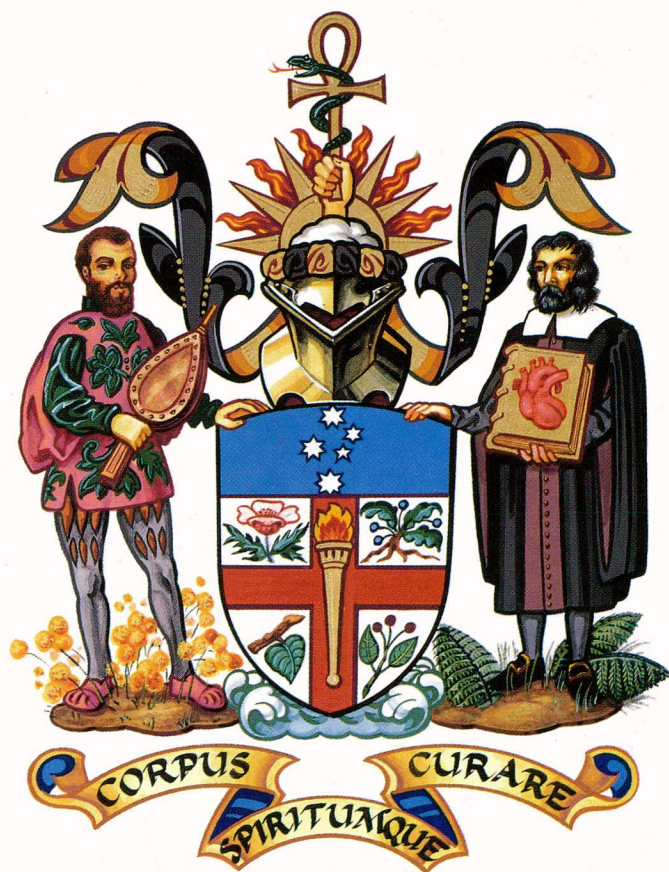


AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852



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EDITORIAL

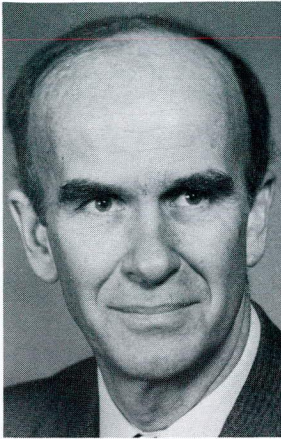
Mrs J.M. Sheales, *Editor*
Prof. J.M. Gibbs
Dr I. Rechtman

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PRESIDENT'S MESSAGE



The College has a new home. An offer to purchase a stately building at 630 St Kilda Road, Melbourne has been accepted and contracts exchanged. Settlement will be in ninety days. The building which was once a Physician's home and is now offices, is of a size such that after minor refurbishment the College can move in and it will be business as usual. Naturally all the facilities available at

the Spring Street Headquarters will not be immediately provided, but agreement has been reached with the Royal Australasian College of Surgeons that our access to the Great Hall and lecture rooms will not, for the next few years, vary from what applies now.

Purchase of the building will be possible from College reserves and there will be no levy. Once the purchase has been finalised I will provide more comprehensive information about our new home.

Having just returned from the Annual Scientific Congress in Adelaide, I must say that the College should feel proud of its contributions at the Congress. The Scientific Programme was one of the best we have had for many years and one which was of benefit to all Fellows whatever the nature of their practice.

Our Foundation Visitors and our Australasian Visitor were excellent and were complemented by many good local speakers. The social events were relaxed and happy and I do believe showed a unity in the College. Successful meetings do not just happen and the local Organising Committee must be congratulated and thanked for all their efforts on our behalf.

There are a number of important professional and standards issues that are on the College agenda and usually also on the agenda of Government.

The escalating medical indemnity premiums are of great concern, particularly in the larger States. When

discussed recently at the Executive Committee Meeting, it was questioned as to why anaesthesia should remain a high risk group because of our improved teaching and training, our involvement in quality assurance activities, critical incident reporting and most importantly, our monitoring policy document. It transpires there has been a significant increase in the size of indemnity payments and legal costs associated with claims made relating to events that occurred some years ago, prior to our recent initiatives.

There is continual confusion about the implementation of the anaesthetic curriculum of the training programme of the Faculty of Rural Medicine of the Royal Australian College of General Practitioners (RACGP). The College has endorsed this curriculum which is to be trialled in 1993, however to date, we have received no details as to these trials. At a recent meeting of our Joint Consultative Committee Anaesthesia, it was agreed that good communication must exist between our two Colleges. As more information comes to hand it will be passed onto the Fellowship.

Fellows in two Regions are involved in discussions relating to work contracts. Whilst financial matters are outside the brief of the College and involvement specifically precluded by our Memorandum and Articles of Association, the College will involve itself in industrial matters if and when they impinge upon teaching, training and standards. To indicate the interest of the College in this area I have written to the professional organisations involved in industrial matters requesting that in their negotiations on our behalf they take into account our teaching, training and standards requirements.

Two policy documents of great relevance in discussions on work contracts are our documents E6 and E8 which respectively outline the duties of an anaesthetist and an intensive care specialist in Hospitals with Approved Training Posts. These documents outline the need for Specialists to have adequate time outside the Theatre or Intensive Care Unit for administration, quality assurance and educational activities including teaching and research.

Further quality assurance Legislation has been passed by Government. Late last year the Federal Government passed Legislation which overrides State Legislation where the matter can be dealt with by a Federal Court and which can apply to quality assurance activities not covered by State Legislation. The Commonwealth Act is similar to that applying in most States but is not altogether acceptable to the Committee of Presidents of Medical Colleges and the Australian Medical Association. The specific concern is a clause which permits the Minister to authorise the release of factual information about an indictable offence.

This is the last opportunity I will have to communicate with the Fellowship before the new Council meets. On your behalf I would like to thank all the Council for their loyalty and hard work, the Registrar and her staff for their untiring efforts and the many Fellows who quietly work behind the scenes and help make the College what it is.



MICHAEL HODGSON



The President, Dr Michael Hodgson, signing the Transfer to obtain the title deeds to the College Headquarters at 630 St Kilda Road, Melbourne with Dr Michael Davies, Vice President.

STANDARDS UPDATE

It has been a busy time in the world of standards writing both nationally and internationally. Australia has its first standard on anaesthetic machines, entitled AS4059-1992 Anaesthetic machines — Non-electrical — For use with humans. The standard specifies basic requirements for anaesthetic machines and associated components up to and including the common gas outlet. In keeping with Standards Australia's philosophy the document is based on ISO 5358 Anaesthetic machines for use with humans. Requirements of this publication have been modified to take into account local conditions. The standard does not apply to machines which depend primarily on electric or electronic means for control and major differences from ISO 5358 are in areas such as mandatory colour coding of vaporisers, the reduction in allowable leakage of gases and proper performance testing of pressure regulators.

Currently in draft are standards on respiratory therapy equipment viz — jet nebulisers and jet nebuliser air pumps, and peak expiratory flow meters, both of which do not have any guidelines for manufacture. These devices are very widely used in the community in the treatment of asthma and concerns were expressed by the Department of Health, Housing and Community Services about the lack of accuracy of for example peak expiratory flow meters on the market. Their concerns were that treatment regimen were being instituted in an uncontrolled fashion. These two standards, currently in draft phase, are being overseen by Committee HT7.

Internationally we now have standards on pulse oximeters and capnometers, arguably two of the most important pieces of equipment in an anaesthetist's armamentarium.

Other recent areas of interest overseas have involved scavenging systems and standards on alarm signals. In Washington D.C. in October 1992 the Australian delegation was paramount in the introduction of a scavenging system which would be fool proof to the hazard of misconnection, resulting in back pressure to the patient circuit and consequent morbidity. This problem has occurred in Australia and was not fully appreciated internationally. A collection system (for waste gases) conforming to a directional gender connection series (i.e. male to female, male to female) was proposed by Australia. This was eventually modified and accepted. Australia had won the day!

Alarm signals and their standardisation had been the source of controversy for a long time. A document on visual alarm signals has now been published as a standard. It is pleasing to see some of the newer monitors conforming to the standard on visual alarm signals. A second part to the document on auditory alarm signals has generated enormous discussion. As practising clinicians many of us become constantly confused over the cacophony of alarms in the operating theatre, unsure as to which monitor is alarming, and the degree of importance of these noises. It is not easy to try and reach a consensus on a simplified set of auditory signals which could be used as a common basis for all auditory alarm signals.

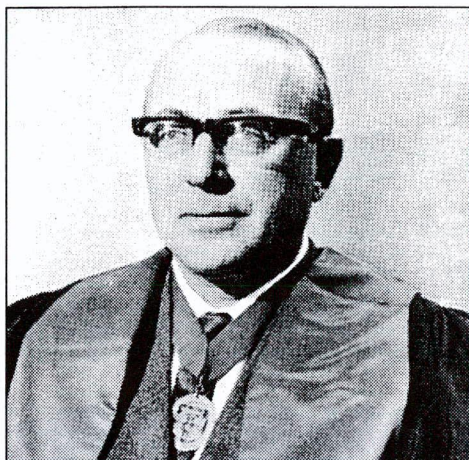
A standard is being drafted on the "new generation anaesthesia machines" which include gas mixing devices and other electrical monitors. To date this document has generated spirited discussion and it will be some time before the standard is finished.

CHRIS JOSEPH

OBITUARY

PROFESSOR WILLIAM MUSHIN

HONORARY FELLOW



Professor William Woolf Mushin, CBE, Professor and Director of Anaesthetics, at the Welsh National School of Medicine, 1947-75, died on January 22, 1993 aged 82. He was born in London on September 29, 1910.

William Mushin played a major role in transforming anaesthesia from a shaky art, almost wholly practised by General Practitioners, to a scientific speciality which is now the largest in the hospital service. He also contributed greatly to pain relief, intensive care and resuscitation.

He went to Wales in 1947 from Oxford University, where he had been first assistant to Sir Robert Macintosh. His task, to found a new department, resulted largely from the concern of the Cardiff Coroner about the excessive contribution anaesthesia was then making to deaths under surgery. After searching analysis, Mushin recommended that university and hospital authorities reorganise their services and suggested a rotational scheme for post-graduate training. He emphasised the need for research and pointed to serious deficiencies in obstetric anaesthesia and pain relief. After that, the anaesthetic services so improved that death from anaesthetic became unusual despite the fact that much more surgery was carried out on high risk patients.

In 1982 Mushin was chosen to lead a national study on post-operative deaths, and from this emerged the present National Confidential Enquiry, an audit which has won high praise from all over the world. From a situation in which there were few specialists in Wales, Mushin's trainees came to fill more than a hundred consultant anaesthetist posts.

The university chair to which he was appointed was only the second in the United Kingdom. From it Mushin put into practice his belief in the importance of the basic sciences — physics, pharmacology and physiology — to anaesthetics by appointing a physicist and a physiologist to his department. One of his first textbooks, *Physics for the Anaesthetist* (with Robert Macintosh, 1946, 4th edition 1987) is a classic.

Mushin's emphasis on a knowledge of gas flows and breathing circuits for clinical management, became even more important when artificial ventilation was introduced for cardiothoracic surgery. Outside the operating theatre it had a vital function in the period after the 1952 polio epidemic.

It had by this time become crucial to understand how the increasing number of lung ventilators could be assessed. Mushin's textbook *Automatic Ventilation of the Lungs* (1959, 3rd edition 1980) for the first time classified ventilators as well as analysing their

interaction with patients with varying lung function. This was an essential step for progress in intensive care.

