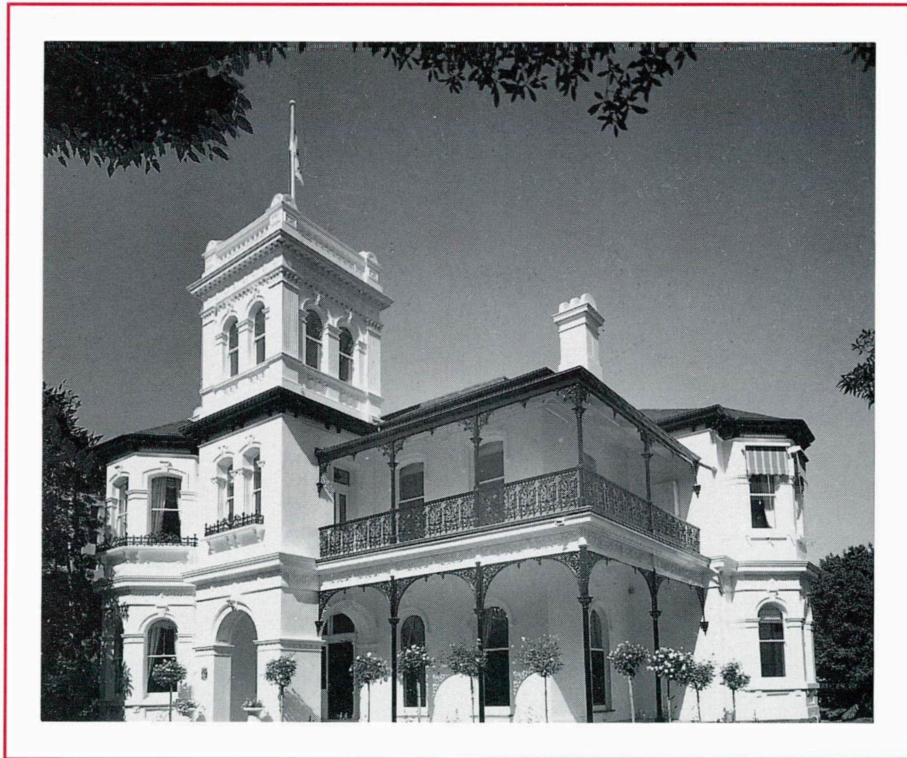
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852



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BULLETIN

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CONTENTS

Page	
1	President's Message
2	Presentation of Mace
5	ASM - Opening Address, Sir Guy Green
6	Excerpt from RACS President's Newsletter
	Honours and Appointments
7	Citation - M.A. Denborough - Honorary Fellow
	- A.B. Baker - Robert Orton Medal
9	Part-Time Training in Anaesthesia and Intensive Care
10	Citation - L.E. Mather - Douglas Joseph Professorship
11	- P.D. Livingstone - RACS Court of Honour
12	Tasmania - A Link in Our Past - G. Wilson
16	Photographs of Gifts to the College
18	Research Awards Advertisements
20	Fellows' Apparel
21	Faculty of Intensive Care
22	Law Report - M. Gorton - Leases
	- Sharing Practice
28	Intensivist's Prize
	Golf Tournament Results
	Regional Committee Reports
35	New South Wales
36	Western Australia
37	Victoria
41	Tasmania
42	New Zealand
44	Queensland
	Examination Prize Winners
45	South Australia
46	Australian Capital Territory
47	Annual Accounts
48-49	Pie Charts
55	Statement of Cash Flows
56	Honorary Treasurer's Report
58	Future Meetings
59	Overseas Meetings
60	Policy Documents Index

EDITORIAL

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

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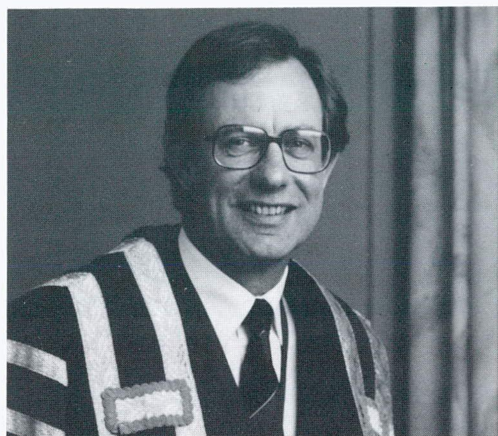
President's Message



The first independent Annual Scientific Meeting of the Australian and New Zealand College of Anaesthetists and the Faculty of Intensive Care has been a great success in Launceston. This was the first occasion in forty-two years that we have met as a separate College and Fellowship. Over four hundred Fellows supported this initiative by registering for this Meeting – the largest registration for any of our General Scientific Meetings.

Launceston was the site of the first administration of ether for a surgical procedure in Australia by Dr William Pugh in 1847 and it was appropriate that it be the site of our first independent Scientific Meeting one hundred and forty-seven years later. The scientific, social and ceremonial components of the Meeting were a great success attributed to the hard work, detailed planning and original initiatives by Mike Martyn and his Tasmanian Organising Committees, Joan Sheales and her staff.

The Scientific Programme organised by John Madden presented the registrants with a broad exposure to many different facets of Anaesthesia and Intensive Care. The Foundation Visitors – Professor Carl Hug and Dr José Carvalho, were excellent Speakers presenting many papers on their respective specialties of Cardiovascular Anaesthesia and Obstetrical Anaesthesia. Professor Laurie Mather, the Inaugural Douglas Joseph Professor of Anaesthetics, improved our knowledge of pharmacology and continued the tradition of ensuring that the Australasian Lecture remains a most important finale to our Annual Scientific Meeting.

There were 113 papers, Lectures or Posters presented at this Meeting with contributions from all parts of Australia and New Zealand and a number of international contributions. The programme was strengthened by Sessions organised by the Special Interest Groups of Day Care Anaesthesia, Cardiothoracic and Vascular Anaesthesia, Rural Anaesthesia, Anaesthetic Research and Neuro Anaesthesia.

The College Ceremony was a very impressive occasion. Mr David Theile, President of The Royal Australasian College of Surgeons presented our College with a stunningly beautiful Ceremonial Mace – a most generous gift. The Stage Party consisted of many representatives of our Sister Medical Colleges and other Medical Organisations as well as many international anaesthetic organisations. Their presence added significantly to the importance of the occasion. Dr Bob Brown delivered a thought-provoking oration and the historical re-enactment of Pugh's first anaesthetic administered in 1847 received audience acclaim.

The College was presented with generous gifts from the Royal College of Anaesthetists, the Academy of Medicine of Malaysia and the Royal College of Anesthesiologists of Thailand which are depicted in this *Bulletin.*

Dr John Hains, on behalf of the Australian Society of Anaesthetists, presented the portrait of our first President – Associate Professor Peter Livingstone. Two of our Fellows – Dr Gwen Wilson and Prof. Bernard Brandstater – each presented us with a magnificent historical book. All these gifts are now displayed with great pride at Ulimaroa.

The social programme organised by Rob Paton rivalled those of any previous Meeting. His ideas were original, well thought out and carefully executed such that they were thoroughly enjoyed by all in attendance.

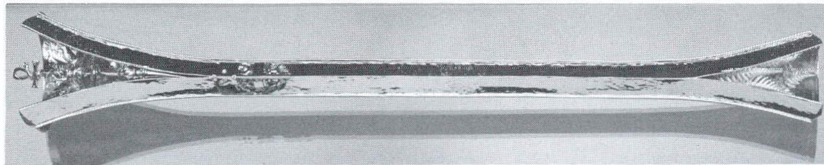
The Accompanying Persons programme organised by Elaine Blaxland and Caroline Fraser was well received, being both varied and innovative. The Health Industry Exhibition was described by that industry to be their best exposure at any Meeting for some time. Stewart Bath was responsible for this aspect of the Meeting.

Anaesthesia and Intensive Care had considerable press coverage during the Meeting in Launceston and Hobart with some national exposure. This was our best publicity from any of our Meetings.

There is no doubt that this Meeting has created a new vitality, a new intangible feeling amongst the Fellowship of our College and Faculty. We should capitalise on this by promoting our specialties of Anaesthesia and Intensive Care at every opportunity.

MICHAEL DAVIES

PRESENTATION OF THE COLLEGE MACE



The College Mace was presented by Mr David Theile, President on behalf of the Royal Australasian College of Surgeons, at the commencement of the Annual Scientific Meeting at The Albert Hall, Launceston on 30 April, 1994.

Mr President, Your Excellency, Ladies and Gentlemen,

On behalf of the Royal Australasian College of Surgeons I wish to present to the Australian and New Zealand College of Anaesthetists a Ceremonial Mace. This mace of sterling silver gilt, with Argyle diamonds, was crafted by Flynn of Kyneton to a design to which senior office bearers of your College brought from your heraldry, emblems which recognise the origins, materials and ethos of Anaesthesia as well as the Southern Cross and sprays of wattle and fern giving recognition to the two countries of your College.

Mr President, will you accept this gift as a demonstration of our part in your history and a permanent expression of our good wishes for your future. May this mace serve your College well as a symbol of authority.

DAVID E. THEILE

Your Excellency, Mr Mayor, Distinguished Guests, Ladies and Gentlemen,

Welcome to the College Ceremony of the first independent Scientific Meeting of the Australian and New Zealand College of Anaesthetists. On behalf of the Fellows of the College, I would like to thank the Royal Australasian College of Surgeons for this most generous gift. The mace is a symbol of authority for our College and it is most appropriate that it be given to us by the College of Surgeons with whom we were associated for forty years as the Faculty of Anaesthetists.

This mace was designed using the symbols incorporated in our College Crest which represent the origin of our specialty. The Registrar, Joan Sheales, had a major input into the design which was beautifully crafted by the Flynns of Kyneton in Victoria. I would encourage you to take the opportunity to study this magnificent gift from the College of Surgeons which will remain on display after the ceremony tonight.

MICHAEL J. DAVIES

In 1993 the College commissioned Dan and John Flynn to design and create a College Mace. During the early stages of design, the Royal Australasian College of Surgeons offered the Australian and New Zealand of Anaesthetists this most generous gift.

The brothers, together with their mother, Mrs Catherine Flynn, continue the successful artistic family business established in 1949 by their father Dan, one of Australia's foremost silversmiths. This creative man is described as a prince of all trades who could turn his hand to many crafts. Following father Dan's training as an engineer, his interest in fashioning items from silver and gold soon became his love and profession. He was self-taught, studying the art from books, museums and important artefacts displayed in art galleries.

The Flynn brothers, similarly to father Dan, did not pursue their original careers. John, 38, trained as a zoologist and Dan, 36, as an architect. The Flynn brothers have carved a niche in Australian and overseas markets with their production of presentation items hand-crafted in silver. Pieces of Flynn silver now reside at Buckingham Palace, the White House and a number of royal houses in Europe. Silver pieces made by the brothers are presented to distinguished people overseas and at home by the Commonwealth and State Governments. The brothers turn silver, crystal and opal into unique works of art often on special commission from

major corporations, churches and individual connoisseurs. A Flynn-made chalice of silver and opal was used by Pope John Paul II at his Melbourne Mass in 1986. Recently, a magnificent glass paperweight topped by a sterling silver platypus was selected as Australia's gift to more than 40 visiting heads of state. The Flynns use native Australian flora and fauna as motifs for their creations in jewellery, decanters, bowls, cufflinks, teaspoons and many other gifts. Flynn's distinctive marks, which include a Celtic cross, are now registered at the London Goldsmiths Hall.

The design of the College Mace, with input from the College Registrar, Mrs Joan Sheales was derived from the Armorial Bearings of the College and was based around a lily to symbolise the creation of the new College of Anaesthetists.

This design was developed using the rich symbolism of the Armorial Bearings and based on the form of a lily containing elements from the College Arms. Australia and New Zealand are represented in the Head of the design with the fern and wattle cast in silver and silver gilt respectively. An inscription inside the lily denotes the presentation from the Royal Australasian College of Surgeons.

Moving up the stem, the shield is cast in relief with the Victorian Southern Cross set with Argyle diamonds sized in proportion to the star's brightness. The charges in the four quadrants, being the four plants which symbolise the pharmacology of anaesthesia, have been interpreted on a larger scale than in the shield to emphasise their differences.

With the College's close ties to the Royal Australasian College of Surgeons, the Torch of Glory sits in a position of greater prominence above the shield. There the torch supports the Crest as depicted in the Armorial Bearings and is surrounded by the motto engraved on the inside face of the lily form.

Materials used in the construction of the Mace include 3000 grams of sterling silver, heavily plated gilt sterling silver and five Argyle diamonds, totalling 33 points. It was cast in 19 separate pieces using the lost wax process at the Kyneton workshop by Dan and John Flynn, who consider our College Mace to be the most important commission undertaken by them to date.

The Mace was commissioned and made during 1993 and early 1994 prior to presentation to the College by Mr David Theile, President of the Royal Australasian College of Surgeons, at the Annual Scientific Meeting in Launceston 30 April 1994.

The design of the Armorial Bearings was crafted to include the Australian and New Zealand origins of the College, the College's derivation from the Faculty of Anaesthetists, Royal Australasian College of Surgeons, and the links particularly in intensive care with the Royal Australasian College of Physicians. The College's geographical place in the world, and the place of its headquarters (incorporation and College building) were also featured, as was the dependence of the specialty on anatomy, physiology and pharmacology, each depicted in the Arms.

The Supporters were chosen as very famous historical figures whose work was vitally important in changing not only knowledge, but the way in which people thought about that knowledge. Andreas Vesalius is on the left. He lived in Padua in the 16th century and his anatomical work *De Humani Corporis Fabrica* published in 1543 changed anatomy because it overthrew the Galenical dogma (based largely on apes and monkeys) with human cadaver dissection, and the scientific view of challenging dogma by direct experience. Vesalius was also the first person to show that an animal who had ceased to breathe could be resuscitated by using artificial respiration through a reed inserted into the windpipe – hence in the Arms he is holding a bellows to signify this act which is reproduced each day by anaesthetists. The bellows also signifies the experimental scientific basis of the specialty following the lead of Vesalius. His view is outward looking to signify his broad academic outlook and to indicate the widespread place of artificial ventilation in anaesthesia and intensive care.

William Harvey, who lived in England in the 17th century, but who had studied in Padua in Italy is depicted on the right holding a book with a heart etched on the front cover. The heart and book represent the contribution made by Harvey in 1628 when he published *De Motu Cordis* which for the first time described the circulation of blood through the lungs and around the body. The book also symbolises the College's respect for academic learning. Harvey looks towards Vesalius to explain that the discovery of the circulation depended on prior anatomical description by Vesalius and others (i.e. physiology followed anatomy), and also because Harvey studied in the Italian Medical Schools which were made famous largely by the reputation and attitudes flowing from Vesalius.

These two Supporters represent the heritage of the specialty based as it is on respiratory and cardiovascular physiology together with anatomy and physiology. The place of pharmacology which is the third scientific base for the specialty is addressed by use of the botanical specimens in the Charges of the Shield.

The Supporters stand on land separated by water which forms the Compartment of the Arms. These separate

lands signify not only the countries of Australia and New Zealand, but also the separation of the New World of Australasia from the Old World of Europe (and the Not-So-Old World of North America where anaesthesia was first demonstrated and broadcast to the world in the mid-19th century). The sea also indicates the significance of sea travel in the transmission of the introductory news about anaesthesia from North America to Europe and eventually to Australia and finally New Zealand. The Cootamundra Wattle *(Acacia baileyana)* illustrated on the land on which Vesalius stands represents Australia and the Silver Fern or Ponga *(Cyathea dealbata)* on the land on which Harvey stands represents New Zealand.

The Shield contains two parts. The Chief of the Shield contains the Southern Cross indicating the College's geographical place in the Southern Hemisphere because the Cross is at 60°S and therefore not visible from most of the Northern Hemisphere. The five stars are represented with the number of points representing their real brightness in the night sky: alpha – 8 points; beta – 7 points; gamma – 7 points; delta – 6 points; epsilon – 5 points. This representation is also that taken by the State of Victoria and is not taken by any other State or country using the Southern Cross and thus symbolises the College's founding and headquarters in Victoria.

