



AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852



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

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EDITORIAL

Mrs J.M. Sheales, *Editor*
Prof. J.M. Gibbs
Dr I. Rechtman

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PRESIDENT'S MESSAGE



The College Council has recently adopted an ambitious programme to change the public image of anaesthesia. Image has always been important but has assumed greater significance in the 90s. There is little doubt that the public has a poor understanding of our role, knowledge of our training, education or the significant responsibilities we accept as normal. Our surgical and medical colleagues have a poor understanding of our specialty and its rapid progress in the past 15 years.

We need to develop a better image. Most reports about anaesthesia in the media are negative, reporting anaesthetic mishaps rather than changes which continue to make anaesthesia even safer. Perhaps this is our own fault because most of our case discussions are about complications. Why not consider difficult cases which are managed uneventfully because of the skill, knowledge and care of the anaesthetist? Next time the press reports the NH&MRC anaesthetic mortality in Australia we should emphasise the 1.7 million anaesthetics which our patients survive without any problems.

Anaesthetists feel comfortable in the operating theatre environment, but this is a mysterious

place poorly understood by the public. We need to promote our significant contributions outside the operating theatre. Our expertise in resuscitation, pain relief, intensive care, pre-operative assessment, education and administration is considerable and should be widely recognised.

The College has sought professional advice about how we should proceed to upgrade our image. This programme is highlighted elsewhere in the *Bulletin*. There is no doubt that all Fellows need to contribute. We need to improve our professional appearance, our patient communications and actively seek opportunities to improve public perceptions of anaesthesia.

Fellows have made significant advances in patient care by continually improving the quality and safety of anaesthesia. It is time we let the public know of these advances and improve our image.

MICHAEL DAVIES
President

HIGHLIGHTS OF THE FEBRUARY 1995 COUNCIL MEETING

INTERNAL AFFAIRS

Election of President-Elect

Associate Professor Neville J. Davis, WA, was elected President-Elect to take office following the Annual General Meeting in June.

Election to Fellowship under Regulation 6.2

Dr John Sear, Oxford, UK and Associate Professor Christopher Eagle, Calgary, Canada were elected to Fellowship under Regulation 6.2.

Election to Fellowship — Regulation 6.3.1

Regulation 6.3.1 was amended and appears elsewhere in this edition of the *Bulletin*.

Communications

Council approved the involvement of the College with Internet and E-Mail, requesting the Computer Sub-Committee to review the activities to be included.

Public Relations

Following consideration of a presentation by Mr Eddie Dean, Council approved a communication programme for the College.

Initially this will involve the production of a Flagship Information Sheet, Basic Information Leaflet for Patients and encouragement of Fellows to present at meetings of Community and Service organisations.

Assessment of Overseas Trained Doctors

Council resolved that assessment of any foreign qualified doctor who is not eligible for assessment via the Australian Medical Council process, will be charged half the OTD assessment fee for any College assessment of their qualification and training.

Policy Document

Council approved a Policy Document on "*Infection Control in Anaesthesia*" which is published in this *Bulletin*.

EXAMINATIONS

Observers to Examinations

Council resolved that:

1. Observers to the Primary Examination be Fellows who are three years post Primary Examination.
2. Unless in exceptional circumstances, Fellows eligible to observe the Final Examination must be three years post Fellowship.

Examiners — Tenure of Appointment

In accordance with the Australian Securities Commission's requirements for the re-appointment of Councillors every three years, Council agreed that the term of appointment of the Panel of Examiners be reduced to three years with an aggregate tenure of twelve years. Previously the term of appointment was four years with an aggregate of twelve years.

**CONTINUING
EDUCATION
AND QUALITY
ASSURANCE**

1996 Annual Scientific Meeting — Perth

As the Australian Society of Anaesthetists will not be mounting its Annual Scientific Meeting in 1996, the Council has agreed that a Combined Scientific Meeting of the Australian and New Zealand College of Anaesthetists and the Australian Society of Anaesthetists be held in Perth from October 26-30, 1996, which will include the Geoffrey Kaye Oration and the Annual General Business Meeting of the Society.

Australasian Anaesthesia

Following a suggestion that the Proceedings of the World Congress of Anaesthesiologists be circulated to all Fellows in 1996 in lieu of Australasian Anaesthesia, Council has resolved that Australasian Anaesthesia will be published and distributed to all Fellows and Trainees in 1996.

Special Interest Group

Council approved the change of name of the Neuro Surgical Anaesthesia Special Interest Group to "***Neuroanaesthesia Special Interest Group***".

Pre- and Post-Congress Satellite Meetings

Pre-Congress Satellite Meeting. Council agreed to support a Pre-Congress Satellite Meeting in conjunction with the American Society of Ambulatory Anesthesia, the ANZCA Day Care Anaesthesia SIG and the Australian Society of Anaesthetists on Ambulatory Anaesthesia.

Post-Congress Satellite Meeting. The College agreed to support, with the Australian Society of Anaesthetists, the Post-Congress Satellite Meeting in Sydney on Clinical Information Systems in Anaesthesia and Intensive Care.

**MAINTENANCE
OF STANDARDS
PROGRAMME**

The Council resolved to offer the ANZCA Maintenance of Standards Programme to non-Fellows at a fee of A\$200 for 1995. Along with College policy, this fee will be reviewed annually.

**FORMAL
PROJECT
PRIZE**

Council approved the Regulations relating to the Formal Project prize and confirmed that the first session for such prize will be conducted during the forthcoming Annual Scientific Meeting in Townsville. The Regulation relating to this Prize is Appendix 3.

FINANCE

A request for Subscription Concession for Fellows working part-time was considered but not supported by Council on the basis of such Fellows having full access to the College activities and privileges.

EDUCATION

South-East Asian Trainees

Council reaffirmed the current requirement for South-East Asian Trainees to complete one year of training in Australia and New Zealand to be awarded Fellowship of the College in accordance with Regulation 15.7.1

Council also reaffirmed its previous resolution to assist the local South-East Asian training, examining and credentialling bodies with their activities.

Paediatric Anaesthesia in Non-Paediatric Hospitals

Council has requested the Education Committee to produce a draft policy document on this matter for consideration by Council.

CHANGES TO THE ANAESTHESIA FELLOWSHIP EXAMINATIONS

R J Willis, Chairman of Examinations

Introduction

Both the Primary and the Final Examinations have been an important function of the Faculty and the College for many years.

During the last decade, the examinations have been regularly reviewed and professional advice sought from specialists in medical education. These examinations have served us well.

In recent years however, developments and research in education have focussed on the examination process and have led to discussions within and between the various Australasian Specialist Colleges. ANZCA Examiners have been involved in these wide-ranging discussions for at least the last five years. These talks have been particularly valuable and have given rise to some innovative examination techniques, some of which have been followed closely by the other Colleges.

Why the changes?

Good examinations need to be able to give consistent results (reliability) and moreover, need to be able to assess the examination candidates on the appropriate knowledge and application (validity).

Both reliability and validity need to be achieved at reasonable cost of time, space and money. Ideally, an examination should exhaustively test every candidate in all aspects of the knowledge required, of their competence to use that knowledge and their performance. Unfortunately, this is just not practical. Generally the examination performance on one topic will not predict how well the candidate will do on another. Thus, present educational research suggests that the best overall assessment is achieved by multiple short topics both in the written and in the oral examinations. The problem of having small numbers of long questions is known as "content specificity". This is why the long essay questions are being phased out.

Tests of basic knowledge are a fundamental part of the examination. The present carefully prepared multiple

choice questions (MCQs) are still the most reliable method of testing knowledge and MCQs will continue to be used in the Final examination. It is intended to introduce MCQs to the Primary early in 1996. MCQs continue to be investigated to see if some of the newer forms can minimise the effect of cueing and more purely measure the level of knowledge.

In the past the longer questions meant that few questions (only two in the old Final) could be asked. This introduced a major element of luck for the candidates. Short answer questions (SAQs), which are mini-essays of 10 minutes duration, allow many more topics and reduce the luck component. They have already replaced the long essays in the Final and will be introduced this year into the Primary examination.

"Structuring" of oral examinations exposes the candidate to a wide and predictable variety of topics. While this involves examiners in more time-consuming preparation, it certainly helps to produce a greater consistency to the questions and is therefore fairer to the candidate and achieves greater reliability. Structuring of questions is already occurring in the Final examination and will commence in the Primary examination from the first examination in 1996.

During the many discussions which occurred prior to the introduction of these changes, a recurring theme has been the importance of monitoring the training that the candidates receive.

With regular College inspection of training programmes and the in-training assessments recently introduced, the College has addressed this issue. In theory, if our training programmes were perfect, there would be no need to have the examinations.

Details of the current Examinations

Changes to the Final Examination format have been introduced over the last two years. These have preceded the introduction of changes to the Primary examination format which will occur during 1995 and 1996.

1. Primary examination (same for both Anaesthesia and Intensive Care)

Written

1995:

Two Short Answer Question papers

Physiology (including clinical measurement)
10 SAQs in 100 minutes (10 minutes per question)
each SAQ in a separate examination booklet
each SAQ is worth equal marks

Pharmacology (including statistics)
10 SAQs in 100 minutes (10 minutes per question)
each SAQ in a separate examination booklet
each SAQ is worth equal marks

1996 and thereafter:

Two written papers
MCQ paper
SAQ paper
Details to be advised during 1995.

Oral

1995:

Two vivas each of 20 minutes duration, one in physiology and one in pharmacology
Three examiners per table, only two examining each candidate.

1996:

Two structured vivas each of 20 minutes duration, one in physiology and one in pharmacology
Two examiners per table.

2. Final Examination in Anaesthesia

Written:

Two papers
MCQ paper: 150 questions in 150 minutes
SAQ paper: 15 questions in 150 minutes.

Oral

Twelve vivas each of 19 minutes duration
Of these twelve vivas —
9 are **anaesthesia**
3 are **medical** of which one is on **clinical investigations** and two involve directed patient examination.

With the exception of the two vivas involving patients where two examiners may participate, all other vivas have one examiner and are extensively structured. Temporary isolation of candidates enables similar questions to be asked for each half day session.

3. Final Examination in Intensive Care

The Faculty of Intensive Care has no immediate plans to alter the format of its Final Examination.

