AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

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

BULLETIN

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EDITORIAL

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

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PRESIDENT'S MESSAGE

Ulimaroa has been opened. The Headquarters of the Australian and New Zealand College of Anaesthetists were officially opened by the Governor-General of the Commonwealth of Australia, The Honourable Bill Hayden, AC, on the 19th February. It was a great day for the College and all Fellows in Australia and New Zealand. Over 300 people attended the Opening including many Presidents and representatives of our sister Medical Colleges and medical organisations. Fellows from all Regions attended thus ensuring that the day was the most memorable occasion in the history of the Faculty/College.

Ulimaroa will become a focus for Anaesthesia and Intensive Care in Australasia. The College will use this building for all our important functions, including the planning and administration of our training programmes, our continuing education programmes and our research activities. The Examinations will be conducted here as will some of our Primary and Final Examinations Courses. The College Council and its Committees will meet here as will those of the Faculty of Intensive Care.

The building will house two of our most important assets: the Library and the Museum. The Geoffrey Kaye Museum of Anaesthetic History has not been adequately displayed for many years but will now be able to be viewed by our Fellowship and our Visitors. This Museum is one of three major anaesthetic Museums in the world and must continue to be fully supported.

Many people should be thanked for their contribution which has allowed us to open this building. Firstly, there were a number involved with a search for our College Headquarters – a search which continued for many years. They included Professor Barry Baker who initiated the search, our two Past Presidents Peter Livingstone and Michael Hodgson, who continued the search and finally Ian Rechtman, who found the building during Michael Hodgson's presidency.

The College received excellent professional advice from representatives of the Hooker Corporation, Tony Sallman and Warwick Padey. We were also assissted greatly by helpful legal advice from Michael Gorton.

The renovations and decorations of the property were overseen by Murray Sheldrick – a design and interior decorator with a great deal of talent and an excellent eye for detail. He gathered together some excellent craftsmen to complete his ideas including John Beaumont the builder, and Arnold O'Farrell the painter. Joan Sheales, our Registrar, deserves a very special accolade for this building. She has worked tirelessly for several months with Murray Sheldrick and the tradespeople to ensure that every detail of the renovation was carried out on time, within budget and to the highest quality of workmanship.

Finally, the Fellowship of our great College should be thanked. They paid for the purchase of this building and its renovation and have ensured that the College is appropriately housed for the next twenty to thirty years and probably for a substantially longer period.

Ulimaroa will enhance the status of anaesthesia amongst our medical colleagues and the community. It is important that we seize this time and continue the momentum in order to improve the image of anaesthesia and intensive care both in Australia and in New Zealand.

MICHAEL DAVIES
PRESIDENT

'ULIMAROA'

EARLY HISTORY

The new home of the Australian and New Zealand College of Anaesthetists is believed to be the work of noted early Melbourne architect John Augustus Bernhard Koch (1845-1928). German-born Koch entered practice in 1874, designing many public, industrial and private buildings.

The original owner and builder of the house in 1889-1890 was the Rev. Dr Edwin Iredale Watkin (1839-1916), a Wesleyan Minister whose father was an early Missionary in Tonga in the 1830s and later in New Zealand. Dr Watkin spent his entire career in Victoria and was President of Wesley College from 1883-1889.

The Traill family were the first occupants of the house in 1890 which they purchased from Watkin in 1900. The family continued to live at Ulimaroa until 1946, although Traill himself died in 1918.

Traill was Chairman of Huddart, Parker and Co. Ltd., coal importers, merchants and coastal shipping. He had a profound interest in and knowledge of the South Pacific and its history and named his home 'Ulimaroa', which was an early name given to Australia appearing on Canzler's map of the 'Polynesian Island World of Australia/South Indies' in 1795. Later in 1908, Traill had commissioned a 5777-ton passenger and cargo vessel for his company from Scotland. This twin screw steamer was also named 'Ulimaroa' and plied between Australia and New Zealand – thus giving an historical connection between the two countries of this College.

At the time of the Traills arrival, the house was described as a twelve roomed brick house, which was considered an inaccurate description, there being nine main rooms, a kitchen and three servants' rooms. In 1906, a detailed plan reveals that a closet was provided in the upstairs bathroom; this appears to be the only change to the building prior to John Traill's death in 1918. The house is recorded as comprising of four bedrooms, a bathroom and servant's sitting room, cupboards and two servants' rooms at the rear, drawing room, billiard room, breakfast room and study, the room in the tower was known as the sewing room.

In 1944 the house was sold to Dr Harvey Barrett, a grand-nephew of Traill, who lived there and also had his surgery there.

In 1959 Repco Ltd. purchased Ulimaroa for its corporate headquarters when the Company Chairman, Sir Charles McGrath with input from architects D.G. Lumsden and G. Sommers, provided immediately for its transformation into offices and meeting rooms for the senior executives. The property was subsequently owned by Clarendon Finance Pty Ltd from the late 1980s until the College became the new owner on September 1, 1993.

These structural alterations included partial demolition of the rear wing and reconstruction to accommodate the directors' lounge and dining room, kitchen, lunch room, board room, toilets and office space, with a verandah overlooking the former rear garden. The building work was carried out by Swanson Brothers Pty Ltd, and upon completion late in 1960, Geoffrey Sommers, architect, was retained to decorate the interior.

INTERIOR

Sommers obtained sections of wall panelling and doors for Ulimaroa which came from 'Goathland' (later 'Tara Hall') in Kew.

Goathland's original owner was George Ramsden and later in 1903 Sir Malcolm McEacharn. It was the work of architects Ellerker and Kilburn, who also designed the 'City of Melbourne' building on the corner of Elizabeth and Collins Streets simultaneously in 1888. Unfortunately, 'Goathland' was demolished in 1960 but had it survived would have been one of the State's most important Elizabethan Revival residences, and the opulent Queen Anne styled French polished woodwork is a remarkable expression of the joiner's craft as it was practised during the late 1880s.

Certain aspects of the exterior are indicative of the architect's style. Features such as sculpted classical masks, foliated scrolls and consoles, often located on parapets and skylines. Koch was a talented and versatile architect who was City Architect and later Mayor of Richmond, designing more than 60 buildings in Richmond and Hawthorn, and other projects associated with the Women's Hospital of which he was honorary architect. He later became President of the Royal Victorian Institute of Architects.

SURROUNDS

The house is a late Victorian Italianate villa and is of State historic importance as a design typical of many formerly situated on St Kilda Road.

St Kilda Road was substantially developed as a late Victorian boulevard characterised by a spacious landscaped carriageway, cable tramway, many substantial Italianate villas and expensive public gardens including the Government Domain, the Queen Victoria Gardens and the Alexandra Gardens and was for over half a century Melbourne's most spectacular upper middle class residential boulevard. It was at this time one of the most powerful expressions of nineteenth century planning principles and the social values and economic forces which underlay them, in Australia. Of the forty-one large detached villas in existence in 1895 on St Kilda Road, only five remain in 1994.

SOURCES:

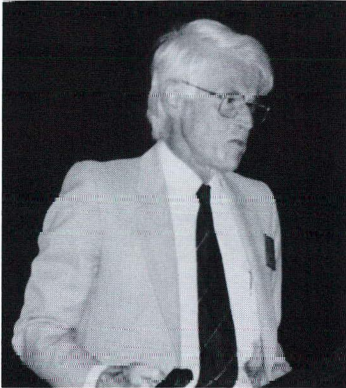
Conservation analysis & policy. Andrew C. Ward & Assoc. 1988.
Australian Dictionary of Biography, Vol. 9. Melbourne University Press.

MICHAEL G. COOPER
Honorary Historian, ANZCA

Academic Anaesthesia in Australia Symposium held at the Victorian Arts Centre

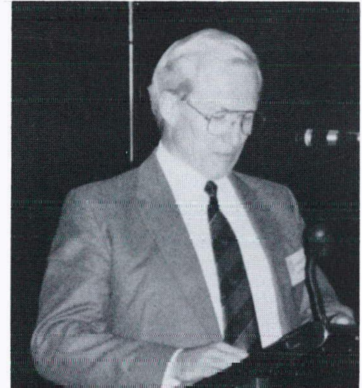
19 February, 1994

The following Professors delivered presentations at the above Symposium held in conjunction with the Opening of Ulimaroa.



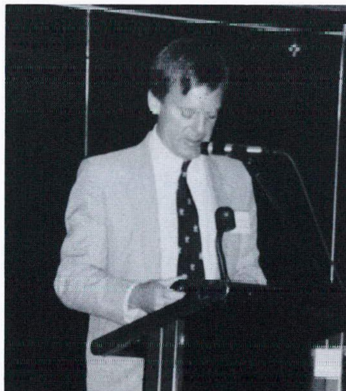
Professor John Gibbs, Professor of Anaesthesia, University of Otago, Christchurch Hospital

Professor Colin Goodchild, Professor of Anaesthesia, Monash University, Monash Medical Centre

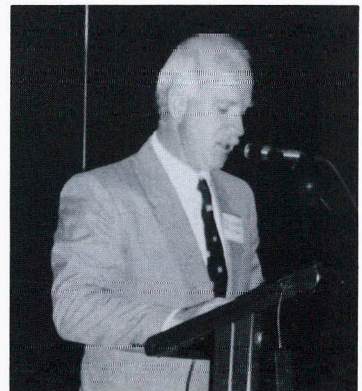


Professor Garry Phillips, Professor of Anaesthesia and Intensive Care, Flinders University of SA, Flinders Medical Centre

Professor Geoff Cutfield, Professor of Anaesthesia and Intensive Care, University of Newcastle, John Hunter Hospital



Professor Ken Hillman, Professor of Anaesthesia and Intensive Care, University of New South Wales, Liverpool Hospital



Professor Douglas Jones, Professor of Anaesthetics, University of Queensland, Royal Brisbane Hospital

Professor Bill Runciman, Professor of Anaesthesia and Intensive Care, University of Adelaide, Royal Adelaide Hospital

Professor Duncan Blake, Professor of Anaesthesia, University of Melbourne, Royal Melbourne Hospital

Professor Barry Baker, Nuffield Professor of Anaesthetics, University of Sydney, Royal Prince Alfred Hospital

Address by The Honourable Bill Hayden
Governor-General of The Commonwealth of Australia

On the Occasion of Opening the Headquarters of the Australian and New Zealand College of Anaesthetists Melbourne – Saturday, February 19, 1994

Thankyou for the welcome. It is a privilege for me to be with you this afternoon for the official opening of this lovely building – 'Ulimaroa' – as the Headquarters of the Australian and New Zealand College of Anaesthetists.

This is in fact, a double celebration.