The lower part of the Shield contains the Cross of St. George indicating the links between the College and its British counterpart, the Royal College of Anaesthetists, as well as the Christian heritage of the College. The Torch of Glory symbolises the direct derivation of the College from the Faculty of Anaesthetists of the Royal Australasian College of Surgeons. The College of Surgeons has The Torch of Glory in its Arms and has also the motto *"Fax mentis incendium gloriae"* – "The torch of glory inflames (inspires) the mind". The Charges in the four Quadrants symbolise the plants which together form the basis for the pharmacology fundamental to anaesthesia and intensive care. In the upper left Quadrant the opium poppy *(Papaver somniferum)* signifying analgesia, and in the upper right Quadrant the mandrake plant *(Mandragora officinaron)* signifying sedation and anaesthesia. These Charges also symbolise the Old World Plants. The New World Plants are depicted in the lower Charges. In the lower left Quadrant is the curare vine *(Chrondrodendron tomentosum)* signifying neuromuscular paralysis, and in the lower right Quadrant the cocaine leaf and fruit *(Erythroxylum coca)* signifying local anaesthesia.

Together these Charges represent general anaesthesia and local anaesthesia, with neuromuscular paralysis allowing surgeons access to the abdomen and thorax and anaesthetists the ability to take control of respiration for the welfare of the patient, and sedation and analgesia to assist the patient to survive the onslaught of surgery and many other unpleasant medical interventions. All the drugs derived from these plants are highly dangerous but in controlled use by Fellows allow the marvels of modern anaesthesia, surgery and intensive care to exist.

The Crest consists of the Helmet which is unusually affronté (or facing forward) with a closed visor to indicate alertness and readiness for any urgent action. This type and position of Helmet is similar to the Royal College of Anaesthetists again linking the College to this fraternal organisation. The colours of the College gown (black and gold) are incorporated into the Wreath on the Helmet and its lambrequin (or cape). The Rising Sun behind the Helmet indicates the geographical place of the College in the East next to the International Date Line; and also symbolises links with the Royal Australasian College of Surgeons and the Royal Australasian College of Physicians both of which have similar rising suns for the same symbolic reason. The Hand of the Carer (Physician) rising from the Lord's Cloud representing Almighty guidance links the College back to the Parisian medical influence and to the foundations of the modern European medical tradition in 12th century Paris, and symbolises the Fellow's hand guided by the Lord, caring for the patient's life. The hand holds an Ankh, the Egyptian hieroglyph for life, which links the major responsibility of the College Fellows – the preservation of life – to the roots of Western Medicine in Egypt in the 5th to 3rd millenia BC.

The Snake of Aesculapius entwines the Ankh to symbolise the links with the heritage of Greek medicine and the ethics of doctor-patient relationships which derive from that time.

Finally, the Motto reads *"Corpus curare spiritumque"* which is translated as "To care for the body and its breath of life" and which aptly summarises the main aim for Fellows of the College. There is an intended pun in the motto which uses the Latin word *curare* (to care) which is also a word, derived differently from Amazonian Indians, used daily in the specialty for the drug *curare* or its analogues which cause the state of neuromuscular paralysis or curarisation. This action characterises the role of the anaesthetist who knowingly takes away temporarily by paralysis the patient's ability to breathe in order to allow surgery to proceed, and in doing so protects and cares for the patient's bodily functions including this most vital function of respiration.

The Armorial Bearings of the College were designed by a Committee chaired by Professor Barry Baker, currently Nuffield Professor of Anaesthetics in the University of Sydney, Australia.

OPENING ADDRESS - ANNUAL SCIENTIFIC MEETING
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS
LAUNCESTON - 30 APRIL 1994

The Honourable, Sir Guy Green, AC, KBE - Lieutenant-Governor of Tasmania

I would like to add my welcome to you all to this conference. I would also like to extend a special welcome to Tasmania and in particular to Launceston to all our visitors from interstate and overseas.

Launceston is a charming very special city which has made a number of unique contributions to Australian history and culture. Many are well known but some of the less well known make an interestingly diverse miscellany. For example Launceston has the oldest school, the oldest pharmacy, the oldest building society and the oldest art society in Australia. It witnessed the first pancreatic transplant operation in the world, it was the venue for the first First Class Cricket Match in Australia and it hosts the longest running outdoor rock concert in Australia. On the other hand one contribution to western civilisation which Launceston is pleased to be able to say that it did *not* make is that — unlike Hobart — it made no contribution whatsoever to the education of Errol Flynn. And if all that were not enough Launceston founded the home of your College, the City of Melbourne.

But as I am sure you all know Tasmania and Launceston in particular also have special significance for this conference. For it was in Launceston that Dr William Russ Pugh administered the first anaesthetic for a surgical operation in the southern hemisphere.

Dr Pugh emigrated to Tasmania in 1835. He first arrived in Hobart but then did what any Launceston person will tell you was the only sensible thing to do and walked 200 kms north and settled in this city. Twelve years later after a number of trials he undertook that first historic procedure.

Almost exactly 100 years after Pugh landed the Australian Society of Anaesthetists was established in Hobart and now today Launceston has the honour of hosting this inaugural scientific meeting of the new Australian and New Zealand College of Anaesthetists.

There is yet another Tasmanian connection with your discipline. For the last twenty-five years or so busloads of tourists to Tasmania have been exclaiming over the lovely carpets of pink and white flowers they see dotted over the countryside only to fall into an uneasy silence when they learn that they are opium poppies. Having been led to believe what a nice, safe, law-abiding place Tasmania is it comes as a bit of a shock when it suddenly appears that the State is being presented to them as the southern extremity of the golden triangle. But of course Tasmania only produces licit opiates and the security measures which prevent the diversion of the poppies into unlawful markets have proved to be most effective. The Tasmanian opium poppy industry, which is the only lawful producer in the Southern Hemisphere supplies one-third of the world's opiate needs. It invests heavily in research and development and new poppy varieties, new sowing techniques, a highly mechanised harvesting process and advanced technology have all resulted in this being a most efficient and productive industry which has the highest opiate alkaloid yields in the world. Amongst his many other pursuits Dr Pugh cultivated an extensive garden of medicinal herbs. I do not know whether they included any with anaesthetic or analgesic properties but nevertheless I think he would have approved of the development of this distinctive Tasmanian industry so closely related to his own areas of interest.

The history of the development of your discipline over that period from its beginning in 1847 to the recent incorporation of this College has been truly remarkable. Within a relatively short time what began as a small group of doctors brave enough to experiment with a radical new technique grew and developed first into state sections and then into the Australian Society of Anaesthetists.

For some 40 years anaesthetists were a Faculty of the Royal Australasian College of Surgeons and now that Faculty has developed into this separate College which itself comprises sub-disciplines and its own Faculty of Intensive Care.

The history of the development of your College provides an example of the effects of the near exponential growth in scientific knowledge and the great increase in specialisation within our science-based professions which have characterised the history of science and the professions in the 20th century. Those developments are of course to be welcomed and encouraged. But I do suggest that whilst increased specialisation is inevitable it is important that one retains a capacity to occasionally step back and view the whole discipline globally. I think that that is particularly important when you are charting new directions for the College or making value judgements about priorities or the allocation of resources.

I think that it follows that conferences of this kind are of increasing importance because in addition to enlarging your understanding of your own particular field they help to encourage that global perspective by alerting you to developments in other areas with which you might not be as familiar.

Ladies and gentlemen, we are proud that you have chosen Tasmania as the venue for this historic inaugural meeting of your new College. I hope you find it stimulating and productive. And although I know you are here to work I do hope that you find some time to enjoy some of the delightful amenities which this lovely city and this island state of ours have to offer.

I declare this annual scientific meeting of the Australian and New Zealand College of Anaesthetists open.

The following is an excerpt from the Royal Australasian College of Surgeons' 'President's Newsletter', March, 1994:

Australian and New Zealand College of Anaesthetists

ANZCA's own building, "Ulimaroa", at 630 St Kilda Road, was opened on 19 February 1994 by the Governor-General, Mr Hayden. The dignified opening ceremony took place in the front garden in perfect weather.

It is an elegant building and the refurbishment is quite superb.

On 25 February 1994, ANZCA physically moved out of the College in Spring Street, ending 42 years of the Faculty of Anaesthetists and then ANZCA in our building.

They will continue to use our library and we have an agreed arrangement for their ongoing access to our larger meeting rooms.

The forthcoming ASC in Hobart will be the first at which ANZCA will meet quite geographically separately from us – they will meet in Launceston at the same time as our meeting.

The obvious interdependence of surgeons and anaesthetists will keep our two Colleges close and interacting.

DAVID E THEILE

HONOURS AND APPOINTMENTS

Professor Michael J Cousins, NSW – The Ralph Waters Award

Emeritus Professor Tess Cramond, Qld – Elected to the Australian Resuscitation Council Roll of Honour

Professor Laurie Mather, NSW – John J Bonica Medal

Professor Lucien E. Morris, USA – Honorary Doctorate of Science, Medical School of the University of Ohio, USA

Professor G.A. (Don) Harrison, NSW – Professor of Anaesthesia, University of New South Wales, St Vincent's Hospital

Professor Cedric Prys-Roberts – President Royal College of Anaesthetists

HONORARY FELLOW
CITATION – MICHAEL ANTONY DENBOROUGH

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

Mr President, I have the honour to present to you **Michael Antony Denborough.**

Michael Antony Denborough is Professor at John Curtin School of Medical Research. He is a graduate of the University of Capetown and is a Fellow of the Royal Australasian College of Physicians. He has a D.Phil Oxford and a D.Sc. and MD from the University of Melbourne. The title of his D.Sc. thesis was "Studies on Malignant Hyperpyrexia and on Glycoproteins in Man". He has been the recipient of a number of awards – Rhodes Scholarship, the Selwyn-Smith Prize for Medical Research from the University of Melbourne in 1970. This was the first awarded and was shared with Professor Morris. He was awarded the Eric Sussman Prize for Medical Research from the Royal Australasian College of Physicians in 1972, and received the Gold Medal at the Fifth International Congress on Neuromuscular Diseases at Marseilles in 1982.

He spent six years as first assistant and then Reader in Medicine at the University of Melbourne and in 1975 was appointed as Professorial Fellow and Acting Head of the Department of Clinical Science at John Curtin School of Medical Research, Australian National University.

Professor Denborough has had the rare achievement of making a giant contribution to a specialty other than his own – to Anaesthesia. Professor Denborough has researched and published widely on malignant hyperpyrexia and has been a world leader in the field. His work has been of great value. He has studied the effect of many anaesthetic agents as well as the molecular and biochemical basis of the disease. He has published approximately 150 papers, many of which have relevance to our specialty. The major thrust of his recent investigation has been the regulation of myoplasmic calcium in relation to malignant hyperpyrexia and sudden infant death syndrome.

Anaesthetists owe a great deal to Michael Denborough. His research has benefitted our specialty – or more specifically our patients to a great degree. The initial publication on malignant hyperpyrexia was a letter to the editor, published in the *Lancet* in 1960. This was a case report on a 21 year old man with a dreadful family history – 10 relatives had died during or soon after ether anaesthesia. The investigation of this family set Professor Denborough on a path that has been of great benefit to our specialty – or more specifically to our patients. The 34 years since that report have involved much research into various aspects of malignant hyperpyrexia – genetics, biochemistry and the evaluation of risk factors. Michael Denborough has done a great service to the specialty of anaesthesia. It is fitting that he be awarded an Honorary Fellowship of this College.

Mr President, I have the honour to present **Michael Antony Denborough** for conferment of Honorary Fellowship.

Neville J Davis

ROBERT ORTON MEDAL
CITATION – ARTHUR BARRINGTON BAKER

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

Mr President, I have the honour to present to you **Professor Arthur Barrington Baker.**

In 1993, we listened to the Citation delivered by Dr Michael Hodgson in Adelaide when Barry was presented for admission to the Court of Honour of the Royal Australasian College of Surgeons. I ask him to pardon me if what I say seems to him to be repetitive. It is none the less most appropriate that we honour Barry again tonight for his contributions to both the Faculty of Anaesthetists of the Royal Australasian College of Surgeons and to the Australian and New Zealand College of Anaesthetists. I do not intend to repeat the extensive list of tasks which Barry has undertaken on behalf of this and other organisations. Nevertheless a few matters must be mentioned. This College has come into being through the work of many people. Barry's name would be near the top of any listing of significant contributors to our establishment. His work capacity was immense. The College's Coat of Arms stands proudly before you. Barry was a major force in the sometimes complex negotiations which accompanied its gestation. One Council Meeting was enlivened by brisk debate between some better educated Councillors on matters related to the true meaning of the College Motto 'Corpus Curare Spiritumque'. Barry was in his element. As David McConnel mentioned on another College occasion, Barry is the only person to have examined in our Primary Examination as well as in the Final Examinations for both Anaesthesia and for Intensive Care.

Barry gained his initial medical qualification from the University of Queensland and subsequently joined a very select group of Australian and New Zealand anaesthetists who have completed a Doctorate of Philosophy. In Barry's case his degree was from the University of Oxford. Of course he also holds the Fellowship of this College endorsed in both Anaesthesia and in Intensive Care as well as the Fellowship of the Royal College of Anaesthetists.

Until he went to Oxford, Barry was very much a Queenslander, being educated at Brisbane Grammar School and the University of Queensland before doing his residency and early specialty training at the Royal Brisbane Hospital. In Oxford, he held a number of posts in that Mecca for many Commonwealth Anaesthetists, the Nuffield Department of Anaesthetics. While there, he married Jane – also an anaesthetist.

In 1972 he returned to Australia to the position of Reader in Anaesthesia in the Department of Surgery of the University of Queensland. In 1975, he took up his position as Foundation Professor of Anaesthesia and Intensive Care at the University of Otago Medical School in Dunedin. He held this position until his return to Australia in 1992 when he became the Nuffield Professor of Anaesthetics in the University of Sydney at the Royal Prince Alfred Hospital. Given his earlier association with the Nuffield Department in Oxford, this was a most fitting move.

Academic clinicians are required to have expertise in teaching, in research and in their own medical discipline. Barry has excelled in all of these areas. He has contributed greatly to teaching and research in all the posts he has held. He is a highly competent clinical anaesthetist and intensivist. I can personally attest to the mark he has made professionally in New Zealand both in

relation to anaesthesia, intensive care and to other facets of University, Hospital and community life. His continuing work in applied respiratory physiology has led to many publications in this area and has been the stimulus for continuing work by students, both undergraduate and graduate.

Mr President, the sole criterion for the award of the Orton Medal is distinguished service to Anaesthesia. Barry has contributed greatly to this College, to four University Departments of Anaesthesia and towards the wider acceptance of anaesthesia as an independent medical specialty in two countries. As well, through his work as a teacher, he has been a motivator of young people. There are numbers of you here tonight who owe much to Barry for his timely encouragement of your careers.

In recent years, Barry has pursued his interest in the history of Anaesthesia. The detailed and erudite presentations that we have heard at a number of College General Scientific Meetings and Annual Scientific Congresses attest to his energetic and thorough pursuit of knowledge. This has led to his holding the Diploma of the History of Medicine of the Society of Apothecaries. He is also a mean chess player!

I mentioned Barry as a motivator. This includes not only intellectual motivation. Members of the Dunedin Department and even casual visitors to Dunedin have found themselves in various wide-open spaces, near the top of some formidable New Zealand mountains, in situations which they had certainly not intended.

At risk of being repetitious I emphasise again the criterion of distinguished service to anaesthesia. Barry, with the ongoing support of Jane and their family, has certainly given that service in full measure. As a bonus he has contributed widely to the lives of many of us through his generosity in both professional and personal ways.

Mr President, it is an honour to present **Arthur Barrington Baker** to you for the award of the Robert Orton Medal.

John M Gibbs

PART-TIME TRAINING IN ANAESTHESIA AND INTENSIVE CARE

During 1993, the Australian Society of Anaesthetists conducted a survey of the views of female anaesthetists under the heading "Does gender matter in the pursuit of a career in anaesthesia?" Through the courtesy of Dr John Hains, the thorough collation of results which was undertaken by Dr Di. Khursandi has been made available to the College.

Question 21 asked whether there should be more flexibility in the training scheme to fit in with family responsibilities. There was a 79% affirmative response rate to this question. Notwithstanding that strong expression of opinion, few respondents were able to offer concrete suggestions as to how that flexibility might be achieved.

Question 22 asked what changes the respondents would like to see in the training scheme. 55% of respondents wanted to see part-time training and job sharing.