4. Venues for Anaesthesia Examinations

The written examinations will be held twice yearly in all major centres as at present.

The Primary oral examination will be held twice yearly at the College Headquarters (Ulimaroa) in Melbourne and may be held once yearly in Hong Kong. The Final oral examination will be held twice yearly, once at the College Headquarters (Ulimaroa) in Melbourne and once in Sydney, usually at one of the major public hospitals.

The future

There is little doubt that minor modifications to both examinations will be required from time to time over the coming years. Such changes will be notified to all Registered Trainees, Supervisors of Training and Directors of Anaesthesia.

Development of an improved system for the selection, training and assessment of examiners is currently under consideration.

Continuing involvement of ANZCA Examination Committee Members in joint College examination workshops will be encouraged.

Summary

Extensive changes to the ANZCA anaesthesia examinations have occurred over the last two years and will continue for the next two years. These changes have and will result in even more reliable and valid examinations.

The College wishes to thank those many Fellows who have devoted countless hours of their own time to develop an examination process of world class.

SHIP'S OFFICERS.

W. J. WYLLIE	---	Commander
R. JONES	---	Chief Officer
R. J. WEBB	---	2nd Officer
W. J. KNIGHT	---	3rd Officer
J. F. SCOTT	---	4th Officer
C. L. DAWE	---	Purser
E. M. BAIN	---	Wireless Operator
R. A. FYFE	---	Chief Engineer
H. J. CROCKFORD	---	2nd Engineer
A. E. KENDALL	---	3rd Engineer
G. A. HENDERSON	---	4th Engineer
A. IPKENDANZ	---	5th Engineer
G. J. KEYBURN	---	6th Engineer
A. J. DREW	---	7th Engineer
B. J. RASMUSSEN	---	8th Engineer
A. GILLESPIE	---	9th Engineer
F. STONE	---	Chief Steward
L. SCOTT	---	2nd Steward

SHIP'S MILITARY STAFF.

Captain G. BRIDGER	---	(Quartermaster)
Q.M. Sergt. J. D. RIVERS	---	(Asst. Quartermaster)
Staff Sergt. T. M. JENNENS	---	(Lie "Records")
Staff Sergt. I. D. WALKER	---	(Dispenser)

On Active Service.

His Majesty's
New Zealand
Transport
T.S.S.

ULIMAROA

Christmas, 1916

"ULIMAROA"

"Ulimaroa"—May her trade increase:
Was built of course for times of peace,
But she like others of British Breed,
Can alter her job in times of need.
Cover her fittings with plain pitch pine,
Rip out her berths but you'll hear no whine,
She's with her country, and out for war,
So does her duty.—"Ulimaroa."

With
Christmas Greetings and
Nearest Good Wishes
for the Coming Year

To you three
From me four

1916.

The College is greatly indebted to Dr Nerida Dilwaith, WA, who found the above Christmas card in her late mother's possessions. The Stones (Chief Steward and his family "we four"), were great friends of Dr Dilwaith's grandparents and her mother ("you three").

IMAGE AND PROFILE - A MATTER FOR ALL FELLOWS

The survey of Fellows performed in August 1994 has been an important step in the ongoing development of the College. The majority of Fellows (96% of survey replies) supported efforts of the College to improve the image and profile of Anaesthesia in Australia and in New Zealand. At the February Council Meeting a Public Relations and Community Education Programme was endorsed (described elsewhere in this *Bulletin*). This particularly significant strategic direction by the Council will help determine the future well being of all Fellows and of the College.

This Programme provides for wide ranging activity aimed not only at the media, business, industry and the political arena but also at the community and our patients.

However, a base requirement of this programme is to encourage dialogue and communication between Fellows and with the College Headquarters. The College Headquarters is opening an E-mail address and investigating the establishment of a World Wide Web site and anaesthesia "Newsgroup" on Internet. This is one method of providing for information flow and dialogue between Fellows and to the College Headquarters. The August survey results supported the *Bulletin* but suggested changes which will help improve the *Bulletin* as another form of communication.

Fellows are currently involved with over two million patients each year, throughout all regions of Australia,

New Zealand and surrounding countries. This requires not only effective and safe practice, but also provides great opportunity for the modification of community image and perceptions. Many Fellows are probably already engaged in various community oriented education or promotion activities.

These can include representation on non-health committees, presentations to community groups, schools, clubs, or even more specific involvement in antenatal education. No matter what the involvement, there is the ability to promote the important role and professionalism of anaesthetic practice.

We are all fellows of a College with a high international standing. This has been achieved over many years through the considerable effort and work of many Fellows, office-bearers and supporting staff. We need to ensure our own future and maintain that of our College in these changing times by raising our domestic image and profile. This does not necessarily require the more extreme commitments of serving on College Council or other College Committees, but does require a personal commitment to effect change.

Any Fellows who are involved in promotional activities or have suggestions are encouraged to write to the Registrar so that ideas can be disseminated and more specific strategies developed.

Are you willing to help?

MIKE MARTYN

ADMISSION TO FELLOWSHIP BY ELECTION
UNDER REGULATION 6.3.1(b)

NANETTE CRIMMINS, QLD
JOHN STREETER MALE, WA

DOUGLAS BALDWIN WELCH, TAS

ADMISSION TO FELLOWSHIP BY ELECTION
UNDER REGULATION 6.3.1(c)

PHILIP NEIL OGDEN, TAS

JAMES WALLACE SLEIGH, NZ

ADMISSION TO FELLOWSHIP BY ELECTION
UNDER REGULATION 6.2

CHRISTOPHER J EAGLE, CANADA

JOHN WILLIAM SEAR, UK

DR GWEN WILSON MD.

The College congratulates Dr Gwen Wilson, Emeritus Historian of ANZCA, on being granted her Doctorate in Medicine from Sydney University for her published works on the History of Anaesthesia in Australia. There exists only a handful of MD's in the history of medicine in Australia, and we are proud that our specialty is recognised and represented in such a way.

Gwen's substantial submission is truly characteristic of Australian anaesthesia. Her two books to date were each supported by the two organisations that represent anaesthesia in Australia:

- (i) A Bibliography of References to Anaesthesia in Australian Medical Journals, 1846-1962, which was published by the then Faculty of Anaesthetists, RACS.
- (ii) Fifty Years. The Australian Society of Anaesthetists, 1934-1984.

Also submitted were many papers of original historic research that have been published in *Anaesthesia and Intensive Care*, *Medical Journal of Australia*, International Symposia on the History of Anaesthesia, and other journals – all furthering the knowledge of the factors that have influenced the evolution of anaesthesia in Australia.

These publications represent over thirty years work researching the development of our specialty in Australia by Dr Wilson.

Her doctorate will be conferred in the Great Hall of Sydney University at 2pm, Friday 5th May, 1995.

Dr Wilson has now completed her work "One Grand Chain" which the College hopes to publish later this year.

MICHAEL COOPER
Honorary Historian

Honours and Appointments

Dr David H McConnel, Qld – Clinical Associate Professor, Department of Surgery, University of Queensland

Dr Richard G Walsh, NSW – President, 1996 World Congress of Anaesthesiologists

Professor Michael D A Vickers, Honorary Fellow – Foundation Fellow, Hong Kong College of Anaesthesiologists

Dr Gwen C M Wilson, NSW – Doctorate of Medicine, University of Sydney

Professor Malcolm M Fisher, NSW – Elected Fellow, Royal College of Anaesthetists.

Dr Ian Steven, SA – Officer of the Order of Australia (AO)

Dr Ron V Trubuhovich, NZ – Life Membership, Australian and New Zealand Society of Intensive Care.

MAINTENANCE OF STANDARDS PROGRAMME

DECLARED UNDER HEALTH INSURANCE ACT

The College's Maintenance of Standards Programme was gazetted in the Australian Commonwealth Government Notices on 21st December 1994 after the application under the Health Insurance (Quality Assurance Confidentiality) Amendment Act 1992 was declared by the Minister for Health, Dr Carmen Lawrence, on the 7th December, 1994. The Maintenance of Standards Programme is thereby declared a quality assurance activity under the Health Insurance Act 1993 and is an activity to which Part VC of that Act applies.

This declaration affords protection to both participants in the Maintenance of Standards Programme and others involved in its activities, such as Peer Review, Quality Assurance or Practice Quality Review components, as information gathered is not accessible by other agencies. It provides protection for subpoena, and confidentiality for information that becomes known through the Maintenance of Standards Programme activities. The College has an obligation to provide non-identifying information regarding participation of its Fellows to the Commonwealth Minister for Health annually.

The gazetted notice is as follows:

Maintenance of Standards Programme of the Australian and New Zealand College of Anaesthetists

The Maintenance of Standards Programme is an activity to ensure the involvement of anaesthetists in a range of ongoing educational quality assurance activities which maintain clinical standards once Fellowship is granted, and evaluation of the quality of their practice, so that they continue to provide the highest quality of patient care. The activity involves a programme in which participants demonstrate participation in continuing education and quality assurance activities, as well as assessment by peers, and review of individual anaesthetists' practice. The activity is managed by Professor Garry Phillips MBBS, FANZCA, FFICANZCA — Medical Practitioner, and Mrs Joan Sheales — Registrar of the Australian and New Zealand College of Anaesthetists (ANZCA), under the auspices of the ANZCA which is an association of health professionals and a post graduate medical education organisation. The activity relates to health care services which involve Medicare Benefits, Public Hospital Services and prescribing of pharmaceutical products under the Pharmaceutical Benefits Scheme. It involves specialist anaesthetists in all States and Territories of Australia. While the activity will not directly determine the clinical practising rights of anaesthetists, the peer review of anaesthetists' will be conducted with procedural fairness. The ANZCA will publish information regarding participation and compliance under the Maintenance of Standards Programme as part of its general reporting activities to its Fellows and to demonstrate that the implementation of the Programme is meeting the ANZCA objectives — a copy of which is to be provided to the Commonwealth Minister for Human Services and Health annually.

9404146

New Zealand Participants should be aware that the protection provided to Australian Participants by the Health Insurance Act does not extend to New Zealand Participants. It is understood that similar legislation is being prepared currently in New Zealand.

MAINTENANCE OF STANDARDS PROGRESS

The Maintenance of Standards Programme is now established, many Fellows having registered in the first few weeks of 1995. With the registrations have come letters seeking clarification of particular aspects of the programme, and requests for allocation of points to a wide variety of activities.

