACP, the Faculty stream (or both).
- (b) The option will exist for RACP trainees who have successfully completed basic physician training as laid down by the RACP and who have passed the written and clinical FRACP examinations either prior to or in the first year of advanced training, to also enrol with the Faculty and seek Fellowship of the Faculty by fulfilling its training, final examination and other requirements. Such practitioners will be exempt from the ANZCA Primary Examination.

Documents are currently being drawn up for submission to the RACP and the Board of Faculty.

#### **Intensive Care Medical Liaison Committee**

This Committee last met on the 31st January 1995. Issues discussed included:

- Definitions of intensive care for the Australian Health Information Agreement
- Faculty of Intensive Care Minimum Standards document
- NH&MRC draft guidelines for donation of cadaveric organs and tissues for transplantation
- Recognition as an Intensive Care Specialist
- Manpower in intensive care

#### Annual Scientific Meeting, 1995

This was the Faculty's first two day meeting. Dr Charles Hinds of St. Bartholomew's Hospital, London, was the the Foundation Inaugural Visitor. The programme was a balanced one containing workshops, presentations on defined topics and free papers.

#### Annual Scientific Meeting, 1996

This will be held in October in Perth. Unusual circumstances exist in 1996 in that the World Congress in Anaesthesiology will be held in Australia so the College has delayed its meeting until the second half of the year. Unfortunately this separates it by only two weeks from the National ANZICS Meeting. Because of these factors the intensive care component of the meeting is to be reduced to one day for this Annual Scientific Meeting only.

Professor Oh is a confirmed speaker for this meeting. Other possible speakers include Dr Norman Swan, Sydney (science and medicine presenter on radio) and Dr Stephen Lewis, Adelaide (neuroscience research).

#### **Diplomas**

These have been finalised and will be distributed in the near future.

> G.M. CLARKE Dean Faculty of Intensive Care May 1995

May 1995 Bulletin

# FACULTY OF INTENSIVE CARE FOUNDATION INAUGURAL VISITOR

### **Dr Charles Hinds**

The Inaugural Faculty of Intensive Care Foundation Visitor to the Annual Scientific Meeting in Townsville was Dr Charles J. Hinds. Dr Hinds holds qualifications in both internal medicine and anaesthesia, and is currently Consultant and Senior Lecturer in the Department of Anaesthesia and Intensive Care at St Bartholomew's Hospital, London, where he directs the Intensive Care Unit. He has made a wide contribution to the intensive care literature, and has published extensively in areas including sepsis and septic shock, organ donation, neuromuscular weakness, and the management of complications of malignant disease.

Dr Hinds was an active contributor to our Meeting and took part in the Acute Renal Failure workshop, the panel discussion on acute renal failure, and spoke on neuropathy and myopathy in the ICU. His Foundation Visitor's Lecture entitled "Maintaining supranormal oxygen delivery — is it rational?" was both controversial and of wide interest to Intensivists and Anaesthetists alike. Following a review of the commonly cited literature supporting the use of

treatment goals designed to force oxygen delivery and consumption to supranormal values in order to improve outcome in critical illness, Dr Hinds reviewed his own recent studies as well as several others that refute the suggestion that goal-directed therapy is useful. Evidence was presented showing that goal-directed treatment serves only to demonstrate that patient groups have the necessary physiological reserve to survive their critical illness.

Dr Hinds' paper entitled "Neuromuscular Disorders in the Critically Ill" gave a current overview on this important topic and provided a new classification based on histology and electrophysiological studies. Much of this work has been carried out in St Bartholomew's Hospital.

The Board should be congratulated on its choice of Dr Hinds as the Inaugural Faculty of Intensive Care Visitor, and one can only hope that those who follow will be of a similar calibre.

P.D. THOMAS





All five candidates for the Faculty's Fellowship Examination were successful. From left: Drs B.R. Marsh, WA, Kin Way, Au Yueng, SA, C.L. Cole, NSW, P.R. Hicks, NZ and K.K. Young, Hong Kong.



The successful Faculty Fellowship Examination candidates with the Examiners. From left: Drs Louise Cole, Kin Way Au Yueng, Brian Marsh, Prof. Ken Hillman, Drs Peter Hicks, Karl Young, George Skowronski, Steve Edlin; in the foreground are Education Officer Dr Felicity Hawker, Chairman of Examinations Dr Richard Lee, and Dr Jim Tibballs.

Bulletin

# ITEMS OF INTEREST FROM THE MAY 1995 BOARD MEETING

#### **EDUCATION**

#### Objectives of Training in Intensive Care

A recent workshop has made progress with the review of this document and it is anticipated that a revised draft edition of the Objectives of Training in Intensive Care will be available at the end of the year. This document will be forwarded to Regional Committees for consideration.

#### In-Training Assessment

A draft policy document outlining the Faculty's proposal for In-Training Assessment was considered. The Board has agreed in principle with the requirement for this method of assessment, however a number of matters requiring clarification were identified. The Board resolved that a working group will be established to address the following issues.

- 1. How prospective assessments can be applied to trainees undertaking the elective components of training, and how overseas trainees will submit assessments.
- 2. The ramifications of an unsatisfactory assessment. Should it cause a delay in eligibility to sit the Examination?
- 3. How unsatisfactory reports will be dealt with, i.e., the mechanism, and corrective measures.
- 4. Will in-training assessment extend beyond successful completion of the Examination?
- 5. Who will conduct assessments for the elective components of training, and the process for ensuring this is done.
- 6. Is a separate appeals mechanism from the College required?
- 7. How to involve trainees in being responsible for responding to assessments.