Part-time training has been a recognised option for College trainees for a number of years. Current Regulations do require that the first two years of training be on a whole-time basis and that the Primary Examination has been passed. Thereafter, part-time training is possible. It must be on a minimum 50% basis and must include both in-hours and out-of-hours duties. The total duration of training cannot be altered for a trainee in a part-time position.

A trainee doing the maximum permissible amount of part-time training would take at least eight years to obtain the Fellowship.

Respondents to the questions recognised the problems of balancing training needs with demands of family. Some have been able to job-share although it seems that not all employers will accept this as an option. It must be noted that while the College makes demands on trainees (in terms of knowledge, time and experience), it does not employ them. Some of the frustrations experienced by trainees relate as much to their employment as they do to training. In my opinion, the same pattern of responses to the questions referred to above might well be obtained from male trainees. Certainly a few males have taken the part-time training option for a period to allow for family care. The ASA should be encouraged to repeat its questionnaire for the men as well!

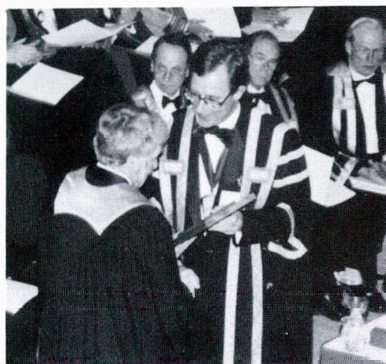
The College does wish to respond to the needs of its trainees and will look carefully at any matters related to flexibility in training provided that proper standards can be maintained. As Education Officer, I am very willing to enter into dialogue on any suggestion related to this difficult area.

JOHN M GIBBS

THE DOUGLAS JOSEPH PROFESSOR OF ANAESTHETICS

CITATION – LAURENCE EDWARD MATHER

"The Douglas Joseph Professorship of Anaesthetics is awarded quadrennially at the discretion of the College Council to Fellows who are making an outstanding contribution to the advancement of the specialty to pursue scholarship and research in human anaesthesia in Australia and/or New Zealand."



Mr President, I present **Laurence Edward Mather** to you for the award of the inaugural Douglas Joseph Professor of Anaesthetics.

Professor Mather is presented this award as an outstanding contributor to the advancement of our specialty both in the past and through his ongoing scholarship and research in human anaesthesia. The latter will be very significantly assisted by receipt of this award from the College.

Laurie Mather was born and raised in Sydney, and educated at the University of Sydney. The latter is particularly befitting, although not at all contrived, as it is the University where Douglas Joseph held the first significant Chair in Anaesthetics in Australasia. Laurie initially graduated in Science, majoring in Organic and Physical Chemistry, but quickly proceeded to his Masters and subsequently his Doctorate in Pharmaceutical Sciences, with a thesis on studies related to the absorption, distribution, metabolism and excretion of drugs by adult and neonatal humans. This laid solid foundations to his subsequent outstanding research and teaching career in the pharmacology and application of drugs used in anaesthesia and analgesia.

The formal career in anaesthesia of Laurie Mather continued with appointments over four years in the Department of Anesthesiology at the University of Washington in Seattle, U.S.A. His research was prodigious and highly productive, resulting in many papers and presentations mainly in the areas of local anaesthetic and analgesic pharmacology. This success and activity continued on his return to Australia, this time at the Flinders University of South Australia where he joined Michael Cousins at the newly established Department of Anaesthesia and Intensive Care. Over the next 15 years, mostly at Flinders, Laurie's research, teaching, publications and other activities continued to significantly add to the local and international understanding of drugs used by anaesthetists and other medical practitioners. In 1983, he was appointed Associate Professor at Flinders University and in 1990 Professor of Anaesthesia and Analgesia Research at Flinders University. In 1991, Laurie returned to the University of Sydney as Professor of Anaesthesia and Analgesia (Research), based at the Royal North Shore Hospital of Sydney, a position which he holds with great productivity and distinction to this day.

It is rare in the international community of anaesthesia and analgesia to find a non-anaesthetist so highly regarded as Laurie Mather. Most anaesthetists in Australia and New Zealand would be well aware of his achievements, particularly through his contributions to their education and clinical practices. He has had over 130 papers published in reputed medical and scientific journals, and has contributed to over 35 volumes or books. He has been invited to lecture at many anaesthesia meetings throughout Australia, New Zealand, the United Kingdom and the United States of America.

Laurie Mather was elected to Fellowship of the Faculty of Anaesthetists R.A.C.S. in 1983 in recognition of his contributions to the Faculty and anaesthesia generally, and was elected to Fellowship of this College with its formation in 1992. It is significant that his initial election was during the term of Professor Douglas Joseph serving on the Board of the Faculty.

Throughout his professional lifetime, Douglas Joseph was committed to the advancement of anaesthesia as an academic specialty in medicine, and Laurie Mather's achievements and current practice reflect the fruits of Douglas' dreams. As a student, trainee, colleague, admirer and friend of the late Douglas Joseph, I believe that he would have been very proud to endorse the awarding of the inaugural Douglas Joseph Professor of Anaesthetics to Laurence Edward Mather.

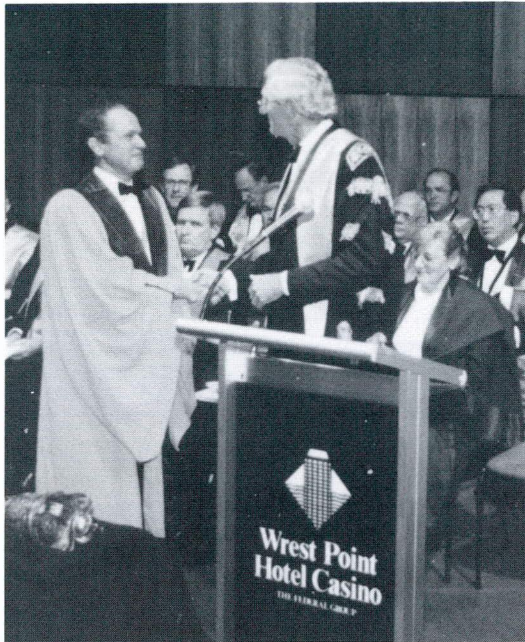
Mr President, I have the honour to present the Douglas Joseph Professor of Anaesthetics, **Laurence Edward Mather.**

Richard G Walsh

COURT OF HONOUR

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

PETER DAVID LIVINGSTONE



Peter David Livingstone is a most worthy choice for admission to the Court of Honour in 1994. His contributions to the Faculty of Anaesthetists of the Royal Australasian College of Surgeons and to the anaesthetic community must stand as a great example to all young anaesthetists.

Peter Livingstone graduated from the University of Queensland as did the Dean before him, Barry Baker, and the President of the College of Anaesthetists after him, Michael Hodgson.

Peter Livingstone was one of the earliest Fellows to complete all his training in Australia. Initially, he gained his Diploma in Anaesthetics, University of Melbourne, after training appointments at the Royal Brisbane Hospital (1961-1962), in Melbourne at the Royal Children's Hospital and the Royal Women's Hospital in 1963 and at the Alfred Hospital in 1964. There he came under the influence of Dr Bob Orton, Dr Bill Crosby and Dr Kevin McCaul.

He returned to Brisbane to be appointed Senior Visiting Anaesthetist in 1970 and was influential in introducing epidural anaesthesia in obstetrics in Queensland.

Then as a working Senior Anaesthetist, Peter Livingstone studied and completed the FFARACS in 1973. He joined the Regional Committee of the Faculty and became CHairman in 1977. He went on to convene the Faculty section of the General Scientific Meeting in 1979.

In 1981 Peter Livingstone was elected to the Faculty Board of the Royal Australasian College of Surgeons. From an early stage it was obvious that he would make a major contribution. He was elected Treasurer in 1982 and during the next six years of intense personal commitment he spent long hours working on the Faculty finances and contributing to Council discussion. At this time he initiated the "subscription in advance" scheme to the Faculty.

In retrospect these years of quiet activity set the scene for a financially strong Faculty that could eventually move smoothly towards becoming a College and into new College headquarters in 1993.

With the strong, generous support of his wife Lurlene, he moved to Chairman of the Executive in 1984 and became Vice Dean until 1989.

As the last Dean of the Faculty in 1990 to 1993 he proved a persuasive advocate in support of the Articles of Association of the new College. Again his strong organisational skills and his devotion to his beloved Faculty and College must rate as a memorable contribution.

Peter Livingstone effectively speeded up the foundation of the Australian and New Zealand College of Anaesthetists. It was not surprising then that he was elected as the first President of the College in 1992 and he retired as the last Dean in 1993.

R L ATKINSON

TASMANIA - A LINK IN OUR PAST

Presented by Dr Gwen Wilson, Emeritus Historian - Launceston ASM

Mr Chairman, Ladies and Gentlemen,

I would like to thank the Programme Committee of this historic meeting for allowing me to make a contribution, in a State and city which will always arouse my excitement.

This is the third occasion on which Tasmania has been the scene of significant steps in the history of anaesthesia in Australia and New Zealand, and in the fiftieth year since I entered the specialty in 1944, it is my great pleasure to be involved.

It was a cold, drizzly morning on June 7, 1847, when William Russ Pugh walked from his home to St John's Hospital to keep his appointment with three patients he had carefully selected, a group of his colleagues, and a few special observers, one of whom was the editor of the *Launceston Examiner*. With what thoughts he walked we cannot know, but certain it is that he could not have envisaged this meeting 147 years later.

Pugh was about to give what were almost certainly the first anaesthetics for surgical operations in Australasia, for the date of the anaesthetic for surgery in Stroud, New South Wales is still in doubt, and the ether anaesthesia given in Sydney in the week or so before June 7 was for dental procedures.

Whatever a future Historian may find, however, so far as I have discovered there are features connected with Pugh's anaesthetics which are unique in the world history of our specialty.

It would appear that Launceston was the most remote place in the world where anaesthesia had been administered by June, 1847, for Launceston, unlike other cities and towns where the pioneers worked, was not on a main sea route, was two days by coach from Hobart, and some miles up the Tamar River.

In many countries one can visit the building where the first anaesthetic was given, or the home of the pioneer, but nowhere else in the world can one stand in a garden square and survey the church where a first administrator was married, his home with its attached laboratory where he prepared his ether and his apparatus, and the hospital where he gave his first anaesthetics. Thanks to Launceston authorities all these buildings are much the same as they were in 1847, and all are still in constant use.

Pugh himself contributed to his uniqueness, for the paper he wrote which appeared in the July 1847 issue of the *Australian Medical Journal* is certainly the only one published in the world which was written on the same day as the author's first anaesthetics were given. Anybody who has kept a diary of a trip, or a ship's log will know that a record written on the very day of an event is quite different from one written later. We know a great deal about Pugh and his life, but there still are spaces to be filled. For instance, we know nothing of his life before he came to Tasmania, save that his father accompanied him to the London Wharf where he caught the steam tender to take him to the "Derwent" on 9 August 1835.

We do know his date of birth, in 1805; his date of death, in 1897, the date of his marriage on May 6, 1836. His grave, in the green cemetery of Brighton in England, has been restored by the united work of the Australian Society and the AAGBI, and a plaque donated by

Dr Mary Burnell of South Australia has been affixed to the headstone. From his diary, from the *Launceston Examiner* and the newspapers of Melbourne, we can know the man himself, a colourful character.

There are five thick files on Pugh in our archival collection, but none contain the answer to the question which has teased me ever since I first read about his anaesthetics.

Why Pugh, of all doctors in Australasia, in the then tiny Launceston, of all places?

At first the answer seems easy, for in a paper to celebrate the centenary of anaesthesia in 1946, Dr Crowther of Hobart stated categorically that Pugh was the nephew of Robert Brown, the world famous botanist of Flinders' voyage, and the discoverer of Brownian Movement.

On a visit to Tasmania I spoke to Dr Crowther and asked for his reference for this statement.

His answer? "I think I just assumed it".

Dr Crowther was then in his eighties, and I now know how the background piece of paper for a fact which has become ingrained can be lost in a pile of files. At the time of my visit I thought "assumed" was a strange word to use, but re-reading documents for this paper today, combined with knowledge acquired from many hours of reading Robert Brown papers and correspondence has made me rather more critical.

The name Browne appears three times in the available Pugh archives; twice in his diary, and on his death certificate. Each time the name is spelt BROWNE, whilst Robert Brown is BROWN. This could be simply a printing mistake, but the recent re-reading leaves more doubt. In the Pugh diary is a description of his climb of Mt Wellington, the day before he set off on his walk from Hobart to Launceston. What does he say of Mt Wellington? "There is much that would interest a botanist". A botanist? Does that sound as if his own uncle was a world-famous botanist?

I would love Pugh to be related to Robert Brown, and somewhere in or around Launceston is what was described to me as a "vault full" of family papers which might tell us. Dr Reg Lewis arranged for me to meet a solicitor in Launceston who was a descendent of Pugh's wife's sister, who was a Mrs Gleadow. It was this gentleman who told me that he had this collection, but said it was unnecessary for me to look at it, for he himself proposed to write the family history upon his retirement. Fate intervened and illness and death prevented this project, but I trust the vault of documents still exists, and perhaps an anaesthetist from Launceston today may be more fortunate and persuasive than I was some years ago.

It is almost as important, for the sake of Historians of the future, to find that Pugh was not related to Brown, as it would to be to find that he was, for Dr Crowther's statement has been copied and used many times. For my own part, I have spent much time attempting to establish the relationship. Documents exist in the libraries of Launceston, Hobart, Sydney, the Botanical Gardens in Sydney, which Brown designed and then carried out the first plantations, and above all, the huge collection in the Botanical section of the Museum of Natural History in London. Study of these revealed nothing about Pugh, or any nephew, but did produce the interesting information that Robert Brown was a regular correspondent of both Dr Jacob Bigelow in Boston and Dr Boott in London. You will remember that Bigelow's letter to Boott, describing Morton's anaesthetics, was productive of the first anaesthetics in Britain and hence in the world beyond Europe. It could have been so simple. Bigelow to Boott, Boott to Brown and Brown to Pugh, but to save those future Historians the same long search, there is no evidence.

I read F.F. Cartwright's "English Pioneers of Anaesthesia" with great interest, which became excitement when I reached page 294, for a footnote provided another possible solution to the "Why Pugh?" question.

Living a few miles from Launceston was the Glover family of artists. John Glover was a prominent anti-transportationist in Launceston, as was Pugh, so they obviously knew each other, and Glover would have been aware of Pugh's wide scientific interests.

The footnote in Cartwright's book describes his discovery of the only extant letter of our pioneer in anaesthesia, Henry Hill Hickman, written to his wife from Paris, whilst he was attempting to interest the French Court in his work on "Suspended Animation", which had been disregarded in Britain. The letter mentions "John" and "John Glover" in terms indicating not only friendship, but the possibility that Hickman made his approach to the King and Court through Glover, the Court's appointed artist. Glover emigrated to Launceston in 1831 and it seems to me entirely possible that he spoke to Pugh of Hickman's work, so interesting him and preparing him for a successful venture when the news of anaesthesia arrived.

Pugh and his wife moved to Melbourne in 1854, being farewelled at the Launceston port by a large crowd of grateful patients and townspeople and being presented with the sort of gifts of recognition of service which, alas, no longer reach our profession from the public.

Following his move was another puzzle for Historians. A man who had been deeply involved in every activity in Launceston; a man who, with his partner, rented a building and started a hospital; a man who made contributions to virtually every issue of the *Australian Medical Journal* then published in Sydney from 1846-1847. In Melbourne this same man did not join the Medical Society; he did not apply for any hospital honorary position, and he wrote only one article, and that on wheat, for the new *Australian Medical Journal* published in Melbourne from 1856.

He was classified as one of "people of note" in Melbourne, but any record of his medical activities is missing, save his appearances as a witness in court cases involving other practitioners.

The answer to this mystery was probably solved by Mr Best, first archivist to the Royal Australasian College of Surgeons and the then Faculty of Anaesthetists, on a visit to Scotland.

With the quarter of a million immigrants during the gold rush came many charlatan medical practitioners, and the profession decided that qualifications must be carefully checked before admission to the Medical Society or appointments to hospitals.

Mr Best, in Scotland, in consultation with universities and libraries in Glasgow and Edinburgh, could find no evidence of Pugh's graduation or the medical qualifications claimed in the Australian Medical Register. This appears to be the answer to his low profile in Melbourne and perhaps even his return to England in approximately 1872 when government and the profession were again conducting investigations.