Mushin spoke and wrote authoritatively in the debate which he initiated on the role of anaesthetics in intensive care. He disapproved of anaesthetists who were involved only at the technical level in operating a ventilator. In what was often a passionately-conducted debate he expressed his views in public and the medical journals with commendable moderation. In the United States he became the first non-American to deliver the prestigious Rovenstine Lecture to the American Society of Anaesthesiologists on "The Rise and Fall of the Anaesthetist". As a result of his initiative there was a great leap forward in the standard of intensive care. These days more than 90 per cent of intensive care units in the U.K. are directed by anaesthetists.

Mushin was also a pioneer in the treatment of chronic pain, so helping those whom other doctors could not treat. At first, like others, he attempted only nerve blocks. But he soon realised that these brought limited success and began to teach the importance of reviewing the whole patient and offering sound, sympathetic support. He was a founder of the Pain Society and for his contribution was elected life president.

His research output focused too, on drugs, in particular anaesthetics and analgesics, and his carefully executed work resulted in his appointment to the newly formed Committee on Safety of Medicines and later, the Medicines Commission.

He led the specialty as Dean of the Faculty of Anaesthetists of the Royal College of Surgeons from 1961 to 1964. But he believed that as anaesthetics was not a branch of surgery it should have an independent academic organisation. He made his views widely known, with some trenchancy, and for some years the speciality was split. To his great pleasure, in 1992 a charter was granted to the Royal College of Anaesthetists through the sponsorship of the Royal College of Surgeons of England.

William Mushin was religious and had a lively conscience. He had become interested in Progressive Judaism, based upon his broad religious education and subsequent study. He was a founder member of the Reform Synagogue in Cardiff, attracted by the re-examination and re-affirmation of fundamental beliefs and principles in the context of present society.

His is survived by his wife, Betty, three daughters and a son.

DEATHS

Council noted with regret the following deaths:

Dr Vivian E. Rees, SA, FFARACS 1970, FANZCA 1992

Professor William Mushin, CBE, U.K., Honorary Fellow

Dr Alfred L. Nathan, Vic, MFARACS 1956, FANZCA, 1992

HONOURS

Dr G.J.L. Flynn, ACT - Elected to the Roll of Fellows, Australian Medical Association

Professor Teik Oh - Elected Fellow of the Royal Australasian College of Physicians



Dr Scott Germann, Chairman, South Australian Regional Committee, proposing a toast to the College during the College Dinner at the Annual Scientific Congress.

ROBERT ORTON MEDAL

Citation — Ross Beresford Holland

“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.”



Presentation of the Robert Orton Medal to Professor Ross Holland by the President, Dr Michael Hodgson, at the Convocation Ceremony of the Annual Scientific Congress in the Bonython Hall, The University of Adelaide, 12th May, 1993.

Mr President,

I have the honour to present to you, **Ross Beresford Holland.**

Ross Holland was born and educated in Sydney, qualifying M.B., B.S., University of Sydney in 1952. He served his Junior and Senior residencies at St Vincent's Hospital and subsequently moved to Lidcombe Hospital, where he became an Anaesthetic Registrar. Ross completed his training at Royal North Shore Hospital, gaining his Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons in 1959. He then spent nearly twenty years as a Specialist Anaesthetist at Lidcombe Hospital.

In 1966 he served a term as Specialist Anaesthetist with one of the Australian Surgical Teams at Long Xuyen in South Vietnam.

In 1978 he became the first Director of Anaesthesia and Resuscitation at the newly erected and impressive Westmead Hospital. He was appointed a part-time Lecturer in Anaesthetics at Westmead Centre and was a Member of the Board of Clinical Studies at the Institution between 1979 and 1982.

Over a period of ten years, his development of the Department created one of the best training departments in Sydney.

In 1987 Ross was appointed Professor of Anaesthesia in the University of Hong Kong at St Mary's Hospital and served in that position for nearly three years until he returned to Australia to become the first Professor of Anaesthesia and Intensive Care at the University of Newcastle — an appointment from which he has just retired.

Professor Holland has made many and varied contributions to this specialty and there is no doubt that they have certainly been distinguished.

He has outstanding debating skills which always guarantee an impact.

He was awarded the Pfizer Visting Lectureship in 1970, a New South Wales Public Service Board Travelling Scholarship in 1972 and has been a Visiting Tutor and Examiner in Anaesthetics in Singapore since 1979.

Professor Holland has had a long commitment to the investigation of deaths under anaesthesia. His work in this area has had a considerable impact on the safety of Anaesthesia in Australasia. The concept of a Committee investigating deaths had been suggested by Ross to the New South Wales Department of Public Health in 1959 and it was convened in 1960. Ross was the first Medical Secretary, a position he held for fifteen years until he became Chairman in 1975. This Committee has been the blue-print for many other Anaesthetic Mortality Committees formed in Australia and other parts of the world, its database established over thirty years is perhaps the largest for anaesthetic mortality in the world. This Committee gained national and international respect and lead to his involvement with the prestigious International Committee for the Statistics for Critical Incidents in Anaesthesia.

Ross was a major force in the Faculty of Anaesthetists' activities for 24 years. In the 1960's he held many positions with the New South Wales Regional Committee and was a Member of the Board of the Faculty from 1976 until 1988. He was Chairman of the Executive, Vice Dean and Dean of the Faculty of Anaesthetists. During this time he was a major participant in the production of medical standards holding a number of positions with Standards Australia. Ross was also an active participant in the development of the Australian Council on Hospital Standards becoming the Chairman of that body from 1982-1983.

These substantial activities were supplemented by authorship of many anaesthetic papers and chapters in books about matters in anaesthesia and medical practice. Ross was also a great contributor as a presenter for many scientific meetings of both the Faculty of Anaesthetists and the Australian Society of Anaesthetists. His wife, Eileen, has been a great supporter in all of Ross's interests and activities. They have three children and two grandchildren.

Professor Holland was admitted to the Court of Honour of the Royal Australasian College of Surgeons in May, 1989. Clearly, Ross Holland has made most outstanding contributions to Anaesthesia over a long period of time and richly deserves the recognition of these achievements by awarding him the Robert Orton Medal.

Mr President, it is with great pleasure that I present to you **Professor Ross Beresford Holland** for the Award of the Robert Orton Medal, this College's highest award to its Fellowship.

Michael J. Davies

ADMISSION TO FELLOWSHIP BY EXAMINATION ENDORSED IN ANAESTHESIA

Jennifer Ramsay Carden, Vic
Ian Peter Greenway, NZ
Andrew Kent Hilton, NSW
Katherine Leslie, Vic
Peter James Longden, Qld
Rowan Kenneth Neerhut, Vic

Susan Margaret Robinson, Vic
Ranald William Sharpe, NSW
Geoffrey Mark Shaw, SA
Scott Warren Simmons, SA
Teoh Guek Swee, M'sia
Richard John Waldron, Tas

ENDORSED IN INTENSIVE CARE

Mark Skacel, ACT

RACS COURT OF HONOUR

Citation — Arthur Barrington Baker

“Members of the Court of Honour are chosen from those who show continuing personal interest in the College through their wise counsel, and they include benefactors and past Office Bearers of the College and the Faculty of Anaesthetists.”



Mr John Hanrahan, President of the Royal Australasian College of Surgeons, welcoming Professor Barry Baker to the Court of Honour.

Mr President,

I have the honour to present to you, **Professor Arthur Barrington Baker** for admission to the Court of Honour.

Barry Baker, currently the Nuffield Professor of Anaesthetics in the University of Sydney at the Royal Prince Alfred Hospital, is a graduate of the University of Queensland. He is a Fellow of the Australian and New Zealand College of Anaesthetists endorsed in both Anaesthesia and Intensive Care, a Fellow of the Royal College of Anaesthetists and has his Doctorate of Philosophy from Oxford University.

A native of Queensland, Barry was born in Brisbane and attended the Brisbane Grammar School before proceeding to the University of Queensland.

He undertook his resident and higher training at the Royal Brisbane Hospital before proceeding to the Nuffield Department of Anaesthetics at Oxford University where he was Registrar, part-time Medical Assistant (Anaesthetics), part-time Research Fellow and finally Research Senior Registrar.

In 1972 he returned to Australia with Jane, his English born wife, who is also an anaesthetist, to the position of Reader in Anaesthesia, Department of Surgery, University of Queensland, which was the first full-time academic appointment in anaesthesia in Queensland. Further challenges met him with his appointment as Foundation Professor of Anaesthesia and of Intensive Care in 1975 at the Otago University in Dunedin, a position he held until late 1992.

Professor Baker has been an achiever all his life and it is extremely difficult to encompass in this short citation many of these achievements which are so numerous and varied.

In his student days he was Editor of *Trephine*, the journal of the University of Queensland Medical School, Co-Editor of *Galmahra*, the University of Queensland Literary Magazine and a member of both the Council of the Medical Students Society and the University Union.

He has been one of the relatively few anaesthetists to obtain their Doctor of Philosophy.

He has been responsible for developing two academic departments, one in Brisbane and one in Dunedin, and is now aiming to lead his new department to the forefront of academic anaesthesia in Australia and international eminence.

Barry has been a great educator and teacher and has published extensively worldwide. He is sought after as a visiting teacher and examiner.

Research has been a great interest and success for him and throughout his career he has continued to work in the area of applied respiratory physiology. Clinically he has had a particular interest in intensive care management and cardiovascular anaesthesia.

Barry is held in high regard in the medical community and represents his College, his specialty and his University on many Committees and bodies.

He is Chairman of the Education and Standards Subcommittee of the Committee of Presidents of Medical Colleges and a member of the CPMC Working Party on Restructuring the Profession; is a member of the Care Evaluation Programme of the Australian Council on Health Care Standards and was Chairman of the Objectives Working Party of the University of Otago producing goals for the Medical School.

Barry was first elected to the Board of the Faculty of Anaesthetists in 1980 having served for several years on both the Queensland and New Zealand Regional Committees.

Barry is a great ideas man, shows enormous initiative and drive and has the ability to see most of his ideas through to the end with their implementation.

He has shown great leadership.

His time on the Board of Faculty included a string of achievements. He was a great contributor and there was no part of the Faculty's activities which he did not influence in some way.

He was the first Chairman of the Section of Intensive Care, Education Officer (Intensive Care), Chairman of the Workforce Committee, Vice-Dean and finally Dean, a position he held for nearly three years. He is the only Fellow to be an Examiner at some stage in each of our three examinations — Primary, Final Anaesthesia and Final Intensive Care.

Barry stewarded the introduction of the Formal Project, the Provisional Fellowship Year, the objective assessment of Hospitals for accreditation purposes, the requirement for trainees to complete the Early Management of Severe Trauma Course and the Faculty's Management Courses for Fellows, amongst other things.

Research, as you would expect was promoted, with the funds provided by the Faculty being considerably increased, and during his term as Dean he was also responsible for the creation of the Academic Chairs Establishment Grant.

Barry has not only helped anaesthesia but has had a considerable influence on surgery, surgeons and your College.

Whilst an Office Bearer of the Faculty he was a Member of your Council and Executive, a Member of your Selection Committee for the Secretary of the Royal Australasian College of Surgeons, Chairman of the Selection Committee for the Executive Director of Surgical Affairs and a Member of your Research Committee and serves as an Assessor on that Committee.

Barry has wider qualities and interests. He enjoys matters historical and to assist his research obtained the Diploma of the History of Medicine of the Society of Apothecaries, he likes intellectual challenges and is a Life Member of the Australian Chess Federation. He likes the outdoors and is a Life Member of both the University of Queensland Bushwalking Club and the National Parks Association of Queensland. Cultural pursuits include reading, art appreciation, concert music and live theatre.

Mr President, Members of the Court of Honour are chosen from those who have shown a continuing personal interest in the College.