#### Academic Future of Intensive Care

The Board considered the matter of appointments of Professors of Anaesthesia and Intensive Care, in particular where occupants of these positions do not hold a qualification in intensive care. It was agreed that this matter required more detailed consideration and a discussion paper entitled 'The Academic Future of Intensive Care' will be prepared for discussion.

#### Training in Indonesia

A request from the Indonesian Society for Anaesthesiologists for assistance in establishing a programme of Certification in Intensive Care was considered, and it was agreed that the Faculty will assist where possible.

#### Requirement for six months medical training

The Board discussed the requirement for six months of medical training within the intensive care training programme and the preferred timing of this training. The Board agreed it is preferable for the medical requirement to be undertaken earlier in training. However, because of the difficulty trainees have in gaining medical posts in some regions this early placement of the medical component of training is not always possible.

#### Intensive Care 'Rotations'

The possibility of rotations between major teaching hospitals and smaller specialist units for the purposes of training was discussed by the Board. The Board resolved to seek the views of Regional Committees on this matter.

#### PROFESSIONAL

#### **Policy Documents**

A draft policy document on Patient's Rights and Ethics relating to intensive care is being prepared for the next meeting of the Board.

The Policy Document IC-10 'Minimum Standards for Transport of the Critically Ill' has been reviewed and has now been referred to the Australasian College for Emergency Medicine. It is hoped that this document will be promulgated following a response from the ACEM.

The Board resolved that Policy Document IC-6 'Supervisors of Training in Intensive Care' be amended to include the statement that:

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

#### Conjoint Committee on Training and Certification

The Board considered two documents prepared by the Conjoint Training and Certification Committee detailing the structure, functions of a conjoint committee which would oversee a conjoint training programme proposed for all intensive care trainees. A draft document dealing with these matters has been presented at College Council. Council passed a resolution that the Council supports the principle of conjoint training and certification in Intensive Care.

#### Intensive Care Medical Liaison Committee

The Board noted preliminary moves toward a conjoint programme for paediatric intensive care training, and will consider a draft document on this matter in the future.

#### Criteria for Recognition as a Specialist in Intensive Care

The Board noted the Australian Medical Council's detailed guidelines for assessment of overseas trained specialists, and amended its draft criteria for recognition as a specialist in accordance with the AMC's guidelines. This document will be forwarded to the Intensive Care Medical Liaison Committee for final consideration.

#### Maintenance of Standards

A further draft of the proposal for a Maintenance of Standards Programme for the Faculty will be considered at the Board's next meeting in September. The Board noted the importance of the Faculty's programme retaining features common to both the ANZCA and RACP programmes.

#### INTERNAL AFFAIRS

#### Regional Committees

The Board discussed the channels of communication between the Board and Regional Committees, and the importance of this issue.

#### Annual Scientific Meeting — Perth 1996

It is noted that Professor Teik Oh, Hong Kong, Dr Norman Swan (ABC Radio doctor) and Dr Stephen Lewis (Neurosurgeon) have been approached as possible speakers for the Faculty of Intensive Care component of the 1996 ASM in Perth. At this stage a one day meeting for Sunday 27th October is planned for the Faculty.

#### **Election of Board Members**

There was no election for new Board members. The Board of Faculty for 1995/96 comprises:

G.M. Clarke

A.W. Duncan

R.P. Lee

P.D. Thomas

D.J. Cooper

F.H. Hawker

N.I'. Matthews

R.V. Trubuhovich

R.F. Whiting G.D. Phillips (Council representative)

#### **Election of Office Bearers**

The following Office-Bearers were re-elected:

 $egin{array}{lll} \emph{Vice-Dean} & R.V. \ \emph{Trubuhovich} \\ \emph{Censor} & A.W. \ \emph{Duncan} \\ \emph{Education Officer} & F.H. \ \emph{Hawker} \\ \end{array}$ 

and D.J. Cooper was elected Treasurer.