None of these doubts, however, can take away from Pugh's venture in 1847. This man gave those anaesthetics many thousands of miles from their original source, and with, as all the pioneers had, the possibility of loss of practice and reputation if they failed, or were fatal. We must honour him always.

Since William Russ Pugh lived until 1897, he was the only one of our first anaesthetists who could have known of the founding of the first Society of Anaesthetists in the world, which took place in England in 1893. Certain it is that he would be fascinated by the part played by Tasmania in anaesthetic history in 1934, 87 years after his activities in Launceston. In fact, some of the participants in the 1934 development were born before Pugh died.

And so we come to another great step in our history which took place in Hobart in January 1934, 60 years ago. This was the inauguration of the Australian Society of Anaesthetists, the first such society in the Southern Hemisphere. The Society was directly responsible for foundation of the Faculty of Anaesthetists in 1952, and so now has its grandchild, our College, which once more holds an historic meeting in Tasmania, and in Launceston. It is a large and varied circle since 1847, but a circle it is; and I congratulate the Council of the College upon its decision.

At the Australasian Medical Congress in 1911, a suggestion was made that the Congresses of the future should have a Section of Anaesthetics. Nobody disagreed, but for various reasons, including medical politics and rivalries, this did not happen. At that same time, on the other side of the Pacific, in America, a personal disaster was taking place, which in my view was meant to be, to judge by its results.

Dr F.H. McMechan became crippled with arthritis and was forced to retire from clinical practice. Undeterred, he first established a quarterly anaesthetic supplement to the *American Journal of Surgery,* and later became the permanent Secretary of the International Anaesthesia Research Society and Editor of its Journals.

This was not to the liking of Sir Henry Newland of South Australia, a member of the Committee. Sir Henry, as other evidence shows, was in favour of specialisation, which was a bone of contention at that time, so he and his anaesthetist, Dr Gilbert Brown, put their heads together and decided to approach the South Australian Branch of the BMA and ask it to recommend a Section of Anaesthetics at the next Congress in Sydney in 1929.

This the South Australian Branch agreed to, also suggesting that Gilbert Brown should be President of such a Section. It was, historically, a pity that the Section was not included in the 1927 New Zealand Congress, for it was on that occasion that formal announcement was made of the inauguration of the Australasian College of Surgeons, first proposed in 1920 by New Zealand suggestion, and later, in 1924, again proposed by American suggestion.

However, plans and programme for 1929 were put in progress, with Gilbert Brown as President, and Dr F.W. Green of Melbourne as a Vice-President. Again things were meant to be, for in 1928 Dr Green suffered the first of the coronary occlusions which ultimately led to his death. Since he was a man of foresight, who encouraged younger men, he asked an emerging star in Melbourne, the 26 year old Geoffrey Kaye, to research and read the

paper he himself had proposed to give in 1929. Thus two personal medical disasters led to the fateful and significant meeting of Geoffrey Kaye and Francis McMechan, for when Congress assembled, there was McMechan in his wheelchair. The two men had instant rapport. Finding that Geoffrey was about to depart for research and observation in Europe and England, McMechan also invited him to American meetings, and named the places and people he should visit and meet in the United States.

After these adventures, Geoffrey returned to Australia in 1931, determined that Australia should have an association or society such as he had witnessed overseas.

The groundwork was already in preparation, for after the small skilled group had met for the first time at Congress in 1929, both those in Victoria, in 1929 and those in Adelaide, in 1930, had formed Sections of Anaesthetics in their respective branches of the BMA.

Geoffrey Kaye had his mind set on the next Congress, due in Perth in 1932 and had commenced correspondence to get special members of the group together, but fate, in the form of worldwide financial depression, again took a hand. The Perth Committee wrote to what was now the Federal Council of the BMA and said it thought the Congress should be postponed for several years. The Council accepted postponement, but only until 1934, lest it said, "Practitioners should lose the Congress habit". In 1933, after some quaint discussions about the venue, Tasmania won the day.

And then guess what? When the Congress tentative programme was first published, there was no Section of Anaesthetics!

Somebody, and I personally suspect Sir Henry Newland, went rapidly to work and by the second announcements in the MJA, the Section had been included.

Geoffrey Kaye and his typewriter went busily to work, contacting his selected representatives and getting their agreement, and working upon a proposed constitution for the organisation. The Tasmanian programme committee, all unknowingly, included two historic features in the papers for the Section of Anaesthetics.

These came vividly to my mind at the ASA meeting last year in Peth. Gilbert Brown read a paper on his trials of samples of short-acting barbiturates which had been sent to him by various drug houses, which were the forerunners to the revolution of 1935, when the ultra-short acting thiopentone arrived in Australia. Gilbert Troup went one better. He produced the first film ever shown at an Australasian Congress, and this same film was shown in Perth last year, 59 years later.

At the end of the busy week, on Friday, 19 January 1934, Geoffrey's small group of seven met at Hadley's Hotel in Hobart. It was necessary to meet outside the venue of the Congress, for the BMA was in some turmoil at this time. It feared that the establishment of specialist organisations outside the Association would lead to break up of the united front it had taken years to establish in the profession, and that various governments would take advantage of such disunion.

The group of seven thus sat around a table in a special area of the first floor of Hadley's Hotel and discussed Geoffrey Kaye's suggestions. As a result, Gilbert Brown, Harry Daly, Gilbert Troup, Ivor Hotten, Geoffrey Kaye, and the President of the Section of Congress, Dr G.L. Lillies, and the Secretary of the Section, Dr Cedric Duncombe, first inaugurated the Australian Society of Anaesthetists, and then toasted heartily to its success. It was Tasmania again.

In Sydney, in January 1934, a 17 year old young lady was preparing to start her medical course, and if Launceston and a College of Anaesthetists were remote from William Russ Pugh's thoughts in 1847, it certainly never occurred to the young lady that she would stand before you on this august occasion and speak of Hobart in 1934, and of Pugh, and be a Life Member of a distinguished Society of Anaesthetists and a proud Fellow of our College.

Mr President, before I go I wish to present to you a most precious and valuable book. It actually belonged to William Russ Pugh, and has his name stamped on the title page.

The book was written by Count Strzelecki who made explorations of most of the east coast of Australia and named Mt Kosciusko.

It was published in 1845, and a footnote records the author's thanks to W.R. Pugh for the use of his laboratory while Strzelecki was in Launceston.

Without the help of Dr Richard Bailey, Historian to the Australian Society of Anaesthetists, I doubt I would have had the courage to carry a book which has suffered from use during 149 years from Sydney to Launceston. Dr Bailey is also a bibliophile and with his special knowledge and co-operation arranged for preliminary treatment to make it safe for transport.

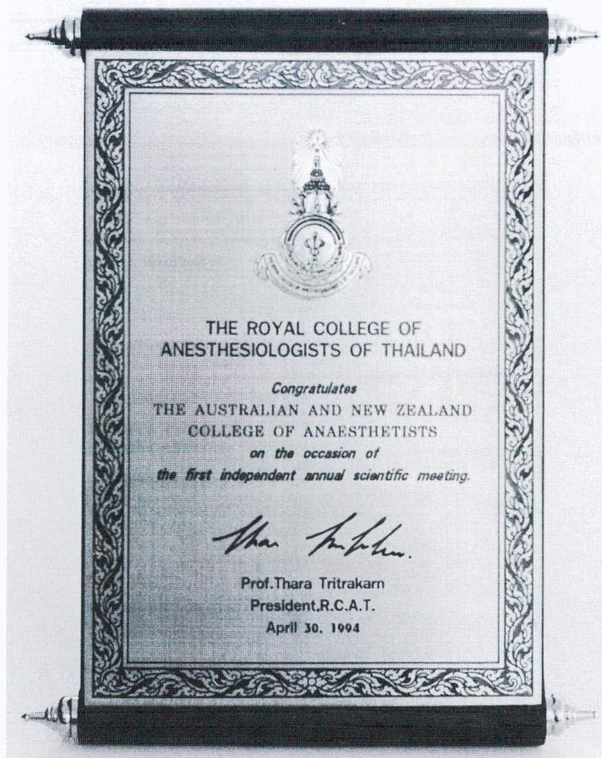
The presentation is thus a mutual venture of Society and College and is wrapped in our mutual colours. It is presented specifically to the College Library, but through the rapport of Historians of anaesthesia has become a gift to Australasian anaesthesia as a whole.

GIFTS DONATED TO THE COLLEGE

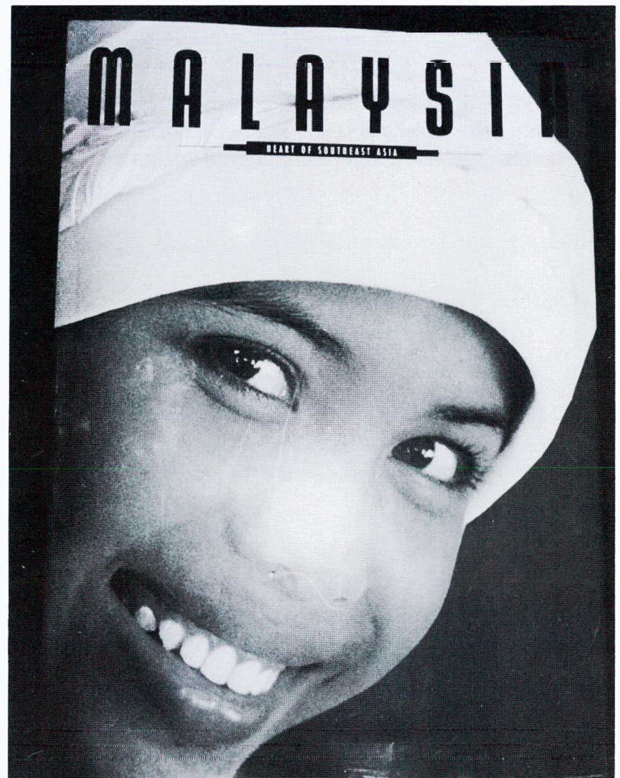
The College is grateful to the following for so generously donating gifts as shown:

The Nuffield Department of Anaesthetics, University of Sydney, Royal Prince Alfred Hospital — a facsimile mounted on canvas of the portrait of the late Douglas Joseph.

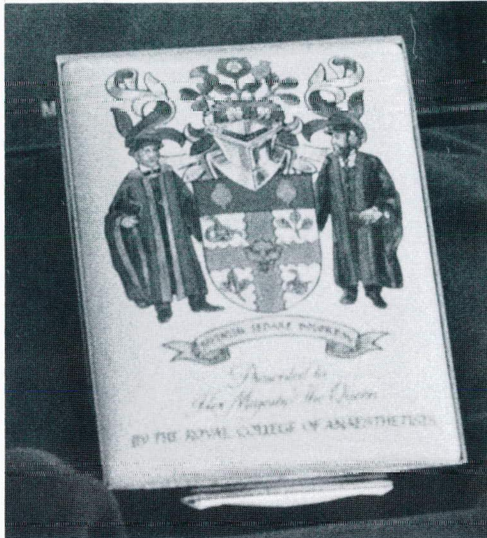
The Australian Society of Anaesthetists — a portrait of the Inaugural President of the College — Associate Professor Peter Livingstone.



The Royal College of Anesthesiologists of Thailand — a congratulatory plaque commemorating the 1994 ASM.

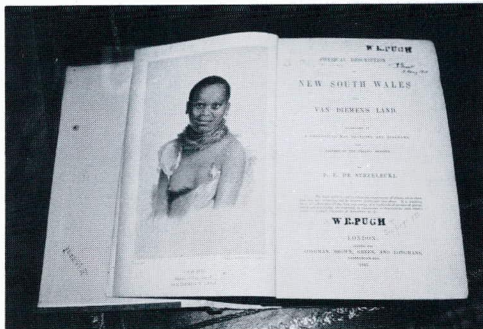


The Academy of Medicine of Malaysia — a book entitled 'Malaysia — Heart of Southeast Asia'.

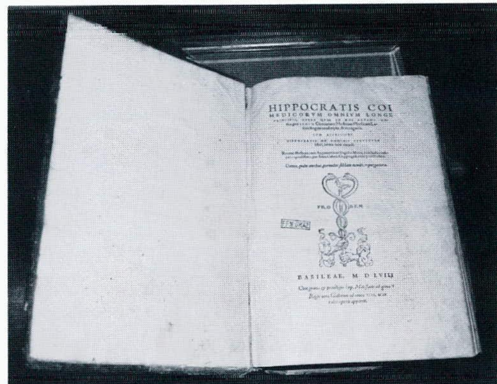


The Royal College of Anaesthetists — a Halcyon Days enamel box depicting that College's Armorial Bearings which is a replica of a gift presented to Her Majesty The Queen commemorating her opening of their College.

Professor Barry Baker, Past Dean of the Faculty of Anaesthetists RACS, who presented the College with the President's Badge of Office.



Dr Gwen Wilson, Emeritus Historian, who presented the College with a book by Strzelecki written in 1845 and owned by Dr William Russ Pugh.



Professor Bernard Brandstater, a Fellow of the College from the USA, who presented a 436-year-old volume containing all the written works of Hippocrates bound in the original leather and manuscript vellum.

Miss Nancy O'Donnell, Administrative Officer of the Faculty of Anaesthetists RACS from 1973-1986 who presented the College with a pen drawing of the RACS Headquarters.

FACULTY OF INTENSIVE CARE

Inaugural Meeting of the Board of Faculty, June 1994

The first meeting of the elected Board of Faculty will take place in early June, following the final meeting of the Interim Board. The Annual Meeting of the Faculty is scheduled for the evening of Tuesday, 7 June at 5pm at Ulimaroa. All Fellows available to attend are urged to do so. At this time I wish to express my sincere thanks to all members of the Interim Board for their hard work and dedication during the establishment of the Faculty.

Annual Scientific Meeting Townsville 1995

An exciting programme has been arranged for the Faculty's participation in this Meeting, and Dr Charles J. Hinds has agreed to participate as the Faculty Foundation Visitor. Dr Hinds is a former President of the United Kingdom Intensive Care Society and is Director of Intensive Care at St. Bartholomew's Hospital in London. His interests include oxygen transport in critical illness and myopathy/neuropathy in the intensive care patient. It is hoped that Dr Hinds will be able to visit other regions as well.

The format of the programme will include workshops, a free paper session, and topics such as shock and sepsis, acute renal failure and oxygen delivery, supply dependency and oxygen extraction ratios. There will also be a session on education and teaching in intensive care.

I strongly encourage all Fellows of the Faculty to support what will be a most exciting contribution to the Meeting for anaesthetists and intensivists alike.

Intensivists Prize

Donations are invited from all Fellows for an Intensivist's Prize, to be awarded annually to the best candidate in the Fellowship Examination. Guidelines for the award of this prize have been prepared, and it is intended that the title of the prize, when decided, will honour a prominent person within the field of intensive care.

Liaison with RACP and ANZICS

Plans are proceeding for the joint meetings between the Faculty and the Royal Australasian College of Physicians and Australian and New Zealand Intensive Care Society. Two committees will be set up; the first committee will examine training and examinations, the second will be convened by ANZICS to discuss areas of common interest relating to policies.

Acronym

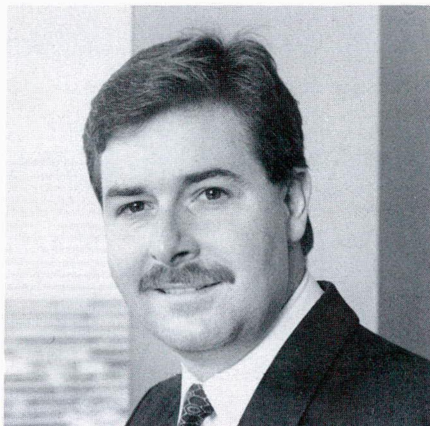
A letter has been received from the National Specialist Qualifications Advisory Committee advising that the Diploma of Fellowship of the Faculty of Intensive Care (FFICANZCA) has been accepted. Fellows may now register this post-nominal with the Medical Board or Council within their region. It is noted that some regions will accept one post-nominal only.

G.M. Clarke
Dean
Interim Board

LAW REPORT

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

LEASES



Every medical practice will either own or lease its own premises. In some cases, rooms may be leased from a private or public hospital. Even where some or all of the doctors in the medical practice own the building, there may well be a lease-back to the medical practice itself.

A lease is a contractual document which contains onerous duties and obligations for tenants.