Here is a man who has great intellect, wide interests, initiative, commitment, leadership abilities and loves hard work. I believe that Barry Baker has shown, and will continue to show a personal involvement in the College and is most worthy of admission to the Court of Honour.

Mr President, I present to you Arthur Barrington Baker for admission to the Court of Honour.

Michael J. Hodgson

A FACULTY OF INTENSIVE CARE

At its June Meeting, Council endorsed the formation of a Faculty of Intensive Care of the Australian and New Zealand College of Anaesthetists. It further called upon the Working Party to produce details of such a Faculty for its next meeting.

We have indeed been fortunate in Australia and New Zealand in having a dual training scheme (ANZCA and RACP) where goodwill and mutual respect have been evident between the training bodies and their graduates. ANZICS has been a strong Society representing intensivists from both streams. Its Annual General and Scientific Meetings are highly successful as are its Continuing Education Meetings which are held in several States and regions and by holding its Meetings with critical care nurses it has fostered the doctor/nurse professional team relationship which is a focal point of good intensive care practice.

The formation of a Faculty of Intensive Care will mean that intensive care training, the examination system, the setting of standards and other matters relating to intensive care will now become the responsibility of intensivists within the College. Foundation Fellows of the Faculty will be those endorsed in intensive care. The Faculty will be subject to Regulations similar to the former Faculty of Anaesthetists though in a more abbreviated form. Council will delegate to the Board of Faculty of Intensive Care responsibility for intensive care provided the Board does not make any decisions which conflict with the Memorandum and Articles of Association of the College. Accommodation will be with the College. By sharing facilities and administrative staff the cost of the whole operation will be kept to a minimum.

The formation of the Faculty will not mean other evolutionary developments in intensive care in this region cannot be pursued. This Faculty need not be an impediment to the formation of a separate College of Intensive Care if that is what Fellows of the Faculty of Intensive Care and other intensivists wish. Nor does it mean that efforts to ultimately have one method of training and certification in intensive care in this region cannot be pursued. Efforts to achieve this aim can continue.

The development of an independent College of Intensive Care would have to be considered very carefully, with particular reference to the following:

1. It would be a radical change in a system which is basically working well and is serving the needs of trainees, intensive care specialists and the community.
2. A new College would be small. There are recent examples of new Colleges being formed and then rejoining a parent College.
3. A separate College would be isolated from the major Colleges and their Fellows with whom we frequently interact during our day to day work. It would be many years before it could be represented on the Committee of Presidents of Medical Colleges (just one of its admission guidelines is a minimum of 250 members or Fellows admitted by examination).
4. It would be extremely costly in terms of money and other resources to set up headquarters and to mount an inspection system, training scheme and examination system superior to the current ANZCA one.
5. The formation of a College could mean that there would be three bodies training intensivists in this region. This would present a confusing choice for candidates. It would also mean that there would be three groups advising governmental and other bodies on matters pertaining to intensive care. Such bodies would tend to accept the advice that suited them best. The more groups there are claiming to represent intensive care then the lower the value placed upon individual opinions given.
6. There would be an inevitable dilution of the time and energy of those who tend to contribute more to teaching, examining and serving on important institutional committees. Loyalties would be further divided. All institutions would ultimately be weakened - including ANZICS.
7. A graduate from such a College with no other primary qualification would be qualified to practise intensive care only. What if he/she failed to secure a hospital based intensive care position?
8. If such a College had a further examination in intensive care then this would further accentuate an examination orientated approach during additional training rather than foster interest in research. The latter is an area needing expansion in Australia and New Zealand.

A Faculty of Intensive Care with an elected Board is seen as a logical step at this time and is the best way for Fellows of ANZCA endorsed in Intensive Care to pursue developments in Intensive Care in Australia and New Zealand.

GARRY D. PHILLIPS
(Chairman)
Faculty of Intensive Care
Working Party

GEOFF M. CLARKE
(Chairman)
Section of Intensive
Care Executive

OUR NEW HOME



The Historical Building Society has provided the following description:

“Ulimaroa” is an important late Victorian Villa residence in the Italianate style which captures the ambience of the late boom years with its centrally situated staged tower, two storeyed corner verandah terminated at both ends by bayed wings and by its rich stuccoed and cast iron decoration.

The cast iron decoration to the main verandah consists of iron columns; curved brackets and friezes to lower level; balustrade, brackets and pendants to the upper

level. In addition, cast iron decoration simulating “balconettes” to the St Kilda Road bay window, and tower enrich the main facade.

The essential element of the stuccoed decoration include ashlar markings; decorated keystones and architraves to windows; the friezes replicate the cast iron verandah frieze, swags and brackets to the projecting window sills; the tower decoration includes fluted corner pilasters with acanthus leaf capitals, balustrade and shell end pilaster terminations and vermiculated chimney stack wind breaks.

THE AMERICAN BOARD OF ANESTHESIOLOGY

There have been questions about the implications of the recently announced change in the policy of the American Board of Anesthesiology (ABA) regarding Royal College certification for international professional exchange and for your Fellows who are, or soon will be, training or practising anesthesiology in the United States.

The ABA is confident that its policy will not have an adverse effect on the exchange of professionals between our countries. Hospitals, university medical centres and other facilities are responsible for evaluating the qualifications of physicians who apply for staff positions or training posts. Their decisions about the qualifications of individual applicants will continue to be based on their assessment of the individual's credentials and experience.

Knowledge of the details of the implementation of the ABA policy should help allay concern about the policy's impact on your Fellows who are, or in the very near future will be, training or practising anesthesiology in the United States. The details of the implementation are:

- *Your Fellows who wish to attain primary certification by the ABA may fulfill the training requirement by satisfactorily completing one year of training as a CA-3 year resident in an ACGME-accredited program **no later than August 31, 1995.** The content of the year of training planned for the Fellow must be approved prospectively by the Credentials Committee of the ABA. The ABA office must receive the Program Director's request for prospective approval at least sixty (60) calendar days before the Fellow begins training. **Requests for prospective approval will not be accepted if received after December 31, 1993.***
- *Alternatively, Fellows may fulfill the training requirement for admission to the ABA examination system by completing no less than two years of full-time anesthesiology practice in the United States or one of its jurisdictions between **January 1, 1992 and December 31, 1995.***
- *Fellows who qualify for ABA examination on the basis of a CA-3 year of training or two years of anesthesia practice in the United States must sit for their first ABA examination no later than 1997. **The deadline for filing an application for the 1997 ABA examination is January 10, 1997.***
- *The rules of the American Board of Medical Specialties require a physician to be a diplomate of the ABA to be eligible to qualify for an ABA subspecialty certificate or the Certificate of Continued Demonstration of Qualifications. Fellows who wish to attain an ABA subspecialty certificate are advised that one year of residency training in an ACGME-accredited anesthesiology program will **not** satisfy the training requirements for both primary and subspecialty certification.*

Fellows and trainees who are concerned about their prospective candidacy for ABA certification should write to the Secretary of the ABA with specific information about their situation for clarification of their status.

WILLIAM D. OWENS, M.D.
Secretary-Treasurer
The American Board of Anesthesiology

MAINTENANCE OF STANDARDS

The background to Council's deliberations on Certification of Maintenance of Standards (The term "Recertification" will not be used in future) was laid out in the November 1992 Bulletin (p.16). Since that time the Working Party has continued to meet and to consider input from Fellows, its own Committees and special Societies.

At its June meeting the following recommendations from the Working Party were accepted by Council.

1. Fellows who complete the programme satisfactorily be awarded a "Certificate of Participation in a Programme of Maintenance of Standards".
2. In principle, participation in the Programme of Maintenance of Standards should include annual documentation of activities.
3. The introduction of the Programme be deferred until a comprehensive programme is developed, but not later than 1995.
4. The first component of Certification be a pre-requisite for completion of the Programme and be one of credentialling, consisting of provision to the College of:
 - a copy of the Fellow's current registration or practising certificate from the relevant Medical Board or Council;
 - evidence of current accreditation at an institution of practice.
5. The second component of Certification take the form of provision of evidence of regular involvement in some or all of the following:
 - attendance at CME Meetings (hospital, regional, national, international), including specific workshops or training exercises;
 - reading of relevant journals;
 - participation in self assessment programmes;
 - participation in Quality Assurance activities, including Peer Review;
 - participation in clinical teaching and clinical research.

This component would be assessed using a system still to be developed, and be a pre-requisite for completion of the programme.

6. The third component of Certification being considered may include:
 - evidence of personal participation in clinical audit;
 - assessment of personal practice by a site visit;
 - assessment of response to critical situations by participation in simulation exercises;
 - Peer Review based on the use of clinical indicators.

This component to be introduced only after pilot studies have been completed.

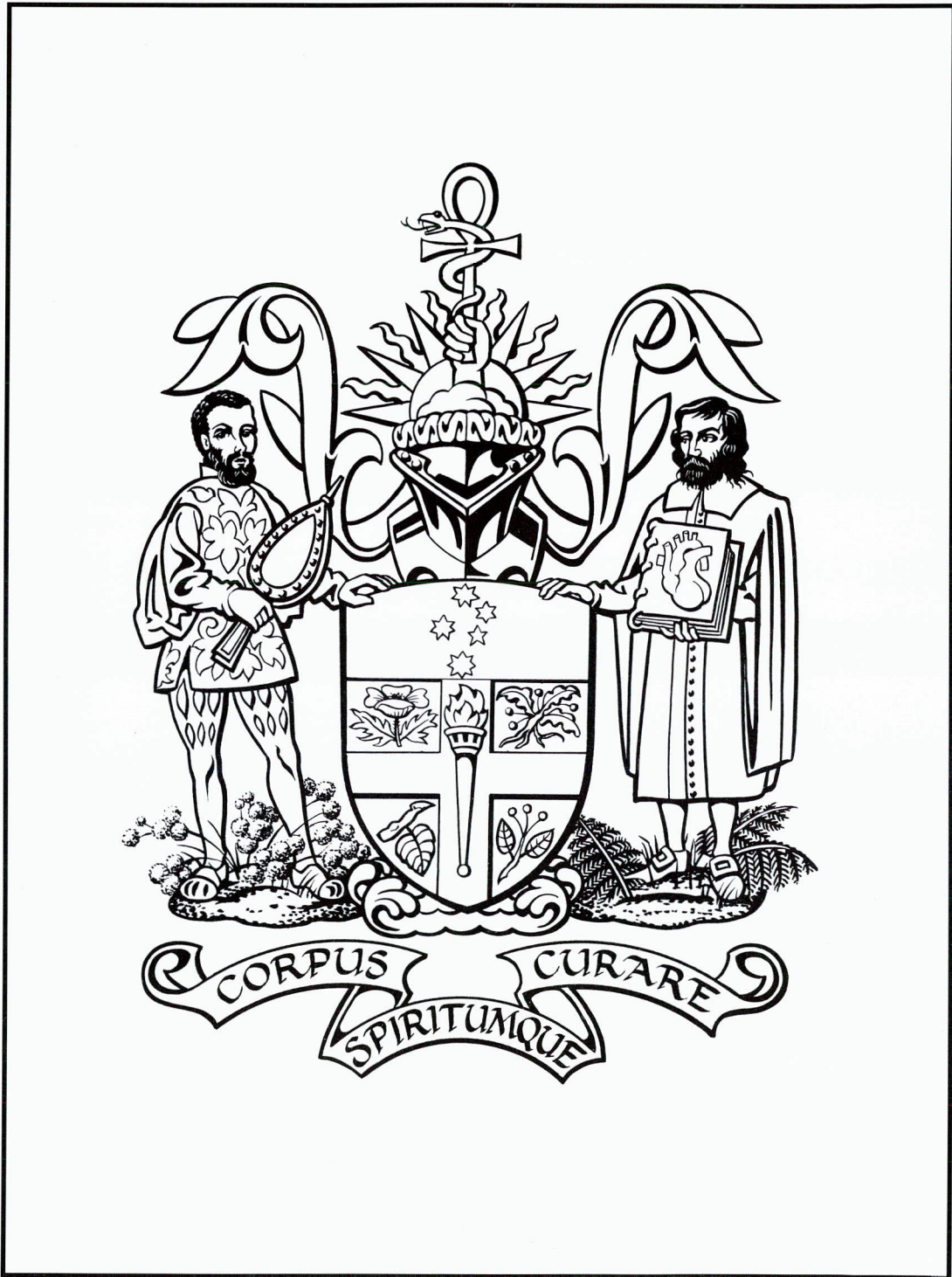
7. The programme be made available to Fellows engaged in clinical practice either in Anaesthesia, Intensive Care or related disciplines.
8. Consideration be given to extending the programme to specialist anaesthetists or medical practitioners who are not Fellows but who engage in clinical practice in Anaesthesia, Intensive Care or related disciplines.
9. Resources for development of the programme and its administration be ascertained.