The following observations may help Fellows who are unsure of their position.

1. *There is no need to apply individually for approval of clearly identified activities such as College, Faculty, ASA, CECANZ and ANZICS Meetings (2.1). These are automatically accredited.*
2. *Meeting organisers do not have to keep records of attendance or submit information to the College. Record keeping is up to the individual.*
3. *It is suggested that organisers of College, Faculty, ASA, CECANZ and ANZICS Meetings should state in the Meeting publicity material that "this meeting is approved for the Maintenance of Standards Programme of the Australian and New Zealand College of Anaesthetists under Item 2.1".*
4. *Item 2.1 provides for 20 points per day if accredited meeting. For meetings of mixed scientific and social content, points should be calculated on the basis of the scientific component contact time. For short, e.g., evening meetings, points should be calculated on the basis of the scientific component contact time as a percentage of a day.*
5. *If in doubt as to whether other meetings will be approved or not, submission of the programme with the enquiry will assist in provision of a response.*
6. *Some activities for which approval has been sought require consideration before a decision can be made. As these matters are resolved, statements will be made in the Bulletin, and subsequently included in the review of the Maintenance of Standards Programme.*
7. *Progress on establishment of an MOS Programme for Intensive Care Specialists appears elsewhere. It is intended that Fellows practising both Anaesthesia and Intensive Care should be able to achieve certification in both specialties. There will be close liaison between College and Faculty on this issue.*
8. *Fellows who have registered for the MOS Programme will receive shortly an Annual Return form for 1995, to be returned in January 1996.*
9. *The College will not be providing any Log Book for recording activities. These records should be kept by the participant in the most convenient manner.*
10. *A review of the programme content will be carried out in 1996. Suggestions, particularly relating to activities which will increase the flexibility of the programme for special groups (e.g remote anaesthetists) are welcome. In making these, bear in mind that they should bear some relationship to the maintenance of clinical standards.*

GARRY D. PHILLIPS

NATIONAL MUTUAL HEALTH SHOW '94

The College, through the NSW Regional Committee, in conjunction with the ASA, organised a booth at the recent Health Show '94 sponsored by National Mutual at Darling Harbour.

Our aim was to raise the status of the anaesthetist in the eyes of the public and try to emphasise the vital role that we undertake during the peri-operative period.

The booth entitled "Anaesthesia and You" was located next to a fully equipped Operating Theatre and Recovery Room and we had considerable input into demonstrations in both these areas.

A Video made at Royal North Shore Hospital followed the progress of a young patient through admission, pre-operative consultation, induction of anaesthesia and her recovery. This was shown throughout the three days of the show and generated considerable interest amongst the public.

Although the overall attendance at the show was below expectations of the organisers, our areas were very well attended and all the volunteers were kept busy. The equipment, generously loaned, included a mannequin upon which we showed intubations, transfusions, etc. Two fully functional anaesthetic machines including simulated physiological parameters were in operation throughout the three days and were constantly manned by our very willing team of volunteers, who both demonstrated and spoke about their work to the many members of the public who visited the booth. We distributed the ASA leaflet "Anaesthesia and You" and took innumerable photos of children dressed in theatre

clothes sitting next to one of the anaesthesia machines. The NIBP and pulse oximetry monitors were in constant use and we diagnosed at least one case of quite severe untreated hypertension in a young man.

The organisation of this venture was undertaken by a small and very hard working band of people – led by Dr Peter Iscrt, whose enthusiasm was very infective and who was indefatigable in his efforts to make the show the success it was. The other members who worked equally hard were Dr Genevieve Goulding and Dr Matthew Swann.

The success of this venture would not have been achieved without the generous assistance we received from the many sponsors who contributed finance, assistance with printing and the loan of all the equipment. I would like to record our thanks to them all:

Mark Baker (Abbott), Michael Brooke, Maree Rutherford (Astra), Compton Allen (Ohemeda), Dr Michelle Rushford (Roche), Marie Ficarra (Hoechst), Chris McClure (Cardiac & Surgical), Alan Bruce (ICI), Jacqui Maunsell (Medtel), Andy Roussos (ULCO Engineering), Mike McGrath (Braun).

Our thanks must also go to all those anaesthetists who came and gave up their time to help us man the booth and who fielded all the questions so expertly.

I hope that this is only one of the first ventures into the public arena for anaesthetists. It is about time we made a higher profile for ourselves and we would all encourage other Fellows who plan similar enterprises.

Jennifer Beckett-Wood
Co-Convenor

LAW REPORT

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

PATIENTS' ACCESS TO DOCTORS' RECORDS



In a major review of the law on access to doctors' records (RACS *Bulletin* Vol. 14, No. 1 March 1994, ANZCA *Bulletin* Vol. 3, No. 1, March 1994), it was noted that it remains generally recognised that records made by a doctor in the course of a patient's treatment are owned by the doctor. However, trends towards greater "patients rights" and court decisions in other countries, notably Canada, suggested that Australian courts might recognise a general duty of doctors to provide access to medical records to particular patients.

There were some concerns that Australian courts might follow the decision of the Canadian Supreme Court in *McInerney v MacDonald* (93 (DLR) (4th) 415).

Those fears may, to some extent, have been allayed by a recent decision of the NSW Court of Appeal which dismissed a patient's attempts to access her own file. The case of *Breen v Williams* confirmed the earlier decision of the NSW Supreme Court that the doctor was the legal owner of the patient records made by the doctor and could, therefore, control access to them. The patient had sought information maintained in the doctor's records in relation to silicone breast implants. The information sought by the patient included basic information, such as the name of the manufacturer and details of the implant product. To some extent this decision represented a test case for access to medical records for many patients, including the many litigants currently involved in breast implant actions.

The NSW Medical Defence Union is reported as welcoming the decision of the court, which is said to recognise the right of doctors to create working papers for their own purposes and to permit doctors to feel free to create private papers in the best interests of the patient.

The decision may still be appealed to the High Court of Australia, and to that extent the issue remains open.

In relation to confidentiality of patient information generally, there are several times when confidential information may be revealed without breach of the doctor's duty:

1. with the consent of the patient
2. discussion of the patient's information with other medical colleagues for the purpose of proper treatment of the patient
3. in accordance with the law or a statutory obligation
4. pursuant to a court order or court process.

It should also be noted that in some States it is a requirement for doctors, in the practice of their professional duties, to report episodes of physical or sexual abuse to children or minors. If a doctor has a belief on reasonable grounds that a child requires protection because he or she has suffered or may suffer significant harm as a result of physical or sexual abuse, the doctor must notify the relevant government department or authority. For example, in November 1993 amendments to the Child and Young Persons Act (Vic) required certain groups of professionals (including doctors) to report cases of abuse or suspected abuse of children.

Medical Reports of Deceased Patients

Sometimes doctors may be requested to provide information about the health, particularly mental health, of a patient who has died. This may particularly apply in situations where the patient may have made a Will shortly before death.

The duty of confidentiality owed by a doctor to a patient continues after the death of the patient. The doctor must

therefore ensure that confidentiality is maintained, particularly in circumstances where there may be some dispute concerning the mental capacity of the patient making the Will.

In such circumstances, the doctor must maintain confidentiality, but may be required to provide evidence to a court as to the capacity and status of the patient. Evidence under oath in court will be protected, even where a breach of confidentiality may be involved.

There may be some information which a doctor can reveal to the parties involved in any dispute, or to the executor of the deceased patient's estate. However, such information will be limited and legal advice should be obtained.

AIDS Case – Unsatisfactory Professional Conduct

A recent decision by the NSW Medical Tribunal has cleared a doctor of professional misconduct, but found that a complaint of the lesser charge of unsatisfactory professional conduct was made out.

It has been reported that the Tribunal accepted that four women patients were cross-infected with HIV at the doctor's rooms, following treatment of an earlier patient who was HIV positive. The Tribunal accepted evidence that if HIV anti-infection guidelines are followed strictly, HIV infection will not take place. The Tribunal rejected theories that some new development in the nature of the virus, or its transmission, may have been responsible, and was therefore satisfied "that there must have been some breach of the proper procedures, or some other intervening act . . . there is nothing to suggest the possibility of any intervening acts other than acts for which the (doctor) is responsible".

As a consequence, the Tribunal stated that "where the consequences of failure to observe all recommended precautions were potentially grave, any such failure must be classified as unsatisfactory professional misconduct, even in the absence of the disapproval of the peers of the (doctor)". Having considered the standing, reputation and seniority of the doctor, the Tribunal reprimanded the doctor and imposed a condition on his registration to the effect that he not operate or perform surgical procedures other than in a hospital. The Tribunal also proposed that the doctor undertake a course of instruction in sterilisation and disinfection procedures and suggested that an approach be made to the Royal Australasian College of Surgeons in organising such a course.

In 1994, the Royal Australasian College of Surgeons issued a policy statement on HIV anti-infection procedures.

Legal action by the infected patients seeking compensation is also pending.

It should be noted that the NSW Medical Tribunal was, however, unable to determine how the cross-infection with the patients occurred, whilst ruling out some new method of transmission related to the virus.

Managing negligence claims

In 1994 the Medical Board of Victoria (now the Medical Practitioners Board of Victoria) supported the publication and issue of a substantial booklet to all doctors in Victoria. "*Law and Ethics in Medicine for Doctors in Victoria*" (Plueckhahn, Breen & Cordner, 1994) contains a useful summary and exposition of many ethical and legal issues affecting doctors and their practice. It deals with statutory obligations on doctors, civil litigation, ethical medical practices, informed consent and related matters.

Of some interest to medical practitioners will be suggestions regarding factors involved in increased medical negligence claims. The publication notes the rise in the number of negligence claims made against doctors in recent decades, and the increase in monetary value of successful claims. The publication notes:

"The increase in litigation and court awards for comparable injuries, during the past 20 years, has been reflected in the great increase in the yearly subscriptions payable by doctors to medical defence organisations in every State of Australia. For example, in 1975 the annual subscription to the MDAV was \$10. By 1985 this subscription had risen to \$550 and in 1993/94 it varied from \$1600 for a non-procedural general practitioner to \$2750 for a procedural physician, \$3000 for gynaecologists, anaesthetists and pathologists, and to \$5500 for specialist obstetricians". (p.85/6).