### COUNCIL OFFICE BEARERS AND COMMITTEES FOR 1995/96

President	N J Davis	<b>Primary Examination Committee</b>	
Vice President	G D Phillips	Chairman	P Roessler
Assessor	J M Gibbs	Deputy Chairman	P Kam
Assistant Assessor	M J Cousins	Chairman of Examinations	R J Willis
Education Officer	R S Henderson	Chairman of Faculty	
Chairman of Executive	G D Phillips	Fellowship Examination	A W Quail
Chairman of Examinations	R J Willis	and up to four Members	R P Lee
Treasurer	R G Walsh		R L Eyres
Chairman of Hospital Accreditation Group	I Rechtman		
Pharmaceutical/Technical and		Final Examination Committee	
Safety Officer (Australia)	M D Westmore	Chairman	K D Cronin
(New Zealand)	R S Henderson	Deputy Chairman	P L Klineberg
Protocol Officer	D H McConnel	Chairman of Examinations	R J Willis
ASM Officer	R J Willis	Council Representative	I Rechtman
Communications Officer	M Martyn	and three Members	D A Scott
Survey Officer	M D Westmore		E Loughman
Maintenance of Standards Officer	G D Phillips		D A Pybus
		Co-opted	C A Morgan
Executive		•	8
Chairman	G D Phillips	General Examinations Committee	
President	N J Davis	Chairman of Examinations	R J Willis
Assessor	J M Gibbs	President	N J Davis
Treasurer	R G Walsh	Education Officer	R S Henderson
and such other Member as the	R J Willis	Chairman of Primary Examination	P Roessler
Council may appoint		Deputy Chairman of Primary Examination	
0 11		Chairman of Final Examination	K D Cronin
<b>Education Committee</b>		Deputy Chairman of Final Examination	P L Klineberg
Chairman (Education Officer)	R S Henderson	Chairman of Faculty	1 L Kimeberg
President	N J Davis	Fellowship Examination	R P Lee
Assessor	J M Gibbs	renowship Examination	It I Lee
Chairman of Examinations	R J Willis	ASM Committee	
CE & QA Officer	R N Westhorpe		D I W:11:
Chairman of HAG	I Rechtman	ASM Officer (Convenor)	R J Willis
Faculty Education Officer	F H Hawker	President	N J Davis
and such other Member as the	M J Cousins	Registrar	J M Sheales
Council may appoint	ni o coubino	Protocol Officer	D H McConnel
common may appoint		Communications Officer	M Martyn
Hospital Accreditation Group		Faculty Representative	R F Whiting
Chairman	I Rechtman	A COMP COLUMN TO A	
President	N J Davis	ASM Scientific Programme Committee	D 1111111
Assessor	J M Gibbs	ASM Officer (Convenor)	R J Willis
Assistant Assessor	M J Cousins	President	N J Davis
Education Officer	R S Henderson	CE & QA Officer	R N Westhorpe
	IV D IICHGCI BOIL	Past Scientific Convenor (Qld)	V I Callanan
Continuing Education and Quality Assura	ince Committee	Present Scientific Convenor (WA)	N M Gibbs
Chairman	R N Westhorpe	Future Scientific Convenor (NZ)	R R Kennedy
President	N J Davis		
Education Officer	R S Henderson	College Representative on Board of	
ASM Officer	R J Willis	Faculty of Intensive Care	G D Phillips
MOS Officer	G D Phillips		
Representative, Faculty of Intensive Care	R F Whiting	Gilbert Brown Prize Adjudicators	
Representation from ASA	W R Thompson	Chairman (ASM Officer to select panel)	R J Willis
Representation from NZSA	A L Garden	,	
Representative from ANZICS	F H Hawker	Formal Project Prize Adjudicators	
and other Members appointed by Council	T E Oh	Chairman (ASM Officer to select panel)	R J Willis
**		Y	DI 1 10 II
Workforce Committee	DH McCerrel	Lennard Travers Professorship	Electoral Colleg
Chairman Progident	D H McConnel	Computer Sub Covereittes	
President	N J Davis	Computer Sub-Committee	MMonte
Education Officer	R S Henderson	Chairman	M Martyn
Survey Officer	M D Westmore	Treasurer	R G Walsh
Assistant Assessor	M J Cousins	Registrar	J M Sheales
Faculty Education Officer	F H Hawker	Accountant	V M Lillie

F H Hawker

M K Radnor

Accountant

and such other Members as

the Council may appoint

Bulletin

Faculty Education Officer

and such other Members as

as the Council may appoint

V M Lillis

C A Morgan

Bulletin Editorial Committee		Representatives/Nominees to other outside Organisations	
Editor	J M Sheales	representatives remines to other outside organization	
	J M Gibbs	Australian Society of Anaesthetists	
	I Rechtman	Executive	President or
Communications Officer	M Martyn		nominee
	-	Joint Liaison Committee	President
			Vice President
Communications Committee			
Chairman (Communications Officer)	M Martyn	Coordinator of Anaesthetic Representat	ives on External
President	N J Davis	Standards Committees	W J Russell
ASM Officer	R J Willis		
Registrar	J M Sheales	National Committee on Day Surgery	D H McConnel
Communications Consultant	E Dean	National Committee on Day Surgery	A K Bacon
Other members as appointed by Council	M D Westmore		II II Bacon
		Anaesthetic Co-ordinating Committee	President
		for AMA Federal Conference	Chairman of
Academic Anaesthesia Review Sub-Com		101 12121 1 0 0 0 111 0 0 0 110 1	Executive
Chairman	G D Phillips		
	J M Gibbs	Anaesthesia and Industry	N J Davis
	M J Cousins T E Oh	Liaison Committee	D H McConnel
:	I E On	maison committee	R J Willis
1.3			
Victorian Chairs of Anaesthesia	G B Donnan	Joint Consultative Committee on	N J Davis
Advisory Committee	P A Lowe	Anaesthesia (JCCA)	DH McConnel
Advisory Committee	I Rechtman		F X Moloney
	T C K Brown		•
	P J Keast	Committee of Presidents of	
	R N Westhorpe	Medical Colleges	President
	-		
		ANZCA/RACS/RACP	President
Joint Advisory Committee of	President or		
Combined Colleges	Vice President	Australasian Board of Cardiovascular	R G Walsh
		Perfusionists	A B Stewart
Australian Resuscitation Council	V I Callanan	Observer to RACS Council	President
	G A Harrison		
		Working Parties	
College Historian	M G Cooper	<i>y</i> =	
Assistant Historian	A J Newson	Pain Management Advisory Committee	
Assistant Historian	A 5 IVEWSOII	Chairman	J M Gibbs
		Olicii Ilicii	M J Cousins
Geoffrey Kaye Museum of Anaesthetic History			T F Little
Curator	R N Westhorpe		C R Goucke
Assistant Curator	C M Ball		D Jones
		Anaesthesia Simulators	
Library Committee		Convenor and Chairman	R S Henderson

Treasurer

MOS Officer

R N Westhorpe

I Rechtman C A Morgan

BF Horan

Councillor

Councillor and Chairman

R G Walsh

G D Phillips

A L Garden

J Zelcer

# CHANGES IN REGULATIONS

# 12. AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS MEDAL

The Faculty of Anaesthetists, Royal Australasian College of Surgeons, Medal was established in 1979 and adopted by the College upon establishment.