There are many issues still to be resolved before the final programme can be instituted. These include the method to be used for assessing participation in CME activities (most other Colleges use a points or credits system) and the question of how much documentation should be required centrally.

Those Fellows who do not recall the detail of the CPMC Statement on recertification published in the March 1993 Bulletin (p.20) are encouraged to re-read it. The Working Party will plan its detailed proposals to accommodate this document.

It is anticipated that a detailed draft proposal will have been prepared for comment by the end of this year and that further input from Fellows, Committees and Societies will be sought.

GARRY D. PHILLIPS
(Chairman)
Maintenance of Standards Working Party



THE ARMORIAL BEARINGS

OF THE

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

The Supporters

On the left Andreas Vesalius the first person to record the use of artificial ventilation to sustain life. He is holding a bellows to signify this, and is looking outwardly to indicate the widespread place of artificial ventilation in both anaesthesia and intensive care.

On the right William Harvey, the first person to record the circulation of the blood. He is holding a book displaying a heart to signify this, and is looking towards Vesalius, because the discovery of the circulation of the blood depended on prior anatomical description by Vesalius (and others), and also because part of Harvey's medical education was in the Italian Medical Schools of the time.

These two supporters represent the heritage of the specialty based as it is on respiratory and cardiovascular physiology together with anatomy and physiology. The issue of pharmacology is addressed by use of the botanical specimens in the charges of the shield.

The Compartments

The supporters stand on land separated by water signifying their two different countries, but also the separation of the New World of Australasia from the Old World of Europe and the significance of sea travel in the transmission of the introductory message about anaesthesia around the world and the separation of Australia and New Zealand by sea. The Cootamundra Wattle (*Acacia baileyana*) illustrated on the land where Vesalius stands represents Australia and the silver fern tree — ponga (*Cyathea dealbata*) on the right hand side where Harvey stands represents New Zealand.

The Crest

The helmet is affronte or facing forward with a closed visor to indicate readiness for any urgent action. This type and position of helmet is similar to the Royal College of Anaesthetists which links us with this fraternal organisation. The colours of the College gown are incorporated into the wreath on the helmet and its lambrequin. The rising sun indicating the place of the College in the East next to the International Date Line. The rising sun links also with The Royal Australasian College of Surgeons and the Royal Australasian College of Physicians which both have similar rising suns. The

hand of the carer rising from the Lord's Cloud representing Almighty guidance links back to the Parsian medical influence and symbolises the Fellow's hand guided by the Lord caring for the patient's life. The hand holds an ankh, the Egyptian symbol of life, linking the major responsibility of the College Fellows with the roots of Western medicine in Egypt. The snake of Aesculapius entwines the ankh to symbolise the medical links as well as the heritage of Greek medicine.

The Shield

The chief of the shield contains the Southern Cross indicating the College position in the Southern Hemisphere. The five stars are represented with the number of points representing their brightness. This representation is also that taken by the Victorian State representation of the Southern Cross, and, as no other State nor New Zealand represent the Southern Cross in this form, it symbolises the College founding in Victoria and the College Headquarters in that State.

The lower part of the shield contains the St George Cross indicating the links to the English Faculty (now Royal College of Anaesthetists) and the Christian heritage of the College. The torch of glory indicates the link to the Royal Australasian College of Surgeons and their 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. Upper left: Opium Poppy Flower (*Papaver somniferum*) signifying analgesia — white to very soft pink with reddish purple blotches on base, large leaves and a stiff hairy blue/grey stem. Upper right: Mandrake Plant including roots and blue flower (*Mandragora officinarum*) signifying sedation and anaesthesia. These charges also symbolise the Old World plants. Lower left: curare vine has a brownish shade bark with orange/yellow cross-sectional pith (*Chondrodendron tomentosum*) together with a leaf signifying neuromuscular paralysis. Lower right: Cocaine leaf and red fruit (*Erythroxylum coca*) signifying local anaesthesia. These charges symbolise the New World Plants.

The Motto

"**Corpus Curare Spiritumque**" is translated "To care for the body and its breath of life".

EDUCATION ASPECTS OF WORKING CONDITIONS IN HOSPITALS

The Committee of Presidents of Medical Colleges believes that there are certain principles which should govern training for specialist medical practice.

1. Continuity of Experience

The educational requirement to observe the whole course of an illness and its management must be considered when working conditions for trainees are established. Rigid hours of work restrict a trainees' opportunity to follow patients through the phases of an illness.

2. Continuity of Care

There are good ethical as well as medical reasons for fostering continuity of clinical care by the one medical team. Such continuity also teaches the trainee the responsibility of a contract to treat a patient throughout the illness. Divided responsibility, as distinct from shared responsibility, is bad for patient care, and it should not be taught either by example or by imposed working conditions.

"Divided responsibility" is an undesirable situation which exists when patient care is carried out by two or more medical practitioners who are not in active and frequent communication about management options and where there is therefore the potential for disagreement between various management options.

"Shared responsibility" exists when patient care is carried out by two or more medical practitioners who reach agreement on management options and the management of care is unified.

3. Educational Time

i) Dedicated Education Time

Time must be available for trainees to attend lectures, tutorials and to do their own private study. Whilst much of this time will occur in the trainees own time, some must also occur during working hours because of convenience for lecturers, trainees, etc. Such activity must be recognised by employing authorities, and the rostered hours of work must allow for some flexibility.

ii) Training Educational Time

Time must be available for bedside training, clinical discussions, pathology and radiology sessions, etc. This time will be of clear management benefit to patients and has to occur during working hours.

The extra time required of specialist trainees when they supervise more junior doctors must also be recognised. Such tutelage is most important to the specialist learning process and yet consumes more time than doing the job independently.

4. Supervision

Specialist trainees require close supervision during their training programme and this must be recognised by making enough specialists available to allow adequate supervision to occur. This process will inevitably slow down clinical activity, but equally will improve the standard of patient care by the interaction between supervisor and trainee. Trainees will also need some measure of independence in later years of their training, but this clinical independence should always have a suitable level of supervision available.

5. Manpower

Manpower affects training both at the trainee level and at the supervision level. There must be enough specialists available to allow appropriate supervision as mentioned above. There must also be enough trainees to ensure that they are not just clinical workhorses but are able to think about their diagnosis and management. Contrarywise there must not be too many trainees so that their clinical experience is diluted. The work rosters and industrial awards must not be so rigid that inefficiency is built into the system by too many trainees being too inexperienced and thus taking longer to carry out their duties which then requires more staff to prevent transgression of industrial awards. The industrial problems that night and weekend work cover entail must be solved amicably to allow both adequate training and adequate rest. An inexperienced doctor is as dangerous as a tired one.

6. Research

For medical science to progress, research is necessary both to forge new pathways and to assess the success of old methods. Trainees should experience the discipline of ordered research projects to understand how such research may validate their clinical management. Hospital employing authorities must recognise this time spent in research, and must accept that duty rosters and service awards need to accommodate the trainees' requirements in research. Such research will ultimately lead to better patient care by these trainees.

All industrial negotiations for medical staff, both junior and senior, must recognise these educational principles, and any industrial decisions should allow enough flexibility of rostering, shift length, fatigue provisions and penalty rates to accommodate the principles. In particular, the industrial regulations must not force employers to curtail important educational experiences because of economic strictures enforced by such regulations. Employers in medical educational establishments have a responsibility to ensure that trainee specialists have full exposure to training opportunities, and that implementation of industrial regulations are reasonable and flexible.

On the other hand, it is recognised that hospitals as employers have to make legitimate demands for service of their medical employees. It is therefore incumbent on trainee specialists that they provide appropriate service, including after-hours and on call work if required. These experiences provide vital training experience as well as being essential if a hospital is to fulfil its need to provide medical attention to the public 24 hours per day. The system of specialist training in Australasia depends on a fine balance of responsibilities; the hospitals must facilitate training experiences, and the trainees must provide the services that are essential for the efficient functioning of the modern teaching hospital.

August 1990

ANNUAL SCIENTIFIC CONGRESS — ADELAIDE

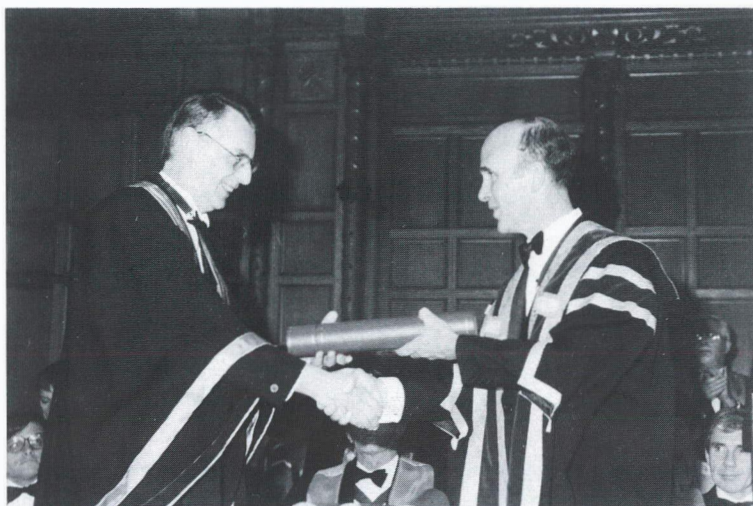
9-14 MAY 1993



Professor Pierre Foëx during one of his presentations at the Annual Scientific Congress.



The President, Dr Michael Hodgson, conferring Fellowship on Professor Michael Roizen, USA, at the Annual Scientific Congress.



Professor Pierre Foëx being welcomed to Fellowship by the President, Dr Michael Hodgson.



Presentation to Professor Michael Roizen of the Ellis Gillespie Medal by the President.

REGIONAL COMMITTEES ANNUAL REPORT 1992-1993

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. Crawford

Dr I.T. Dicks

Prof. D.B. Gibb

Dr B.F. Horan

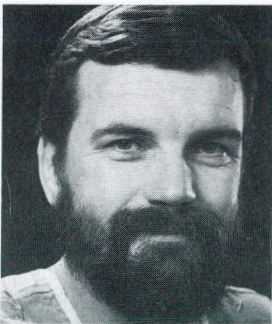
Dr M. Joseph

Dr P.J. Moran

Councillors

Dr R.G. Walsh

Dr D.R. Kerr



Dr G.E. Knoblanche



Dr E. Loughman

NEW SOUTH WALES

Continuing Medical Education

Several meetings have been organised by the ACE Committee lead by Dr Purcell. These included "Pain as An Emerging Specialty" and "Acute Pain Management", November, 1992. "Recertification Issues" March 1992, "Anatomy Workshop" May 1992.