Some factors identified by the publication for the increase in negligence claims include:

1. breakdowns in communication between doctors and patients;
2. demystification in the art of medicine
3. increased utilisation of health care services (particularly universal health cover, bulk billing, etc.);
4. unreal expectations by patients;
5. technological advances (and increased dependence on sophisticated and complex technology);
6. the high costs of medical care and hospitalisation (including the cost of increased testing arising from defensive medicine);

7. the propensity to litigate (in all areas of society);
8. the increasing number and availability of lawyers, and advertising by lawyers.

Additionally, a useful article in *Medical Business Review* (Vol. 1 No. 3) "*Planning for a Negligence Claim*" (Walmsley pp30-33) provides a useful overview of actions which can be taken by doctors to attempt to minimise risks for civil negligence claims. Some suggestions will, of course, be obvious to doctors:

1. maintain insurance;
2. maintain adequate notes of **all** procedures, conversations, explanations given, etc.;
3. keep copies of all records or documents relating to the patient's treatment.

Some suggestions relate to matters which have been well examined in other publications and journals, such as the need to maintain "informed consent" following the High Court decision of *Rogers v Whittaker* (see *RACS Bulletin* Vol. 13 No. 1, pp47-48, *ANZCA Bulletin* Vol. 2 No. 1, p5). The use of consent forms, explanatory brochures and pamphlets will assist, but do not eliminate the overriding legal duty of the doctor to ensure that adequate information is given in a meaningful way to the particular patient. These issues have been previously explored in some detail in earlier *Bulletin* articles.

Some suggestions are more difficult in a busy medical practice, but include:

1. Have a witness available. A nurse may be present to reduce the likelihood of complaints about sexual molestation. A nurse or assistant may be able to confirm that particular procedures have been carried out. If litigation turns on the doctor's word against the patient's word, having a witness or third party to verify will greatly assist the doctor.
2. Giving patients sufficient information before a claim is made or in the early stages of a claim. The "Tito Enquiry" initiated by the Australian Government has made recommendations for legislation to compel early disclosure in litigation of all information relevant to the issues in dispute. This is in an endeavour to quickly identify real issues between litigants, perhaps clarify any misunderstandings and in some cases reassure the patient that "nothing is hidden". The disclosure of information will, of course, be subject to legal advice and direction from the doctor's insurer or medical defence organisation.

3. Explain a mistake or poor result. An early explanation to the patient will sometimes avoid litigation. Again, consultation with your insurer or medical defence organisation should occur, but a frank discussion with the patient may sometimes avoid further unpleasantness.
4. In relation to referrals and second opinions, treat the patient's request with respect. Provide adequate information to the other doctor. Perhaps also send a copy of the referral directly to the other doctor in case the patient is slow to see the other doctor to whom he/she is referred.

Some of these suggestions by Walmsley may not, he admits, meet with universal approval. In most cases where a claim or potential claim is identified, doctors should, of course, discuss the matter with their insurer or medical defence organisation.

Most medical colleges have also participated in the Professional Indemnity Review conducted by the Australian Government under the auspices of Ms Fiona Tito. The interim report of that review has made a number of recommendations which may assist in reducing the cost to doctors and the health system of medical defence and indemnity. Some of those recommendations have been welcomed by medical colleges, including suggestions for:

1. giving clear lines to doctors on disclosure of information to patients;
2. introducing a time limit of three years for patients to sue for injuries arising from medical practice (or six years in the case of minors);
3. clarification of arrangement for vicarious liability of doctors, particularly in public hospitals;
4. specialist accreditation of medical litigation lawyers;
5. improvement in data collection of adverse patient outcomes, and the development of legal claims which may arise from them.

The Medical Colleges have not accepted all of the recommendations, and whilst accepting the thrust of some recommendations, does not accept the proposed implementation or methods recommended in the report.

It is, however, clear that reform of medical indemnity and litigation procedures and processes in Australia are in need of reform.

COMMUNICATING BETTER

The College has adopted a professional communications programme designed to gain a better public profile in general and a more proactive and positive image through the media in particular.

Development of this programme by a communications consultancy follows examination of the College's activities and its customary communications techniques. As well, Fellows were surveyed in August, 1994, about the College's communications, media relations and image; and their overall views on the status and profile of anaesthetists amongst patients, peers and the community in general.

Response to this survey was high, reflecting a strong level of interest in the issues. Fellows also indicated a very high level of preparedness to become personally involved in specified communication projects on behalf of the College. The programme envisages harnessing this support.

The communications programme has five clearly defined target audiences. They are the Fellows themselves, patients, the community in general, the media, and a network of appropriate contacts in business, industry and politics. Segments of the programme have been designed to deal specifically with each of these audiences, and the overall programme will be implemented progressively in coming months.

New print material will be developed to assist in building awareness of the College, the discipline and the role and status of anaesthetists at the patient level. An information brochure explaining the College, its aims and activities, along with the role of anaesthesia and its allied functions is being drafted. A small and concise leaflet spelling out the basic aspects of anaesthesia also is to be prepared, to be available to patients upon admission to hospital; this would precede the pre-operative visit and discussion with the anaesthetist as specified in the College Policy Document P26. Liaison with other professional bodies will be sought in the preparation of such material.

The principal aim of this latter document will be to help ensure greater patient understanding and confidence in both the professionalism of the practitioner and the procedure. Other "fact sheets" will be prepared in due course, covering specific subjects such as pain management, awareness and resuscitation, for issue to individual patients as and when appropriate.

A single page flier will be used to regularly communicate the basic story of the discipline to media, patients prior to hospitalisation where appropriate, and community groups. This will summarise the training and qualifications of anaesthetists, their professional status (including the role of the College in setting and maintaining standards), their key place in the medical team, the relatively low risks of anaesthesia, and the constant improvement in safety.

Other initiatives in disseminating the College's message more widely will be added in time, including the supply of relevant information in print for Fellows to use in improving understanding through community contacts. A proposal for a nation-wide "Anaesthesia Day" is being developed in more detail. The day's programme would be designed to focus media attention on the role of anaesthetists through a specific slogan, and interviews in all levels of print, radio and television – capital cities, provincial cities and country towns, and suburban press. Suitable information would be supplied to participating anaesthetists for supply to media outlets in their area.

A structured programme for increasing the flow of news and information to all facets of the media is contained in the new College communications programme. Apart from news stories for the daily media, the programme calls for the coverage of aspects of anaesthesia in specialist television and radio outlets, and in suburban media. Improved and more extensive media relations will be developed across the nation.

Some changes are proposed for the *Bulletin*, partly in response to the views of Fellows expressed in the survey, and for specific communications needs identified by the programme.

Survey responses give a high priority to the *Bulletin* on receipt: more than 70% of Fellows rated it above medium priority to look at. It is considered useful or extremely useful by a solid 56% of respondents and it is very extensively read – more than 61% read half or more of the contents. Nonetheless, there was strong underlying pressure for a decrease in some aspects of the contents, whilst improving or adding coverage of matters such as issues in anaesthesia, current affairs, Fellows' input by way of letters, and items emphasising and enhancing the College's professional leadership role.

The moves under examination would re-focus the *Bulletin* from being largely a publication of record, to one which also seeks to report more relevant news about

anaesthesia and innovates in the area of constructive and useful discussion. However, the *Bulletin* would continue to supply all the basic information which Fellows currently require and look forward to finding in each issue.

he communications programme proposes, and the College has agreed to the introduction of an E-mail facility for Fellows to access. They would be able to download information of various kinds, which many have suggested they would like to access, at a time which suited their individual schedules. Updated material could

be made accessible sooner than by way of the *Bulletin*, which would improve the information flow to Fellows.

A number of other innovations in the College's communications services and facilities also are contained in the consultants' programme. These are being considered for introduction further ahead in time. Meanwhile, Fellows will be asked to respond to a short, formal survey in 1996 to assess perceptions about the various communications initiatives and their effectiveness.

EDDIE DEAN
Communications Consultant

Letter to the Editor

Dear Editor,

The foetal Faculty has been delivered to become a lusty neonatal College. We are all accredited as specialists by the College. One of the College's first milestones was to implement C.M.E. and M.O.S. This is laudable.

The College has now taken Fellows under its wing for their entire practice lives and its role has changed forever.

Fellows have been blown into many diverse forms of practice by the fickle winds of destiny. The College has to fully inform itself of all the ways that Fellows practice and to actively seek representation from these different areas.

No mode of practice should be disparaged, but perceived inadequacies should be investigated with understanding and mutually acceptable remedies marked out.

Fellows must be drawn into the College family.