ALL LEASES ARE NOT THE SAME

Apart from a few standard printed form leases which have been issued by the Real Estate Institute and Law Institutes, most commercial leases will be drafted by lawyers for the owner and will contain a diversity of terms and conditions. All leases are ***not*** the same.

It is therefore important in all cases that the lease be read through carefully and that it be understood and the terms and conditions accepted by the tenant. In most cases, the owner will be prepared to negotiate on any particular terms and conditions which may be unusually onerous, so long as the owner's interests are not unduly prejudiced or disadvantaged.

COMMERCIAL TERMS

The lease will contain general commercial terms which will have been negotiated with the tenant (usually by the estate agent representing the owner), and include:

- ***rental*** (how much, when payable);
- ***rent reviews*** (market reviews, CPI reviews, when reviews are to take place);
- ***outgoings*** (municipal rates, water rates, State land tax (which should be on a single holding basis), and other charges and expenses relating to the premises);
- ***the term of the lease***;
- ***any further option periods for which the lease can be renewed*** (it is important to fully understand the method of exercise of the option and then strictly observe those terms, so as to ensure that the lease is renewed for the option period).

OTHER TERMS AND CONDITIONS

The bulk of the lease will contain the other terms and conditions of the lease and may be lengthy and difficult for a non-lawyer to completely understand. (Indeed, some drafting by lawyers is not easily understood by other lawyers).

If lawyers made leases easy to understand, then their clients would not need to consult them!

However, because the other terms and conditions of a legal nature may vary substantially from lease to lease, it is always important to ensure that, if there are provisions which you do not understand, ***you seek appropriate legal advice.*** A lawyer's role will be to explain the essential terms and conditions of the lease, explain any unusual or onerous terms and conditions, in many cases carry out enquiries relating to the property (rates, road requirements, planning and zoning requirements, ensure that the owner has good title, etc.).

Some of the important conditions contained in a lease, which will need review are:

1 **Provisions for Assignment of Lease.** At a future date, you may wish to move to new premises, and pass the property onto someone else. Unduly restrictive assignment provisions may prevent you from doing this, and it is therefore important that these provisions be carefully negotiated. In many leases, where the tenant is a company (perhaps a group of doctors), any change in the composition of the shareholding of the company may constitute an assignment

and require the owner's consent. This is a provision which is sometimes overlooked.

2 **Repair and Maintenance Conditions.** The tenant will usually have the obligation to keep the premises and the fittings and fixtures in good order and condition. It is usual to exclude fair wear and tear, and exclude acts of God, fire, storm and other circumstances beyond the tenant's control. It is also important that this clause exclude any obligation for the tenant to carry out any structural or major capital works, which could represent a substantial financial obligation on the tenant.

3 The lease will usually restrict the tenant's **right to carry out alterations** without the owner's consent.

4 The lease will contain **insurance obligations** and, whilst it is usual for the tenant to carry insurance of the property and public liability risks, some owners will require a tenant to pay for insurance for breakdown of machinery, insurance for loss of rental and consequential loss, insurance for removal of debris (upon demolition). In many respects, it can be argued that these latter insurances should all be borne by the owner.

5 Control of **Signage** on the premises.

6 **Payment of the owner's legal costs and stamp duty.** It is always important to obtain a pre-estimate of the likely legal costs and stamp duty of the owner. You will also have to bear your own legal costs.

7 Clauses relating to any possible **damage or destruction to the premises** so that it is unfit for your occupation. If the premises are damaged, in the absence of proper provision, you can be required to continue to pay rental on the property even though you cannot occupy them. It is therefore usual to have a provision that, in the event of damage or destruction, the rental will be suspended for such period as you are unable to occupy them. However, it is important that the lease also provide that outgoings be suspended during this time. It would also be recommended that the lease provide that you are able to terminate if you are unable to occupy the premises for any lengthy period of time.

Clearly, if the premises cannot be rebuilt or reinstated within a short period of time, it will be desirable for you to obtain new premises and become re-established in another location quickly. A usual provision is to provide that, if the owner has not commenced rebuilding or reinstatement within three months, or if the reinstatement or rebuilding has not been completed within six months, then the tenant should have a right to terminate.

8 **Default Provisions** (upon any failure to pay rental or other default under the agreement by the tenant).

9 **The right of the owner to enter the premises to carry out works.** It is important to provide that the owner's rights in this regard can only be exercised so as to cause minimal disruption to the tenant's business.

10 **Repainting requirements.** Some leases will contain a requirement that the premises be repainted after every several number of years. This may seem unduly onerous if the premises do not require repainting. Accordingly, such provisions should only provide that the repainting is to be carried out to the extent **reasonably** required having regard to their state and condition.

11 The lease will contain a number of **indemnity provisions,** whereby the tenant will be responsible to the owner for any loss or damage to property or personal injury caused in or near the premises, and to indemnify the owner if any claim is made against the owner by third parties. Whilst these provisions are difficult to negotiate, it should always at least exclude any loss or damage which is, in fact, caused by the owner or the owner's representatives, or arises from any act, omission or negligence of the owner or the owner's representatives.

12 **Penalty Interest.** In the event of failure to pay any moneys under the lease, the tenant will be subject to penalty interest. Many leases still provide for penalty interest at high rates (18–20%), even though interest rates are now at a much lower level.

13 Requirements for the tenant to comply with all applicable legislation (Health Act, Environment Protection Act, etc.). Again, this should exclude the tenant being responsible for any structural or major capital works, except as may be required as a consequence of the tenant's particular business.

14 The most important condition in the lease from the tenant's point of view, is to ensure that the tenant is given **exclusive occupation** of the premises. This is the tenant's fundamental right.

15 The lease will usually not contain a provision obliging the owner to carry out any works required to maintain the premises (other than the general repair and maintenance obligations of the tenant). It is therefore important to attempt to negotiate to have such a

provision included. Many tenants believe that the owner is under a general obligation to carry out any repairs or works on the premises where necessary, but are surprised to learn that there is no provision for that in the lease. It is important that these matters be dealt with expressly in the lease documents. For example, an obligation for the owner to maintain air-conditioning, heating, water, etc. might be thought to be automatic, but, unless expressly included in the lease, it may be difficult to obtain the owner's co-operation.

16 The lease may also contain personal guarantees which require you to enter into personal obligations with the owner. In many cases, even if you assign the lease to a new tenant, your personal obligations will continue, and you will therefore be, in effect, guaranteeing the obligations of the new tenant. Again, it is important that any such provisions be negotiated so as to attempt to exclude personal liability in the event that the owner consents to an assignment of the lease to a new satisfactory tenant.

I hope that this has satisfactorily explained why a lease should be reviewed by your legal adviser in most cases, or particularly, where you have any doubts or concerns.

DOCTORS GETTING TOGETHER *(AND HAVING FUN)*

There are a variety of ways in which doctors can share practices, each depending on the particular circumstances of the doctors, the level of development of the practice, the seniority of particular doctors and the commercial needs of particular doctors.

The choice of structures involves legal considerations, accounting/financial considerations and sound business management considerations.

Some of the more common arrangements of doctors sharing a practice are:

1 Sessional Arrangements

A doctor maintains an autonomous practice and simply shares resources on an agreed basis. The doctor will contribute to rental, overheads, use of equipment and consumable items. The agreement may include sharing secretarial arrangements, receptionist/appointment arrangements, all in accordance with a negotiated agreement. Like any lease agreement, all of the major terms of the arrangements should be contained in a written agreement, including:

a. the agreed cost sharing arrangement covering all items;

b. the period of the agreement and the right to terminate upon an agreed period of notice;

c. whether the patients will be regarded as the patients of the doctor for all purposes (including record keeping); and/or

d. any agreement to restrict the doctor from operating in the area after termination of the sessional arrangements.

2 Assistant or Assistant with View

A method of obtaining assistance in the development of a growing practice, but without (at this stage) full profit sharing or sharing the ownership of the practice, is to introduce an Assistant.

It has been suggested by competent practice managers that the income level of a practice required to support an Assistant should have at least reached $500,000.00. After advertising for an Assistant and conducting interviews and enabling prospective Assistants to view the practice, a decision should be made to offer the position to an Assistant on an agreed basis. Again, a written agreement should be entered into, so as to clearly define the terms of the arrangement, including:

i. ***the period of the arrangement*** (usually at least 1 year);

ii. ***the salary and other financial remuneration arrangements*** (salary may be up to $2,500.00 per week, with consequent cash-flow implications for your business);

iii. ***whether the Assistant can take up public hospital positions*** (and practice managers will often recommend that this not be permitted);

iv. ***a probationary period, or performance guarantee*** (so that the arrangement can be terminated in the event that the arrangement does not work in accordance with certain agreed performance parameters);

v. ***conditions to protect the practice*** (and prevent any eventual poaching by the Assistant), including protection of confidential information, a restraint on the Assistant taking work in the area after termination, etc.

3 Associateship

At some appropriate stage, the position of an Assistant may be reviewed to consider entering into Associateship on an agreed fee-sharing basis.

Doctors working in association with each other will use common facilities such as medical equipment and consumables. They will each contribute to the running costs of the practice, either in equal proportion, or through some agreed formula (e.g. fixed overheads may be shared on an agreed percentage basis, consumables allocated as used by the individual practitioners, and then some variable expenses allocated on a pro rata basis, according to the particular billings of each practitioner).

There would normally not be any **"buy-in price"** for a new Associate, since the Associate does not acquire any share of goodwill. Consequently, there is also no **"buy-out"** payment when and if an Associate leaves.

Again, there may be some protection of the goodwill of the practice by requiring Associates to maintain the confidential information of the practice, and agree to enter into restraint arrangements in the event that they leave the practice in the future.

It has been suggested by some practice managers that there also be a requirement for the Associate to live in the area. This is seen as a clear advantage in servicing patients of the practice.

It has also been suggested that Associates maintain the same fee structure, so as to reduce any internal friction from **"competition"** amongst themselves.

In Associate arrangements where there is clearly a "senior partner", it has been seen to be advisable that the "senior partner's" practice be the main address of the practice as a whole.

It has been suggested that the main advantage of an Associateship is the flexibility and freedom enjoyed by individual practitioners. The ability to take holidays, work shorter hours or pursue special interests may be done without necessarily taking advantage of the other practitioners in the group. Doctors who may have particular popularity or special skills can generate higher incomes and not feel that they are subsidising others in the practice.

However, some of the disadvantages of Associateship include the feeling that the doctors in the arrangement may actually be **in competition with each other.** If the volume of work decreases, this may be a source of friction. Problems arise if doctors do not charge uniform fees. An extreme example is when one or more members of an Associateship start to bulk bill all patients. Unless the costs of the arrangement are being shared on a sensible and fair arrangement, this can also be a source of friction, with some doctors believing that they may be subsidising others because the arrangement is not seen to be fair. For example, a doctor may resent paying for an expensive piece of equipment which may not be used by all of the doctors in the practice.

Other issues for consideration include:

1. **Agreement to renew major pieces of equipment on an agreed basis** (for example, agreement to renew a computer system every 5 years). If these matters are agreed in advance, then the friction which may arise when the decision is to be made in the future is minimised.
2. **The involvement of a spouse in a practice is always a contentious issue,** particularly if the spouse is in a position to direct work (by operating as nurse, receptionist, business manager, etc.).
3. **Arrangements for life insurance** should be agreed in advance. Clearly, the death or disablement of an Associate will have an adverse affect on the practice. There will be costs necessarily incurred in replacing the Associate and building up the practice as a result of any patients lost. This can be overcome if appropriate insurances are taken out, and will help to reduce the financial burden.

4 Partnership

A partnership arrangement may be by way of a formal partnership, or an incorporated partnership where the doctors are shareholders of a company or unitholders in a trust.

Under a partnership, two or more people pool their resources and energies to form a joint business. Unless incorporated, a partnership is not a separate legal entity, and the partners are personally liable for all of the debts and losses of the partnership. The liability of one partner can be passed on to the other partners in the group and, accordingly, it is important that you **"choose your partners carefully"**. *(For this reason, in an Associateship arrangement, it is important that the business not hold itself out as being a partnership. On all letterhead, stationery, receipt books, etc., it is important that you make it clear that the Associates are operating independent practices.)* Again, a partnership agreement (or, in the case of companies and trusts, a shareholder agreement) should be entered into in writing with provisions covering all major aspects of the business, including:

i *the name and type of business and the place from which it is to be carried on;*

ii *the capital contribution of each partner;*

iii *the term of the partnership, its commencement date and rights of termination;*

iv *a mechanism for resolving disputes;*

v *entitlements to profits and losses, agreement as to cost-sharing;*

vi *procedure for transferring interests in the partnership, or **"selling-out"**;*

vii *other personal arrangements, which may apply to any particular partnership.*

A partnership is a separate entity for taxation purposes and is required to file its own tax return *(although the partnership itself is not liable to pay the tax, each of the partners being liable for their own share of the profits of the partnership and the tax on that profit).*

As distinct from Associateships, the advantages of a partnership are seen to be the security of cash-flow (particularly when holidays may be taken), long service leave arrangements may be taken, etc. In a partnership the income and costs are shared between all of the partners on an agreed basis.

By having doctors with a wide variety of particular interests and skills, partnerships can also offer a more comprehensive service. Doctors working in a partnership are not necessarily **"competing"** with each other, but are working for the common good of the partnership and may therefore be more inclined to steer patients of the practice towards the relevant partner best able to deal with a particular problem.

Some disadvantages are seen in partnerships in that individual members may feel that they are contributing more to the partnership than they are receiving (by way of their share of profits). This occurs if a doctor is contributing significantly more than others to the income of the partnership. One partner may be working longer hours than others, giving rise to friction. This is as distinct from doctors working in Associateships, and therefore essentially "working for themselves".

In all of these arrangements, many problems which may arise and many sources of friction that may develop can be avoided or minimised by a carefully developed agreement between the participants. Clearly, arrangements by which Associates and partners can leave the practice on an agreed basis **(with any buy-out, etc)**, should be in the agreement and developed whilst all are talking to each other. Once a source of friction has arisen and a dispute occurs, clearly the participants are less likely to be talking to each other, and less likely to be able to resolve the dispute on an amicable basis.

A careful analysis of the financial nature of the business should be conducted before entering into any of these arrangements, so as to ensure that they are workable. Careful budgeting and financial planning can again minimise any future disappointment. If work dries up, or the amount of future work has been over-estimated, again friction will arise, as expectations are not met.

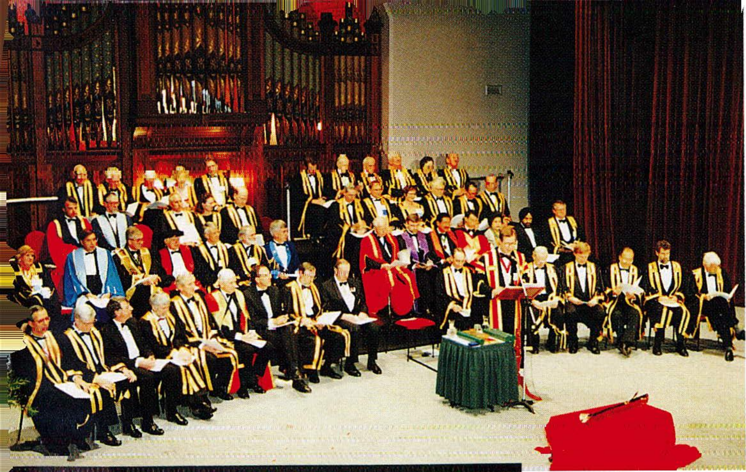
Associates and partners should agree as to the extent to which any personal expenditure may be taken into account in the practice. Again, personal expenditures for travel (albeit justifiable for tax purposes) may be a source of friction for those who do not travel as frequently if paid for by the practice.