Training Issues

The committee has continued to be concerned about the potential for inadequate training in sub-specialty areas, particularly paediatric anaesthesia where the number of training posts in the region to be increased. Avenues have been explored to optimise the training opportunities in this area and those responsible for these services have been encouraged to consider the issues.

Registrars' Scientific Meeting held in Sydney in 1992.

The Meeting attracted ten (10) papers for presentation of a commendable standard. Attendance at the meeting by the wider community of anaesthetists and trainees was poor.

Hospital Departments

In reviewing hospital departments for accreditation of training positions, the committee reviewed several hospitals including the establishment of a training rotation at the Woden Valley Hospital.

Practice Issues

The committee provided advice on the practice of regional anaesthesia in Accident and Emergency Units by those not trained in anaesthesia, and on the issue of sedation for patients having electro-physiological studies when an anaesthetist was not present. Much consideration was given to the issue of legislation prohibiting compulsory retirement on the basis of age and the State Government was advised through the Medical Committee.

The Committee undertook a review of the Clinical Indicators developed by the Australian Council on Health Care Standards and established a pilot study of these indicators into Sydney Teaching Hospitals.

Representation by Committee Members

Members served on several Advisory Appointments Committees, as well as on Working Parties of the Department of Health, The Red Cross Transfusion Service and the Australian Council on Health Care Standards Day Survey Committee.

Members of the Anaesthetic Continuing Education Sub-Committees: Dr W.J. McMeniman, Dr P.L. Klineberg, Dr M.R. Crawford, Dr G.A. Goulding, Dr G.J. Purcell, Dr R.G. Walsh, Dr G.F. O'Sullivan.

Members of the Education Sub-Committee: Dr P. Kam, Dr M.J. Bookallil, Dr G.F. Bishop, Dr G.E. Knoblanche, Dr P.L. Klineberg.

Representative of the ASA Committee of Management: Dr W. McMeniman.

Formal Project Officer: Dr P.L. Klineberg.

E. LOUGHMAN
Honorary 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 Coordinator

Dr A.F. Merry

Other Members

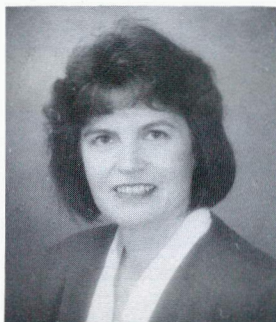
Dr David Murchison

Dr R.V. Trubuhovich

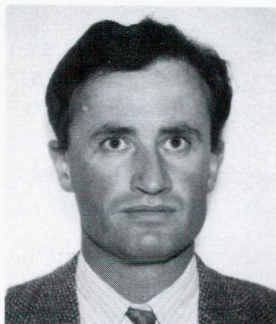
Councillors

Professor J.M. Gibbs

Dr R.S. Henderson



Dr L.F. Wilson



Dr C.J. Pottinger

NEW ZEALAND

This is the first Chairman's report to an annual meeting of Fellows of the Australian and New Zealand College of Anaesthetists (and yes, I am a Chairman, rather than a Chair or Chairperson). Yet again the last year has seen many changes in the environment in which we work, and in our own College.

Awards

Our congratulations to: *Dr Chris Joyce* – awarded the Harry Daly Research Fellowship; *Dr Tony Smith* – won the Renton Prize; *Dr Charles Minto* – awarded the BWT Ritchie Anaesthesia Scholarship; and *Professor Barry Baker* – elected to the RACS Court of Honour.

Your Committee

Our congratulations to Dr Stuart Henderson, who was elected to the College Council and will now join Professor John Gibbs as the second New Zealander on the Council. Stuart has made a significant contribution to our Committee, especially in the areas of training, continuing medical education and discussions about recertification, and we look forward to his continuing presence on the Committee as a Councillor.

At the New Zealand Committee elections, Drs David Jones, David Murchison and Chris Pottinger were elected. David Murchison and Chris Pottinger were previously coopted members, Chris being the assistant Honorary Secretary.

Barry Baker has retired from the Council, and our July meeting was his final one. It was sad to farewell Barry – he has worked very hard for our Committee (as well as the Board/Council) and we will miss his wide ranging medico-political knowledge and succinct advice. We also farewell Cedric Hoskins who has served on the Committee for 12 years, the last two as Chairman, with unfailing good humour and boundless enthusiasm.

In the last Council elections only 40% of New Zealand Fellows cast valid votes, despite having a New Zealander stand for the first time. I would urge everyone to vote in the elections – if we don't, we will find it very difficult to complain convincingly about the decisions made by those elected!

Legislation**The Anaesthetic Mortality Assessment Committee**

We, together with Cam Barrett (President NZSA) and John Walker (lawyer, Medical Protection Society) have continued to make efforts to urge that the Amendment of the Hospitals Act 1991 be further amended to ensure total confidentiality for all reports to that Committee.

The Hon. Katherine O'Regan, Associate Minister of Health, has replied that she intends that the new Medical Practitioners' Bill will include indemnity for all practitioners participating in such programmes. This, however, will not ensure full confidentiality for all reports and so we are continuing to work towards that end. We will of course be making submissions to this effect when the Medical Practitioners' Bill reaches Select Committee stages (at present we have no certain information on when that will be).

The Health Commissioner Bill

Dr John Stokes presented the Committee's submission on this Bill to the Select Committee earlier this year.

The Crimes Act 1961, Sections 155 and 190 "Medical Manslaughter"

The Committee is attempting to have the Crimes Act amended so that a charge of manslaughter would be reserved for cases of doctors demonstrating gross carelessness rather than inadvertent error. We are acting together with the Medical Council of New Zealand, the Council of Medical Colleges and NZMA, but to date no real progress has been made.

(New Zealand continued)

“The Funding of Clinical Training”

An advisory group chaired by Professor David Stewart from the Health Reforms Directorate in the Department of the Prime Minister and Cabinet is investigating the funding of clinical training of health professionals.

We have submitted that:

Firstly, the proposal to link the funding of clinical training to workforce planning should be treated with caution until the science of workforce planning becomes more exact.

Secondly, that the assumption that teaching hospitals have excess costs not attributable to clinical training has not been proven. However, if such excess costs exist, then they should be met from Vote Health by allowing teaching hospitals to charge a higher unit price for each unit of output.

Thirdly, that Undergraduate Medical Education should be funded from Vote Education and Postgraduate Medical Education from Vote Health in the most administratively simple manner.

We are now awaiting the next draft paper, to which we will doubtless be making further submissions.

The Medical Council of New Zealand has produced a discussion document, entitled “The Count-down to Vocational Registration” which deals with the concept of vocational registration and recertification.

We have submitted that, while a vocational register is consistent with College policy, we have reservations about a *restrictive* vocational register. At present a significant proportion of anaesthetic service in New Zealand, especially in smaller hospitals, is provided by non specialist anaesthetists, and their position would be in doubt if a restrictive vocational register is introduced. The Medical Council has also proposed that doctors not on the vocational register be restricted to supervised practice; we have submitted that the terms “supervision” and “independent practice” will need precise definitions and that the introduction of such a proposal may cause problems, especially in smaller hospitals.

We have also submitted that Intensive Care would need to be recognised as an independent specialty by the Medical Council (at present intensivists are classified as either anaesthetists or physicians).

On the related topic of recertification, we submitted that the College supports in principle a formal mechanism of continued maintenance of standards for its Fellows, and that a working party has been set up to investigate its implementation.

However, this may not fulfil the Medical Council’s aim of recertification as a mechanism of identifying those performing below a minimum standard. The other problems that will arise are those consequent upon non-recertification of medical practitioners previously certified.

There is to be further discussion between the Medical Council and Council of Medical Colleges.

The Council of Medical Colleges is a valuable forum for the Chairmen of all the Colleges to deal with such matters as vocational registration, medical manslaughter, and allow us to produce a unified viewpoint. The Council also wrote to the Minister of Health outlining our concerns about the effects of the changes in Health Care on patients’ care, and the lack of any monitoring of this. Subsequent to that Dr Brian Trenwith (the Chairman of CMC) has had meetings with the Minister of Health, Director General of Health and the Joint Quality Project, seeking input into Health changes.

(New Zealand continued)

The Expert Witness File

A Seminar on "The Expert Witness" was run late last year by John Walker and Hugh Rennie, QC. This helped to clarify for many of us the role of the expert witness in our legal system. Subsequent to this a workshop was organised by John Walker and John Gibbs. In this both lawyers and anaesthetists practised presentation and cross examination of the evidence in chief in a court room. This was an invaluable experience for those considering becoming "expert witnesses". The presentation by The Rt. Hon Mr Justice Hardie Boys on the role of the expert witness was published in the November 1992 edition of the College Bulletin.

Academic Anaesthesia in New Zealand

In view of the potentially parlous state of academic anaesthesia in New Zealand, the Committee has agreed to explore the requirements for establishing an endowed University Chair of Anaesthesia in New Zealand.

Hospital Inspections

This has been a quieter year of Hospital Inspections. In November, Dr Steuart Henderson and I inspected Taranaki Base Hospital, Rotorua and Waikato Hospitals were also inspected.

The work of the Committee continues to increase and I would like to thank all the Committee members for the work they put in; not only at our Committee Meetings; but also acting as our representatives at other meetings, taking part in Hospital Inspections, helping to prepare submission to the Government (an ever increasing industry) and taking part in other College activities such as examining in College examinations.

I should also make special mention of the "Wellington workers", Dr Isobel Ross, our Honorary Treasurer, who assiduously but pleasantly keeps all our finances in order; Dr Chris Pottinger, the Honorary Secretary who does the work that ensures that the organisation runs smoothly and effectively and Mrs Lorna Berwick, in the office, who has been a great help to all of us. After re-evaluation of the work that Lorna did, we decided that we needed a full-time rather than half-time secretary, and so from the beginning of September last year, Lorna has worked full-time for our College.

Leona Wilson
August 1992

ADMISSION TO FELLOWSHIP UNDER ARTICLE 12(c)

13th March 1993*Fellows*

David Henry Alltree, WA
Laurence John Battaglia, NSW
Robert John Campbell, WA
Arthur James Carroll, Vic
William Hull Cochrane, NZ
Colin Crichton Pope Eagle, WA
Leonard Barry French, Qld
Desmond Alexander McQuillan, NZ
Kattayat Mohandas, M'sia
Givindasamy Narayana, S'pore
Tharmapoopathy Ponnuthurai, M'sia
Suzanne Elizabeth Powrie, UK
Stephen James Robinson, Vic
Graeme Ormiston Stewart, WA
John H. Tinker, USA

24th April 1993*Honorary Fellow*

William Derek Wylie, UK

Fellows

Franklin Rajendram Bhupalan, M'sia
Kerry Ann Frances Boytell, NSW
Andrew Paul Forrest, NZ
Sydney Jacobs, UK
Anthony John Kirkwood, NSW
Amy May-Sien Lam, HK
Anthony Park Morton, Qld
David John Reed, USA
Colin Arthur Shanks, USA
Kok Chun Si-Hoe, S'pore
Mark Graham Somerville, NZ
John Gary Williams, SA

Regional Committee

Chairman

Dr P.A.S. Germann

Deputy Chairman

Dr J.M. Marshman (until Aug. '92)

Deputy Chairman

Dr B.L. Duffy (from Sept. 92)

Honorary Secretary

Dr P.M. Franklyn

Honorary Treasurer

Dr D.P. Tomkins

Other Members

Dr J.A. Crowhurst

Dr J.A. Russell (until Aug. '92),

Prof. W.R. Runciman

Dr L.T. Seow

Reg. Edn. Off. - Anaes. (co-opt. mbr)

Dr A.R. Laver

Reg. Edn. Off. - I.C. (co-opt. mbr)

Dr N.T. Matthews

Younger Fellows' Rep (co-opt. mbr)

Dr T.J. Semple

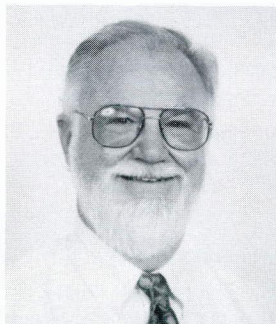
Councillors

Prof. G.D. Phillips

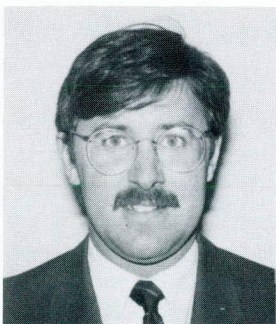
Dr R.J. Willis (from June '92)

Ex Officio - ASA Representative

Dr J.D. Richards



Dr P.A.S. Germann



Dr P.M. Franklyn

SOUTH AUSTRALIA

Meetings

The Annual General Meeting of the South Australian Regional Committee was held on Wednesday, 2nd September, 1992 at the Don Bradman Room, Adelaide Oval, commencing at 9.30 p.m. This followed the scheduled CME meeting, which commenced at 7.00 p.m.