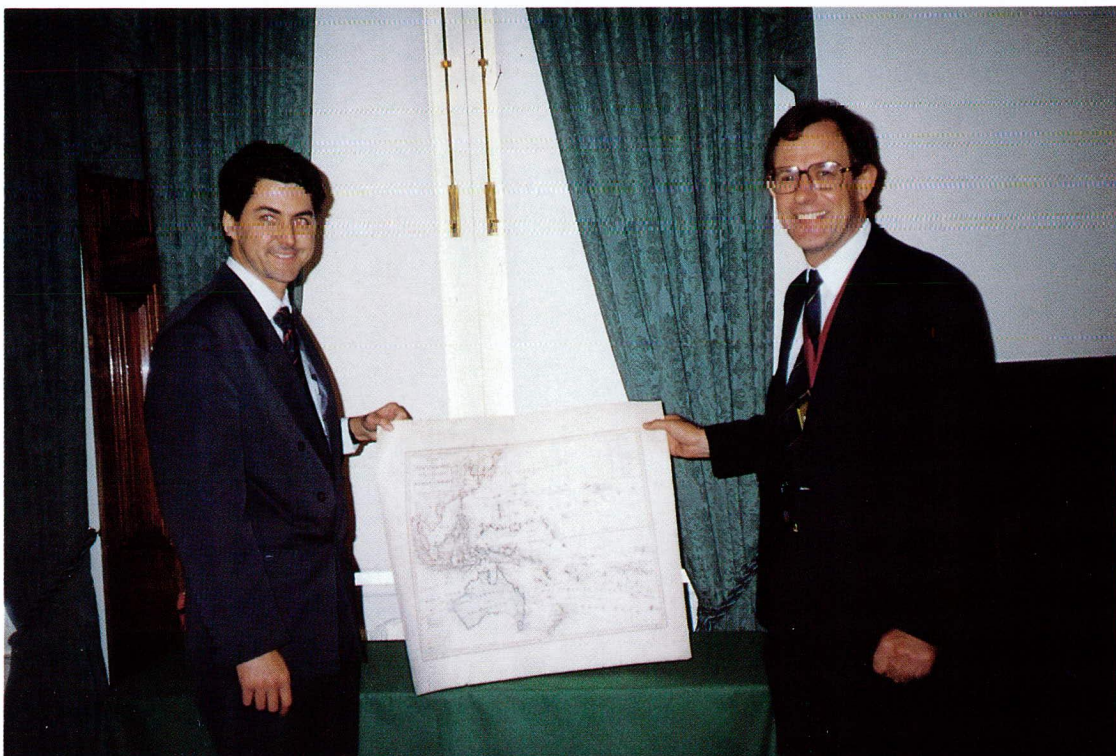
D G Fenwick, FANZCA
Adelaide

ADMISSION TO FELLOWSHIP BY EXAMINATION

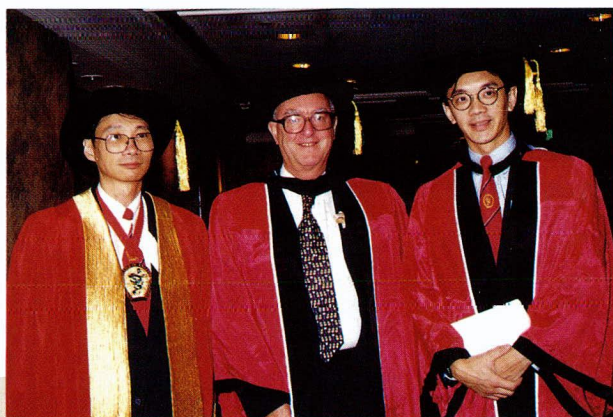
David Leslie ALLEN, VIC	Peter LLOYD, NZ
Richard James BOUGHER, WA	Anton Ellis LOEWENTHAL, QLD
Deane Harold BOWRING, NSW	Jennifer Anne LUCAS, VIC
Peter Douglas BROWN, VIC	Judith Carmen LYNCH, NSW
Christopher Stuart BUTLER, NSW	Bruce Graeme MARKS, VIC
Shui Ning Rebecca CHAN, SA	Lisa Jane McEWIN, SA
Ann Roberta CHEE, NSW	James Gregory MILROSS, NSW
James Richard CHENOWETH, VIC	Stewart Robert MONTANO, NSW
Yu Fat CHOW, HK	Michael John MORRIS, NSW
Andrew Osborne Garton CLAPIN, WA	Michelle Janice MULLIGAN, NSW
Richard Anthony CONNOLLY, NSW	Craig Leonard Franklin NOONAN, VIC
John Raymond CORMACK, VIC	Andrew Philip PEMBROKE, NSW
James Lachlan DERRICK, NSW	David Charles PESCOD, VIC
Glenn Osborne DOWNEY, VIC	Terry Thomas PRYOR, QLD
Catherine Maree DUFFY, QLD	David Patrick RILEY, NSW
Brendan Thomas FLANAGAN, VIC	Nicholas Charles ROBSON, NSW
Mary-Ann Louise FOX, SA	Nola Joanne SCHENK, VIC
Francis GEORGIAKAKIS, NSW	Trevor Ian SHUM, NZ
Gerard John HANDLEY, VIC	Rex Anthony SMITH, NZ
Christopher HAYES, NSW	Jennifer Anne STRACHAN, QLD
Peter Dale HEBBARD, VIC	Barbara Elise TRYTKO, NSW
Kok Eng KHOR, NZ	Maurice Peter VIALLE, SA
Susan Elizabeth LAWRENCE, NSW	Helen Margaret WEIR, NZ
Elizabeth LESLIE, VIC	Michael Scott WHITEHEAD, SA
Frank John LISKASER, VIC	Susan Kaye WINTER, NSW

ADMISSION TO FELLOWSHIP UNDER REGULATION 6.3.15

CHOONG-HOWE WONG, MALAYSIA



▲ An 1806 corrected edition of the 1795 map from a copper engraving with original hand colouring was presented to the College by Drs Gwen Wilson, Richard Bailey and Michael Cooper. This map is of particular interest as it describes Australia as "Ulimaroa". Dr Michael Cooper presented this gift to the President during a recent visit to the College.



▲ Dr Ronald Lo, President Hong Kong College of Anaesthesiologists, with Professor Michael Vickers following conferment of his Foundation Fellowship of the Hong Kong College and Dr John Low.



◀ Dr Stephanie Delfos receiving the 1995 John Boyd Craig Research Award from Dr Craig for her project "Assessment of Outcome in the Treatment of Percutaneous Radiofrequency Lesions and Percutaneous Cyroprobe Lesions".

FACULTY OF INTENSIVE CARE

DEAN'S MESSAGE



There has been widespread interest among Intensivists that training and certification should become more unified. This belief led to dialogue between the Faculty of Anaesthetists and the Royal Australasian College of Physicians in both the 1970s and again in the 1980s. A satisfactory solution could not be found, possibly because of ideological differences between the Colleges relating to selected issues. A major one appears to have been whether or not an exit examination in specialty training was a desirable feature.

The Conjoint Committee on Training and Certification (FICANZCA/RACP(SAC-IC)/ANZICS) is taking a third bite at this cherry and definite progress is being made.

Basically we have sought common ground in developing a model with the following features:

- it did not substantially interfere with the current function of either College
- it did not increase the training period of either College
- it did not disassociate intensive care from either current training body (FICANZCA, RACP)
- it provided or had the capacity to develop a conjoint training committee which would oversee the training programs of intensive care trainees from both the Faculty and the RACP (SAC-IC)
- it provided a common exit examination.

The model agreed upon by the Committee, though still in the proposal stage, is both simple and practical. It provides a good starting point from which further evolutionary changes can occur.

Key points in this proposal are as follows:

1. Candidates holding the RACP examination are exempt from the ANZCA Primary Examination for the purpose of being eligible to sit the Final Examination of the Faculty of Intensive Care, ANZCA.
2. Such candidates must register with the Faculty of Intensive Care, ANZCA as a trainee.
3. To be eligible to sit the Final Examination and gain the diploma FFICANZCA, they must fulfil the training and other requirements of the Faculty of Intensive Care.
4. All trainees from both the Faculty and those registered with the RACP(SAC-IC) will have their training supervised by a conjoint committee with members from the Faculty, RACP(SAC-IC) and an ANZICS representative. In the initial stages committees of the two training bodies currently supervising training would run in parallel with the new conjoint committee until it became fully functional.

Perusal of the training requirements for intensive care of both the Faculty and of the RACP (SAC-IC) reveal that the flexibility of both schemes allows Faculty training requirements to be easily met by the RACP candidates. However this necessitates such candidates completing one year in anaesthesia in a department having posts approved for training by ANZCA and completing two years of compulsory intensive care training in posts approved by the Faculty for this purpose.

Candidates from the RACP and from ANZCA can acquire, within approximately the same training periods, double qualifications. For those initially starting with the RACP it could be FRACP and FFICANZCA. For those initially qualifying in anaesthesia it could be FANZCA and FFICANZCA.

There is no compulsion for people to seek double endorsement. RACP candidates can continue to seek only the FRACP, and Faculty trainees can still pursue FFICANZCA as a sole qualification. In both cases however, training is likely to be jointly supervised.

Though all of this is still in the proposal stage, it is the wish of the Faculty Board and members of the Conjoint Committee that Intensivists are aware of what is being proposed. It is the Board's wish that Fellows of the Faculty of Intensive Care, ANZCA, will endorse these proposed changes as an important step in the search for further unity in training and certification.

G.M. CLARKE, *Dean*

REPORT OF THE FEBRUARY 1995 FACULTY BOARD MEETING

EDUCATION

Maintenance of Standards

The Board is currently considering a draft document on Maintenance of Standards.

Objectives of Training

The Objectives of Training in Intensive Care continue to be reviewed, and it is anticipated re-drafting will be completed later in the year.

In-Training Assessment

The Faculty has drafted Guidelines for In-Training Assessment, based on a combination of elements used by both the ANZCA and the RACP.

Accreditation

The Board debated at some length the principle of approving units for training as opposed to posts, which would allow for an unlimited number of posts. However it was agreed that the matter would be reconsidered at a later date.

Recognition of Units for Anaesthetic Training

The Board recommended that the three months compulsory training for anaesthesia trainees be conducted in Units approved for Compulsory or Optional training, provided such units do not have a narrow casemix.

INTERNAL AFFAIRS

Election of Dean-Elect

Dr G.M. Clarke was re-elected as Dean, for a further year of office, commencing in June of this year.

Regional Committees

Regional Committees have now been established in all regions except Tasmania, the Australian Capital Territory and the Northern Territory, and most committees have held their inaugural meetings. A list of members and office bearers is included in this issue.

Faculty Gowns

The Board approved designs for gowns for the Fellows and Board members of the Faculty. The gown is similar in design to the Anaesthetists' gown, incorporating two stripes of royal blue and gold on each side of the front of the gown. Order forms for these gowns are available from the Faculty office.

Diplomas

The Board approved a design for the Diploma of the Faculty, and these are currently being printed and will be circulated to Fellows.

Examinations

Dr Richard Lee has been appointed Chairman of the Fellowship Examination Committee and has been co-opted to the Board.

ADMISSION TO FELLOWSHIP

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

Andrew BELESSIS, FANZCA, NSW
 John Victor GREEN, FANZCA, SA
 Anthony John MULLENS, NSW

The Board awarded the Inaugural G.A. (Don) Harrison Medal for 1994 to Andrew Belessis for his outstanding performance in the Fellowship Examination.

PROFESSIONAL

Policy Documents

The Board approved a new Policy Document IC-8 entitled "Ensuring Quality Care".

A statement on patients' rights and responsibilities is being considered, and a review of the document "Minimum Standards for Transport of the Critically Ill" will be re-drafted and referred to the Australasian College for Emergency Medicine for consideration.