- 12.1 This award is made at the discretion of the Council of the College in recognition of major contributions to the status of anaesthesia, intensive care or related specialties.
- 12.2 Nominations may be considered at any Council Meeting and shall be made in writing by two members of the Council.
  - 12.3 Nominations must be accompanied by a curriculum vitae, and be submitted at least 30 days prior to the Council Meeting.
  - 12.4 Voting on the nomination shall be by secret ballot.
  - 12.5 No award shall be made unless threequarters of the Council Members present vote in favour.
  - 12.6 Nominations rejected by the Council may be reconsidered at a subsequent meeting but must be formally proposed and seconded again.

#### 20. LENNARD TRAVERS PROFESSORSHIP

The Lennard Travers Professorship was established by the Faculty of Anaesthetists, Royal Australasian College of Surgeons, in 1968. It is a prestigious award which provides support for a Fellow of the College to work in an area of his/her choosing towards the advancement of knowledge in a nominated area of anaesthesia in Australia and/or New Zealand. This Professorship was adopted by the College upon establishment.

20.1 The Professorship will be available at intervals determined by the College Council – normally four years. Intention to appoint a Lennard Travers Professor of Anaesthesia will be advertised in the College *Bulletin* 

- with a specified closing date. Candidates for the award will be required to submit a letter of application to the Registrar. This letter should contain the information required in 20.2. Three referees should be nominated.
- 20.2 The letter of application will detail the nominated area of work and the way in which the study will be carried out. The letter of proposal should be limited to three pages of single spaced A4 typescript with one additional page of information concerning the proposed budget. It is necessary that applicants establish how the award can be held concurrently with any other duties and sources of income. A full curriculum vitae should also be included with the application.
- 20.3 Applications for the Professorship will be collated by the President who will use a panel of the Electoral College to assist with this task. The President will bring a recommendation as to the award of the Professorship to Council which has final responsibility for the award.
- 20.4 The holder of the Professorship will be known as *The Lennard Travers Professor of Anaesthesia*. The tenure of the award will ordinarily be for one year. Any variations are at the discretion of Council. Council reserves the right to cancel or terminate the Professorship if in its opinion, the purpose of the Professorship is not being pursued.
- 20.5 The amount of the emolument will be determined by Council. It will be paid to the Professor on an agreed basis.
- 20.6 The Lennard Travers Professor of Anaesthesia will be required to give a lecture at the Annual Scientific Meeting of the College on the subject of the Professorship. Visits to at least two regional centres in Λustralia and/or New Zealand will also be required.
- 20.7 The Professor shall be bound by the terms and conditions of the award.

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# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

# STATEMENT ON AIDS AND HEPATITIS

#### INTRODUCTION

The ongoing Acquired Immune Deficiency Syndrome (AIDS) epidemic, the ever present risk of hepatitis infection and the ongoing elucidation of knowledge about the different types of hepatitis continue to focus the attention of anaesthetists and intensivists on these two conditions and the agents which cause them. The College's statement on the topic deals with:

- 1. Access to medical care.
- 2. Infection control policy.
- 3. The anaesthetist or intensivist with hepatitis or human immunodeficiency virus (HIV) infection.
- 4. General considerations.

#### 1. ACCESS TO MEDICAL CARE

The patient infected with HIV or a hepatitis virus has the same right to treatment and care as any other patient. That notwithstanding, patients who know themselves to have or to be antibody positive for either of these diseases have a duty to inform their medical attendants of the fact when invasive procedures are planned.

#### 2. INFECTION CONTROL POLICY

These diseases are transmitted by the transfer of body fluids from an infected individual to others. Known routes of transmission include inoculation via needlestick injuries, transconjunctivally or via breaches in the skin such as wounds and abrasions. It is extremely important that doctors, nurses and paramedical staff take adequate precautions against transmission of all blood-borne infectious diseases.

#### 2.1 Protection of all Health Care Personnel:

#### 2.1.1 Vaccination

All anaesthetists, intensivists and other health care personnel at risk of contracting Hepatitis B from patients should be vaccinated. In the absence of a vaccine against HIV and Hepatitis C, health care workers must rely on physical measures for protection.

# 2.1.2 Physical measures (universal precautions)

Objectives of these measures include:

(i) Protection of the doctor or health care

worker against contact with all patients' body fluids. Such measures include the routine wearing of gloves and eye protection when there is the possibility of such contact. Special measures may be needed to protect against aerosols.

(ii) To reduce the risk of cuts, needlestick injuries and skin lacerations. Such measures include the use of blunt rather than sharp drawing-up needles; the use of techniques other than injecting with a needle through a bung when administering drugs into intravenous lines; the immediate disposal of sharp needles and other sharp objects by the operator after use; never recapping needles; the use of PVC rather than glass ampoules; the widespread availability of sharps disposal containers conveniently located; the provision of suitable work surfaces when procedures (e.g. IV cannulation) are being performed at

The need for universal precautions to be employed in the emergency setting as well as the elective is stressed.