Firstly, it marks the virtual completion of the refurbishment of this house – this gracious, Italianate villa built just over a century ago – and which I understand is today one of only five detached houses remaining on St Kilda Road from the 1890s.

It was – it still is – one of the great boulevards: the spacious carriageway, the tree-lined streets, the public gardens. And although the residential land is now mostly given over to flats and offices, this is still a splendid setting for your Headquarters.

And of course, that is the second and more important reason why we are here today.

Just two years after the College received its Certificate of Incorporation and established itself as an independent legal entity from the Royal Australasian College of Surgeons, you now have your own and quite separate premises.

I think you will agree that this is an important step in the life of your institution.

Of course relations between the two Colleges remain entirely amicable and supportive. Properly so. You do not need me to tell you of the very close and necessary teamwork that exists between surgeons and anaesthetists in the operating theatre.

In fact the anaesthetists were a Faculty within the Royal Australasian College of Surgeons for some 40 years.

But as any organisation – like any individual – grows and matures as part of a family over the years, there comes a time when there is a need to establish yourself in your own home, as it were.

Yet while some things naturally change and evolve, the closeness of the relationship remains unimpaired – and so it is in this case.

I am reminded that when the Faculty was formed in 1951, there were 69 Foundation Fellows. It represented a relatively new and growing specialty.

With the very great support of the College of Surgeons in all respects, the Faculty set and maintained professional standards and education in Anaesthesia and Intensive Care throughout Australia and New Zealand.

Today, you represent the third largest group of medical specialists. Indeed, I believe that your College now has more than 2200 Fellows and some 600 trainees, the majority of them resident in this country.

It goes without saying that the College is continuing the activities previously carried out by the Faculty: maintaining standards, education, training and examinations in the related disciplines.

It is interesting that last November the College established its own Faculty of Intensive Care, which will now be responsible for these matters.

I know that many Fellows of the College give most generously of their time in teaching and examining trainees, in reviewing hospitals for accreditation of training programmes that will give students the maximum breadth and continuity of experience. As of last year, I understand, there were 23 rotational training programmes.

In fact you are giving considerable support to a review of examinations, and also to establishing a programme that will assist Fellows to maintain professional standards on a continuing basis.

There is the important need to constantly expand the frontiers of medical knowledge. And in this respect, I understand the College spends approximately $250,000 annually on research into aspects of anaesthesia, intensive care and pain management.

Ladies and gentlemen, in all of this it can properly be said that the College of Anaesthetists is meeting the noble aims of the profession expressed in the motto you have adopted. In translation, 'To care for the body and its breath of life'.

To maintain the breath of life – a very just and beautiful description of the function that you perform in the practice of modern medicine and surgery.

For while the introduction into clinical anaesthesia of drugs aimed at relaxing muscles, as well as relieving pain, may have made many more complex surgical procedures possible, they also reduced the patient's ability to breathe spontaneously.

The need therefore arose for artificial respiratory support during an operation, and consequently anaesthetists had to become specialists in respiratory and circulatory physiology, in support and monitoring systems, in the drugs that act upon them, and of course in the techniques of intensive care.

It would be idle of me to give a lecture on anaesthetics, especially before this distinguished audience. But I must say I was impressed at the care that has been taken to express the tradition and the essentials of your profession in the Coat of Arms awarded to the College.

Take for example, the two supporters. On the left stands Andreas Vesalius, the great anatomist and physician, who was the first to record the use of artificial ventilation to sustain life. He holds a bellows and looks outwards to indicate the importance of this.

On the right is William Harvey, the Englishman who was the first to record the circulation of blood – the heart on the book he is holding signifies this.

And of course what these supporters represent is the heritage of your specialty, based as it is on respiratory and cardiovascular physiology, together with anatomy and physiology.

The four plants on the shield signify the fundamental pharmacology of anaesthesia: the opium poppy flower, mandrake plant, curare vine and cocaine – plants from the old and new worlds. We see, too, that the supporters stand on Australian wattle and New Zealand's silver fern tree.

There are many other symbolic reminders. The rising sun, linking you with the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians, which both have similar rising suns. The torch of glory on the shield is another link to the College of Surgeons.

The Cross of St George symbolises the connection to your English colleagues, as well as the christian tradition of the College. There is the hand of the carer holding an ankh, the Egyptian symbol of life, entwined with a snake which reminds of medicine's Greek heritage.

I should also mention the Southern Cross – which not only affirms your place in the Southern Hemisphere, but this particular presentation is used only by Victoria, emphasising your connections with this State.

I could go on. Symbolism and the many levels of its meaning is a fascinating topic. But even in this abbreviated form I hope I have been able to touch on some of the important historical and professional associations of your College.

They are proud traditions and noble ones, as I said before: Working with the surgeon to care for those who are sick and in pain – to maintain that most precious of all things, the breath of life.

Even this building is not without its symbolic aspects. The name 'Ulimaroa' is said to be the Polynesian name for Australia, and it appears on Canzler's map of the Polynesian Island World of Australia and the South Indies, published in 1795.

It was the name given to this house by its first occupant, Mr Traill, who was a student of Pacific history and chairman of a merchant shipping company which later commissioned a passenger ship – also called 'Ulimaroa' – which plied between Australia and New Zealand . . . an interesting connection between the two nations that together form the membership of this College.

The building has gone through some changes since then, of course: altered and redecorated as a company headquarters for Repco Ltd. among its other owners, which installed the fine panelling from another Melbourne house that has since been demolished.

The College purchased the building last September and now your own refurbishments are nearly complete.

And as you move into your new headquarters over the coming days and weeks, may I express my every good wish for your continuing success in the dedicated service that you perform in the best interests of your patients and your profession.

As I say, this is an important day in the life of your institution. Another milestone. I offer my congratulations to all who have been involved.

In so saying it is my pleasure to officially declare open 'Ulimaroa' as the Headquarters of the Australian and New Zealand College of Anaesthetists. Thankyou.

TOAST TO THE COLLEGE AND 'ULIMAROA'

by Brian Dwyer

On the occasion of the dinner to celebrate the opening of 'Ulimaroa' as the headquarters of the Australian and New Zealand College of Anaesthetists

Saturday, February 19, 1994

Thank you Mr President for the invitation to propose this historic toast.

My friends, today we are enjoying a simply splendid house-warming as we honour *Ulimaroa,* this gracious building, so beautifully situated in this great city. Now restored to its past glory, it will serve with distinction in the years ahead as the home of this College, which is now recognised as the intellectual and professional base of Australian and New Zealand anaesthesia.

It was proper that the Governor-General should inspect and open the College's new home – a task he performed with distinction and with a self confidence which was somewhat surprising in view of a natural anxiety which one might expect as he faces possible retrenchment in the foreseeable future.

Furthermore, one could only delight in the recognition of New Zealand's equal presence in our midst through the retention of the name Ulimaroa which traditionally links our two countries in the Polynesian Islands world of the South Indies.

The Council was obviously determined to make today's event memorable. Not only did we have the symbolic presence of the Queen in Australia in the person of the Governor-General, but we were offered a learned symposium on "Academic Anaesthesia". This was a subject with which I was unfamiliar and which beforehand I had presumed to be some recent Australasian discovery. I guessed it must be something akin to general and regional anaesthesia but without their complications with the possible exception of induced amnesia. In fact, I was quite wrong as it was really an excellent presentation by academic anaesthetists on their familiar subjects.

Finally tonight there has been this marvellous dinner which has given the Council a rare opportunity to mobilise a select if diminishing group of College Fellows best identified by their outstanding loyalty to their specialty. Many have fought their battles in other places and at other times, but now they are easily recognised as the "sprightly" members of "Dad's Anaesthetic Army".

For me this is the correct time to record the comments of one of the Army's early volunteers, the late Len Shea, who would say "Old Deans never die, they just lose their faculties".

For all this, something was missing. Council had apparently failed to recognise that Ulimaroa is not just bricks and mortar, but has the same spirit or soul which is found in every home. This was specially significant today in view of the deep spirituality which is continually exhibited by anaesthetists. On virtually every day, in every operating theatre throughout the country one can hear them calling for divine assistance, be it for themselves, their patients or the surgeon who is having some problems.

Against this background, I would have expected Ulimaroa to have received a full liturgical blessing performed at least by a member of Melbourne's religious hierarchy.

Personally I would have preferred Archbishop Mannix for the occasion, but I believe that for some time now has been retired from pastoral work.

On the other hand to plan the opening of Ulimaroa in this International Year of the Family was absolutely inspirational since Ulimaroa is destined to become not simply the headquarters of this College, but the home of the extended anaesthetic family. The College now should be proud to be seen as the mature offspring of the Australian Society of Anaesthetists and the former Faculty. If childhood and adolescence has not always been easy, parental support was ever present and most effective. Naturally, help from the ASA was to be expected, but it was the strength of the support given by the College of Surgeons during the growth decades of the

1960s to the late 1980s that was quite extraordinary. The debt the Faculty and College of Anaesthetists incurred during this period should not be underestimated.

It is for these and other reasons that I urge this College to take positive steps to maintain a close social, professional, and scientific relationship with the surgical college. Apathy or indifference could produce a weakening of our ties with surgeons at all levels which could lead to that unhealthy situation which often dominates the scene in the USA. Patient, surgeon and anaesthetist under such circumstances may all suffer in varying degrees.

I was surprised that during the lead-up to the formation of this College, much emphasis was placed on the perceived need for anaesthetists to be independent, to be themselves, their own person. It is now on record that for financial reasons in 1989 complete autonomy for the Faculty was vital if its future security was to be ensured.

Mr Gorton, the College solicitor gave this advice which was promptly acted upon by Barry Baker the Dean, and his Board. An independent College of Anaesthetists had to be formed as soon as possible, and we applaud them for their subsequent wise and courageous action.

However, other reasons for independence fail to impress me for the reason that from 1973 onwards I had been convinced that it was the College of Surgeons which had an identity problem and not the Faculty or its Fellows.

It happened like this: in 1973 the College had its first GSM outside Australia, in Singapore. The redoubtable E.S.R. Hughes was the chairman of the organising committee responsible for this high profile window-dressing exercise for the College. As you would understand, the tension in the lead-up period became progressively more overwhelming with some of the preparations appearing to be in rather a muddle. This forced the surgeons, led by Mr Hughes to submit some of their independence and authority to the then Dean as they sought help and guidance. From that time onwards, things began to look up and surgical pride was preserved; but at a high price. To a degree, the surgeons had become dependent to the anaesthetists; a situation which is not unfamiliar to many observers even to this day. Might I say, the Dean at the time was the indomitable Teresa O'Rourke Brophy.