Conjoint Committee on Training and Certification

The Committee is continuing to develop a joint training programme designed to enable RACP/SAC(IC) trainees to undertake the Faculty's training program and the SAC program simultaneously, graduating with both diplomas. It is anticipated the proposal will be circulated to Fellows of the Faculty for consideration and discussion.

Intensive Care Medical Liaison Committee

This Committee recently considered a number of matters of common interest, including definition of critical care units, recognition as a specialist, the ANZICS manpower survey and the NHMRC draft guidelines on donation of cadaveric organs and tissues for transplantation.

The Board approved the draft definition of critical care referred by the National Health Data Committee Working Party, subject to its review in twelve months time.

Criteria for Recognition of a Medical Practitioner as a Specialist in Intensive Care

The Board further reviewed a set of criteria which will be referred to the Intensive Care Medical Liaison Committee. This definition will enable both intensive care training bodies and ANZICS to have a common set of criteria to present to Specialist Recognition Advisory Committees.

Annual Scientific Meeting 1995

A programme for the Faculty has now been finalised, which features several presentations by the Faculty Foundation Visitor, Dr Charles Hinds. Dr Hinds will be speaking on "Neuropathy and Myopathy in the ICU" and "Maintaining Supranormal Oxygen Delivery in Sepsis - Is it Rational?"

Younger Fellows' Conference

The Board has nominated Dr Chris Anstey of Queensland, and Dr Graeme Duke of Victoria as the Faculty representatives at the Younger Fellows' Conference.

GEOFFREY M. CLARKE
 Dean

INTENSIVE CARE IN RWANDA

The decision by the Australian Government to contribute a support contingent of some 300 personnel to the United Nations Assistance Mission in Rwanda (UNAMIR) was a significant one in several respects. Firstly, this was the first time since the Vietnam war that medical support of this magnitude had been deployed overseas, and it occurred at a time when the numbers of experienced war trauma surgeons and anaesthetists was dwindling in this country. Secondly, it was the first real trial of a joint-force medical operation, since elements of nursing and medical corps personnel from our Army, Navy and Air Force made up the contingent. And finally, the decision to provide Intensive Care as part of the surgical team represented official military recognition of the specialty in this country. I therefore considered myself fortunate to have been invited to join the first surgical team to go to Rwanda.

The Australian contingent consisted of approximately 100 medical and nursing corps personnel, 100 support personnel and 100 infantry whose role was to protect the medical elements. Our mission was to provide medical and health support to some 6000 UN soldiers in Rwanda. However, with any spare capacity, we were authorised to provide humanitarian assistance to the people of Rwanda. An orthopaedic surgeon, a general surgeon, an anaesthetist and an intensivist made up the surgical team, and such teams have spent two month rotations in Rwanda since August 1994. In addition to the medical specialists, there were three general duties medical officers and one dentist to handle the workload. Most of the Rwandan doctors and nurses were either dead or had fled the country when the war was at its height in April/May 1994.

Our main job was to provide a hospital facility for UNAMIR, and we did this from a wing of the central hospital of Kigali, the capital. The hospital was badly war damaged and had been trashed and looted. The hospital area designated for the UN was formerly the private wing, which had been built by the Belgians in 1968; every door had been kicked in or broken. The rumour was that patients had been locked in, and the militia had come and killed them all. Bullet holes in walls and floors beneath hospital beds suggested that the rumour might have been true. Amidst the noise and dust of our engineers and technicians who were beginning essential maintenance to repair the main generator, re-establish the water supply and sewerage system, repair the roof and make the laundry operational, we provided surgical support to the non-government organisations' operating theatres

as well as treating UNAMIR and local patients in our own wards and theatres.

We set up a three bed ICU and five bed HDU in the old ICU of the hospital. During our seven week stay in Rwanda, our surgeons performed 168 surgical cases, we gave almost 200 anaesthetics, and 28 patients were admitted to ICU (23 Rwandans, 5 UN personnel). Not surprisingly, the bulk of the ICU workload was post operative war trauma, but trauma from road traffic accidents increased as people attempted to return to their homes and as more international aid arrived in the country.

The aeromedical evacuation of a Belgian national with a severe closed head injury back to Brussels was safely achieved because of the intensive care capability of our contingent. I encountered many of the exotic tropical diseases that I recall reading about as a medical student, and several interesting medical emergencies were admitted to the ICU. These included cerebral malaria, meningitis, snakebite and renal failure due to dehydration from dysentery. We had insufficient beds or consumables to manage the many tetanus patients, several of whom contracted the disease following episiotomy. These patients were taken home to die among their family.

Our diagnostic capability was limited; the nearest CT scanner was in Nairobi, and we were restricted to simple x-rays, biochemistry, haematology and microbiology. The ELISA plates we took for HIV testing all deteriorated in the heat and had to be replaced. We were thus compelled to clinical decision making based on the history and examination rather than poring over x-rays and laboratory results at the foot of the bed.

Epidemiological data collected prior to the war indicated positive HIV antibody testing in approximately 30% of surgical patients, 32% of women attending antenatal clinics, and 60% of patients in medical wards — most of whom presented with tuberculosis (pulmonary and/or extra pulmonary), cryptococcal meningitis, chronic diarrhoea, and "slim" — the characteristic wasting disease of AIDS. Interestingly, pneumocystis pneumonia is rare in central Africa (2-3% incidence).

Our monitoring and life support equipment was lightweight (Propaq EL, Bird avian ventilators, infusion pumps and syringe drivers), had battery backup and served us well. We took three dialysis cartridges to

Rwanda with us, and could have instituted continuous arteriovenous haemodialysis had it been necessary.

There were many challenges and frustrations in our two months away from home; perhaps the greatest was the appalling postoperative care that occurred in the "public" beds of the hospital. Wound infection rates were high, and as Rwandan doctors and nurses attempted to return to work, they would disappear — presumably abducted or executed or conscripted into the victorious Rwandan Patriotic Army. The sounds of gunfire and mine explosions at night were a continual reminder of the summary executions that occurred throughout our time in Rwanda as people tried to return home; this was the reason that we were never able to clear the backlog of war-surgery and it was also the explanation for the cessation of all elective surgery in the country.

Civil war has existed in Rwanda since 1990, although its history is one of long established inter-ethnic disputes

between the Hutu and Tutsi tribes, arising from deeply ingrained rivalry and hatred between these two principal tribal groupings. The country is at a standstill because of the recent genocide.

As an editor of the *British Medical Journal* stated, "There have been many massacres in the world, but what sets Rwanda apart is that they happened in such a short space of time and they were so intimate". Until the racial hatred ceases, the problems of this potentially beautiful land are insoluble; only history will show whether the UN effort in Rwanda was worthwhile, but I have yet to meet anyone who has been there who considers the effort futile.

P.D. THOMAS

Reference

Dillner L. Human rights group condemns UN in Rwanda. *British Medical Journal*, vol. 309, 8 October 1994.

The G.A. (Don) Harrison Medal

**The Inaugural G.A. (Don) Harrison Medal
has been awarded to**

ANDREW BELESSIS, NSW

*for his outstanding performance in the
1994 Fellowship Examination*



Dr George Skowronski, President ANZICS, presented the Dean with a 19th century mahogany writing compendium, of German origin, to commemorate the establishment of the Faculty. Also pictured are Drs Geoff Dobb, Felicity Hawker, Alan Duncan and David Tuxen.

POLICY DOCUMENT**IC-8 (1995)****FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS****ENSURING QUALITY CARE**
*Guidelines for Departments of Intensive Care***1. INTRODUCTION**

- 1.1 Regular review and improvement of the quality of care being provided is considered essential for the delivery of effective and efficient intensive care services.
- 1.2 All Departments of Intensive Care should implement an overall Quality Program. This Program should incorporate and integrate the various mechanisms and activities necessary to evaluate and improve the standard of care and services being provided within the Department.
- 1.3 Standards of care should be consistent with other accepted standards including relevant Faculty Policy Documents.
- 1.4 Where an institution does not have a formally structured Department of Intensive Care, these Guidelines refer to any Intensive Care Services as if they are Departments.

2. QUALITY PROGRAM

- 2.1 The Quality Program will typically combine a variety of mechanisms and activities which may be categorised into two main groups:
 - 2.1.1 Mechanisms which ensure that the Department of Intensive Care fulfils certain minimum standards in terms of process and outcome (often referred to as **Quality Assurance**).
 - 2.1.2 Mechanisms which ensure that aspects of the quality of care and service are reviewed and upgraded as appropriate and that any problems are promptly identified and rectified (often referred to as **Quality Improvement**).
- 2.2 Differences in the size, complexity, organisation and casemix of institutions will necessitate that individual Quality Programs contain a unique mix of activities and mechanisms as appropriate to the particular institution.
- 2.3 Wherever possible, the Intensive Care Quality Program should be interfaced with, or part of, an institution-wide Quality Program.

- 2.4 An essential element of all Quality Programs is the collection and review of appropriate objective data.
- 2.5 Results obtained through the Quality Program should be the subject of regular Departmental meetings for evaluation and action as necessary.
- 2.6 Quality Programs should be constructive in character and should emphasise learning and outcome improvement.
- 2.7 Patient and staff confidentiality must be respected and protected.

3. ELEMENTS OF A QUALITY PROGRAM

Mechanisms and activities are recommended to be instituted at appropriate time intervals on some or all of the following:

- 3.1 The performance of the Department as a whole, including:
 - 3.1.1 The staff and staffing:
 - 3.1.1.1 Numbers and qualifications, including senior, junior, nursing, technical and secretarial staff.
 - 3.1.1.2 Appointment criteria and procedures, and allocation of duties and levels of supervision.
 - 3.1.1.3 Workload and conditions for work.
 - 3.1.2 The physical facilities:
 - 3.1.2.1 Equipment, including compliance with standards, preventive and other maintenance and replacement.
 - 3.1.2.2 The working space for all clinical and non-clinical activities.
 - 3.1.3 Financial aspects of the Department, including:
 - 3.1.3.1 Budgets.
 - 3.1.3.2 Expenditure.