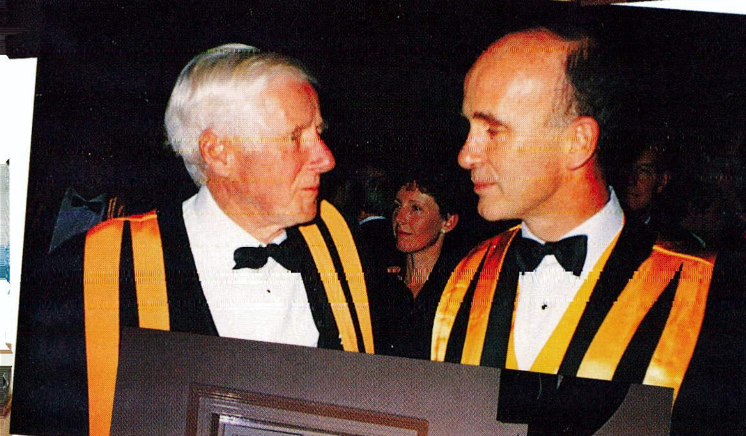
In appropriate cases, the practice should be protected by appropriate restraint provisions and confidentiality provisions. There should be no hesitation in including these types of provisions **"up-front"**, so as to make it clear that any goodwill of the practice is intended to remain with the practice. In the case of Associates, incoming Associates generally will not obtain any interest in the goodwill and therefore will not be paid out when they leave. Associates are there to simply share the costs at the time and earn their own income at the time.

Restraint provisions particularly must be carefully drafted. As a general rule, Australian courts will not enforce restraints which are not seen to be **reasonable,** having regard to the interests that they attempt to protect. A restraint that extends for too long a period of time, or which covers too wide a geographical area, will not be enforced by courts if they are unreasonable. What is **"reasonable"** must be judged by the particular circumstance of each practice, and the members of the practice, and therefore careful advice is necessary. For example, protecting a practice which operates within the suburb of Carlton by preventing a doctor from entering a practice after termination within all of Melbourne would be unreasonable, because the restraint extends over too wide an area, having regard to the area of the practice (only Carlton).

With all arrangements, the need to maintain appropriate insurances cannot be under-estimated. Appropriate insurance, linked with **"buy-out"** provisions (particularly on the death or disablement of a practitioner) can minimise the financial loss to the practice and the partners in the future. It is not unusual, where there has been no future planning, that when a doctor in a partnership dies, his or her family suffers unnecessarily because they cannot sell the partnership interest for its full worth. By linking agreed **"buy-out"** arrangements upon death or disablement to an insurance policy, the doctor's family can be properly paid for the true worth of the partnership interest and the practice has sufficient moneys to pay for the **"buy-out"**, because of the proceeds of the insurance policy.

Because of the complexity of all of these issues, the need for a properly considered agreement becomes obvious.





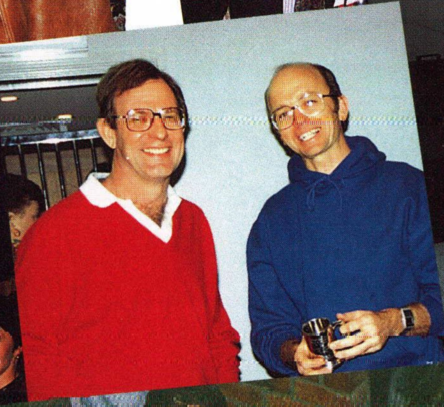
Following the conclusion of the Scientific Meeting, the Historian (Dr Michael Cooper), Archivist (Dr Rod Westhorpe) and Emeritus Historian (Dr Gwen Wilson) lunched at Morton House with other guests pictured outside.

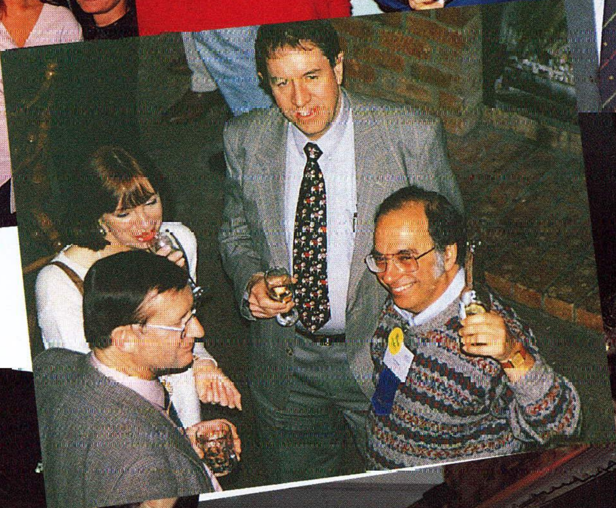
Dr Carl Hug following his Ellis Gillespie Lecture.

Dr Michael Davies, President, presenting Dr Jose Carvalho with the Foundation Visitor's Medal.

Presentation of Australasian Visitor's Medal by the President to Prof. Laurie Mather.

COWGIRLS

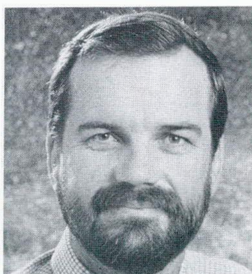




REGIONAL COMMITTEES ANNUAL REPORT 1993-1994

Regional Committee

Chairman
Dr G.E. Knoblanche
Vice-Chairman
Dr W.J. McMeniman
Honorary Secretary
Dr E. Loughman
Education Officer (Anaesthesia)
Dr P.L. Klineberg
Education Officer (Intensive Care)
Dr G.F. Bishop
Supervisors of Training
Part I Course - Dr P. Kam
Part II Course - Dr M.J. Bookallil
Other Members
Dr J. Beckett-Wood
Dr M.R. Crawford
Dr I.T. Dicks
Prof D.B. Gibb
Dr M.A. Joseph
Dr R.K. Kerridge
Dr F.X. Moloney
Dr P.J. Moran
Councillors
Dr B.F. Horan
Dr D.R. Kerr
Dr R.G. Walsh



Dr G.E. Knoblanche

Dr E. Loughman

NEW SOUTH WALES

Continuing Medical Education

Two full day meetings were held in Sydney, one with Dr M. Roizen as the overseas visitor in May and the other with Dr A. Brain in November. A one day Anatomical Workshop was also held. In addition, for a similar programme for the coming year, plans were also made to hold additional meetings outside Sydney.

Training Issues

Two hospital surveys were undertaken and the Committee considered the adequacy of subspecialty training in relation to several other proposed changes to accredited training positions.

Practice Issues

The Committee reviewed several of the College Policy documents and drafted a new Policy Statement on HIV and Hepatitis.

The Committee responded to requests for advice from the Department of Health regarding support for overseas trained doctors to fill positions at Liverpool and Nepean Hospitals where difficulties have been experienced attracting Australian or New Zealand practitioners. The Committee's attention was brought to a similar situation in Armidale and following a visit to Armidale by Dr Moloney advice was provided for the Department of Health.

The Committee addressed the difficulties presented by enrolled nurses acting as the assistants to the anaesthetist when they were restricted from being able to give intravenous injections. Consideration was also given to how anaesthetists could be relieved when patients were receiving anaesthesia for long durations.

Office Accommodation

The Committee's office moved from its shared accommodation with the Royal Australian College of Physicians in Macquarie Street to independent accommodation near the western side of Circular Quay. This provides secretarial office space, access to a meeting room and Boardroom for the Committee's meetings. I wish to record our thanks to the RACP for housing the Faculty and College over the years.

Members of the Anaesthetic Continuing Education Sub-Committee

Dr M.R. Crawford, Dr G.A. Goulding, Dr M.A. Joseph, Dr P.L. Klineberg, Dr W.J. McMeniman, Dr R.G. Walsh.

Members of the Education Sub-Committee

Dr G.F. Bishop, Dr M.J. Bookallil, Dr P.L. Klineberg, Dr G.E. Knoblanche.

Representative of the ASA Committee of Management

Dr W.J. McMeniman.

Formal Project Officer: Dr P.L. Klineberg.

Attendances at Regional Committee Meetings

Dr J. Beckett-Wood	4/6	Dr M. Crawford	4/6
Dr I. Dicks	5/6	Prof D.B. Gibb	5/6
Dr M. Joseph	6/6	Dr R. Kerridge	4/4
Dr F. Moloney	6/6	Dr G. Knoblanche	6/6
Dr P. Klineberg	6/6	Dr E. Loughman	5/6
Dr P. Moran	2/6		

Dr Ross Kerridge joined the Committee through the year following the election of Dr Brian Horan to the College Council.

Attendances Ex-Officio

Dr B.F. Horan 4/6 Dr D.R. Kerr 5/6 Dr R.G. Walsh 4/6

Regional Committee

Chairman
Dr M. Westmore
(Dr Westmore agreed to complete her term as Chairman despite her recent election to Council)

Deputy Chairman and Secretary
Dr N. Gibbs

Regional Education Officer (Anaesthesia)
Dr G. Turner*

Treasurer
Dr H. Spiers

Continuing Education Officer (Anaesthesia)
Dr L. Coombs

Regional Education Officer (Intensive Care)
Dr S. Edlin*

Other Members
Dr P. Smith
Dr G. Mullins*

Councillor
Dr N. Davis

ASA Representative
Dr D. Hayward

*Co-opted members

Special Interest Groups Representatives
Acute Pain: Dr G. Turner
Rural Anaesthesia: Dr G. Dale
Day Care: Dr B. Donovan
Cardiac Anaesthesia: Dr K. Williams
Neurosurgical Anaesthesia: Dr W. Thompson
Anaesthetic Research: Dr N. Gibbs
Medical Education: Dr R. Wong

Dr M.D. Westmore

Dr N.M. Gibbs

WESTERN AUSTRALIA

Continuing Education
During the year the following CME meetings were organised:

May 7: Professor P. Foex spoke at an evening meeting on "Cardiac Risks of Anaesthesia".

July 3: The scientific programme of the Annual General Meeting included a lecture by Dr Michael Davies entitled "Regional Anaesthesia for Vascular Surgery". In addition there were free papers by Dr G. McAuliffe, Dr M. Paech, Dr N. Gibbs, Dr W. Weightman, and Dr T. Pavy.

November 18: Dr A. Brain spoke at an evening meeting on the "Laryngeal Mask Airway".

March 1: Dr J. Wheatley spoke at an evening meeting on "Acute Pain Management".

Country Visits to Rural General Practitioner Anaesthetists
During the year there were two ANZCA organised meetings to rural areas. In May Dr R. Goucke, Dr L. Coombs, Dr G. Mullins, and Dr G. Dale contributed to two day meetings in Geraldton. In September Dr P. Maddern and Dr P. Cameron visited Port Hedland and Broome.

Regional Education
Dr P. Maddern resigned as Regional Education Officer in October 1993 and was replaced by Dr Grant Turner who was co-opted to the Committee. Dr Maddern will be sorely missed, but will maintain his association with the Regional Committee by being involved in the planning of the 1996 ANZCA ASM in Perth. Dr J. Harriott and Dr R. Wong continued the organisation of the Primary Examination tutorial programme. The Final Fellowship tutorial programme recommenced under a new format and is being coordinated by Dr W. Weightman. High success rates were achieved in the Primary and Final Fellowship examinations.

Nerida Dilworth Prize
This ASA (WA)/ANZCA Regional Committee sponsored prize (for the best registrar presentation at an ASA or ANZCA meeting) was won by Dr S. Delfos.

1996 ASM
Planning for the 1996 ASM in Perth has commenced and the major venues have been booked. Dr P. Maddern, Dr L. Coombs, Dr G. Turner, Dr N. Gibbs and Dr M. Westmore comprise the organising committee.

Other Matters

Rural Anaesthetic Practice.
Dr Westmore continued as a member of the Western Australia Anaesthetic Reference Group which seeks to improve anaesthetic standards and services in rural areas. The Committee also organised continuing education for rural GP anaesthetists. The Committee was assisted in these matters by Dr P. Smith who is a Committee member in full time rural anaesthetic practice.

Combined ANZCA/ASA Activities.
There continues to be close co-operation between the ANZCA and ASA with cross-representation at Regional Committee Meetings, and sharing of office facilities. A combined Newsletter was circulated in April.

Regional Committee

Chairman
Dr Garry Donnan
Deputy Chairman
Dr Tony Weeks
Honorary Secretary
Dr Steve Chester
Honorary Treasurer
Dr David McCuaig
Education Officer (Anaesthesia)
Dr Peter Roessler
Education Officer (Intensive Care)
Dr Jamie Cooper
Assistant Education Officer (Anaesthesia)
Dr Mark Fajgman
Safety/Library
Dr Fred Rosewarne
CME Officer
Dr Philip Ragg
Formal Project Approval Officer
Dr Geoff Beemer
Councillors
Dr Michael Davies
Dr Ian Rechtman

Dr G. Donnan

Dr S.C. Chester

VICTORIA

The following are comments which I believe should be included in this report:

1. **Consultative Council on Anaesthetic Mortality and Morbidity**

   In the past year the 5th report of the Council was distributed, covering the years 1987 and 1988. At present the 7th report, covering the years 1989-1991 is in preparation.

   In 1993 a new computer software system was installed for data collection and further modifications have been made to the reporting forms in an attempt to obtain maximum information and overcome objections about the complexity of the form. There is no doubt that a photocopy of the anaesthetic and recovery sheets is the most valuable information and leads to much better evaluation by the Council of the problems that have been reported and a better appreciation of the particular strategies undertaken by the anaesthetist.

   The Council has issued two information bulletins in the past year. These have been well received and serve to provide more recent information on complications, particularly in relation to newer techniques and drugs. Careful comments are made when particular trends are noted and when the Council believes such comments may aid anaesthetists in obtaining better facilities and in taking precautions so as to provide safer conditions for their patients. However, it is not the intent of the Council to be seen as dogmatic or averse to embracing new techniques.

   1993 is the first year in which extensive data has been recorded and in which there are more accurate figures on all perioperative mortality and it is expected that when these are analysed and reported there will be a better perspective about the very low rate of anaesthetic mortality.

   Peter Dawson and Pat Mackay have resigned as the Victorian Regional Committee Representatives on this Council.

2. **Safety**

   Problems dealt with during the year included problems with colour coding of gas cylinders and the potential interference of mobile phones with electronic equipment in theatre and similar areas.

3. **Paramedical Personnel**

   The ANZCA, ASA and APSF have supported the initiative to set up a nationally accepted curriculum of training for anaesthetic technicians.

   This curriculum has been compiled after discussion with the Regional Committees in Australia and has been submitted to the National Training Board for endorsement.

4. **Continuing Education**

   Once again a successful program of interesting topics were covered at the evening meetings.
   May 1993: Post Operative Myocardial Ischaemia,
   The Role of Hypoxaemia
   Professor Pierre Foëx, University of Oxford, UK
   June 1993: Hazards for Anaesthetists,
   Risks of Viral Infections especially Hepatitis & HIV
   Miss Kay McNaught, Royal Children's Hospital, Melbourne
   July 1993: Recent Advances in Beta Blocking Agents
   Dr Alan Lisbon, Harvard Medical School, USA
   September 1993: Pre-Emptive Analgesia: Fact or Fantasy?
   Assistant Professor Randall Carpenter, Virginia Mason Hospital, USA
   November 1993: Preservation of the Airway: The Development & Use of the Laryngeal Mask Airway
   Dr Archibald I.J. Brain, Northwick Park Hospital, UK
   December 1993: CPR – An Exercise in Futility?
   Associate Professor Vic Callanan, Townsville General Hospital, Qld

(Victoria continued)

March 1994: Plasma Products: Big Business, But What Risk?
Safety issues of blood products and new developments in Albumin Solutions
Ms Boon Yap, CSL Limited
April 1994: Anaesthesia for the Pregnant Cardiac Patient
Dr José Carvalho, Faculty of Medicine, Brazil

The Annual Combined ANZCA/ASA CME Meeting "Anaesthesia for the Elderly" Meeting held in August 1993 attracted approximately 150 registrants. Professor Leo Booij from The Netherlands proved to be an extremely capable and hard-working visitor.

Arrangements for the forthcoming Annual Combined ANZCA/ASA CME Meeting on "Anaesthesia and Co-Existing Diseases" for Saturday, 13 August, 1994, are proceeding well. A registration form will be distributed shortly. The international guest speaker for this meeting is Professor Robert Stoelting from the Indiana University of Indianapolis.

5. EDUCATION

5.1 Hospital Rotations

There have been changes to the attachments of some of thc rural and smaller hospitals involved in the hospital rotation programs. The increasing number of rotations decreases the ability of the Regional Education Officer to readily assess the trainee load at a regional level; however, it does improve the access of trainees to specialty areas of anaesthesia.

There have continued to be applications for accreditation of additional trainee posts but many of these had been deferred until the apparent shortage of paediatric and obstetric training posts was resolved.

5.2 Formal Projects

The Formal Projects Officer has approved eight projects, one of which needed to be resubmitted. Those projects which were presented at the Registrars' Scientific Meeting were accepted, however, it was resolved by the Regional Committee that there would no longer be acceptance simply on the basis of such presentation, and that they would need to be assessed by the Formal Projects Officer.