Once this present autonomy was achieved, the new independent College obviously needed a home commensurate with its new-found status. The search began, and by a stroke of real estate genius, Ian Rechtman discovered Ulimaroa, whose sale was negotiated by Mr Padey of Hookers for $1.46m. No-one can deny that this ideal property, purchased at such a reasonable price, will fulfil the present needs of the College, and with architectural additions will satisfy future demands without loss of either dignity or grandeur.

Tonight it is proper to salute some of those involved in these historic events. I refer to the Past Presidents of the College, Peter Livingstone and Michael Hodgson, the present incumbent Michael Davies and their Councils, Joan Sheales and her staff, the interior decorator Murray Sheldrick who was responsible for magnificently refurbishing the building, and the architect/planners Arthur Ward and Associates, who assessed the Heritage status of the building and offered some visions for its future.

I would like to now record my admiration for the contributions of Victorian anaesthetists towards the growth of firstly the Faculty, and now the College. This is somewhat difficult for me as a New South Welshman with ambivalent attitudes towards Melbourne and Victorians. Let me hasten to explain my parochialism: In 1949 when playing cricket against Victoria on the MCG I had to resuscitate our youngest batsman, Richie Benaud, who had been rendered semi-conscious with profuse bleeding from the nose due to a fractured frontal sinus after being hit by a bumper from a Victorian fast bowler. The Victorian captain gave expert assistance, and organised for the young 18 year old to be admitted to the Royal Melbourne Hospital. On assuming my position at the wicket as the next batsman I received my own barrage of bumpers. In anger, I uttered certain expletives and questioned the behaviour of the Victorian players. It was some years later that I again met the Victorian captain and we became friends while working and playing cricket together in Oxford. As he was an outstanding anaesthetist and a fine sportsman, I had to review my bias towards Victorian anaesthetists and Victorians generally. I speak of Ian McDonald, who is well known to many of you.

It has been from the Faculty's early beginnings that Victorian anaesthetists have shown special concern for the proper housing and administration of anaesthesia in Australasia. Initially Ray Chapman, the College Secretary, administered Faculty affairs, but in 1970 Kevin McCaul, Douglas Joseph and Tess Cramond secured Nance O'Donnell to take over the administration.

This administrative autonomy within the College of Surgeons proved most effective from the outset and has been further developed by Joan Sheales. But behind these outstanding officers of the Faculty and College there have been numerous Victorian anaesthetists who supervised the educational, archival, library and museum activities with little acknowledgement or thanks from Fellows.

I am certain that future College activities at Ulimaroa will succeed with the ongoing commitment of the Victorians, helped along, I am sure, by the rest of us. From past experience I have no doubt that our Melbourne home is in good hands.

To my mind all great buildings have their own personality. A building can induce a sense of pride for some, while others may experience feelings of belonging, unity or even patriotism. You may recall similar emotions in relation to your own home, or as a traveller at Buckingham Palace, St Peter's Basilica, or as a Melbournian towards the Carlton Football Club.

It is at this time that *Ulimaroa* awakens in me a true sense of unity or of coming home to the family estate; a feeling, I believe, most anaesthetists will experience when they visit in the future. This now must call for old barriers, real or imagined, to be pulled down, differences to be set aside and divisions among anaesthetists to be replaced by the unity and harmony symbolised by this building.

In my mind, the present separation of the ASA and the College tends to drain the physical and financial resources of anaesthetists who are largely members of both organisations. Although I am aware of the arguments used to justify the status quo of the past four decades, the continual reduplication and financial drain induced by professional activities conducted by both groups is now becoming an unwarranted burden. I can see no significant obstacle to unity that cannot be overcome by suitable constitutional changes within the two now fully autonomous bodies. Nor should any changes leading to unity threaten the security or professional status of the individual anaesthetist. *Ulimaroa* under such circumstances could bring the ASA and the College together under its ample roof before the end of this century.

My final reflection is on the potential impact that this grand and independent building might have in its role as protector and guardian of our College and specialty.

Professional security today is under constant threat. Anaesthetists are distressed by medical litigation with its financial and social implications, by political interference and finally by a media campaign of contempt and vilification against doctors generally including anaesthetists from time to time.

All around one sees colleagues frustrated and angry to a degree, which detracts from the satisfaction of their work, often pointing the way to early retirement as a solution. The sense of self-esteem and pride in one's achievement has been diminished encouraging a ready submission to the dictates of lawyers, even when they presume to criticise the very essence of clinical anaesthetic practices.

Now I do not have any quick fix for these debilitating problems, but I am confident that their effects can be minimised by certain attitudinal changes on our part towards a more positive, even aggressive approach towards the way we present our specialty.

The press, politicians and lawyers should be publicly reminded of the progress made by anaesthetists throughout this country, which has allowed modern surgery to prosper, the various manifestations of pain to be controlled, and life-saving resuscitation made available for the benefit of the whole community.

That done, one must organise support for colleagues criticised eschewing further criticism of one's own, educate the community about anaesthesia and the training of anaesthetists, and always demand to see the credentials of our public persecutors. One should remember that any sober judgement will show that we have much to be proud of, and little of which to be ashamed.

Finally I would ask you to look with pride on *Ulimaroa* and consider what it means to you now, and what it will mean to you in the future, and to those who will follow.

Again I express admiration and gratitude to those who have initiated this historic step in the evolution of anaesthesia in Australia and New Zealand.

With best wishes for the future and thanks for the past, I ask you to join me in this toast to ***The College and its Home.***

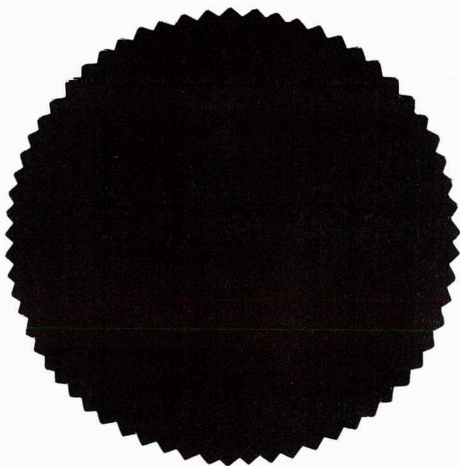
HONOUR AND APPOINTMENTS

PROFESSOR BARRY BAKER, NSW – was awarded the Orton Medal which will be presented at the College Ceremony during the Launceston Annual Scientific Meeting.

DR RONALD LO, Hong Kong – President, Hong Kong College of Anaesthesiologists

PROFESSOR GARRY PHILLIPS, SA – Chairman Medical Advisory Committee, St John's Ambulance, South Australia; Member Medical Standards Committee, St John's Ambulance, Australia.

The Royal Society of Medicine sends greetings and congratulations to the Australian and New Zealand College of Anaesthetists on the occasion of the opening of your magnificent new building. The historical links between our nations in medicine are well established and have been greatly assisted by the close relationship we have enjoyed to date with a number of Australasian medical institutions. We in Britain hope that this situation will be enhanced through collaboration with your own College and we send you our sincere hopes for a prosperous future in your specialty.



George Pinker

Sir George Pinker KCVO FRCOG
President
Royal Society of Medicine

February 1994

ADMISSION TO FELLOWSHIP BY EXAMINATION ENDORSED IN ANAESTHESIA

Michele Veronica Brooks, NSW
Winifred Jeanette Burnett, Vic
John Stuart Algernon Currie, NZ
Robert Eadie, Vic
John Kenneth Falconer, Qld
Sophie Georghi, Vic
Peter Lawrence Hann, NSW
Kin Ming Ho, Hong Kong
Robin Leigh Holland, NZ
David Barrie Kinchington, NSW
Michael James King, NSW
Ei Leen Lee, NZ
Jan Peters Lehm, NSW
Guy Lawrence Ludbrook, SA
Douglas Charles McEwan, Qld
Nicholas Stephen Melhuish, ACT
Ian Richard Metcalfe, SA
Giuseppe Pasquale Mezzatesta, Vic
John Thomas Moloney, Vic
Sing Yun Mui, Hong Kong
Neale Norman Mushet, NZ
Zarir Nanavati, NSW
Joseph Novella, Vic
Igor Oleinikov, Vic
Anthony Pearce, SA
William Wemys Richards, SA
Grant Ryan, NZ
Edmund James Sweeney, NSW
Sze Tak-suen, Hong Kong
Fook Tuck Andrew Thang, Qld
Mark Vincent Tuck, Vic
Annette Mary Turley, NZ
Stewart Ross Wallace, NSW
Alistair Richard Walpole, Vic
Gregor Henry Wills, Qld
Jerome Wladyslaw Wisniewski, WA

ADMISSION TO FELLOWSHIP UNDER REGULATION 6.3.15

Che Ling Kwok, Hong Kong

ADMISSION TO FELLOWSHIP BY ELECTION UNDER REGULATION 6.2

Jose Carlos Almeida Carvalho, South America
Carl Casimir Hug, Jnr, USA

ADMISSION TO FELLOWSHIP BY ELECTION UNDER REGULATION 6.3.1(a)

Colin Stanley Goodchild, Vic.

ADMISSION TO FELLOWSHIP BY ELECTION UNDER REGULATION 6.3.1(d)

Sasanka Sekhar Dhara, Singapore
Ashok Kumar, Singapore

HIGHLIGHTS OF THE FEBRUARY 1994 ANZCA COUNCIL MEETING

EDUCATION

Intensive Care

Following the establishment of the Faculty of Intensive Care at the October 1993 Council Meeting and the delegation of activities relating to Intensive Care, the College resolved to disband the Education Committee (Intensive Care) and that its business be adopted by the Interim Board of the Faculty of Intensive Care.

Regulations relating to training requirements for Fellowship of the Faculty of Intensive Care have been amended to:

For trainees commencing approved vocational training on or after the commencement of the 1994 Hospital Year trainees must complete:

24 months compulsory intensive care (one year must be continuous, the second year may be spent discontinuously in two periods of six months each)
12 months clinical anaesthesia
6 months medicine
18 months optional training.

Optional training may include any combination of: General Medicine, Specialist Medicine, Emergency Medicine, Surgery, Research (limited to one year), Clinical Anaesthesia, Other discipline related to intensive care.

EXAMINATIONS

Council resolved that

In the first examination of 1995 short answer questions will be introduced to replace the previous two essays paper format in physiology, pharmacology, clinical measurement and statistics.

In the first examination of 1996, in association with the short answer questions, a multiple choice question paper, covering all topics, will be introduced into the Primary Examination.

Final Examination Committee

Council approved the leave of absence for twelve months of Dr Keith Cronin and approved the appointment of Dr Peter Klineberg as Deputy Chairman of the Final Examination Committee for 1994.

FINANCE

Attendance at International Standards Meetings

Council approved the support for one representative to attend the International Standards Meeting in Madrid.