Anaesthetists and intensivists have a responsibility to educate those who work under their direction in the use of these measures.

#### 2.1.3 Prophylaxis

the bedside.

Should potential inoculation occur during the treatment of a known or suspected HIV positive patient through a needlestick injury or other means, urgent consultation with a specialist HIV clinician is important as prophylactic antiviral drug therapy may be indicated.

#### 2.2 Policy on testing for antibodies

While the importance of universal precautions is stressed, nonetheless when a patient whose history reveals the presence of risk factors for HIV or hepatitis infection is to undergo surgery, it is important that where possible the patient's

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antibody status be known. The information should be available to the surgeon, anaesthetist and theatre staff before the anaesthesia begins.

#### 2.3 Protection of Patients

#### 2.3.1 Blood Transfusion

It is well known that HIV and hepatitis can be transmitted to patients through blood or blood product transfusion. Hence the transfusion of homologous blood should only be undertaken for sound indications. Measures to reduce the need for homologous transfusion such as autologous transfusion, haemodilution and blood scavenging should be employed when appropriate.

#### 2.3.2 Anaesthesia Equipment

To date transmission of HIV via anaesthetic appratus has not been demonstrated. Nonetheless, the potential for infectious diseases to be spread by this route makes the highest standards of cleanliness and hygiene mandatory. See College Policy Document P28 'Infection Control in Anaesthesia'.

#### 3. HIV OR HEPATITIS POSITIVE ANAESTHE-TISTS OR INTENSIVISTS

No patient or staff member's health should be endangered by the actions of an anaesthetist or intensivist with hepatitis or HIV. Such practitioners should not perform procedures which carry the risk of transmission of their disease, other than on patients seropositive for the same condition as themselves. The seropositive anaesthetist or intensivist should consult a specialist in the disease in question regularly and be guided by their opinion on such matters as the practitioner's fitness to continue to practise. The rights of HIV and hepatitis positive practitioners must be respected and they should receive the support of their colleagues and assistance in continuing in appropriate professional practice.

#### GENERAL CONSIDERATIONS

#### 4.1 Referral Policy

4.

Any hospital must be capable of implementing the precautions described above. Referral of surgical patients to specialist units on the basis of antibody status alone is neither indicated nor justifiable.

June 1995

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.

August 1995 Bulletin

#### 04

## Review P15 (1995)

# GUIDELINES FOR THE PERIOPERATIVE CARE OF PATIENTS SELECTED FOR DAY CARE SURGERY

Day Care Surgery means that the patient will ordinarily be discharged from the hospital or unit later on the day of the procedure. Anaesthesia for the procedure may require general, regional or sedative techniques.

#### SELECTION GUIDELINES

- Procedures suitable for day care surgery must entail:
  - 1.1 A minimal risk of post operative haemorrhage.
  - 1.2 A minimal risk of post operative airway compromise.
  - 1.3 Post operative pain controllable by outpatient management techniques.
  - 1.4 No special post operative nursing requirements.
  - 1.5 A rapid return to normal fluid and food intake.
- 2. Patient requirements for day care surgery include:
  - 2.1 A willingness to have the procedure performed together with an understanding of the process and ability to follow discharge instructions.
  - 2.2 Physical status of ASA I or II. Medically stable ASA III or IV patients may be accepted for day care surgery following consultation with the anaesthetist concerned.
  - 2.3 Normal term infants of over three months of age or ex-premature infants (less than 37 weeks gestation) of more than 60 weeks post-conceptual age. Prior consultation with the anaesthetist is essential.

In all cases, the ultimate decision as to the suitability of a patient for day care surgery is that of the anaesthetist. The decision as to the type of anaesthesia must remain in the province of the anaesthetist and will be based on surgical requirements, patient considerations, the experience of the anaesthetist and the facilities of the day care surgical unit.

- 3. Social requirements for day care surgery include:
  - 3.1 A responsible person able to transport the patient home in a suitable vehicle.
  - 3.2 A responsible person at home for at least the first night after discharge from the unit.

A responsible person is an adult who understands the instructions given to them and is physically and mentally able to make decisions for the patient's welfare when appropriate.

#### 4. PATIENT PREPARATION

- 4.1 College Policy Document P7 'The Pre-Anaesthetic Consultation' describes the essential nature of this consultation for all patients who are to receive anaesthesia.
- 4.2 College Policy Documents P22 'Statement on Patients' Rights and Responsibilities' and P26 'Guidelines on Providing Information about Anaesthesia' are both relevant to preparation for day stay surgery.
- 4.3 Patient assessment can be assisted by:
  - 4.3.1 A standardised anaesthesia questionnaire.
  - 4.3.2 Preliminary nurse assessment.
  - 4.3.3 Prior surgical referral in cases of doubt as to suitability for day care surgery.
- 4.4 Patient information in an understandable written format must include:
  - 4.4.1 General information about the processes followed in the day care unit.
  - 4.4.2 Instructions for fasting according to the following guidelines:
    - 4.4.2.1 Limited solid food may be taken up to six hours prior to anaesthesia.
    - 4.4.2.2 Unsweetened clear fluids totalling not more than 200 ml per hour may be taken up to three hours prior to anaesthesia.
    - 4.4.2.3 Only medications or water ordered by the anaesthetist should be taken less than three hours prior to anaesthesia.
    - 4.4.2.4 An H2-receptor antagonist should be considered for patients with an increased risk of gastric regurgitation.

These guidelines may be modified in some patients, particularly infants and small children, on advice from the anaesthetist.