5.4 Supervisors of Training

The meeting of Supervisors of Training was held on 27 July, 1993, with an excellent attendance. This meeting was preceded by a special address by Dr K Cronin regarding the new format for the Fellowship Examinations.

With regard to the changes in feedback to candidates for the Primary Examinations there was strong support and appreciation.

In relation to the regional courses there was a general feeling of sympathy towards trainees from other regions who do not have the same opportunity to attend courses. However, it was agreed that although trainees from other regions should be welcomed, when there is a limitation on numbers, Victorian trainees should not be disadvantaged.

5.4 Courses

These continue to be well attended and well received. The format of the courses has been so successful that they have remained unchanged over the past few years. An additional one week tutorial type "short" course was commenced last year for Victorian trainees.

Dr Noel Cass organises the Primary courses and Dr Garry Donnan organises the Part II courses; they are to be congratulated for the sustained excellence of these courses.

Dr Noel Cass has retired as Convener of the Primary Fulltime Course after a remarkable contribution spanning approximately 30 years. We are very grateful for Noel's tremendous contribution. Dr Philip Ragg has agreed to take up the challenge, along with Dr Garry Donnan.

(Victoria continued)

6. Intensive Care

Numbers of vocational Intensive Care trainees in this State appear to be progressively decreasing. This is true for both RACP and ANZCA based trainees. At the same time, many of our larger units are increasingly staffed at a junior level by emergency medicine trainees. This trend is of concern to Victorian Intensivists.

Faculty of Intensive Care

With the formation of the Faculty of Intensive Care this year, regional Faculty structures are under discussion.

Accreditation visits completed:

July 1993: Geelong Hospital; February 1994: Monash Medical Centre;
March 1994: Wellington Hospital, Dunedin Hospital, Christchurch Hospital.

7. Formal Project

The following formal projects were approved while Dr Geoff Beemer was the Formal Projects Officer of the Victorian Regional Committee.

1993:

The Pharmacokinetics of Tiopentone Isomers – Dr Dianne Stephens

Complications of Continuous Spinal Anaesthesia – Dr Philip Peyton

ACE-Inhibitors, Calcium Antagonists and Low Systematic Vascular Resistance Following Cardiopulmonary Bypass: A Case-Control Study – Dr Igor Oleinikov

Carbon Dioxide, Temperature and Laparoscopic Cholecystectomy – Dr John Monagle

Pharmacokinetic Interactions between Midazolam and Propofol: An Infusion Study – Dr Jin Hui Teh

Efficacy of Oxygen Supplementation during Upper Gastrointestinal Endoscopy – Dr Colin Royse

Autonomic Hyperreflexia Induced by Passive Muscle Stretching: Implications in Anaesthetic Management of Spinal Cord Injured Patients – Dr Geoff Frawley

Anaesthetic Agents and Myocardial Ischaemia: A Review – Dr J Cudis

An Audit of Anaesthetic Gas and Vapour Consumption in a General Hospital – Dr Mark Colson

1994

Primary Pulmonary Hypertension: Prolonged Cardiac Arrest and Successful Resuscitation Following Induction of Anaesthesia for Heart-Lung Transplantation – Dr Jenny Hall

Amniotic Fluid Embolism: Case Report and Management Guidelines – Dr Robert McDougall

Pain on Injection of Propofol: Modification by Nitroglycerin – Dr Malcolm Anderson

Volumetric Estimation of Cardiac Output using TEE – Dr Mathew Benson

The Effect of Scavenging on Nitrous Oxide Pollution in the Delivery Suite – Dr Barbara Heath

Combined Epidural and General Anaesthesia Versus General Anaesthesia for Abdominal Aortic Surgery: A Prospective Randomised Trial – Dr Frank Liskaser

End-tidal Oxygen Measurement Compared with Patient Factor Assessment for Determining Preoxygenation Time – Dr Howard Machlin

Single Versus Double Occlusive Dressing Technique to Minimise Infusion Thrombophlebitis: Vialon and Teflon Cannulae Reassessed – Dr Winifred Burnett

Double Sequential Lung Transplantation – Dr John Moloney.

(Victoria continued)

8. Treasurer's/Finance Report

The forward planning and anticipated expenses involved in expansion of the secretariat has been allowed for in the budget process.

Primary	25300.00
Primary Tutorial	1000.00
Part II	9100.00
Medical Refresher	525.00
CME Meeting ($2220.94 = 50% ANZCA/50% ASA)	1110.47
TOTAL	**$37035.47**

I wish to acknowledge Mr Ross Blain's support and guidance and trust he enjoys his retirement. I welcome the continuing support of the new College Accountant, Mr Julian Miller.

9. Victorian Medical Postgraduate Foundation Inc.

The VMPF has continued its tradition of educating and supporting medical practitioners and has several current activities including:

- Benzodiazepine Package
- Drug and Alcohol Education Strategy
- National Medical Placement Matching Service
- Metropolitan Education Program
  - — occupational medicine
  - — advice to the traveller
  - — emergencies in general practice
- Country Education Programs

Following meetings of the Medical Professional Association, including the Victorian Regional Committee, ANZCA, recommendations for the Healthcare Professional Association Section on Statutory Immunity for Quality Assurance activities was submitted including guidelines for appointment of a Committee, accountability and action plans.

10. Social

A dinner was held at Café La for Dr José Carvalho following his recent presentation on "Anaesthesia for the Pregnant Cardiac Patient".

11. Other Activities

11.1 College Opening

Although not a formal Victorian Regional Committee responsibility, this day was probably the highlight of the year. The new premises are extremely impressive and the Committee will make full use of the facilities in the conduct of its activities.

11.2 Training

The Committee has attempted to address the difficulties faced for some time in providing sufficient training positions in obstetrics and paediatrics. With the support of the Health and Community Services Department an additional four positions have been accredited at the Royal Children's Hospital, Royal Women's Hospital, Monash Medical Centre and Mercy Maternity Hospital. An additional four positions have also been accredited in the rotations to complement these positions. Further solutions are also being sought to ensure that all trainees gain adequate training in all specialised areas.

11.3 Purchase of Equipment

The Victorian Regional Committee has undertaken to purchase audio-visual and other equipment for use at "Ulimaroa". This will be used for educational activities including Part I and Part II short courses.

(Victoria continued)

11.4 Health and Community Services

On 9 May Dr Michael Davies and Dr Garry Donnan met with Dr John Patterson, Secretary, Health and Community Services to discuss his paper "A New Look at Medical Workforce Strategy".

Generally, Dr Patterson was pleased with the organisation of anaesthetic training in Victoria and agreed that this College is not restricting the numbers of specialist anaesthetists in training. Dr Patterson accepted an explanation of the duties of full-time anaesthetists and their involvement in training, research and administration. Matters relating to workplace distribution, remuneration and future planning were discussed.

11.5 Victorian Regional Committee Secretariat

Mrs Veronica Quetglas holds this position and has worked extremely hard to ensure that the Committee has functioned efficiently. Her assistance has been greatly appreciated by the Committee.

Garry Donnan
Chairman

TASMANIA

Regional Committee

Chairman
Dr Mike Martyn
Deputy Chairman & Secretary
Dr Lachlan Doughty
Treasurer
Dr Simon Fraser
CME Officer
Dr John Madden
Regional Training Officer and Formal Project Officer
Dr Michael Lorrimer

Dr Mike Martyn

Membership of Regional Committee

The composition of the Regional Committee underwent some change in the past twelve months. Dr Zacks resigned in July 1993 as he was accepting an appointment in Vanuatu for two years. Consequently Dr S. Fraser was co-opted to the committee.

Biennial elections were held during April 1994. Drs Martyn, Madden and Doughty stood down. Drs Matters, Blaxland and Walker were elected in their place and Drs Lorrimer and Fraser were re-elected. Areas of responsibility have not yet been decided.

Committee Meetings and Attendance

23 May 1993, Launceston; 8 August 1993, Launceston;
16 October 1993, Hobart; 27 February 1994, Launceston.

Drs Martyn, Lorrimer and Doughty attended all meetings; Drs Madden and Fraser were unable to attend one meeting only.

College Meetings; Visiting Speakers

The Combined College/ASA Annual Scientific Meeting was held at the Wrest Point Casino, Hobart, 16 October 1993. The visiting speakers were Professor Thara Tritrakarn (Thailand) and Dr Andrew Ross (Vic).

As the College ASM was held in Launceston in May 1994 the usual local scientific meeting for May has been held over. The ASM will be reported separately, but first impressions are that it was both a scientific and social success.

On the retirement of Dr John Madden from the Committee I would record the appreciation of the rest of the Committee and the Tasmanian Fellowship in general for his dedication and consistent effort which have resulted in the high quality of scientific meetings enjoyed by us all while he has been CME Officer.

Training

Five candidates sat for the Primary exam, four were successful. One candidate sat the Final exam and was successful.

Other Issues

The entire Regional Committee has been involved in the Organising Committee of the ASM which has occupied most of our available time. However, the Regional Committee has made submissions to Council on both "informed consent" and "maintenance of standards".

The only continuing matter outstanding is the function and relationships of the NH&MRC working party on deaths under anaesthesia.

Lachlan Doughty
Secretary

Regional Committee

Chairman
Dr L.F. Wilson
Deputy Chairman
Dr J.H. Havill
Honorary Secretary
Dr C.J. Pottinger
Honorary Treasurer
Dr I.A. Ross
Education Officer (Intensive Care)
Dr F.E. Bennett
Education Officer (Anaesthesia)
Dr M.E. Futter
Dr D. Jones
Projects Co-ordinator
Dr A.F. Merry
Other Members
Dr D. Murchison
Dr R.V. Trubuhovich
Councillors
Professor J.M. Gibbs
Dr R.S. Henderson

Dr L.F. Wilson

Dr C.J. Pottinger

NEW ZEALAND

Awards

Dr Mayne Smeeton was awarded the OBE in the New Year's Honours list for services to sports Medicine.

New Zealand Regional Committee

Sharon King from Christchurch is the new co-opted Younger Fellow, replacing Chris Pottinger who was elected on to the Committee at the last election.

The Past President, Dr Michael Hodgson, attended our March Committee meeting, meeting with Wellington Fellows the preceding evening. His visit provided a welcome opportunity to discuss with him the Committee's special concerns, whilst also allowing greater insight into Council's thinking on various matters.

Legislation – The Crimes Act 1961 Sections 155 and 190
''Medical Manslaughter''

The Committee's efforts to obtain an amendment to the above Act are slowly gaining momentum.

In July Dr Wilson took part in a delegation led by Alistair Scott which met with the Minister of Justice to seek the desired amendment. Also in the delegation were Robin Briant (Chair, Medical Council of New Zealand), Peter Martin (Chairman, Council of Medical Colleges), and David Collins (medical lawyer).

Dr Wilson also met with the Associate Minister of Health, Katherine O'Regan, the Director-General of Health, Chris Lovelace, Chief Medical Adviser Sharon Kletchko, the Opposition Spokesperson on Health, Helen Clark and written to the Core Health Services Committee.

In all the discussions we have emphasised firstly that New Zealand law is at odds with common law from other jurisdictions such as Australia and Canada in that it applies the civil standard (simple negligence) in a criminal law, where gross or reckless negligence is usually required. Secondly, we outlined the threat to standards and costs of health core services that **not** changing the current law and its application poses.

There has been some indirect indication that an amendment may be introduced into the House early next year, but the Committee still needs to continue lobbying for change.

The Medical Practitioners Bill still has not been promulgated. We have made a submission to the Social Services Select Committee on the Supplementary Order Paper to the **Health Commissioners Bill.**

Anaesthetist Mortality Assessment Committee

The Committee has discussed its request for an amendment to the Act to ensure total confidentiality of all reports to the Committee with Katherine O'Regan, Chris Lovelace, Sharon Kletchko and Helen Clark. Initially, efforts were directed towards achieving this via the now mythical Medical Practitioners Bill, however, because of the delay in its introduction, other legislative means are being explored. At the same time we have also been asking for this confidentiality to be given to reports to all such Committees, and that indemnity be given to all health professionals who take part in quality assurance and audit activities. Dr Wilson has been in contact with the Maternal Mortality Research Committee, which faces the same problems with the Anaesthetic Mortality Assessment Committee. Discussions have begun about developing an enquiry like the British Confidential Enquiry into Perioperative Deaths (CEPOD), however, this also awaits a change in the legislation.

Government Enquiries – Core Health Services

Regional Committee representatives have attended workshops to discuss the reports on Cardiac Surgical Services and Neurosurgical Services – meetings of debatable usefulness, but ones at which the Committee needed to be represented. No further such workshops have been held.

(New Zealand continued)

Professor David Stewart's Report to the Department of Health on **Entry to Specialist Medical Practice** was discussed at a workshop with interested groups. The report was received only two days prior to the workshop; the report itself was obviously hurriedly written and had major factual inaccuracies. We corrected the most obvious inaccuracies and protested at the superficial manner in which the perceived problems had been looked at.

Professional Matters – M. Med. degree

Both Otago and Auckland Universities are developing a proposal to introduce a postgraduate specialist medical degree, the M.Med. At present it is unclear whether it will be a full alternative specialist qualification, or an academic qualification complementary to the current specialist qualification.

The force driving this seems to be the funding crisis affecting the Medical Schools, and their perception that their contribution to postgraduate medical training is not recognised. While we have recognised the problems that Academic Anaesthesia and the Medical Schools face, and wish to support them, we do not consider that introduction of an alternative university based qualification is the way.

We see many problems with the M.Med. as a specialist qualification. Firstly, the universities appear to have an inadequate workforce, which is only present in a few hospitals. Secondly, the proposed qualification would not have the international recognition that our Fellowship does. Thirdly, the College has the ongoing commitment to continuing medical education, setting standards of professional practice. Fourthly, the College is less susceptible to political pressure, and more accountable to the profession. And fifthly, there is always our suspicion that anaesthesia may get "swallowed up" and lose its identity.

The Council of Medical Colleges is to meet with the Deans of the Medical Schools in November, when we are promised a properly set out proposal to discuss.

Dr Wilson attended the **Council of Medical Colleges** meeting, at which matters already referred to are discussed. In this way we can coordinate our activities so that we gain strength through unity. Chris Pottinger attended a Medical Council workshop on **"Sexual Abuse in the Doctor/Patient Relationship"**. We have a resource kit available for loan to aid discussions that Departments may have on this matter. Steuart Henderson and Dr Wilson attended a Glaxo meeting in which all the Colleges and specialist groups discussed their developments in recertification. Various members of the Committee have attended New Zealand Medical Association assemblies.

Internal Matters

This year the hospitals in the Auckland rotation were inspected, and they are now working to remedy the problems detected.

Cressy Free represented us on the Working Party of Standards for Pain Management. The New Zealand representatives on the Special Interest Groups are Alan Merry for Cardiothoracic and Vascular Anaesthesia, Mark Chapman for Day Stay Anaesthesia, Rob Fry for Acute Pain Management and Steuart Henderson for Neurosurgical Anaesthesia. Members of the Committee have also assisted in enquiries by the Medical Council and Area Health Boards into complaints.

The ground floor of Elliott House has been rented and the money received will cover many of the outgoings on the house.

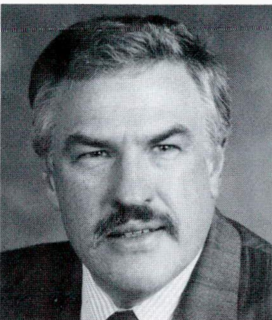
The Committee members have devoted much time and effort to the College, and I would like to thank them very much for their help for the work they put in and their tireless enthusiasm for the Committee's activities. I would like to mention especially Jack Havill, the Deputy Chairman; Isabel Ross our Treasurer; Chris Pottinger, the Honorary Secretary and Lorna Berwick our Administrative Officer for all the hard work they do to keep the Committee running smoothly, coordinating all its activities and ensuring that the College is well represented in New Zealand.