Registration Fees for ANZCA CME Meetings

Council resolved that:

1. **As a guiding principle, *all* people attending ANZCA involved CME Meetings are responsible for paying the registration fee, travel and accommodation expenses. This includes all speakers, organisers, Council members, etc.**
2. **Invited speakers from outside the specialty may be paid expenses.**
3. **Keynote invited speakers from the specialty may be paid expenses. These should be limited to four for a major national meeting and two for a SIG or Regional Meeting.**

4. **Special invited guests and Presidents of sister organisations may be offered complimentary registration.**
5. **That Fellows permanently retired from all medical and related practice be granted an exemption from the ASM and CME Meetings Registration. Such Fellows would be required to pay for the social activities.**
6. **That Fellows working in a missionary or similar field where income is small be granted a 50% concession from the ASM and CME Meetings Registration. Such Fellows would be required to pay for the social activities.**
7. **That registered ANZCA trainees be granted a 25% concession from the ASM and CME Meetings Registration. Such trainees would be required to pay for the social activities.**

CONTINUING MEDICAL EDUCATION AND QUALITY ASSURANCE

Annual Scientific Meeting 1995

Council agreed to fund an official Faculty of Intensive Care Visitor to this Meeting in Townsville.

Annual Scientific Meeting 1997

Council accepted the recommendation of the New Zealand Regional Committee that the 1997 Annual Scientific Meeting be held in May in Christchurch, New Zealand.

INTERNAL AFFAIRS

The Faculty of Intensive Care representation on College Committees

College Council resolved to include a representative of the Faculty of Intensive Care on the Education Committee, General Examinations Committee and Continuing Education and Quality Assurance Committees.

Memorandum and Articles of Association

Following the disbandment of the Faculty of Anaesthetists by the Royal Australasian College of Surgeons, and the establishment of the Faculty of Intensive Care within the Australian and New Zealand College of Anaesthetists, Council proposed amendments to the Memorandum and Articles of Association. These proposed amendments will be forwarded to the Fellowship shortly.

Statement on AIDS and Hepatitis

Council approved a Statement on this topic which is published elsewhere in this *Bulletin.*

AMA CRAFT Group

Council supported the nomination of Dr Michael J. Hodgson as the AMA CRAFT Group representative for Anaesthesia.

CIREBA Meeting

Council agreed to offer to host the Conference of International Reciprocating Examining Boards of Anaesthesia in Melbourne associated with the World Congress of Anaesthesiologists in April, 1996, in Sydney.

College Logo

Following consideration of a submission, Ms Phillipa McConnel was requested to proceed with the design of a College logo.

FEMALE ANAESTHETISTS - ASA QUESTIONNAIRE 1993

'Does gender matter in the pursuit of a career in anaesthesia?'

PRELIMINARY REPORT

METHOD AND RESULTS

Of the 298 Questionnaires sent, 199 were returned (67%). The questionnaire was in 8 sections: only 5 sections (ACFGH) will be reported here. The results of the remaining sections will appear in a subsequent edition of the *Bulletin.*

SECTION A: GENERAL INFORMATION

A1: 114 respondents gave their names (57%). 85 (43%) remained anonymous.
A2: The age range was from 77 (born 1916) to 28 (born 1965). 50% were over 40; 50% were under 40.
A3: 32 (16%) had a medically qualified parent.
A4: 115 (56%) are currently working full time, (3 variable, depending on work); 68 (34%) part time; 14 (7%) were retired; 82 (41%) VMOs [20% full time, 21% part time]; 43 (21.5%) Staff specialists [18% full time, 3.5% part time]; 13 (6.5%) Full time private; 15 (7%) Part time private; 12 (6%) Registrars; 6 (3%) Directors; 4 (2%) Academic [3 overseas]; 4 (2%) Provisional Fellowship year [1 part time]; 2 (1%) Overseas/part time.
A6: The number of respondents from each state was approximately in keeping with state populations:
NSW 60 (30%); VIC 52 (26%); QLD 34 (17%); WA 13 (7%); TAS 3 (1.5%); ACT 2 (1%).

SECTION B: MEDICAL CAREER

In section B, the respondents were asked for the names of role models. Many respondents quoted anonymous men and women: heads of department, sessional anaesthetists, VMOs, staff specialists, parents, siblings, friends, etc, but many were mentioned by name as inspiring and encouraging the respondents to take up anaesthesia as a career.

SECTION C: ANAESTHETIC CAREER

C12: Dates of obtaining the Fellowship were from 1951 to 1993; there were 6 with a diploma in anaesthetics, and 3 who practised as specialists under the grandmother clause. 10 (5%) were registrars.
C13: 137 (69%) respondents had the Australasian Fellowship; 17 (9%) had two Fellowships.
C14: 115 (58%) had passed their exams at the first attempt; a further 53 (27%) had passed either the primary or the final at their first attempt.
C15: 32 (16%) thought that there had been a bias against females for acceptance into the training scheme.
Some older women reported instances of blatant discrimination which today would be unthinkable. In recent years attitudes have improved considerably.
C16: "Have you been offered advancement in your career in return for sexual favours?" Two respondents said Yes! Three others made comments: "Not so far!". "Not as a serious suggestion". "So what's wrong with me?" (You guys can't win!)
C17: 41 (21%) had been subjected to sexual harassment at some stage in their careers. Very few of the offenders were anaesthetists – some were surgeons. One surgeon used to steer his female resident around corners with his hand on her bottom. One senior woman anaesthetist said she had both received and given sexual harassment.
C18: Were there any unacceptable questions in your job/exam interviews? No: 142 (71%); Yes: 53 (27%).
Many cited unacceptable questions on boyfriends, plans for marriage, husbands' jobs, plans for pregnancy, arrangements for childcare etc. One or two commented that such questions were fair.
C19: Were you treated unfairly during your training because of gender/pregnancy/marital state? No: 146 (73%); Yes: 50 (25%).
One respondent was put on cardiac arrest call when advanced in pregnancy.
C20: Were you given special consideration, fairly or unfairly, due to gender/pregnancy/marital state? No: 140 (70%); Yes: 55 (28%). 5 (2.5%) said they were treated unfairly; 24 (12%) said they were treated fairly.
C21: Would you like to see more flexibility in the training scheme? Yes: 157 (79%); No: 28 (14%).
C22: What changes would you like to see in the training scheme? **A** Part-time training = 105 (53%); **B** Job Sharing = 104 (52%); **C** After-hours commitment = 20 (10%). Several respondents made the comment that out of hours experience was very important and that the trainees **must** do their equal share of this component; **but:** part time training does **not** imply **less** training. It merely means that such training is completed in more than the full time trainee's allotted time span. **D** Travel with training to be more flexible = 13 (7%). **E** All of the above options = 17 (9%). Some respondents expressed concern at the number of female trainees dropping out of the training scheme.
C23: Does being a woman make it more or less difficult to get a job? Nearly a half said: No difference = 94 (47%); Over a quarter said: More difficult = 54 (27%); Less difficult = 9 (5%). Six (3%) said there was no difference with public jobs but private jobs were more difficult.

SECTION F: PART-TIME WORK

F37: Have you done/do you do part-time work? Over half had worked part time: Yes: 112 (56%). A third had **never** worked part time: No: 66 (33%). From Section A, 115 are currently in full time work (3 variable), 68 are in part time work, 14 are retired.

F39/40: 83 (74%) of the 112 who had done part time work had done so due to domestic commitments. 19 (28%) of the 68 respondents who are currently working part time were intending to return to full time work. Some respondents made a plea for hospital creches.

F41: Should professional bodies grant fee reductions for practitioners working part time? Yes: 133 (67%); No: 21 (11%). It was mentioned that this should be available to **all** doing part time work, not just women, and should include various concessions for retirees. Several mentioned specifically the medical defence societies' subscriptions.

SECTION G: PRIVATE PRACTICE

F42: Have you worked in private practice? Yes: 149 (75%); No: 44 (22%). Many made comments about regular and "sought after" lists being alloted to males, and comments about the "old school tie" and the "old boy" network. Many said that women were looked upon as less reliable, and not serious about their career. Several comments were made about the difficulty or impossibility of admission to existing male groups. One senior female anaesthetist approached a private group recently and was told "we don't take women". Several made comments that private practice was a good area for part-time work. Others disagreed. A few said there were no problems. In this section, as in all sections, there was a very wide range of opinions in comments made.

SECTION H: SERVICE ON COMMITTEES

H49: Have you served on any professional committees? Yes: 97 (49%); No: 101 (51%).

H50: Have you ever been approached to serve on committees? Of the 101 respondents who had not served on committees: 82 (81%) had not been approached; Only 16 (15%) had been approached and refused.

H51: Reasons for refusal to serve on committees: Family commitments 3; no time 8; domestic 1; personal 1; other 3.

H52: If you have not already served, would you do so in the future? Of the 101 who had not served: Yes: 56; No: 30. Maybe: 9. Two respondents mentioned that they were on an ASA committee, but did not want to be State Chairman – one gave family commitments as the reason.

SUMMARY:

From this preliminary analysis, there seem to be many problems to be addressed; it is very difficult to reach acceptable compromises, both in attitudes, and in practice, between the careers of women and their necessary biological function of child bearing (and, to a lesser extent, their usual role of child raising).

Female anaesthetists, like most women, usually have the primary care of the young, and attitudes of employers, colleagues and officials to the inevitability and importance of this role, and the need for child care facilities, are not yet universally acceptable. Career compromises are still frequently made by women as mothers and wives and occasionally, but less frequently, by men, as fathers and husbands.

I believe this survey shows that there is a need for more acknowledgement of this career compromise, and more exploration of ways to coordinate parenthood and careers to the detriment of neither. One area that stands out as requiring a change in attitude is that to part-time practice. Many respondents commented that, as part timers, they were regarded as less capable, less serious about, and less committed to, their careers, less available (even when fully available), and resented for a variety of reasons.

Our overall image as female anaesthetists is also somewhat poorer than that of our male colleagues. They at least do not get called "nurse" by patients, as did many of the women who responded to the survey.

After 25 years in anaesthesia, 20 of them full time, I was asked by a young surgeon recently if I was a career anaesthetist.

Hopefully by identifying these problems we are halfway towards solving them: we can now explore possible solutions; more flexibility in training schemes, and a change in attitude of some colleagues and surgeons, may be two appropriate areas in which alterations of current attitudes and practice could now occur.

DIANA C STRANGE KHURSANDI

FACULTY OF INTENSIVE CARE

Participation in Faculty Activities

The Faculty wishes to assure all Fellows of the College who have an interest in intensive care that they are welcome to attend and participate in its scientific and education meetings. Similarly, Fellows of the College are welcome to communicate with the Faculty on any matters relating to intensive care.