#### 5. RECOVERY FROM ANAESTHESIA

5.1 College Policy Document P4 'Guidelines for the Care of Patients Recovering from Anaesthesia

- in the Recovery Area' establishes requirements for the facilities and staffing of recovery areas. This document is fully applicable to day care units.
- 5.2 An area must be provided with comfortable reclining seating for patients to complete recovery prior to discharge home. This area must be adequately supervised by nursing staff and should also have ready access to resuscitation equipment, including oxygen and suction equipment. Patients must not leave this area unaccompanied.

## 6. DISCHARGE OF THE PATIENT FROM THE DAY CARE UNIT

The discharge area should have easy access to wheel chairs, a parking area and ambulance facilities so as to minimise walking for the post operative patient and to aid transfer of the patient to inpatient hospital care when this is necessary.

The following criteria apply to patient discharge:

- 6.1 Stable vital signs for at least one hour.
- 6.2 Correct orientation as to time, place and relevant people.
- 6.3 Adequate pain control with oral analgesics.
- 6.4 Ability to dress and walk should be equivalent to preoperative standards.
- 6.5 Minimal nausea, vomiting or dizziness.
- 6.6 May tolerate oral fluids without vomiting.
- 6.7 Minimal bleeding or wound drainage.
- 6.8 Has passed urine. This is particularly important after central neural blockade or pelvic surgery.
- 6.9 A responsible adult to take the patient home. For children, and in other situations where necessary, there should be an adult escort as well as the vehicle driver.
- 6.10 Discharge should be authorised by surgeon and anaesthetist or their designated alternative after the above criteria have been satisfied.

- 6.11 Written and verbal instructions for all relevant aspects of post anaesthetic and surgical care must be given to the patient and the accompanying adult. An emergency contact place, person and telephone number must be included.
- 6.12 Suitable analgesia should be provided for at least the first day after discharge. Advice on any other regular medication is also necessary.
- 6.13 A telephone enquiry as to the patient's wellbeing on the following day should be made whenever possible.

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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## Review P4 (1995)

### GUIDELINES FOR THE CARE OF PATIENTS RECOVERING FROM ANAESTHESIA

#### 1. GENERAL PRINCIPLES

- 1.1 Recovery from anaesthesia should take place under supervision in an area designated for the purpose.
- 1.2 This area should be close to where the anaesthetic was administered.
- 1.3 The staff working in this area must be trained for their role and able to contact supervising medical staff promptly when the need arises.
- 1.4 In some situations (for example, paediatric hospitals) minor variations in these Guidelines may be appropriate.

#### 2. THE RECOVERY AREA

#### 2.1 Design Features

- 2.1.1 The area should be part of the operating or procedural suite. Access should be available to medical staff who are not in operating suite clothing, so that they may continue to supervise the patient's care. Provision should be made for rapid evacuation of patients from the area in an emergency.
- 2.1.2 It should have ventilation to operating theatre standards.
- 2.1.3 The space allocated per bed/trolley should be at least 9 square metres.

  There must be easy access to the patient's head.
- 2.1.4 The number of bed/trolley spaces must be sufficient for expected peak loads and there should be at least 1.5 spaces per operating room.
- 2.1.5 Each bed space must be provided with:
  - 2.1.5.1 an oxygen outlet
  - 2.1.5.2 a vacuum outlet complying with the current requirements of the relevant national Standards.
  - 2.1.5.3 two General Power Outlets
  - 2.1.5.4 lighting to allow accurate detection of cyanosis
  - 2.1.5.5 emergency lighting

- 2.1.5.6 appropriate facilities for mounting and operating any necessary equipment and for the patient's chart.
- 2.1.6 Space must be provided for a nursing station, storage of drugs, of clean linen as well as a utility room.
- 2.1.7 There must be appropriate facilities for scrubbing up for procedures.
- 2.1.8 There should be a wall clock with a sweep second hand or analogue display clearly visible from each bed space.
- 2.1.9 Communication facilities should include:
  - 2.1.9.1 an emergency call system to areas such as the Department of Anaesthesia.
  - 2.1.9.2 a telephone and access to the Hospital paging system.
- 2.1.10 There should be easy access for portable X-Ray equipment with appropriate power outlets provided in the area.

  There should also be an X-Ray viewing box.
- 2.1.11 An emergency power supply should be available in the area.

#### 3. EQUIPMENT AND DRUGS

- 3.1 Each bed space should be provided with:
  - 3.1.1 oxygen flowmeter and patient oxygen delivery systems
  - 3.1.2 suction equipment including a receiver, appropriate hand pieces and a range of suction catheters
  - 3.1.3 a pulse oximeter
  - 3.1.4 a sphygmomanometer which may be automated and include cuffs suitable for all patients
  - 3.1.5 a stethoscope
  - 3.1.6 a means of measuring body temperature