Leona Wilson
Chairman

Regional Committee

Chairman
Dr E.J. McArdle
Vice Chairman
Associate Prof. V.I. Callanan
Secretary
Dr M.D. Cobcroft, OAM
Treasurer
Dr J.P. O'Callaghan
Regional Education Officer (Intensive Care)
Dr R.F. Whiting
Regional Education Officer (Anaesthesia)
Dr J.M. Parslow
Continuing Education Officer
Dr J.F. Murray
Other Members
Dr B.J. McKenzie
Dr P.J. Moran
Dr R.L.S. Pascoe
Councillor
Dr D.H. McConnel

Dr E.J. McArdle



Dr M.D. Cobcroft, OAM

QUEENSLAND

Training
Courses were held for the 1st part candidates preparing for examinations. Formal teaching sessions open to all trainees are held at the Royal Brisbane Hospital. Some trainees have difficulties obtaining time off from clinical duties to attend these courses.

Congratulations to trainees successful in examinations this year. It is gratifying to see higher pass rates in the recent 1st part examinations.

Training positions are being lost, due to inadequate staffing of teaching hospitals. Currently, there are shortages at the Gold Coast, Nambour and Royal Brisbane Hospitals. Four positions will be lost when Repatriation General Hospital Greenslopes ceases its current modus operandi at the end of 1994. Redcliffe, Toowoomba, Princess Alexandra and Cairns Hospitals intend applying for extra positions.

In April, I convened a meeting between the Acting Director-General of Queensland Health and various representatives of the Anaesthetic Interest Groups. The deficiencies in the anaesthetic services in public hospitals particularly as they pertained to anaesthetists and anaesthetists-in-training were described. The Regional Committee had already contributed to a committee set up by Queensland Health to recommend improvements in staffing of Queensland public hospitals.

Continuing Education
The ANZCA/ASA combined regional meeting at Noosa in 1993 was very successful, and unfortunately over-subscribed. This year's meeting is on 2/3 July at the Gold Coast Sheraton Mirage.

The Country Meeting at Ipswich in November 1993 was well attended, mainly by Brisbane anaesthetists.

In May 1995, the College ASM will be held in Townsville.

Through my position representing ANZCA on the Queensland Committee of Medical Colleges, I was unavoidably drawn into debate with Queensland Health when they raised the proposal of using private hospitals for public patients. This proposal has subsequently been almost abandoned, at least for the time being.

I thank fellow committee members for their support over the years, and thank those who have represented the College when asked and/or been co-opted.

E.J. McArdle
Chairman

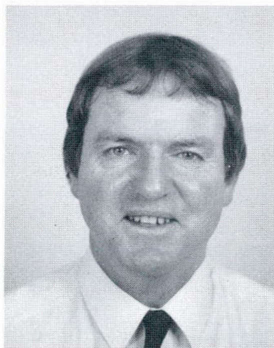
EXAMINATION PRIZE WINNERS

The Renton Prize for the half year ending 30 June 1994 was awarded to **Dr Peter A. Watt,** Queensland.

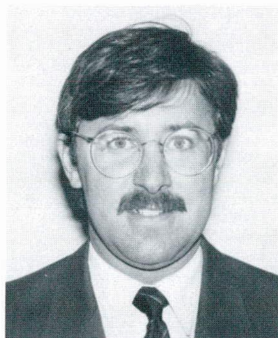
The Cecil Gray Prize for the May 1994 Examination was awarded to **Dr Pamela A.K. Edwards,** Queensland.

Regional Committee

Chairman
Dr B.L. Duffy
Deputy Chairman
Dr D.P. Tomkins
Honorary Secretary
Dr P. Franklyn
Honorary Treasurer
Dr D.P. Tomkins
Regional Education Officer, Anaesthesia
Dr A. Laver
Regional Education Officer, I.C.
Dr N. Matthews
Younger Fellows' Representative
Dr T. Semple (1993)
Dr A. Pearce (1994)
Ex Officio
Member of the Board Prof G.D. Phillips
Member of the Board Dr R. Willis
ASA Representative Dr J. Richards
Other Committee Members
Dr J. Crowhurst
Dr M. Cowling
Dr L. Seow
Dr T. Semple
Dr A. Laver
Dr S. Germann



Dr B.L. Duffy



Dr P.M. Franklyn

SOUTH AUSTRALIA

Meetings

The Annual General Meeting of the South Australian Regional Committee was held on Wednesday, August 4, 1993 at Calvary Hospital.

Continuing Education Meetings were held monthly at the Calvary Hospital unless stated otherwise:

1. June 2, 1993 - presentation by Dr Peter Farran of Foothills Hospital, Calgary, Canada: "Veterinary Anaesthesia in the Canadian Prairies".

2. July 7, 1993 - Registrars' Evening - Drs M. Fox, Nor, I. Metcalfe and G. Ludbrook participating.

3. August 4, 1993 - presentation coordinated by Dr John Russell, "Anaesthetic Machine Update".

4. September 1, 1993 - presentation "What do Anaesthetists and Computers Have in Common?" - Drs Bob Webb, R. Lee & D. Sainsbury participating.

5. November 10, 1993 - Dinner meeting at the Don Bradman Room, Adelaide Oval - "Acute Pain Management". Speakers were Drs Glenda Rudkin, D. Tomkins, T. Semple, S. Simmons and D. Jervis.

6. November 17, 1993 - presentation at Ashford Hospital by Dr Archie Brain of Northwick Park Hospital, Harrow, United Kingdom. "Development and Clinical Usage of the Laryngeal Mask Airway".

7. March 2, 1994 - presentation "Liver Transplantation: Interesting Aspects for the Anaesthetist". Speakers were Prof. G. Phillips and Drs P. Lillie and S. Inglis.

8. April 6, 1994 - presentation "Chemical Dependency and Anaesthesia". Speakers were Prof. Ross Kalucy and Drs J. Pattison and C. Acott.

AFC Meeting was held in Adelaide from May 9-14, 1993.

YFC Meeting was held at Wirrina, south of Adelaide from May 7-9, 1993, with the theme "Factors Affecting Surgical and Anaesthetic Practice Before the Year 2000".

Matters of Concern to S.A. Fellows

Certification of Maintenance of Standards
The working party document was well received as was the opportunity to forward comments to the Council. The ongoing development of this issue remains of major interest to all Fellows.

Qualification in Pain Management
Following acceptance of the Policy Document E12 "Minimum Standards for Pain Management Units" consideration will be given to matters of curriculum and training for a qualification in Pain Management. The Regional Committee will have a role in implementation of the matters.

College Guidelines
Concerns were expressed by the Regional Committee, about the suggestion of restrictive workload criteria in a V.H.A. article entitled "Concern over ANZCA Accreditation Visits". It was felt the College should vigorously defend its recommendations on the level of anaesthetic staffing.

Informed Consent
With the NH&MRC having promulgated general guidelines on consent, the College Council is looking at more specific guidelines in relation to Anaesthesia and Consent.

Anaesthetic Assistants
Following the receipt of the draft copy of "Competence/Skills Required by Anaesthetic Technicians or Persons Providing Assistance to Anaesthetists", the Regional Committee felt this developmental document was aimed at setting acceptable standards which

(South Australia continued)

training courses will be expected to meet, whether they be for anaesthetic technicians or anaesthetic nurses. It was suggested the requirements will vary from state to state. Currently in South Australia, the feeling is that there are many obstacles to the development of anaesthetic technicians independent of nursing staff. This will remain an important long term issue in this region, with the development and definition of acceptable standards a positive move.

Supervisors of Training
Concerns were expressed regarding the legal issues/problems potentially facing Supervisors of Training in regard to registrar assessments and appointments. It was felt a more quantitative assessment of clinical performance may help avoid problems by providing more objective data. It is understood the Council is considering matters of In-Training Assessment, and with further development greater guidelines for assessors/ supervisors can be expected.

Correspondence and Major Discussions

Faculty of Intensive Care / ANZCA
Special Interest Groups
The Impaired Anaesthetists/Medical Competence - Age/Health
Burnell Jose Visiting Professorship - 1995
Rural Anaesthesia - Visiting Proceduralists, Guidelines SAHC
- Certification of Rural GPs
DRGs for Anaesthesia
College Headquarters
Australian Hospital Care Study - SA/NSW
Workforce Requirements

P. Franklyn
Honorary Secretary

AUSTRALIAN CAPITAL TERRITORY

Regional Committee

Chairman
Dr B.T.S. Kwan
Secretary Treasurer
Dr R.W. Cook
Regional Education Officer
Dr T.L. Dobbinson
CME Officer
Dr G.J. Flynn
Other Member
Dr H.J. Lopert

Dr B.T.S. Kwan

Dr R.W. Cook

Honours
Our first Honorary Fellow of the College, Professor Michael Denborough, had his Fellowship conferred at the College Ceremony in Launceston. Professor Denborough's original achievement is well known to all anaesthetists, less well known are his efforts over the years to ensure continuing research into neuromuscular disorders at John Curtin University with the provision of testing for Malignant Hyperpyrexia susceptibility for patients referred from across Australia.

Dr Gerald Flynn has been elected a Fellow of the Australian Medical Association.

Education
Last year's *"Art of Anaesthesia"* was most successful with thanks to the many people who helped. We plan to hold another this year - 17th & 18th September - in another intriguing venue.

Whilst the VMOs dispute was disruptive to many activities, registrar training was able to continue.

Congratulations to the two successful Primary candidates. Currently the two training positions are occupied with one vacant.

HONORARY TREASURER'S REPORT

The Annual Audited Financial Statements of the College for the year ending 31 January 1994 are presented. This report provides an interpretation of the figures shown in the Statement and Statutory Report.

For the second year in a row, these statements are complicated by two major factors. Firstly, the purchase of the new College Headquarters, "Ulimaroa", has resulted in a restructure of the Balance Sheet. Cash & short term investments were applied in paying for this building which led to a reduction in the Current Asset "Investments" and a corresponding increase in the Non-Current Asset "Property, plant and equipment". Reflecting this transaction in the Equity section there was a transfer from the Development and Trainees Funds to the Fellows Funds which "holds" the building asset. The second factor is that the figures for 1993 (for the year ending 31 January 1993) are those for the College only, which was established on 7 February 1992 and received the financial assets of the Faculty of Anaesthetists RACS on 2 March 1992. In other words, direct comparison of these published figures for 1993 and 1994 are in many cases invalid. The 1993 consolidated figures of the College and the Faculty were published in the August 1993 *Bulletin* of the College and should be referred to for a more realistic comparison with the Financial Statements for 1994.

Reference may also be made, in understanding the current Financial Statements of the College, to the November 1993 *Bulletin* article entitled "What do we get for our College Subscriptions and Trainees' Fees?"

REVENUE AND EXPENDITURE STATEMENT

This statement outlines all revenue and expenditure of College funds. On the basis of these figures, revenue increased by only 2% and expenditure actually decreased by 12% compared with the consolidated figures for 1993. (Refer to Figures 1 & 2 respectively for a breakdown of total revenues and expenses).

The surplus of $952,732 is somewhat deceptive as a stand-alone figure, as about $352,000 was from earnings on deposits with financial institutions, which are distributed proportionally to each fund held by the College (particularly the ANZCA Foundation), and about $240,000 was distributed as always from the Subscription Account to the Development Fund and the Foundation Fund. (Refer to Figure 3). This leaves a realistic surplus of nearly $360,000 for the 1994 year – a relatively modest contribution to the strategy set three years ago in building up the reserves of the College in anticipating the major expense of establishing the College and purchasing a College Headquarters.

BALANCE SHEET AS AT 31 JANUARY 1994

This statement presents the overall monetary value of the College in the Auditor's terms. The total assets of the College are shown as $7.435 million. The net assets, after deducting liabilities, are $5.27 million. In summary this may be dissected as follows. The majority (almost $1.8 M) of the liabilities are subscriptions-in-advance and prepaid trainees' fees for the coming year. This amount will show as a revenue item for the year ending 31 January 1995 and is not a "real liability" (in that money is owed to an external party). With the assets, approximately $1 M is held in liquid cash and sundry debtors, $4 M is in short and medium term investments and $2.5 M is tied up in land and buildings, including our new headquarters.

The various Funds in the Equity section represent the net assets of the College. In particular, the Fellows Fund with a balance of $2.7 M, represents the day-to-day working capital and as stated earlier "holds" the physical assets such as the building. The Foundation Fund, with a balance of $2.2 M, represents funds held for research and continuing education activities. It should be kept in mind that Equity equals Total Assets minus Total Liabilities. Therefore a balance in any particular Fund does ***not*** represent cash awaiting disbursal.

As stated above the true cash reserves of the College are just over $1 M. For a non-profit organisation with an annual expenditure of over $2 M and visions of further promoting the status and role of our profession, $1 M is not regarded by the College Council as an excessive cushion for financial complacency.

SUBSCRIPTION ACCOUNT

This account provides for the daily running of the College and includes expenditure on administration and various special activities. (Refer to Figures 3 and 4). 10% is transferred annually to both the Foundation Fund and the Development Fund, and a proportional contribution is transferred from the Trainees' Fund to the Subscription Account for administrative costs of the training and examination system. Increased expenditure over 1993 is attributed mainly to the cost of renovating the new College Headquarters and the cost of incorporating the new College.

The surplus of $204,094 was transferred to the Fellows' Fund, which along with the Trainees' Fund surplus of $154,086, represents the total operating surplus referred to above. Although not shown in numerals, the nett deficit of the Subscription Account at 31 January 1994 was therefore zero.

FELLOWS' FUND

This fund represents the Fellows' share in net assets of the College and includes a proportion of the value of the College buildings and other physical assets. Increases in the value of this fund relate to income from investments, surplus from the Subscription Account and transfers from other funds for the purchase and renovation of the new College Headquarters. The Fellows' Fund is to be amalgamated with the Development Fund in the current year and renamed with a more descriptive title.

FOUNDATION FUND

The ANZCA Foundation receives funds from several sources for use on research and educational activities. (Refer to Figures 5 and 6). The corpus has risen to over $2.2 M, enabling major funding of research projects and other special educational activities. General donations to the Foundation are minimal and disappointing.

DEVELOPMENT FUND

This fund was established many years ago for the specific purpose of holding and expending assets to be used for major building and other purposes. The fund has been significantly utilised for the purchase of the new College Headquarters and the balance will be incorporated with the Fellows' Fund into a new renamed Fund in the new year.

TRAINEES' FUND

This fund provides for the College training and examinations system, aiming to run at a minimal and safe surplus in terms of projected expenditure. The circumstances of purchasing and renovating the new College Headquarters necessitated a significant contribution from the accumulated balance of the Trainees' Fund for this purpose. (Refer to Figures 7 and 8). The surplus for 1994 was $154,086, reduced from the 1993 figure, all resulting in an end of year balance for the Fund of $167,539 – considered by Council as an uncomfortable cushion when annual expenditure exceeds $900,000.

CONCLUSION

As Honorary Treasurer of the College, I have no hesitation in stating that the financial status of the College is very sound.

It is most notable that our cash reserves have been built up over a number of years in anticipation of the costs of the establishment of the College, the requirement to acquire and occupy premises for a College Headquarters, and new and necessary initiatives on behalf of Fellows and Trainees. These activities have been achieved thus far without any levy, special fee or other fund-raising activity being imposed. The policy of Subscriptions in Advance may be controversial but it must be acknowledged that interest earned from such payments has significantly contributed to the ability of the College to support research and education in our professions by over $230,000 in the year ended 31 January 1994.

Subscriptions and Trainees' Fees to all professional bodies are always a burden but ultimately lead to advancement of the specialty, especially towards the status and promotion as professionals. The currently recognised major status and stability of our new College reflects much planning and foresight by past Boards and Councils of the Faculty-cum-College, particularly assisted by the financial guidance of past Treasurers, Associate Professor Peter Livingstone and Dr Michael Davies.

Special thanks for this report again go to Mr Ross Blain, Head of our Finance Department. Ross recently resigned from his position in the College having served the Faculty/College as its first independently-employed financial advisor and accountant. His departure is regretted, especially given the great success that Ross has had in guiding the new College into its new financial status as a totally independent body. In the meantime, I welcome Mr Julian Miller as the College Accountant.

Finally, I note the indebtedness that all Fellows and Trainees must acknowledge to the College Registrar, Mrs Joan Sheales, and all other College employees for their efforts and personal devotion to administration of the College. As medical practitioners, we are always wary of moneys spent on "administrators" and their employees. Responsible for every College dollar spent, I state that I believe the staff of the College perform their duties with extraordinary excellence.

I invite all Fellows and Trainees to study this Report and accompanying Financial Statements ending 31 January 1994, and to express (in writing to me) any queries or concerns.

RICHARD G. WALSH

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

May 1994