Annual Scientific Meetings

i. 1994

Support is sought for our College's first stand alone Annual Scientific Meeting at Launceston, April 1994. The intensive care contribution follows the format of previous years, being a full day's session for intensivists, and anaesthetists with intensive care interests.

ii. 1995

Note that for next year's meeting in Townsville, the Faculty will provide a full two day intensive care meeting (Saturday afternoon to Monday morning), so you are urged to plan ahead. Approval has been granted for an official Faculty Visitor for this meeting.

Other Faculty Matters

Since the inaugural Board meeting of the Faculty of Intensive Care in October 1993, the Board has met on two further occasions (December 1993 and February 1994). Much has been achieved.

Regulations

The Faculty now operates under its Regulations (which have undergone further revision) as well as the Memorandum and Articles of Association of the College. These Regulations are seen as a practical set of rules under which to operate and will be further supported by Administrative Instructions.

Administrative Instructions

So far, Administrative Instruction 1, dealing with training and examination has been completed. This document incorporates important changes which affect training requirements for trainees commencing training in approved vocational posts on or after the commencement of the 1994 hospital year. Compulsory time in anaesthesia has been reduced to one year. The training period involving various options is now 18 months with:

2 years of intensive care (compulsory)
1 year of anaesthesia (compulsory)
6 months of medicine (compulsory).

Optional training may be 18 months in any combination of:

a. general medicine
b. specialist medicine
c. emergency medicine
d. surgery
e. research (limited to 1 year)
f. intensive care
g. clinical anaesthesia
h. other discipline related to intensive care.
(Note that any such training must comply with the details set out in the AI-1 document).

These changes allow greater flexibility in content of training. A person wishing to become doubly qualified in anaesthesia and in intensive care can still "count" 2½ years of anaesthesia from approved training posts. One could envisage other situations where 18 months surgery or two years medical training might form part of the 5 years of approved training programme. Another scenario might be 3½ years intensive care, one year anaesthesia, and 6 months medicine.

FFICANZCA

The above acronym as the post nominal of Fellows of the Faculty of Intensive Care has been approved by the Board. The Registrar of the College has written to the New Zealand Medical Council, the Medical Boards in the various States and Territories of Australia, the National Specialist Qualification Advisory Committee (NSQAC), and the General Medical Council UK, requesting recognition of the qualification for specialist registration purposes.

Policy Documents

So far six Policy Documents have been extensively revised and approved. Others require further work and discussion with other bodies such as ANZICS, Australasian College for Emergency Medicine, etc.

The following documents have been approved:

IC-2 "The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts".

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

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

IC-5 "Duties of Regional Education Officers in Intensive Care".

IC-6 "Supervisors of Training in Intensive Care".

IC-7 "Secretarial Services to Intensive Care Units".

IC-1 "Minimum Standards for Intensive Care Units" is in the final review stage. Other documents require further work.

Supervisors of Training and Regional Education Officers

Supervisors of Training in Intensive Care now become the Faculty Supervisors of Training. Similarly, the Education Officers in Intensive Care in the various States and regions of Australia and in New Zealand become Faculty Education Officers.

Regional Representation and Lines of Communication

Currently the regional representative of the Faculty is the Board member in a given region. If a region does not have a Board member then the Regional Education Officer for Intensive Care becomes the regional representative. Such regional representation by either of these people is covered by the Regulations of the Faculty, but is essentially an interim measure until Regional Committees of the Faculty are established.

It is anticipated that the newly elected Board (to take office in June 1994) will instruct the Regional Education Officer in each region containing a significant number of Fellows of the Faculty to call meetings for the purpose of election of Office Bearers for the Regional Intensive Care Committee. These committees will handle local affairs affecting intensive care and can refer matters back to the Board where appropriate. Such committees will also take over the role of providing the local member for an inspection team, for commenting on future policy documents etc.

An Elected Board of Faculty

The interim Board will be replaced by an elected Board. Fellows will have received notification, with a call for nominations (closing at 5 p.m. on the 31st March 1994) for eight positions on the Board. The results of the poll will be announced at the Annual Meeting in June.

Liaison

An exploratory meeting was held between the Dean, Chairman of Examinations, and Education Officer from the Faculty, the Chairman (Board of Censors), Chairman (Committee of Physician Training) and Chairman (SAC) from the RACP, and the President and Secretary of ANZICS.

Similarities and differences between the two training programmes and methods of assessment were reviewed. Other models of joint training programmes were also considered (the haematologist/pathologist scheme and the nuclear medicine training programme).

The likely outcome of this meeting is that:

i. A liaison committee of the Faculty, ANZICS, and the Specialist Advisory Committee in Intensive Care (RACP) will be set up to consider matters of policy and standards affecting the practice of intensive care.

ii. A committee of FICANZCA and RACP Fellows with ANZICS representation is to look into training and assessment of intensive care trainees.

Admission of Fellows

As previously advised, Fellows of the College endorsed in Intensive Care were admitted as the Foundation Fellows of the Faculty.

Subsequently, the following have been admitted to Fellowship:

By Examination:
Peter van Heerden, WA
Christopher Anstey, QLD
Ian Jenkins, WA
John Gallagher, SA

By Election:
Lindsay Worthley, SA
Geoffrey Barker, Canada

A welcome is extended to these new Fellows of the Faculty.

Ron Trubuhovich
Vice-Dean.

Geoffrey M. Clarke
Dean.

OBITUARY

DR MATTHEW SPENCE

Dr Matthew Spence ("Matt"), the first full-time intensivist in Australasia, died from a heart attack in his car while going boating on the morning of October 27, 1993.

He was born in Scotland in 1918. During World War II he doubly qualified both in medicine and dentistry, and was posted to India in the Royal Army Medical Corps. Post-war he obtained his DA then FFARCS Eng. Rebelling against the (then) English medical system, he emigrated in 1954 to New Zealand "for two years", to a full-time specialist post in Anaesthesia at Auckland Hospital. He received his FFARACS in 1954. Once he was settled here, none could have embraced his adopted country more firmly. He loved the sailing and fishing it provided for him.

In 1955 Matt Spence became interested in working with the infectious diseases physicians to try to stop people dying from acute ventilatory failure, initially from polio and tetanus. For the rest of the fifties he struggled to provide artificial ventilation for patients in scattered hospital wards, under the most adverse of conditions. By 1958 he had acquired dedicated bed space within the Infectious Diseases ward. This was New Zealand's first "intensive care unit", where he was also treating asthma, polyneuritis, barbiturate poisoning and chest injury.[1]

His efforts culminated in the commissioning of a free standing Acute Respiratory Unit, opened in 1962, to which Matt Spence was appointed Medical Officer in Charge.[2] Although mechanical ventilation for ventilatory failure was becoming increasingly accepted by this time, it was typical of Matt Spence to be one jump ahead, and early on he was placing endotracheal tubes in patients otherwise dying from reversible acute airway obstruction, particularly from paediatric causes. In the early sixties this bold innovator quickly extended his activities to treatment of acute brain failure, particularly following cranio-cerebral trauma, after the lead from the American neurosurgeons Langfitt and Rosomoff. He treated meningitis and encephalitis patients for "acute brain swelling" and consequently, children became a considerable portion of his practice. Once Matt showed paediatricians that many of their patients should not needlessly die they became among his staunchest supporters.

When I first met him in 1964, I was fascinated by the diverse range of life-saving activities going on his his department.

Matt Spence and his unit had become well known and respected throughout New Zealand and Australia, and following a 1961 world tour in-depth study of intensive care units, also further afield. Through this time Matt maintained close links with his Australian colleagues of similar interests, Victor Hercus and John Stocks, among others.

Matt's Annual Reports were widely welcomed throughout Australasia (and in the foremost units in North America) as intensivists waited to read of new activities and treatments Matt was launching himself into. As well, they received an updated precis of relevant intensive care literature. (He was a voracious reader of the latest journals and Auckland Hospital's medical librarian received repeated complaints that they always seemed to be marked out to Matt Spence).

With the proliferation of intensive care units, Matt changed the name of his unit to the Department of Critical Care Medicine in 1972. It was moved to the new main building at Auckland Hospital in 1976, in a unit designed largely to his specifications. He ruled this kingdom with a very firm hand until he retired in 1983. After retiring he secured a part-time position at the Blood Transfusion Unit for a few years. He then joined the Accident Compensation Commission as a medical adviser until, on attaining his 75th birthday on September 4 last year, he was finally and reluctantly obliged to retire.

Together with Bob Wright, Matt Spence was co-founder of the Australian and New Zealand Intensive Care Society, ANZICS, from which so much of the strength of intensive care has derived in Australasia. The Society acknowledged his role with the striking of the Matt Spence Medal in his honour in 1981. It is now a highly sought after honour at the Annual Australian and New Zealand Scientific Meeting on Intensive Care. It was a touching scene when he presented "his" Medal at the ANZICS Meeting in Auckland last year.

Matt Spence's pioneering contribution to the development of intensive care in New Zealand and Australia has been immense. He always believed that intensive care was a full-timer's occupation, and his unit could be described as the archetype of completely full-timer units. About the time he started, any Australasian intensive care unit starting up was always within an existing department of anaesthesia. After his early days of working in collaboration with infectious diseases physicians at Auckland Hospital he set up a standalone intensive care unit, run full time independently of any other department, and responsible directly to the Medical Superintendent alone. His was a tremendous one man effort: this loner often battling with indomitable tenacity in the face of resentment and opposition. He had great courage in his own convictions, and was a pugnacious fighter for what he believed in. By sheer determination and unrelenting drive, he often carried the day by force of personality and character. He was no power maniac or empire builder, however. To him it was always "the patients" who mattered. Matt himself was exceedingly active in every aspect of patient treatment. He had little in the way of junior medical staff initially and the sheer personal input, especially in those early years, represented a staggering workload. He quickly acquired a reputation for "always being there" and being ready to take on cases others had already consigned to oblivion. It was an exceedingly demanding life which took a heavy personal toll both on his own health and his family life.

Matt rapidly gained a body of expert and incredibly loyal nursing staff to whom he always gave credit for the recovery of their patients. He was fiercely proud of his nurses and his junior staff, and protective of us all. The nurses loved him and the doctors respected and admired him, even if at times somewhat grudgingly. He did not suffer fools gladly. At times he appeared intolerant of the opinions of others and could be difficult to work for. At the same time, he rewarded hard work and initiative with respect and attention.

The ideas of registrars were to be translated into action only after the most careful scrutiny and often vigorous argument and heated debate. Out of this evolved respect and support and later friendship.