- 3.1.3.3 Cost effectiveness.
- 3.1.4 Departmental teaching programs.
- 3.1.5 Departmental research activities.
- 3.2 The patient management activities of the Intensive Care staff including, for example:
 - 3.2.1 Criteria for admission to the Intensive Care Unit, including severity of illness and diagnostic groups, and monitoring of patients refused admission.
 - 3.2.2 Patient assessment and investigation on admission.
 - 3.2.3 Patient management during Intensive Care stay, including:
 - 3.2.3.1 Diagnostic methods utilised (e.g. clinical, laboratory, imaging).
 - 3.2.3.2 Indications for specific therapies.
 - 3.2.3.3 Indications for and utilization of monitoring (techniques and equipment).
 - 3.2.3.4 Record keeping.
 - 3.2.4 Post discharge follow-up.
 - 3.2.5 Patient outcome in terms of morbidity and mortality assessed against severity of illness, agreed clinical indicators and critical incident monitoring.
 - 3.2.6 Staff well-being as assessed by health, morale and occupational safety record.
- 3.3 The individual performance of Intensive Care staff in activities relating to:
 - 3.3.1 Patient management.
 - 3.3.2 Continuing education and teaching.
 - 3.3.3 Participation in Quality Program activities.
 - 3.3.4 Health, morale and safety.
 - 3.3.5 Research.

4. CLINICAL INDICATORS

- 4.1 Clinical indicators are process or outcome parameters which can be objectively measured and correlated with quality of care issues.
- 4.2 Currently, there is no agreed uniform set of clinical indicators for the intensive care setting and therefore individual Departments may need to consider developing their own clinical indicators.
- 4.3 Where in-house clinical indicators are developed within Departments of Intensive Care, parameters should be chosen which are:

- 4.3.1 Clinically pertinent to the Intensive Care setting.
- 4.3.2 An outcome (or a process which can be reliably linked to an outcome).
- 4.3.3 Able to be measured with accuracy and relative ease.
- 4.3.4 Amenable to improvement efforts.

5. HUMAN AND PHYSICAL RESOURCES FOR QUALITY PROGRAMS

- 5.1 A Quality Program will only be effective if adequate resources are committed to its operation.
- 5.2 One or more Quality Program Co-ordinators should normally be appointed for a period of two years with eligibility for re-appointment.
- 5.3 The Quality Program Co-ordinator/s should be provided with an appropriate allocation of time, secretarial and other support to satisfactorily perform the necessary duties.
- 5.4 Information systems which provide relevant, complete, timely, and accurate data will be required to support the Quality Program.

6. PLANNING AND AUDIT OF QUALITY PROGRAMS

- 6.1 Each element of the Quality Program should be fully planned and defined before undertaking the study.
- 6.2 The nature and validity of elements of the Quality Program should be reviewed from time to time. Regular reassessment of effectiveness is an important step in the process of refining and improving any Quality Program.

This policy should be interpreted in conjunction with the following Policy Documents of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists:

- IC-1 "Minimum Standards for Intensive Care Units."
- IC-2 "Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts."
- IC-3 "Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Intensive Care."

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.

February, 1995

REGULATION 6.3.1 — ELECTION TO FELLOWSHIP

- (a) A Professor or other Academic Head of a Department at a recognised University or College or a Director of a Department of Anaesthesia at a University Hospital or Clinical School approved by the Council provided that the applicant holds a qualification in anaesthesia acceptable to Council.
- (b) Duly qualified medical graduates who practise anaesthesia in Australia or New Zealand and who have held a higher qualification with completed training for five years which is acceptable to the Council. Such nominees/applicants must have been resident in Australia or New Zealand for five years preceding nomination/application.
- The number elected in any one year under this paragraph shall not exceed ten.
- (c) Duly qualified medical practitioners of not less than 15 years standing resident outside Australia and New Zealand and invited to take part in the activities of the College, and who have held for five years a qualification in anaesthesia as in 6.3.1 (b) and have completed training acceptable to Council.
- (d) Duly qualified medical practitioners of at least 25 years standing and not less than 60 years of age, who have made a significant contribution to anaesthesia or related disciplines, in isolated or country areas of Australia or New Zealand, or in other circumstances acceptable to the Council of the College and who are residents of Australia or New Zealand.
- The number elected in any one year under this paragraph shall not exceed four.
- (e) Under exceptional circumstances Council may elect to Fellowship specialist anaesthetists with a qualification acceptable to Council who have made a significant contribution to College activities.
- (f) No nomination or application shall be considered under more than one paragraph of 6.3.1.

NOTE: Any person invited to accept Fellowship by Election must notify the Registrar of acceptance of this election and pay the prescribed fees within three months of invitation otherwise such invitation will lapse.

REGULATION 22 — THE FORMAL PROJECT PRIZE

- 22.1 The Prize shall be awarded to the Trainee, Provisional Fellow or Fellow within 1 year of award of the Diploma of Fellowship who is judged to make the best contribution at the Formal Project Session held as part of the Annual Scientific Meeting. This Session will only be open to Trainees or Fellows to present material related to their Formal Project as defined in Policy Document E11.
22. The Prize will take the form of a medal.
- 22.3 Eligibility for the Prize will be limited to current or past registered trainees in Anaesthesia who fulfil the criteria in Regulation 22.1.
- 22.4 The Council shall, from time to time, appoint three adjudicators for the Prize. This task may be delegated to the ASM Officer. Adjudicators shall have the power to co-opt at the meeting should one or more of the adjudicators be unable to attend.
- 22.5 If, in the opinion of the adjudicators, no presentation attains a sufficiently high standard, the Prize will not be awarded.
- 22.6 If necessary, the Scientific Programme Committee for the ASM will pre-select presentations to the Formal Project Session on the basis of a 200 word abstract. Presentations will take the form of a ten minute paper which must be based on the topic of the Trainee's Formal Project. Performance during five minutes of discussion will also be considered by the adjudicators.
- 22.7 That the title be "The Formal Project Prize".

PATIENT-CONTROLLED INTRAVENOUS OPIOID ANALGESIA

(Advisory Guidelines)

1. Introduction

- 1.1 Patient-controlled analgesia (PCA) may be very useful in the treatment of acute pain.
- 1.2 PCA allows the patient to titrate their own pain relief according to the pain stimulus.
- 1.3 PCA opioids are usually delivered intravenously but the subcutaneous or epidural routes of administration can also be used.
- 1.4 One factor responsible for the inherent safety of PCA is that if the patient becomes sedated from the opioid they will not press the demand button of the PCA machine and, in the absence of a continuous "background infusion", further doses of opioid will not be delivered. However, side effects including respiratory depression may still occur and appropriate monitoring is still required.

2. Responsibility

- 2.1 A medical practitioner, who should have the appropriate training, is responsible for the prescription and supervision of PCA.
- 2.2 The medical practitioner is responsible for ensuring that nursing staff monitoring the patient and programming the PCA machines have received the appropriate education and been assessed as competent to do so.
- 2.3 Each hospital should establish specific policies and procedures for patient-controlled analgesia.

3. Equipment

- 3.1 The pumps should be reliable and serviced regularly.
- 3.2 In the wards, the key to the PCA pumps should be kept with the keys to the cupboard where opioids are stored.
- 3.3 If PCA is administered in conjunction with other intravenous fluid(s) then an appropriately sited anti-reflux valve(s) should be used.

4. Solutions for PCA

- 4.1 To minimise dilutional and administration errors, standard concentrations of opioid should be used

throughout the hospital. If possible, the solutions should be prepared by Pharmacy.

- 4.2 PCA bags or syringes must be clearly labelled with patient name and record number, name and quantity of the opioid that has been added, concentration of opioid in milligrams (or micrograms) per millilitre and the expiry date of the solution if it has been prepared by Pharmacy.
- 4.3 Hospital protocols (procedures and documentation) for the administration and discard of opioid drugs must be followed.

5. Orders for PCA

- 5.1 Orders for PCA opioids should contain the following:
 1. drugs to be used and concentration of the drug
 2. instructions for dilution of the drug (if not prepared in Pharmacy)
 3. size of the bolus dose and permitted alterations to that dose
 4. other parameters to be programmed into the machine such as lockout, internal and background infusion
 5. monitoring requirements
 6. orders for the recognition and treatment of side effects, including when the medical practitioner should be notified of a problem
 7. the name of the medical practitioner(s) to be contacted in case of problems.
- 5.2 Monitoring should include assessments of sedation, respiratory rate and pain relief. Note that a decrease in respiratory rate is an often late and unreliable sign of respiratory depression and that sedation is considered to be an earlier and more reliable sign.
- 5.3 Supplemental oxygen is advisable especially in high risk groups such as the elderly, following major intra-thoracic or intra-abdominal surgery or patients with significant respiratory disease.

February, 1995

CONTINUOUS INTRAVENOUS OPIOID INFUSIONS

(Advisory Guidelines)

1. Introduction

- 1.1 Continuous intravenous opioid infusions may be useful in the treatment of acute pain.
- 1.2 The infusion must be titrated to suit each patient and to suit different pain stimuli within the same patient.
- 1.3 It must be recognised that when an opioid is administered by continuous infusion it takes five half-lives of the drug to reach a steady state. This means that side effects including respiratory depression, may not be seen until some time after the start of the infusion. The full effect of any increase or decrease of the infusion rate will also not be seen until this time.
- 1.4 Continuous intravenous opioid infusions are probably less safe than the other common method of intravenous opioid administration – patient controlled analgesia (PCA) – and may be more accessible to tampering of the infusion bag or syringe than a PCA pump.

2. Responsibility

- 2.1 The medical practitioner, who should have the appropriate training, is responsible for the prescription and supervision of the infusion.
- 2.2 The medical practitioner is responsible for ensuring that nursing staff monitoring the patient and altering infusion rates have received the appropriate education and are assessed as competent to do so.
- 2.3 Each hospital should establish specific policies and procedures for continuous intravenous opioid infusions.

3. Equipment

- 3.1 Ideally the infusion should be delivered by a volumetric infusion pump or syringe pump.
- 3.2 If a pump is not available, a burette with a micro-drip chamber should be used. The amount of solution in the chamber should be limited to that which is to be infused over one hour.
- 3.3 The pumps should be reliable and serviced regularly.

- 3.4 If an opioid infusion is administered in conjunction with other intravenous fluid(s) then an appropriately sited anti-reflux valve(s) should be used.