- 3.2 Within the recovery area there must be:
  - 3.2.1 a means of inflating the lungs with oxygen in a ratio of one per two bed spaces, but with a minimum of two such devices
  - 3.2.2 airway management and intubation drugs and equipment
  - 3.2.3 emergency and resuscitative drugs
  - 3.2.4 a range of I.V. equipment and fluids and a means of warming those fluids
  - 3.2.5 drugs for pain control
  - 3.2.6 a range of syringes and needles
  - 3.2.7 electrocardiographs with a minimum of 1 to 3 bed spaces.
- 3.3 There should be easy access to:
  - 3.3.1 a 12 lead electrocardiograph
  - 3.3.2 a monitor for measurement of direct arterial and venous pressures
  - 3.3.3 a capnometer
  - 3.3.4 a defibrillator
  - 3.3.5 a neuromuscular function monitor
  - 3.3.6 a bronchoscope with sucker and grasping forceps
  - 3.3.7 a warming cupboard
  - 3.3.8 a refrigerator for drugs and blood
  - 3.3.9 a patient warming device
  - 3.3.10 a procedure light
  - 3.3.11 a simple surgical tray
  - 3.3.12 blood gas and electrolyte measuring
  - 3.3.13 diagnostic imaging services
- 3.4 The recovery trolley/bed must:
  - 3.4.1 have a firm base and mattress
  - $3.4.2 \quad \mbox{tilt from one or both ends both head up} \\ \mbox{and head down at least 15 degrees}$
  - 3.4.3 be easy to manoeuvre
  - 3.4.4 have efficient and accessible brakes
  - 3.4.5 provide for sitting the patient up
  - 3.4.6 have secure side rails which must be able to be dropped below the base or be easily removed
  - 3.4.7 have an I.V. pole

3.4.8 have provision for mounting monitoring equipment, patient ventilation equipment, oxygen cylinders, underwater seal drains and suction apparatus during transport of patients.

#### 4. STAFFING

- 4.1 Staff trained in the care of patients recovering from anaesthesia must be present at all times.
- 4.2 A registered nurse trained in recovery area care should be in charge.
- 4.3 Trainee nurses and registered nurses who are not experienced in the care of patients recovering from anaesthesia must be supervised.
- 4.4 The ratio of registered nurses to patients needs to be flexible so as to provide no less than one nurse to three patients, and one nurse to each patient who has not recovered protective reflexes or consciousness.

#### 5. MANAGEMENT AND SUPERVISION

- 5.1 Written protocols for management should be established. The Director of Anaesthesia, or the Anaesthetist-in-Charge, should be responsible for the medical aspects of these policies.
- 5.2 A written routine for checking the equipment and drugs must be established.
- 5.3 Observations should be recorded at appropriate intervals and should include state of consciousness, oxygen saturation, respiratory rate, pulse rate, blood pressure and temperature.
- 5.4 All patients should remain until they are considered safe to be discharged from the recovery area according to established criteria.
- 5.5 The anaesthetist responsible for the patient should:
  - 5.5.1 accompany the patient until transfer to recovery area staff is completed
  - 5.5.2 provide written and verbal instructions to the recovery area staff
  - 5.5.3 specify the type of apparatus and the flow rate to be used for oxygen therapy
  - 5.5.4 remain in the vicinity until the patient is safe to be left in the care of recovery area staff
  - 5.5.5 supervise the recovery period and authorise the patient's discharge from the recovery area. It is recognised that in some circumstances it may be necessary for the anaesthetist

previously responsible for the patient to delegate these duties to a trained recovery area nurse or to another anaesthetist who should be fully informed of the clinical state of the patient.

5.6 The practitioner responsible for the patient's overall care should be available to consult with the anaesthetist should the need arise in the recovery period and, where appropriate, to authorise the discharge of the patient.

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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# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

# STATEMENT ON SUB-SPECIALTY EXPERIENCE FOR ANAESTHESIA TRAINEES

Council recognises the importance of sub-specialty training and makes the following statements for the guidance of Fellows and Trainees:

- Experience in sub-specialty areas of anaesthetic practice is an essential part of the training of an anaesthetic specialist as outlined in *Objectives of Training in Anaesthesia*, *Second Edition – 1991*.
- . When training programmes are being inspected, a particular note will be taken of the capacity of that programme to provide a broadly based training in anaesthesia with exposure of all trainees to sub-specialty areas of experience.
- While the College does not require trainees to obtain specific numbers of cases or to spend a specified time in each area, the following guidelines may be used as an indication of Council's views as to necessary experience during the first four years of approved training.
  - 3.1 Neurosurgical Anaesthesia. A three month block attachment for emergency and elective neurosurgery is desirable. Where this cannot be obtained, trainees should be involved in the management of at least 25 intracranial procedures in both emergency and elective situations.
  - 3.2 Thoracic and Cardiac Anaesthesia. A three month block attachment for emergency and elective thoracic and cardiac surgery is desirable. Where this cannot be obtained, trainees should be involved with the perioperative management of at least 25 intrathoracic cases. These should include:
    - (a) a minimum of ten cases for bypass cardiac surgery;
    - (b) a minimum of fifteen cases involving the use of double-lumen tubes and management of one-lung anaesthesia.

- 3.3 Paediatric Anaesthesia. A three month block attachment devoted exclusively to paediatric anaesthesia is desirable. Where this cannot be achieved, trainees should be involved with the management of anaesthesia in at least 100 children aged less than four years and with 200 children aged between four and ten years of age.
- 3.4 Obstetric Analgesia and Anaesthesia. A three month block attachment devoted exclusively to obstetric analgesia and anaesthesia is desirable. Where this cannot be achieved, trainees should be involved with the management of at least 150 obstetric patients of more than 24 weeks gestation. Experience of the management of Caesarean Section by both general and regional anaesthesia must be included.
- 4. Council strongly advises trainees to keep a logbook of their experience during training. This record should allow identification of the specialty area and any cases of particular interest. Training Departments may be able to assist with computer generated records but primary responsibility should remain with trainees so that they are able to identify areas in which their experience may be deficient.
- 5. Sub-specialty experience as recommended above should be obtained during the first four years of training. This gives the opportunity for any areas of deficiency to be corrected during the provisional fellowship year.
- 6. Council recognises that there are other areas of sub-specialty training of importance to the specialist anaesthetist which are not specifically mentioned in this statement. It is considered that the principles used in arriving at the statements above could also be used in planning training at an individual or Departmental level. In all cases, the statement of *Objectives of Training in Anaesthesia, Second Edition 1991* is a valuable resource for planning purposes.