Matt Spence was a bold and visionary clinician who encouraged us all to attempt the impossible and to expect miracles. He would countenance no defeatism ("If you don't bloodywell try you will always be right"). Under such advocacy for his patients, we who followed him learnt to perform and were rewarded by all the miracles which are critical care at its best. As a clinician he was instinctive: he saw subtle signs of complications and reacted to them while at times we might wonder what he was talking about.

Some found his intuition uncanny. Eventually we learned to attend to the nuances of our patient's progress and react in the instinctive way which the expert taught us.

He inspired many of us to a career in intensive care. In a very real sense we in New Zealand, and particularly those of us fortunate enough to work in his department (DCCM), stand on his shoulders. Were it not for him we would not be in the strong position in which we find ourselves today. Were it not for his vision we would not continue to expect so much of our selves and for our patients.

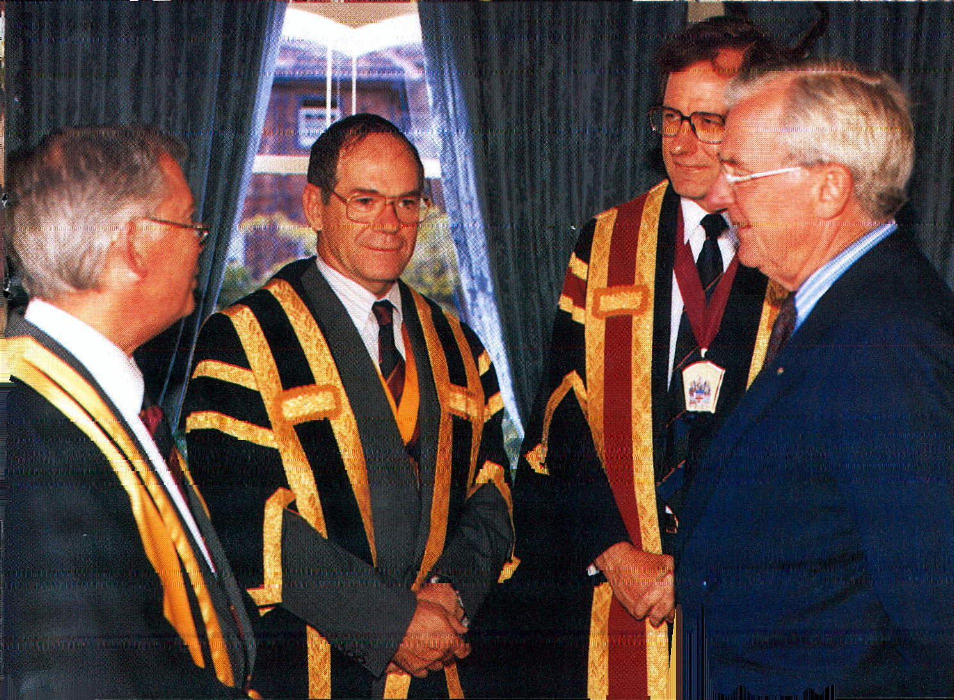
Matt Spence, we salute you.

R V Trubuhovich
Chairman, DCCM
Auckland Hospital.

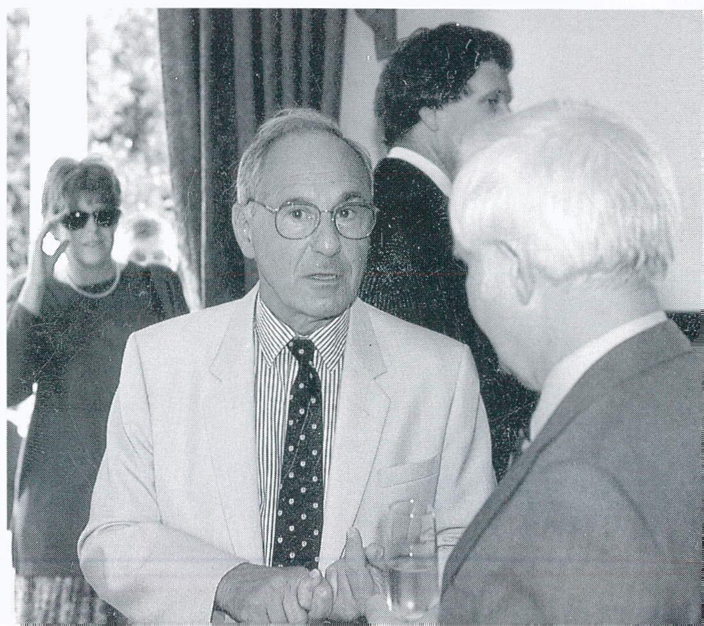
Matt Spence is survived by his ex-wife Barbara, his son Grant, a general practitioner in Auckland, and daughter Robyn, who lives in Sweden where she works for Astra.

References: by Matt Spence

1. The Emergency Treatment of Acute Respiratory Failure. *Anesthesiology 1962;* **23**, 524-37.
2. An Organisation for Intensive Care. *Med J Aust* 1967; **1**, 795-801.



ULIMAROA
WAS OFFICIALLY OPENED
AS THE HEADQUARTERS OF THE
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS
BY
THE HONOURABLE BILL HAYDEN, AC
GOVERNOR-GENERAL OF THE
COMMONWEALTH OF AUSTRALIA
ON 19TH FEBRUARY, 1994



LAW REPORT

Michael Gorton, LL.B, BComm.
Partner, Abbott Tout Russell Kennedy, Solicitors

DOCTORS' RECORDS

With recent trends to promoting "patient's rights" and greater emphasis on those rights by the courts, there have been some recent subtle developments for the medical profession in relation to ownership of, access to, confidentiality and privacy of doctors' and patient' records.

The recent case of *Rogers v Whittaker*[1] in Australia has revised the obligations of a doctor to inform a patient of relevant aspects of medical treatment. That case is recognised as increasing the legal burden of doctors generally in their relationship with patients. Further trends in State and Federal legislation and decisions by the courts may now impose greater obligations on doctors in relation to the confidentiality of and access to patient records.

OWNERSHIP

It remains generally recognised that records made by a doctor in the course of a patient's treatment are owned by the doctor. The records are created for the doctor's purposes to assist in treating the patient and are therefore the doctor's property and are not "owned" by the patient. However, under certain circumstances, discussed below, the patient may have a right of access to such records.[2]

This general principle differs in the case of reports obtained by the doctor on a patient's behalf (e.g. pathology, radiology etc.), especially where the costs of the reports are met by the patient or his or her relevant health fund. In circumstances where a report is obtained by the treating doctor at the cost of the patient, it is generally regarded that such reports are "owned" by the patient. In Victoria there is a legislative requirement for a patient to receive a copy of any radiograph upon written request by the owner of an ionising radiation apparatus used for radiological purposes.[2A]

In addition, a recent Canadian Supreme Court case,[3] following American precedents, has suggested that a doctor has a general duty to give patients access to their records. The imposition of such a legal 'duty' on doctors represents a unique development in the thinking of courts. Whilst that case has not as yet been adopted in Australia, given recent trends, it provides a salutary warning as to the likely path such matters may follow in the future. If adopted in Australia any patient records and reports may be accessible by patients. Consultants and specialists in particular might have their reports made available to relevant patients through their referring doctor (without the permission or even the knowledge of the consultant or specialist).

The principle that a doctor has ownership of medical records produces complications for doctors practising through public and private hospitals and doctors practising in partnership or through private companies. Records created within a public or private hospital are likely, in most circumstances, to be the medical records of the hospital and therefore "owned" by the institution. Similarly, records created by doctors in partnership or where a doctor is the notional employee or contractor of an incorporated medical practice may find that the medical records created are in fact owned by the partnership as a whole or owned by the private company. Whilst this is unlikely to produce any problems in most circumstances, in the event of a partnership dispute or a falling out between the doctors engaged jointly through an incorporated medical practice, a dispute as to ownership of medical records may produce unwanted results. The retiring doctor in a dispute may find the medical records remain with the partnership/incorporated practice. This may produce difficulty for the doctor seeking to continue treatment for his or her former patients. These are certainly matters which should be dealt with in the terms of any partnership agreement or agreement in relation to an incorporated practice.

ACCESS BY PATIENTS AND OTHERS

As noted above, notwithstanding a doctor's ownership of medical records, a patient may in a number of circumstances be entitled to access to those records and to take copies.

Freedom of information legislation

At the present stage no State or Federal law obliges private doctors to provide patients with access to medical records regarding their private treatment, particularly in relation to records created by the doctor at their own practice or rooms (other than in Victoria in respect of radiographs). However, freedom of information legislation of the Federal Government and most State and Territory Governments now provides a general right of access to patients' medical records in public institutions.[4] The provisions of the various Federal and State laws are not uniform and some issues remain as to:

- whether it is the patient solely or the patient's guardian or legal representative who may seek access
- precisely what information a public institution may be required to provide (and whether a summary is sufficient)
- whether the public institution is required to provide any follow up information in the event of any queries which may arise.

In some States, even access to records in private hospitals may, under certain circumstances, be provided to patients. For example, in New South Wales a licensee of a private health establishment may be required to provide access to patients' or residents' records.

Most Freedom of Information legislation contains an exception for the disclosure of information or records which may be prejudicial to the health or well-being of the patient (e.g. Victorian Freedom of Information Act 1982/Tasmanian Freedom of Information Act 1991).[5]

Litigation

Medical records may be accessed pursuant to a court order in the course of litigation. The access may be obtained by the patient or, in some cases, by a third party who is participating in the litigation, seeking details of the patient's medical history and records. In some States the privilege of a doctor's confidential relationship with a patient is protected at law, particularly in relation to civil rather than criminal proceedings.[6]

Research/Quality Assurance activities

There is no general right of access to patient records for those conducting bona fide medical research.[7] Clearly this would be a breach of patient confidentiality unless the express or implied consent of the patient has been provided. Some doctors may be surprised at this conclusion, since they may have been obtaining patient information for medical or clinical studies without the consent of the patient. Doctors should therefore be wary and acknowledge that obtaining such information without the consent of the patient may give rise to litigation for breach of confidentiality. Certainly doctors should avoid publishing any information of results which may identify a particular patient.

The Report on Confidentiality of Medical Records and Medical Research issued by the Law Reform Commission of Western Australia in August 1990[8] recognised the special position of researchers and the need for access to some medical records. The Commission recommended that access should be permitted to researchers on condition that the researcher is placed under an express legal duty of confidence to each patient whose record is provided, and that there would be a statutory civil remedy against researchers and other third parties who breach this general duty.

In addition, the Federal Government and some State Governments have enacted "Quality Assurance" legislation[9] which permits approved quality assurance activities to have access to information regarding patients (and doctors) on a confidential basis, and usually under the strict proviso that no information is used or revealed which may identify a particular patient.