4. Solutions for opioid infusion

- 4.1 To minimise dilutional and administration errors, standard concentrations of opioid should be used throughout the hospital. If possible, the solutions should be prepared by Pharmacy.
- 4.2 Infusion bags or syringes must be clearly labelled with patient name and record number, name and quantity of the opioid that has been added, concentration of opioid in milligrams (or micrograms) per millilitre and the expiry date of the solution if it has been prepared by Pharmacy.
- 4.3 Hospital protocols (procedures and documentation) for the administration and discard of opioid drugs must be followed.

5. Orders for opioid infusions

- 5.1 Orders for infusion of opioids should contain the following:
 1. drug to be used and concentration of the drug
 2. instructions for dilution of the drug (if not prepared in Pharmacy)
 3. upper and lower limits for the rate of infusion
 4. size and frequency of permitted additional bolus doses of the drug
 5. monitoring requirements
 6. orders for the recognition and treatment of side effects, including when the medical practitioner should be notified of a problem
 7. the medical practitioner to be contacted in case of problems.
- 5.2 Monitoring should include assessments of sedation, respiratory rate and pain relief. Sedation and respiratory rate should be monitored at least hourly. Note that a decrease in respiratory rate is an often late and unreliable sign of respiratory depression and that sedation is considered to be an earlier and more reliable sign.
- 5.3 Supplemental oxygen is advisable especially in high risk groups such as the elderly, following major intra-thoracic or intra-abdominal surgery or patients with significant respiratory disease.

February, 1995

POLICY DOCUMENT

P28 (1995)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

POLICY ON INFECTION CONTROL IN ANAESTHESIA

1. INTRODUCTION

In order to ensure that the practice of anaesthesia is as safe as possible for patients, anaesthetists and other health care workers it is imperative that infection risks to all parties be minimised.

It is impossible to issue a policy which if observed would ensure that infection was never transmitted via anaesthetic apparatus. What follows is a policy based on current understanding of the risks of such transmission. In certain clinical situations there may be a need to adopt more stringent practices. This Policy should be considered with documents on this subject issued by other Authorities.

2. DEFINITIONS

Decontamination: The process of removing infective and unwanted matter from the surface of an object, i.e. thorough cleaning.

Disinfection: A process which eliminates many or all micro-organisms except those spores.

Sterilisation: A process which leads to the complete elimination of all micro-organisms.

Asepsis: The prevention of contact with micro-organisms.

For disinfection or sterilisation to occur there must have been previous thorough decontamination.

For technical aspects of these procedures the reader is referred to the Code of Practice for Cleaning, Disinfecting and Sterilising Reusable Medical and Surgical Instruments and Equipment, and Maintenance of Associated Environments in Health Care Facilities (AS 4187-1994).

3. MINIMISATION OF INFECTION RISK TO PATIENTS

Measures to protect patients against acquiring infections through anaesthesia procedures need to address (i) risks related to invasive procedures; (ii) risks or potential risks related to airway management. In both situations appropriate levels of sterility, disinfection and decontamination are to be applied to all equipment used. A microbiologist should be consulted about any matters requiring clarification with local application of this policy.

Frequent handwashing by the anaesthetist and the anaesthetic assistant is a most important infection control measure. Hands should be washed before handling a new patient or equipment to be used on a new patient, after leaving a patient, whenever they become contaminated and before any invasive procedure. For the anaesthetist's protection protective gloves are to be worn whenever the hands may contact blood, saliva or any other body fluid and are to be removed after such a procedure to minimise contamination of the work place.

3.1 INVASIVE PROCEDURES

Invasive procedures are to be performed with aseptic technique . . .

3.1.1 Vascular Cannulation

The cannulation site is a potential portal of entry of micro-organisms into the sub-cutaneous tissues and circulation. The anaesthetist's hands must be washed and protective gloves should be worn. The skin should be disinfected with an appropriate preparation prior to cannulation being performed in a manner which ensures that the tip and shaft of the cannula remain sterile.

3.1.2 Central Vascular Cannulation

The insertion of central venous and pulmonary artery catheters carries added infection hazards for the patient. Cannulation of central veins is to be performed using full aseptic technique i.e. with sterile gowning and gloving, thorough skin preparation and the use of a sterile field bordered by sterile drapes.

3.1.3 Regional Anaesthesia

When regional blocks are being performed, the hands should be washed and gloves worn, the skin should be disinfected with a suitable preparation and the procedure done in such a way that the needle remains sterile. When a spinal or epidural block is being performed or a catheter is to be left indwelling, full aseptic technique including the wearing of sterile gown and gloves and the use of a field bordered by sterile drapes is recommended.

3.2 ANAESTHETIC APPARATUS

The following measures are intended to minimise the risk of transmission of infection in the respiratory tract via anaesthetic equipment. This policy does not address the processing of equipment during long term ventilation.

3.2.1 Disposable Items

Items of airway equipment to be placed in direct contact with the respiratory tract such as endotracheal tubes and airways labelled by the manufacturer as disposable or for single use only should not be reused.

3.2.2 Devices to be sited in the upper airway

Devices passing through the mouth or nose will become contaminated in the upper airway. Endotracheal tubes, nasal and pharyngeal airways should be kept sterile until used.

Reusable face masks must be thoroughly decontaminated and then undergo disinfection prior to each use. Items to be placed in the upper airway which may cause bleeding e.g. laryngoscope blades and temperature probes, must be disinfected before reuse. It is not ordinarily necessary to package these items separately while they await their next use. Where the manufacturer advises that a particular piece of equipment is to be sterilised before use, e.g. the laryngeal mask, that advice is to be followed. Laryngoscope handles should be decontaminated between uses.

There should be separation of unused items and soiled items during use.

3.2.3 The Breathing Circuit

For each patient the Breathing Circuit should have been sterilised, or decontaminated and disinfected or protected by the use of appropriately positioned new filters. When a filter is used, it is recommended that disposable items between the patient and the filter be disposed of and non-disposable items, including in-line measurement devices, be decontaminated and disinfected prior to reuse.

3.2.4 Sampling Lines for Side Stream Gas Analysis

These need not ordinarily be sterilised before reuse because of the one way flow of gas through them. Sampled gas from a capnograph or other such measurement device should not be returned to the anaesthetic circuit unless it is first passed through a viral filter.

3.2.5 Carbon Dioxide Absorbers

When a filter is used in the circuit as described in 3.2.3 above, sterilisation of the carbon dioxide absorber prior to every case is not necessary nor with most models is it practicable although disposable versions and models capable of being sterilised are available. The device including the unidirectional valves should be disinfected regularly.

3.2.6 Ventilator Circuits and Bellows

These items should be cleaned and disinfected regularly.

3.2.7 Flexible Laryngoscopes and bronchoscopes

The College endorses the policy on the care and handling of these instruments and accessory equipment laid down in the appropriate National Standard.

3.3 PRESENTATION OF DRUGS FOR INJECTION

Because of the potential for cross infection, the use of the contents of multiple dose vials and ampoules for more than one patient is not recommended except in a dispensing situation where different doses are drawn up before administration of first dose to a patient. Likewise it is recommended that the contents of a single dose ampoule are to be used for one patient only.

3.4 PATIENT FACTORS

In immunosuppressed or immune deficient patients to whom infection poses a particular threat, there may be reason to apply more stringent practices than those outlined.

4. PREVENTION OF INFECTION OF HEALTH CARE WORKERS

For the College policy on this topic including discussion of universal precautions, the reader is referred to the College Statement on AIDS and Hepatitis (College Bulletin March 1994, P 33).

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Promulgated: 1995

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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
- E3 (1994) The Supervision of Trainees in Anaesthesia
- E4 (1992) Duties of Regional Education Officers
- E5 (1992) Supervisors of Training in Anaesthesia and Intensive Care
- E6 (1990) The Duties of an Anaesthetist
- E7 (1994) Secretarial Services to Departments of Anaesthesia
- E9 (1993) Quality Assurance
- E11 (1992) Formal Project
- E13 (1991) Guidelines for the Provisional Fellowship Year
- E14 (1994) Guidelines for the In-Training Assessment of Trainees in Anaesthesia
- EX1 (1991) Guidelines for Examiners with Respect to Candidates Suffering Illness (or Accident) at the Time of Examination
- T1 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites
- T2 (1990) Protocol for Checking an Anaesthetic Machine Before Use
- T3 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Units
- T4 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT)
- T5 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries
- T6 (1994) Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites
- P1 (1991) Essential Training for General Practitioners Proposing to Administer Anaesthetics
- P2 (1991) Privileges in Anaesthesia Faculty Policy
- P3 (1993) Major Regional Anaesthesia
- P4 (1989) Guidelines for the Care of Patients Recovering from Anaesthesia
- P5 (1991) Statement on Principles for the Care of Patients who are given Drugs Specifically to produce Coma
- P6 (1990) Minimum Requirements for the Anaesthetic Record
- P7 (1992) The Pre-Anaesthetic Consultation
- P8 (1993) Minimum Assistance Required for the Safe Conduct of Anaesthesia
- P9 (1991) Sedation for Diagnostic and Minor Surgical Procedures
- P10 (1994) The Handover of Responsibility During an Anaesthetic
- P11 (1991) Management of Cardiopulmonary Bypass
- P12 (1991) Statement on Smoking
- P13 (1992) Protocol for The Use of Autologous Blood
- P14 (1993) Guidelines for the Conduct of Epidural Analgesia in Obstetrics
- P15 (1992) Guidelines for the Care of Patients Recovering from Anaesthesia Related to Day Surgery
- P16 (1994) The Standards of Practice of a Specialist Anaesthetist
- P17 (1992) Endoscopy of the Airways
- P18 (1990) Monitoring During Anaesthesia
- P19 (1990) Monitored Care by an Anaesthetist
- P20 (1990) Responsibilities of Anaesthetists in the Post-Operative Period
- P21 (1992) Sedation for Dental Procedures
- P22 (1990) Statement on Patients' Rights and Responsibilities
- P23 (1992) Minimum Standards for Transport of the Critically Ill
- P24 (1992) Sedation for Endoscopy
- P25 (1993) Minimum Standards for Pain Management Units
- P26 (1994) Guidelines on Providing Information About Anaesthesia
- P27 (1994) Standards of Practice for Major Extracorporeal Perfusion
- P28 (1995) Policy on Infection Control in Anaesthesia
- IC-1 (1994) Minimum Standards for Intensive Care Units
- 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: Guidelines for Departments of Intensive Care

March 1995