Continuing Education Meetings

Wednesday, 3rd June, 1992 - Flinders Medical Centre - presentation.

Wednesday, 1st July, 1992 - The Queen Elizabeth Hospital - presentation.

Wednesday, 5th August, 1992 - Private Practice Group Presentation - Dr Ian Wall spoke on Anaesthesia in Indonesia, Dr Pat Moran gave a Case Presentation, Dr Tony Russell spoke on Oximetric Evaluation during PCA Administration, and Dr Steve Petito spoke on Atropine and Glycopyrrolate.

Wednesday, 2nd September, 1992 - Dinner Meeting at the Don Bradman Room, Adelaide Oval - "Drugs and Pain" - Drs P. Macintyre, T. Semple, M. Cardosa, S. Kinnear, A. Pearce, D. Jarvis and G. Hood contributed.

Wednesday, 23rd September, 1992 - Dinner Meeting at AMA House, North Adelaide - Dr Peter Prideaux, Director of Anaesthetic Services at Essenden Hospital and Consultant Anaesthetist to the Royal Melbourne Hospital presented a talk on the Use of Isoflurane in Low Flow Anaesthesia, and Dr Bronwen Evans, a South Australian Registrar reviewed the pharmacological properties of Isoflurane.

Wednesday, 4th November, 1992 - held at Calvary Hospital, North Adelaide - Dr J. Van der Walt spoke on Respiratory Tract Infections and Anaesthesia, Dr Margaret Wiese talked about Blood Conservation and Dr David Sainsbury spoke on Medico-legal aspects of Monitoring.

Wednesday, 3rd February, 1993 - Calvary Hospital, North Adelaide - "Diving & Hyperbaric Medicine" - Drs J. Williamson, C. Acott, R. Capps and R. Webb spoke on this topic.

Wednesday, 3rd March, 1993 - Calvary Hospital, North Adelaide - "Update on Blood Conservation Techniques" - Drs R. Davis and T. Nyman spoke.

Wednesday, 7th April, 1993 - Calvary Hospital, North Adelaide - "An Obstetric Evening" - Drs J. Crowhurst, S. Simmons and Bill Richards participating.

Matters of Concern to S.A. Fellows

Regional:

Country Anaesthetic Services

The provision of anaesthetic services to country areas was again a prominent area of concern to the South Australian Regional Committee. At a specialist level, the Regional Committee was keen to seek input from full-time country anaesthetic specialists. Although invited to fill a casual vacancy on the Regional Committee, no country specialist was able to do so. However, an open invitation was made to country specialists to attend the Regional Committee Meetings when topics of special concern to "country anaesthetic services" arose.

Annual Scientific Congress (ASC) - Adelaide 1993/Younger Fellows Conference

The South Australian Regional Committee thanks the members of the organising committee for their efforts over the last year. The ASC was held in Adelaide from 9-14 May, 1993. The organising committee elected by the South Australian Regional Committee was:

- Dr H. Owen - Scientific Convener
- Professor G.D. Phillips - Member of College Council
- Dr R.J. Willis - Member of College Council
- Dr P.A.S. Germann - Chairman, SA Regional Committee

(South Australia continued)

The Younger Fellows Conference was held at the Wirrina Resort, south of Adelaide, from May 7-9, 1993, the theme being "Factors Affecting Surgical and Anaesthetic Practice before the Year 2000". The Committee thanks Dr T. Semple for his input to the arrangements for this conference.

SA Regional Office - ANZCA

The Royal Adelaide Hospital advised the College of the need to vacate the previous office in November, 1992. However, alternative accommodation was offered, and although neither as spacious nor as comfortable as the previous accommodation, the Regional Committee agreed that maintaining the office at the Royal Adelaide Hospital would be the most efficient and economic option available. The address of the South Australian Regional Committee remains:

Level 2,
Eleanor Harrald Building,
Royal Adelaide Hospital,
North Terrace,
Adelaide, SA 5000.

Mortality Committee

Following the enactment and proclamation of new legislation a little over a year ago, confirming the confidentiality and privilege of any reports made to the South Australian Mortality Sub-Committee, the Chairman, Dr W. Fuller urged anaesthetists to report all appropriate cases so that worthwhile research into the factors associated with perioperative mortality could be carried out. The Regional Committee is pleased to hear that the Mortality Sub-Committee is functioning well, with good input from anaesthetists in South Australia. It should be recognised that unlike reports to the Coroner, reports to the SA Mortality Sub-Committee are voluntary. Forms for Reporting to Mortality Sub-Committee of the Anaesthesia and Intensive Care Committee have been distributed to all hospitals in South Australia.

Federal

Country Anaesthetic Services

At a General Practitioner anaesthetist level, the Regional Committee maintains its interest in assisting developments in this area. Developments have been made largely at a Federal level with the inducement of the ANZCA, RACGP and ASA. An Anaesthetic Curriculum has been developed by the Rural Medicine Curriculum Design Project (RACGP). Assessment may involve ANZCA and RACGP jointly, with Certification by RACGP alone.

Recertification

The concept of Recertification having been raised in 1991 remains an issue of interest to South Australian Fellows. A well attended CME meeting was held in June 1992 with short presentations by Professor G.D. Phillips and Dr P.A.S. Germann, followed by an open forum for discussion.

The Regional Committee now awaits further statements from the Working Party looking at recommendation on this issue. We look forward to contributing to further discussion on Recertification during 1993.

Qualification in Pain Management

The views of the Regional Committee were sought by the Federal Council, in response to the Council's in principle statement on 6 matters relating to the development of a Post Fellowship Diploma in Pain Management.

The response from the Regional Committee expressed some concerns over several issues, with some Fellows feeling the most important issue was that of developing a policy document on minimum standards required for Pain Management Units. Others questioned the relevance of such a diploma and the College of Anaesthetists to the many non-specialist anaesthetic specialists involved in pain management units.

(South Australia continued)

Correspondence and Major Discussions

1. Anaesthetic Assistants:

- (i) Anaesthetic Technicians' Course
- (ii) Anaesthetic Training Course – Nursing

2. Casemix

3. Review of Policy Documents

4. College Crest/College Logo or Emblem

5. SAPMEA – Preparation of Document of Training for 5th and 6th years medical undergraduates.

6. Quality Assurance

7. State Archivist

8. Education Sub-Committee:

- (i) Formal Project – Guideline changes
- (ii) Registrar Assessment Procedures/Forms
- (iii) P.F.Y. – Alice Springs/Port Augusta/Whyalla

9. Australian Council on Health Care Standards:

Document Review – “Field Review of Draft ACHS Standards”.

10. The Regional Committee sadly noted the deaths of Mr Colin Sanderson, whose service to anaesthesia through his employment with CIG and his input to the Anaesthesia and Intensive Care Committee is gratefully acknowledged; and Mrs Elaine Roesler, former Office Manager for the combined State office of the then Faculty of Anaesthetists and Royal Australasian College of Surgeons. The Regional Committee expresses thanks for the contribution made by Mrs Roesler to the functioning of the State Office.

Sub Committees

Education Sub-committee:

Chairman – Reg. Edn. Off.: Dr A.R. Laver (also Coordinator of Training)

Organiser – CME: Dr P.R. Gaukroger

Course Organiser – Primary: Dr T.L. Nyman

Course Organiser – Part II: Dr A.J. Bashford (until Dec. 1992)

Course Organiser – Part II: Dr C.J. Acott (from Jan. 1993)

P. Franklyn FFARACS, FANZCA
Honorary Secretary

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

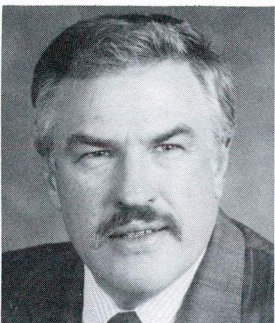
Councillors

Associate Prof. P.D. Livingstone

Dr D.H. McConnel



Dr E.J. McArdle



Dr M.D. Cobcroft, OAM

QUEENSLAND**Education****Trainees:**

Courses were held for the 1st and 2nd part candidates preparing for examinations. 1993 has seen the recommencement of a regular weekly course combining 1st and 2nd part topics, for Brisbane trainees. A similar course had ceased some years back, due to poor trainee attendance.

Our trainees continue to equal or better the national average pass rate, viz. 30% for 1st part exam and 60% for 2nd part. I offer congratulations to successful examinees, and welcome those who have completed their training. Drs Jenny Parslow, Rhonda Boyle, Peter Moran and Jim Bradley have devoted considerable time to organising trainee courses.

Continuing Education:

1. The Queensland College/ASA Continuing Education Seminar at the Gold Coast in June was an outstanding success in terms of quality of lectures, and attendance.

The 1993 combined meeting will be held over the weekend of June 10/11 in conjunction with the Day Surgery Special Interest Group's Annual Meeting on 11 July, at Noosa.

2. A country meeting is to be held in Ipswich in November 1993, covering a variety of topics. The Ipswich anaesthetists have preparations well in hand.

3. Future meetings – The 1995 ASM is to be held in Queensland from Saturday 6 to Wednesday 10 May. We have decided to hold this in Townsville.

Training Programmes

The Royal Brisbane Hospital Professor and Head of Department, Dr D. Jones is to arrive in July.

The Princess Alexandra Hospital Anaesthetic Department shortage of office space is at present unresolved, and the Committee is actively pursuing this to resolution.

The difficulty in staffing provincial hospitals has been highlighted in the past year. Ipswich Hospital, which was inspected in 1992, is still awaiting their third staff anaesthetist. Rockhampton Hospital withdrew an application for inspection, when one of their staff anaesthetists resigned.

Drs Di Khursandi and Ranald Pascoe represent Queensland in the Colleges' looking at rural and remote area anaesthesia. Queensland Health has established a Committee (Medical Workforce Specialist Working Party) to attract specialists to country areas. I have represented the Regional Committee and have reminded Queensland Health representatives of the requirements of country anaesthetists.

I also met with Queensland Health with regard to the flying anaesthetic positions, which have been difficult to fill.

I feel Queensland Health is aware of the problems discouraging anaesthetists in these two areas; whether financial and political factors allow them to be adequately addressed remains to be seen.

Appointments

A Regional Committee representative is invited to all Queensland Hospitals' Staff Anaesthetist/Intensivist position Appointments Meetings. I feel it is important these invitations are accepted, and commend Queensland Health and the hospitals.