Consent

As noted above, access to patient records by researchers, other treating doctors or the particular institutions in which treatment may take place can be freely given with the express or implied consent of the patient. For example, it is generally recognised that there is an implied consent for medical records to be communicated to other doctors or health specialists who may be involved in the course of a patient's treatment.[10]

A general right of access by patients?

As noted above, the Canadian Supreme Court decision in *McInerney v MacDonald* may herald the introduction of a general duty on doctors to provide access to medical records to the particular patient. We have yet to see whether such a principle is applied in Australia.

CONFIDENTIALITY

All doctors will be aware of their general duty to maintain patient information in the strictest confidence. The Hippocratic Oath, as developed in the common law of the United Kingdom and Australia, recognises the professional duty to maintain medical confidence as a fundamental legal principle, with legal liability attaching to any unauthorised breach.

Further, in Victoria, Tasmania and the Northern Territory the general legal position has been modified to some extent by legislation to protect the privilege attaching to medical confidentiality.[11] Under certain circumstances a doctor cannot be compelled in civil proceedings to disclose information which may breach the doctor's duty of confidentiality.

Accordingly, any doctor who proposes to disclose confidential information regarding a patient, must seriously consider the ethical and legal implications that may arise. Whilst there are some clear exceptions to the duty of confidentiality, the legal liability that may attach to any breach would suggest that the doctor should always obtain proper advice in such circumstances.

In general terms the exceptions to the principle of confidentiality are:

1. ***Legislative requirements***
   A doctor may be compelled to provide information under legislative provisions such as the Freedom of Information Act and other health related legislation.

   In addition, some States have now adopted a mandatory reporting regime for child abuse and other circumstances. There is a general duty on doctors to report such circumstances which would override the doctor's duty of confidentiality.

2. ***By court order***
   In the course of litigation, doctors may, by court order, be required to disclose confidential information. This is subject to those legislative provisions in some States where the privilege of confidentiality is protected in civil proceedings.

3. ***By consent***
   The express or implied consent of a patient will permit a doctor to reveal confidential information. Consent will be implied in the case of information provided by a referring doctor or where information would generally be required by other treating doctors in the course of the patient's treatment.

4 ***Possible harm to the patient***
   There is some support for the conclusion that where disclosure is required to prevent harm to a patient, the disclosure is permitted notwithstanding that the patient has not given any consent.[12] This is particularly so in the area of mental health where the disclosure of confidential information may be necessary to ensure that a patient receives proper treatment or where the possibility of further harm may arise without such disclosure (e.g. in the case of a suicidal patient). This general exception is tempered nonetheless by the doctor having to be satisfied that the disclosure of the information is necessary to prevent further harm to the patient.

   This exception is sometimes categorised as permitting disclosure "in the public interest", including circumstances where it is not necessarily further harm to the patient, but harm to others which may arise.[13] In the New Zealand case of *Furniss v Fitchett*[14] there was acknowledgement that in some circumstances disclosure of confidential information may be necessary in the public interest where the possibility of harm to the patient or to others arose. Similar issue arose in circumstances surrounding the Victorian "Queen Street killings" in 1987, where a counsellor/psychologist of the gunman may have been aware of a psychiatric disorder. The Coroner in that case suggested formal mechanisms for referral of such information where harm to the individual or others was possible. Of course, "mandatory reporting" has been a much debated issue, particularly in relation to child abuse. The Victorian Government has recently legislated for mandatory reporting in this area.

   There have also been cases where it has been suggested that a doctor may have a possible *duty* to warn of information, provided on a confidential basis, regarding the possibility of harm to others. In the United States case of *Tarasoff v Regents of the University of California*[15] a psychologist became aware of a threat by a patient to kill the patient's girlfriend. The psychologist issued no warning regarding this intention and the Court determined that the public interest required disclosure, which was not outweighed by the importance of preserving the confidentiality of the doctor/patient relationship. Similarly the English decision of *W v Egdell*[16] involved disclosure by a doctor without the patient's consent of information regarding the psychological state of a patient. The English Court agreed that although the doctor owed a duty of confidence to the patient, the doctor had an overriding duty to the public to put before proper authorities the doctor's opinions and reports in the public interest.

   Again, if the trends in these cases are followed in Australia, a general duty of disclosure may arise. A duty may be imposed on doctors to disclose confidential information where the public interest requires it. How a doctor is to determine what the public interest may require, what the full ramifications of the information may be and what other issues may be involved will no doubt produce further headaches for doctors!

PRIVACY

Whilst our general law has no legal right of privacy, the enactment of the Privacy Act 1988 in Australia and the Privacy Act 1993 in New Zealand have created some

limited forms of a right to privacy in particular circumstances.[17] For example, information regarding employment and credit of individuals now has some legislative protection.

The Australian Privacy Act also empowers the Privacy Commissioner to approve the creation of guidelines for the protection of privacy in the conduct of medical research, so long as the Commissioner is satisfied that the public interest in the promotion of the research is greater than the public interest in maintaining the right to privacy.

REFERENCES

1. Rogers v Whittaker 19 Nov 1992, 109 ALR 625.
2. CCH Australian Health & Medical Law Reporter, para 27-860.

2A. Ibid.

3. McInerney v MacDonald 93 DLR (4th) 415. See Australian Health Law Bulletin (1993) 1 HLB 99, Bunney, "Patients Rights of Access to Medical Records".
4. See (1993) 1 HLB 85, Cahill, "Qld Freedom of Information Act".

   Law Society Bulletin, June 1992, p.17.

   Bampton, "Hospital Records and The Freedom of Information Act 1991 (S.A.)"

   CCH Aust Health & Medical Law Reporter, para 27-870.
5. Ibid.
6. See Aust. Product Liability Reporter (1993) 4 APLR 73.
7. Alternative Law Journal, Vol. 17, No. 5, Oct 1992 — Otlowski, "Confidentiality of Medical Records", p.235.
8. Report on Confidentiality of Medical Records and Medical Research, Law Reform Commission of WA, p.11.
9. See Health Insurance (Quality Assurance Confidentiality) Amendment Act 1992 (C'lth).
10. Otlowski, op.cit., p.235.
11. Journal of Law & Medicine — Vol. 1, Oct. 1993 — Mendelson, "Mr Cruel" and the Medical Duty of Confidentiality", p.124.
12. Otlowski, op.cit., p.232.
13. Otlowski, op.cit., p.233.
    Mendelson, op.cit., p.125.
14. (1958) NZLR 396.
15. (1976) 551 P Zd 334; 118 Cal Reporter 129; 131 Cal reporter 14: See Mendelson, op.cit., p.123.
16. (1989) 2 WLR 689; see Otlowski, op.cit., p.233.

Dr Archie Brain presenting the President, Dr Michael Davies, with one of his three prototype laryngoscopes. He has presented one to the Royal College of Anaesthetists and maintained the third.

The Council and Fellows are most grateful to Dr Stan Schweitzer, his wife Maree, daughter Lucy and Dr Frank Liskaser, for their photographic record of the Opening of Ulimaroa.

DEATHS

Council noted with regret the following deaths:

DR W.L. FOWLES, QLD Foundation Fellow.

DR R J KILLALEA, NSW Fellow, FFARACS 1957, FANZCA 1992

DR M SPENCE, NZ Fellow, FFARACS 1954, FANZCA 1992

DR R WILLIAMS, NSW Fellow, FFARACS 1979, FANZCA 1992

DR A PHIPPARD, FRACP - Member Panel of Examiners

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 005 042 852

STATEMENT ON AIDS AND HEPATITIS

INTRODUCTION

The advent of the Acquired Immune Deficiency Syndrome (AIDS) and the ever present risk of Hepatitis infection have focussed the attention of anaesthetists and intensivists on these two conditions and the agents which cause them. The College's policies on the topic deal with:

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

1. ACCESS TO MEDICAL CARE

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

2. INFECTION CONTROL POLICY

These diseases can be transmitted by the transfer of body fluids from an infected individual to others. Known routes of transmission include inoculation via needlestick injuries, transconjunctivally or via breaches in the skin such as cuts and abrasions. It is extremely important, therefore, that the patient's attendants take adequate precautions against transmission of all blood-borne infectious diseases.

2.1 Protection of anaesthetists and other staff:

2.1.1 Vaccination:

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

2.1.2 Physical measures (universal precautions)

Objectives of these measures include:

i. Protection of the doctor or health care worker against contact with all patients' body fluids. Such measures include the routine wearing of gloves and eye protection. Special measures may be needed to protect against aerosols.

ii. To reduce the risk of cuts, needlestick injuries and skin lacerations. Such measures include the use of blunt rather than sharp drawing-up needles; the use of techniques other than injecting with a needle through a bung when administering drugs into intravenous lines; the immediate disposal of sharp needles and other sharp objects by the operator after use; never recapping needles; the use of PVC rather than glass ampoules.

   The need to adopt univeral precautions not only in the elective surgical setting, but also in emergency resuscitation is stressed.

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

2.1.3 Prophylaxis

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

2.2 Policy on testing for antibodies

While the importance of universal precautions is stressed, nonetheless when a patient whose history reveals the presence of risk factors for HIV or Hepatitis infection is to undergo surgery, it is important that where possible the patient's antibody status be known. The information should be available to the surgeon, anaesthetist and theatre staff before the anaesthesia begins.

Anaesthetists and intensivists who have reason to think they may be positive should be tested for HIV antibodies at appropriately frequent intervals. The purpose of such testing is to establish one's antibody negative status in case seroconversion should occur as a result of a subsequent needlestick injury or other occupational exposure. It also enables the anaesthetist or intensivist to reassure patients that those who perform invasive procedures on them have been tested and shown to be antibody negative.

2.3 Protection of patients

2.3.1 Blood transfusion

That HIV and Hepatitis can be transmitted to patients through blood or blood product transfusion

is well known. Measures to reduce the need for homologous transfusion such as autologous transfusion, haemodilution and blood scavenging should be employed where practicable.

2.3.2 Anaesthesia equipment

To date transmission of HIV via anaesthetic apparatus has not been demonstrated. Nonetheless, the theoretical potential for diseases to be spread by such a route makes the highest standards of cleanliness and hygiene mandatory.

3. HIV OR HEPATITIS POSITIVE ANAESTHETISTS OR INTENSIVISTS

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

4. GENERAL CONSIDERATIONS

Referral Policy

All hospitals must be capable of implementing the precautions described above. Referral of surgical patients to specialist units on the basis of antibody status alone is not indicated.