Bulletin

#### 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.

- E1 (1991) Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Anaesthesia Bulletin Mar 91, p40
- E3 (1994) The Supervision of Trainees in Anaesthesia Bulletin Nov 92, p41
- E4 (1992) Duties of Regional Education Officers Bulletin Nov 92, p44
- E5 (1992) Supervisors of Training in Anaesthesia and Intensive Care Bulletin Nov 92, p45
- E6 (1990) The Duties of an Anaesthetist Bulletin Nov. 90, p22
- E7 (1994) Secretarial Services to Departments of Anaesthesia Bulletin Nov 94, p43
- E9 (1993) Quality Assurance Bulletin Mar 93, p38
- E11 (1992) Formal Project Bulletin Nov 92, p46
- E13 (1991) Guidelines for the Provisional Fellowship Year Bulletin Nov 91, p38
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia Bulletin Aug 94, p62
- EX1 (1991) Guidelines for Examiners with Respect to Candidates Suffering Illness (or Accident) at the Time of Examination Bulletin Mar 91, p43
- T1 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites Bulletin Nov 94, p53
- T2 (1990) Protocol for Checking an Anaesthetic Machine Before Use Bulletin, Mar 90, p12
- T3 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Units Bulletin Nov 94, p56
- T4 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT) Bulletin Nov 94, p59
- T5 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries Bulletin Nov 94, p62
- T6 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites Bulletin Nov 94, p65
- P1 (1991) Essential Training for General Practitioners Proposing to Administer Anaesthetics Bulletin Mar 91, p44
- P2 (1991) Privileges in Anaesthesia Faculty Policy Bulletin Mar 91, p45
- P3 (1993) Major Regional Anaesthesia Bulletin Mar 93, p36
- P4 (1995) Guidelines for the Care of Patients Recovering from Anaesthesia Bulletin, Aug 95, p64
- P5 (1991) Statement on Principles for the Care of Patients who are given Drugs Specifically to produce Coma Bulletin Aug 91, p50
- P6 (1990) Minimum Requirements for the Anaesthetic Record
- P7 (1992) The Pre-Anaesthetic Consultation Bulletin Nov 92, p47
- P8 (1993) Minimum Assistance Required for the Safe Conduct of Anaesthesia Bulletin Nov 93, p33
- P9 (1991) Sedation for Diagnostic and Minor Surgical Procedures Bulletin Mar 91, p45
- P10 (1994) The Handover of Responsibility During an Anaesthetic Bulletin Nov 94, p44
- P11 (1991) Management of Cardiopulmonary Bypass Bulletin May 91, p43
- P12 (1991) Statement on Smoking Bulletin Nov 91, p37
- P13 (1992) Protocol for The Use of Autologous Blood Bulletin Aug 92, p49
- P14 (1993) Guidelines for the Conduct of Epidural Analgesia in Obstetrics Bulletin Mar 93, p37
- P15 (1995) Guidelines for the Perioperative Care of Patients Recovering from Anaesthesia Related to Day Surgery Bulletin Aug 95, p62
- P16 (1994) Standards of Practice of a Specialist Anaesthetist Bulletin Nov 94, p45
- P17 (1992) Endoscopy of the Airways
- P18 (1990) Monitoring During Anaesthesia Bulletin, Aug 90, p38
- P19 (1990) Monitored Care by an Anaesthetist Bulletin, Mar 90, p15
- P20 (1990) Responsibilities of Anaesthetists in the Post-Operative Period Bulletin, Aug 90, p39
- P21 (1992) Sedation for Dental Procedures Bulletin Mar 92, p37
- P22 (1990) Statement on Patients' Rights and Responsibilities Bulletin, Nov 90, p24
- P23 (1992) Minimum Standards for Transport of the Critically Ill Bulletin Mar 92, p40
- P24 (1992) Sedation for Endoscopy Bulletin May 92, p45
- P25 (1993) Minimum Standards for Pain Management Units Bulletin Aug 93, p47
- P26 (1994) Guidelines on Providing Information About Anaesthesia Bulletin Aug 94, p61
- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion Bulletin Nov 94, p46
- P28 (1995) Policy on Infection Control in Anaesthesia Bulletin Mar 95, p38
- IC-1 (1994) Minimum Standards for Intensive Care Units Bulletin Aug 94, p44
- IC-2 (1994) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts Bulletin Aug 94, p49
- IC-3 (1994) Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Intensive Care Bulletin Aug 94, p51
- IC-4 (1994) The Supervision of Vocational Trainees in Intensive Care Bulletin Aug 94, p54
- IC-5 (1994) Duties of Regional Education Officers in Intensive Care Bulletin Aug 94, p55
- IC-6 (1994) Supervisors of Training in Intensive Care Bulletin Aug 94, p56
- IC-7 (1994) Secretarial Services to Intensive Care Units Bulletin Aug 94, p57
- IC-8 (1995) Ensuring Quality Care: Guidelines for Departments of Intensive Care Bulletin Mar 95, p32

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