Cairns Base Hospital has been accredited for vocational training in anaesthesia. The Committee is eager for country hospitals to receive trainees, but College requirements must be met, to ensure trainees are suitably trained if they go to these hospitals.

(Queensland continued)

The Mater Children's and Royal Children's Intensive Care Units have recently been inspected to gain approval for intensive care training.

As Chairman, I thank the members of the Regional Committee, and other anaesthetists co-opted for specific matters, for their commitment and help over the last year.

Ted McArdle
Chairman

Perioperative Mortality: Dr Jim O'Callaghan
Maternal & Perinatal Mortality: Dr Eric Hewett
Australian Resuscitation Council: Dr Paul Mead
Red Cross Blood Transfusion Service: Dr Col Busby
RACS Road Trauma Committee: Dr Bart McKenzie
Doctors' Health Advisory Service: Dr Eric Hewett
Postgraduate Medical Education Committee: Dr Merv Cobcroft, OAM
Queensland Ambulance Medical Advisory Committee: Dr Bart McKenzie
Advisory Panel to Health Rights Commission: Dr Ted McArdle
Committee of Queensland Medical Colleges: Dr Ted McArdle
Medical Workforce Specialist Working Party: Dr Ted McArdle
Anaesthetic Technician Training Committee: Dr Alison Holloway

Regional Committee

Chairman

Dr B.T.S. Kwan

Secretary Treasurer

Dr R.W. Cook

Regional Education Officer

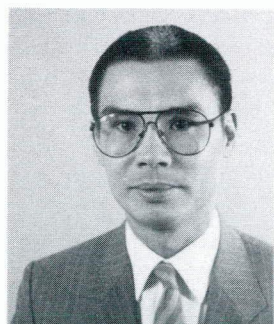
Dr T.L. Dobbinson

CME Officer

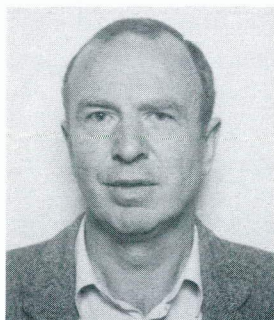
Dr G.J. Flynn

Other Member

Dr H.J. Lopert



Dr B.T.S. Kwan



Dr R.W. Cook

AUSTRALIAN CAPITAL TERRITORY

Thanks to the generosity of the surgeons we have the use of the ACT facilities including conference room and secretariat.

Education

The GSM 1992 went well with presentation to the President of some of the older Fellows of the ACT. In November there was a combined regional meeting with surgeons and gynaecologists on endoscopic surgery. It is intended to hold our first anaesthetic CME meeting in September - The Art of Anaesthesia.

Training

The region has four approved training posts and at present one Provisional Fellow. Of two candidates presented for the Primary Examination with one was successful. Regrettably none of the three younger Fellows could attend the Younger Fellows Conference.

There have been recent sessional appointments in education and quality assurance. The small number of practitioners here with three departments to run, regional ANZCA, AMA and ASA commitments leaves few without added responsibilities. The tolerance and support received from the College and other States is much appreciated.

Regional Committee**Chairman (until 11-6-92 resigned)**

Dr P. Platt

Chairman from 11-6-92

Dr M.D. Westmore

Deputy Chairman until 11-6-92 (resigned)

Dr B.R. Trainer

Deputy Chairman from 11-6-92

Dr P. Maddern

Secretary until 11-6-92

Dr M.D. Westmore

Secretary from 11-6-92

Dr N.M. Gibbs

Treasurer until 11-6-92 (resigned)

Dr J.F. Harriott

Treasurer

Dr H.McL. Spiers

Education Officer (IC) (resigned)

*Dr G.M. Clarke

Regional Education Officer (IC)

*Dr S.A. Edlin

Councillor

Dr N.J. Davis

ASA Representative

Dr R.J. Boulter

* Co-opted member

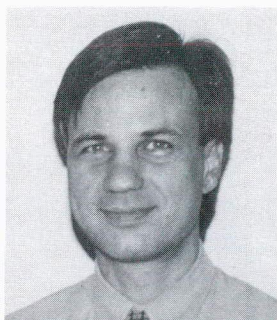
Other Members

Dr L. Coombs

Dr P. Smith



Dr M.D. Westmore



Dr N.M. Gibbs

WESTERN AUSTRALIA**B. Roche/Hoechst Country Visits (to GP Anaesthetists)**

Drs Maddern and Goucke visited Port Hedland and Derby from 10-12 September 1992, and Drs Westmore, Paech, Pribil, Goucke and Coombs visited Albany from 25-26 July, 1992. Positive feedback was received about both visits.

The College/ASA Registrar Prize was awarded to Dr M. Whitby.

Regional Education

Dr P. Maddern continued as REO but announced that he would be resigning from the Committee from July 1993. Dr Harriott has continued the organisation of the 1st part tutorial programme. However, the second part tutorial program was discontinued as from January 1993. A revised programme is currently being prepared and co-ordinated by the trainees.

Successful candidates in the 1st part examination included:

Drs D. Borshoff, Dr H. Swan, Dr E. Visser, Dr A. Miller, Dr G. Chalkiadis, Dr A. Robinson, Dr C. Cokis, Dr B. Russ, Dr J. Bruce.

Successful candidates in the 2nd part examination included:

Dr J. Goh, Dr A. DiFlorio, Dr J. Wisniewski, Dr G. Raper, Dr J. Akers, Dr I. Jenkins (IC), Dr V. Van Heerden (IC).

General Matters**College of Anaesthetists**

There now appears to be unanimous support for the new College. However, there has been only limited support for the proposed 'Coat of Arms'. A competition was held to obtain suggestions for a new College Logo. This was won by Dr I. McGlew who was the only entrant.

Recertification

There appears to be support for the current proposals of the College.

Combined Meeting with the ASA (WA)

There is widespread support in Western Australia for some form of amalgamation between the College and the ASA. To this end there has been two combined meetings of the regional committees (November 3 and March 16). It was felt that both meetings were very useful and that combined meetings should be continued if possible.

Chair of Anaesthesia

This was discussed at length at the first combined meeting. The current feeling is that establishing an independent and fully funded Chair will be difficult to achieve at present. However, there remains strong support for a chair from local anaesthetists, and the sub-committee members (Drs Thompson and Platt) are pursuing the various options.

West Australian Metropolitan Non-teaching Hospitals Agreement

This award was introduced by the Health Department after discussions with the AMA. However, this agreement disadvantages specialist anaesthetists, and encourages or condones anaesthetic practices which do not meet the standards of the College. The College's views were conveyed to the Health Department, the Anaesthetic Reference Group, and the AMA.

New Secretariat

The Regional Committee and the ASA (WA) moved their office to Hampden Road, Nedlands, as from February 1, 1993. The new office secretary is Ms Penny Anderson.

(Western Australia continued)

Annual General Meeting Scientific Programme – June 27, 1992

Special Interest Group Representative (Acute Pain): Dr R. Goucke

Special Interest Group Representative (Rural Anaesthesia): Dr G. Dale

Special Interest Group Representative (Day Care): Dr M. Paech

Patient Controlled Epidural Analgesia: Dr M. Paech

Spinal Anaesthesia for Caesarian Section: Dr C. Sims.

Airway Management by Inexperienced Personnel: Dr A. Watts

Combined Spinal Epidural for Caesarian Section: Dr M. Familton

Condoms and Muscle Relaxation in Anaesthesia: Dr W. Weightman

Critical Care of the Specialty: Assoc. Prof. G. Cutfield

N. Gibbs
Honorary Secretary

AUSTRALASIAN VISITOR



L to R: The President, Dr Michael Hodgson, Australasian Visitor; Associate Professor Victor Callanan and Mr Terry Gallagher, Manager, Boots Hospital Divisions, the Boots Company (Aust) Pty Ltd.

Regional Committee**Chairman**

Dr G.B. Donnan

Deputy Chairman

Dr A.M. Weeks

Honorary Secretary

Dr S.C. Chester

Honorary Treasurer

Dr D.I. McCuaig

Other Members

Dr G.H. Beemer

Dr J. Cooper

Dr M.J. Fajgman

Dr P. McCall

Dr M. Radnor

Dr P.G. Ragg

Dr P. Roessler

Dr F.A. Rosewarne

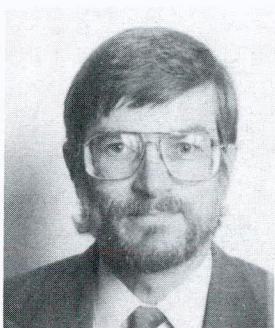
Councillors

Dr M.J. Davies

Dr I. Rechtman



Dr G.B. Donnan



Dr S.C. Chester

VICTORIA**Consultative Council on Anaesthetic Mortality and Morbidity**

During the past year the Victorian Consultative Council on Anaesthetic Mortality has met on ten occasions and has prepared the fifth report of the Council. This was distributed to all Victorian doctors, hospital administrators and other appropriate health professionals in May. Before this date an information bulletin was sent to all anaesthetists and medical practitioners with an anaesthetic interest. This bulletin highlighted some of the more recent anaesthetic problems which the Council believes should be brought to the attention of anaesthetists more quickly.

The Council, through the Chairman participates in the working party on Anaesthetic Deaths in Australia, sponsored by NH & MRC. This body is working toward a uniform definition of anaesthesia related deaths, and of classification of such deaths and uniformity in reporting requirements to departments of Coronial Services. The working party has also identified about 12 specific items for collection for the next triennial report.

The Victorian Council has been fortunate in having the assistance of one of its members, Dr John Santamaria, in the preparation of a new and comprehensive computer programme which will facilitate access to the data and provide rapid feedback in response to enquiries as well as easy transfer of data for national studies.

In June 1992 Dr Geoff Darby resigned. He was a foundation member and has given sterling service to the Council. The Minister has appointed, in his place, Dr Tony Weaver, Director of Anaesthesia and Intensive Care at PANCH who was nominated by the ASA.

The Consultative Council is indebted to all those anaesthetists and quality assurance co-ordinators who are providing information. It recognises that feedback is essential in order to maintain interest and hopes that the forthcoming reports will be helpful and will stimulate even further communication of both mortality and significant morbidity to the Council.

Safety

Relatively few new safety issues have been notified this year. CIG advised that the Mini-Series regulators are now obsolete and that they should be replaced when servicing occurs with new 'O' series regulators. A report from Canada highlighted potentially dangerous levels of volatile agent output when Penlon PPV series vaporizers were overfilled following incorrect filling procedures if the vaporiser dial was set above zero to speed the filling time.

Continuing Education

The weeknight evening meetings have continued on Tuesdays and Thursdays, alternating whenever possible, and attendances have been very satisfactory (usually 40-60). Of special note Professor Brennecke's presentation on the Management of Pre-Eclampsia attracted a capacity crowd for the Hughes Room when about 100 people attended.

The topics for these meetings were:

- | | |
|----------------|---|
| May 1992 | Concepts of Acute Pain Management:
<i>Professor Colin Goodchild</i> |
| May 1992 | Management of Cardiac Patients for Non-Cardiac Surgery:
<i>Associate Professor Roberta Hines</i> |
| September 1992 | Pre-Eclampsia:
<i>Professor Shaun Brennecke</i> |
| February 1993 | Pre-Emptive Analgesia:
<i>Dr Raymond Sinatra</i> |

(Victoria continued)

The Annual Combined ANZCA/ACA CME Meeting with the theme "Outcomes – does what we do make a difference" was held November 14, 1992 at the College. The Convener Dr Patrick Hughes arranged a very successful meeting. The attendance was 190. The Guest Speaker, Associate Professor David Brown from Rochester, Minnesota was an excellent speaker and contributed to all the panel discussions as well. He also held a major seminar for trainees on a separate occasion.