February 1994

ERRATA

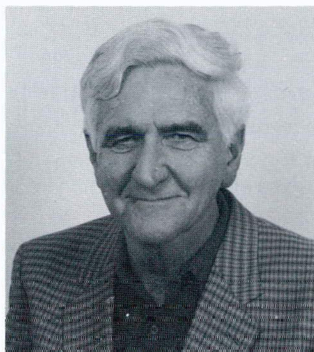
The insert titled *"Intraoperative Issues in Day Care Anaesthesia"* which was distributed with the November 1993 edition of the College *Bulletin* was erroneous in its reference to Dr Bruce Burrow's affiliation. Dr Burrow is Deputy Director of Anaesthesia and Medical Director, Day Surgery Unit, Princess Alexandra Hospital, Brisbane.

Photograph number 2 in the centre spread of the November 1993 issue of the *Bulletin* should refer to Mr Ian Crosby, not Mr Stuart Crosby.

THE FACULTY OF ANAESTHETISTS INAUGURAL FINAL FELLOWSHIP EXAMINATION

This Examination was held in 1956 soon after the formation of the Faculty of Anaesthetists. It is with much pleasure that I can report to Fellows the well-being of all six successful candidates, especially as four of these Fellows are close personal friends. The Fellows are:

Theresa Marie Cockbill (Swaney)
(Victoria)



Bernard (Bernie) Leslie Dunn
(Victoria)

Richard Ewart Rawstron
(New Zealand)

George David Robinson
(Victoria)

Betty Brenda Spinks
(Victoria)

Diana Nowlan Tolhurst (Furness)
(Victoria)

For the interest of Fellows and Trainees, I have reproduced the two Examination papers:

Faculty of Anaesthetists
Royal Australasian College of Surgeons
FINAL FELLOWSHIP EXAMINATION
ANAESTHESIA
1ST PAPER

Friday, 4th May, 1956
9.30 a.m. to 12.30 p.m.

All questions are of equal value
Candidates must answer FOUR questions

1. *Describe the aetiology of apparent cardiac arrest during anaesthesia and how it may be treated.*
2. *Discuss the indications for subarachnoid and epidural analgesia and the complications which may occur.*
3. *Write an essay on the use of Sodium Thiopentone in Anaesthesia.*
4. *State the chemical, physical and pharmacological properties of ethyl chloride. Describe the mode of administration of this drug and the danger involved in its use.*
5. *Discuss the significance of Respiratory Acidosis during general anaesthesia indicating the factors which favour its occurrence and the measures required for its prevention.*

Following the Opening of Ulimaroa, the President presented the Governor-General, Mr. Bill Hayden with an inscribed glass paper weight bearing the College Coat of Arms.

Professor Barry Baker presenting Dr Michael Davies with the President's Badge of Office.

LETTERS TO THE EDITOR

Dear Mrs Sheales,

re: National Day Surgery Committee

At the last meeting of this committee it was suggested that there are still a significant number of procedures which are suitable for day surgery but which, because of traditional patterns of practice, such patients are kept in hospital overnight. This pattern of practice has implications for noscomial diseases, reimbursement for public hospitals, and the financial viability of the private health funds.

Our surgical colleagues are to be asked by their respective organisations:

"To consider a list of procedures which should ordinarily be considered as acceptable medical practice to be day stay cases".

May I ask that publicity be given to this move and Fellows of the College be encouraged to participate in the discussion with our individual surgeons at appropriate moments? It is important that we ensure that standards are maintained, yet there must be change in patterns of practice. In particular it becomes imperative to allow time and place to complete a preoperative assessment with sufficient time for the patient to remember that oft forgotten elusive fact that turns out to be crucial to the anaesthetic management.

Yours sincerely,

ANDREW K. BACON
Victoria

□

Dear Madam,

re: Medical Manslaughter

This subject seems to be in the news both in the *Bulletin* and the Medical Defence Union *Journal* with Dr Lillienthal's editorial and David Collin's article in the *Journal.*

I was convicted of medical manslaughter in Christchurch in 1982. I subsequently appeared before Mr Justice DM Campbell sitting, with two medical practitioners, as the Medical Assessment Tribunal of the Medical Board of Queensland.

Mr Campbell was invited to accept the verdict and summing up of the N.Z. trial as evidence. He demurred; in an aside he confided, "I cannot possibly accept this; either the law in New Zealand is abhorrently strange or Doctor may have been wrongly convicted. This summing up clearly relates to a matter of civil negligence".

In reply to Mr Horton (Defence) who proposed to rely on the Summing Up of the Trial Judge; Mr Campbell remarked (Transcript P7 11s11-13). "But Mr Justice Roper may have misdirected the Jury. As far as I know, before a person can be found guilty of negligence in a criminal court (for an act) resulting in bodily injury or death, there has to be established what is called criminal negligence or gross negligence".

Later (Transcript P9 11 20-24) Mr Campbell continued, "Although Mr Justice Roper has been on the Bench for a long time, I think he may have misunderstood the law of New Zealand. I mean it places a very great responsibility on doctors if they are liable to criminal prosecution simply for ordinary negligence".

Later (P7 150), "It is a remarkably short summing up" and then (P9 11 43-48), "Of course the Board has before it Mr Justice Roper's direction of the Jury. They can see the dangers to the whole medical profession if this were to stand or be acted on even. It would put every doctor in Queensland in jeopardy so far as his individual liberty is concerned".

Finally on P 111 11 14-19 His Honour observes, "From the evidence we have heard, and I can only speak of that, (The Tribunal had the transcript of a 10 day trial before it), I myself would doubt that there would be even a prima facie case of manslaughter made against Dr McDonald".

From the foregoing it would appear that, at any rate in Queensland, if not throughout Australia, exhibitions of mens rhea, gross negligence, or reckless disregard of the public safety apart, successful prosecutions of this nature are unlikely.

Prudent avoiders might think twice before driving a car while touring in New Zealand.

Yours truly,

I R McDONALD
MB BS, DA, MFARACS
Queensland

HIGHLIGHTS FROM THE RACS COUNCIL MEETING HELD 24-25 FEBRUARY, 1994

PRESIDENT'S REPORT

Proposed Changes to the Health System
The President reported on a meeting held on February 5, convened by the AMA with representatives of various Colleges, Societies and Groups where widespread, although not universal opposition was raised to the Government's proposals for managed care.

Future College Training and Examining in Surgery
Council endorsed a draft letter from the President to the Minister for Health seeking the Minister's assurances (previously given verbally) that the Government had no plans to transfer surgical training, examining and certification from the Colleges to the Universities.

AWARDS, ELECTIONS AND HONOURS

Council extended its congratulations to the following recipients of honours and awards:

Awards in the Order of Australia
T S Reeve, AC; D S B Brownbill, AM; W B Conolly, AM;
V H Cumberland, AM; H D D Tyer, OAM

Louis Barnett Medal
Professor G J Clunie was awarded the Louis Barnett Medal which is awarded for significant contributions to education, training and advancement in surgery.

SCIENTIFIC MEETINGS

Annual Scientific Congress – Hobart 1994
Registration fees for the 1994 ASC have been maintained at the same level as for the 1993 ASC.

Annual Scientific Congress – Brisbane 1997
Mr David Robinson was appointed Convenor for the 1997 ASC to be held in Brisbane.

Farm Trauma Conference
A draft programme for a Farm Trauma Conference to be held in conjunction with Farmsafe Australia at the Charles Sturt University, Wagga Wagga, in October 1994 was noted.

EDUCATION

Continuing Medical Education
Three rural meetings are planned for 1994 in Dubbo, Cairns and Darwin.
$48,472.00 in CME funding is available for distribution.

Recertification
It was reported to Council by the Board on CME and Recertification that the overall response of Fellows to the Recertification Information Booklet distributed with the last edition of the Bulletin had been positive.

A surgical audit software programme was demonstrated to Council and information on this programme and its purchase is available from the College Secretary.

PROFESSIONAL AFFAIRS

Female Genital Mutilation
Council registered its opposition to any surgical procedures that cause female genital mutilation.

Clinical Practice Guidelines
A paper prepared by the Executive Director of Surgical Affairs on Clinical Practice Guidelines was before Council, and copies are available on request from the Secretary.

Government Proposals for the Reform of Private Health Insurance
This matter was discussed at length and a letter from the President outlining the position adopted by Council in response to the Government's discussion paper, has been distributed to all Fellows. Further copies are available on request from the College Secretary.

Maxillofacial and Craniofacial Surgery
The Board of Plastic and Reconstructive Surgery has been asked to develop a discussion paper on the current and future role of the College in Maxillofacial and Craniofacial Surgery.

HIV / AIDS
An amended College policy on the management of AIDS (HIV) and Hepatitis B was approved by Council and is available from the College Secretary.

New Technology
The Council Committee on New Technology is looking at the feasibility of introducing an electronic mail/bulletin board system of communication for Fellows.

Informed Decision Making
A policy on informed decision making was approved and is available from the College Secretary.

FINANCE

Remuneration of Honorary Officers
The current position whereby Honorary Officers of the College are not remunerated was reaffirmed by the Council.

INTERNAL

Election of Office Bearers
The following Office Bearers were re-elected: President, D E Theile; Vice President, J P Royle; Censor-in-Chief, B J Dooley, Honorary Treasurer, C U Mcrae.

Also re-elected were: Chairman, Court of Examiners, E H Bates; Chairman of the Board of Examiners, D H Grey.

Director of Development
Council appointed Ms Christine Hazel as Director of Development, to head a Development Office with the dual responsibilities of public relations and the generation of resources and funding for the College.

Research Ethics Committee
Council approved Terms of Reference and functions and composition of a Research Ethics Committee which emanated from the inaugural meeting of the Committee.

Divisional Group of Rural Surgery
Amendments to the Constitution of the Divisional Group of Rural Surgery were approved subject to their adoption by an AGM of the Division.

POLICY DOCUMENTS

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

E1 (1991)	Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Anaesthesia
E2 (1990)	Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Intensive Care
E3 (1989)	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 (1989)	Secretarial Services to Departments of Anaesthesia and/or Intensive Care
E8 (1991)	The Duties of an Intensive Care Specialist in Hospital with Approved Training Posts
E9 (1993)	Quality Assurance
E10 (1990)	The Supervision of Vocational Trainees in Intensive Care
E11 (1992)	Formal Project
E13 (1991)	Guidelines for the Provisional Fellowship Year
EX1 (1991)	Guidelines for Examiners with Respect to Candidates Suffering Illness (or Accident) at the Time of Examination
T1 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites
T2 (1990)	Protocol for Checking an Anaesthetic Machine Before Use
T3 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Units
T4 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT)
T5 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries
T6 (1989)	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 (1991)	Minimum Standards for Intensive Care Units
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
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

March 1994