Education

The courses provided by the Victorian Regional Committee for both Part I and Part II trainees continue to be very well attended. The course fees were not increased this year. In 1993 there was a change to the Primary Courses with abolition of the long course due to adverse feedback from Supervisors of Training on behalf of the trainees at the last meeting in 1992. Further criticism centred around the proximity for the short course to the examinations and the number of trainees attending as well as the necessity to conduct these as lectures rather than tutorials. After considerable discussion and consideration the short course was opened to trainees from all regions and is to be conducted as a lecture course some two to three months preceding the examinations, and this will serve to substitute for the long course. For Victorian trainees there will also be a short tutorial course held about four to six weeks preceding the examinations.

The Medical Refresher Course, although difficult to eradicate hiccups at the start of each course, seems to gather momentum with each session and provides an extremely valuable educational source.

A meeting of Supervisors of Training is planned for July/August. There continues to be reasonably good communication between Supervisors of Training and the Regional Education Officer. The idea of a regular monthly Registrar Meeting/Presentation is being pursued despite some difficulties.

Finally, the Annual Scientific Registrars' Meeting is scheduled for August in Melbourne and the organisation of this is already under way.

Intensive Care

1992-1993 Meetings: The ANZICS (Vic) Continuing Education Meeting was held 1-2 May at the Radisson President. Major topics were IVOX (Mortenson) and endotoxin antibodies (Ziegler). The 1993 meeting was held on May 28-29 at World Congress Centre with topics being Tonometry (Fiddlan Green) and Ventilator Modes (Nahum). The Intensive Care registrars weekend course was held July 3-5 1992. Thirty registrars attended from 4 states. The 1993 weekend is on July 2-4, also at University of Melbourne and is open to ICU trainees from throughout Australia. The 17th ANZICS Scientific Meeting was held October 15-18 in Auckland New Zealand, and covered critical care management, septic shock, HIV and the Oregon Health Plan. The 1993 meeting is in Perth on October 28-31.

Accreditation Visits: Were made at Royal Melbourne, St Vincents, and Epworth ICU's in March 1993.

Moves continue towards both a Faculty of Intensive Care within the ANZCA, and an independent College of Critical Care Medicine comprising intensivists of all backgrounds. Potential areas of conflict exist but hopefully will be resolved over the next 12 months.

Paramedical Personnel

The Australian Society of Anaesthetic and Operating Theatre Technicians (ASAOTT) continues to run its successful diploma course at the Royal Children's Hospital. Entrance criteria for this course include being a member of the ASAOTT and having completed the Mayfield Anaesthetic Technicians course. Discussions are in progress to have the course affiliated with a higher institute of education.

Several city and rural hospitals continue to use technicians as anaesthetic assistants and appreciate the support of the College of Anaesthetists in education and clinical advice.

(Victoria continued)

Discussions are continuing in conjunction with the Victorian Section of the ASA concerning anaesthetic assistance.

Formal Project

Several formal projects were submitted for assessment during the year. It is worth noting that Policy Document E11 was revised in late 1992.

Victorian Medical Postgraduate Foundation Inc.

The Victorian Medical Postgraduate Foundation has in the past been an excellent means by which training visas for foreign medical graduates could be organised. Changes to the Department of Immigration and regionalization has made this more difficult, but the Victorian Medical Postgraduate Foundation is continuing to pursue the government in this area.

Proposed changes to the Health Insurance Act of 1973 (in relation to quality assurance activities) are being considered by parliament after objection by the Victorian Medical Postgraduate Foundation, supported by Colleges and Societies (including the Australian and New Zealand College of Anaesthetists).

The Victorian Medical Postgraduate Foundation kindly offered secretarial and printing assistance to the College of Anaesthetists during our transition to new premises in the near future or on any other occasion.

Multidiscipline educational issues are being planned involving the College of Anaesthetists in topics of palliative care and acute and chronic pain management.

Social

A reception was held at the College to formally welcome Professor and Mrs Colin Goodchild. He formally took up the position as Professor of Anaesthesia in February. This was an excellent opportunity for Victorian Fellows to at last meet Professor Goodchild.

Victorian Chairs of Anaesthesia Appeal

Professor Goodchild took up the Chair in Anaesthesia at Monash University early 1993. The final payment to Monash University was made in December 1992.

Coroner's Panel

The Coroner continues to seek our assistance. I believe this is an important service that the Victorian Regional Committee should provide in this State.

Other Activities

a) Meetings with Chief Medical Officer

Regular meetings are attended by the Chairman and Vice Chairman with the Chief Medical Officer. This is a forum for discussion of mutual problems. Other learned Colleges have regular meetings with the Chief Medical Officer.

b) Diagnosis Related Groups

The Committee is closely monitoring developments related to the introduction of DRG's. The Deputy Chairman has attended workshops organised by the Department of Health and Community Services. At this stage the implications for anaesthetists are relatively small. However, the costs of teaching and research are not included in DRG funding and will need to be vigorously defended.

c) Victorian Regional Committee Secretary

Recently Mrs Allison Burger relinquished her position as secretary to this Committee after four and a half distinguished years of service to become Administrative Assistant of Continuing Education. Mrs Veronica Quetglas has taken over that position since March 1993.

(Victoria continued)

Other Representatives

Ex-Officio:

Chairman, Vic Consultative Committee on Anaesthetic Morbidity and Mortality:
Dr Patricia Mackay

Chairman, Vic Section ASA: Dr Ken Sleeman

Member, Vic State Committee, RACS: Mr Warren Johnson

Cooptions: Dr Mark Radnor, Wangaratta, agreed to join the Committee to represent the interests of non-metropolitan Fellows.

Garry Donnan
Chairman

Regional Committee

Chairman

Dr M. Martyn

Deputy Chairman and Treasurer

Dr M. Lorimer

Secretary

Dr R. Zacks

CME Officer

Dr J. Madden

Regional Education Officer

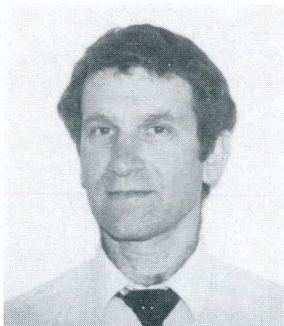
Dr L. Doughty

Councillor

Dr M. Hodgson



Dr M. Martyn



Dr R. Zacks

TASMANIA

Committee Meeting and Attendance

Regional Committee meetings were held on the following dates:

15 July, 1992 — teleconference

10 October, 1992 — Launceston

2 February, 1993 — teleconference

The final meeting of the year is planned for 23 May, 1993 in Launceston.

The experimental new telephone conference idea for Regional Committee meetings not scheduled to coincide with a CME meeting has proved to be practical and successful. Though more impersonal, such meetings seem to be efficient and convenient.

Drs Hodgson, Madden, Martyn and Zacks attended all meetings; Dr Doughty was unable to attend one and Dr Lorimer was away for two meetings.

College Meetings: Visiting Speakers

The combined College/ASA Annual Scientific Meeting was held at Launceston Country Club Casino on 10 October, 1992. The visiting speakers were Dr Andrew Bacon (Victoria) and Dr Hugh Spencer (New Zealand). In addition, Dr Mike Hodgson addressed the meeting.

It was decided not to schedule a scientific meeting in May, 1993 for a number of reasons; a great deal of extra work is required for the '94 ASM, there is no visitor travelling from the GSM, and there have been a number of smaller meetings throughout the year. The following speakers visited both Hobart and Launceston.

- Dr Peter Prideaux (Melbourne)
- Dr Ian McKenzie (Melbourne)
- Dr Peter Brownridge (Adelaide) conducted a 1-day CME meeting in Hobart.

Training

Regrettably, the outstanding record of Tasmanian candidates in the Primary exam has not been maintained. This year, three failed at first attempt, one passing second time round. Tasmanian trainees completed their training during the year, and all have taken up permanent or locum appointments at the Royal Hobart Hospital.

ASM 1994

A landmark decision was taken during the year to separate the meetings of the College of Surgeons and the College of Anaesthetists from 1994. This was prompted by concern that Hobart did not have sufficient suitable venues and accommodation for a combined meeting. It was decided, therefore, that Launceston should host the 1994 College of Anaesthetists ASM. A planning committee, masterminded by Dr Mike Martyn and Dr John Madden with a number of other members from the State is working in conjunction with the College under the chairmanship of Dr Dick Willis.

R. Zacks
Honorary Secretary

CHEMICAL DEPENDENCE AND THE ANAESTHETIST

Chemical dependence is a disease in which drug abuse has developed to the point where the individual is compelled to continue use of the drug(s) despite adverse consequences and becomes unable to cease drug use without assistance. While opioid abuse is a particular problem for anaesthetists, it must be recognised that abuse of alcohol and other drugs acting on the central nervous system may also result in chemical dependence. Individuals who have been successful in ceasing drug use recognise that there is a lifelong potential for relapse but also that permanent remission is an attainable goal.

The Australian and New Zealand College of Anaesthetists recognises that anaesthetists have a greater than normal risk of developing this disease due both to the availability of drugs as an inevitable part of normal practice and to stresses inherent in the profession. Chemical dependence results in deterioration of both professional and personal conduct. When it continues untreated, it is likely to have a fatal outcome.

Anaesthetists have a responsibility to be aware of the risks of this disease and of its features and management. If there is concern about the health of a colleague, this should be shared with a senior and trusted colleague who is likely to hear of other such concerns. This should be simple in departments or groups but may be difficult in more isolated practices. Reporting of this concern is an act of support for the colleague.

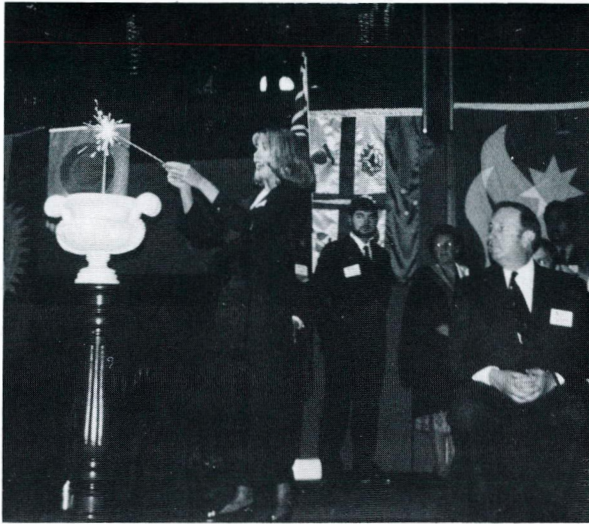
Where serious concerns exist, a planned intervention is necessary. This must be carefully structured so as to bring the chemically dependent colleague into early treatment. Because denial of the problem is very common, assistance in planning the intervention from professionals experienced in these problems must be obtained. An informal approach, no matter how well intended, is almost certainly doomed to failure. Doctors Health Advisory Services or Psychiatrists familiar with the treatment of alcohol and drug abuse problems are potential sources of assistance. The initial process is almost always difficult and stressful but is an essential part of bringing the affected person to an acceptance of their problem.

The prognosis for recovery must be guarded but is by no means hopeless. After treatment and personal acceptance of status as a recovering addict, some individuals are able to return to anaesthetic practice. This is not without its risks but is possible with full disclosure by the affected anaesthetist and in a supportive environment. There is an ongoing need for support and surveillance so that any relapse is detected at an early stage.

J.M. GIBBS

A.M. WEEKS

SPARK OF LIFE CONFERENCE



Ms Fiona Coote igniting the Spark of Life.

The Spark of Life Conference was held in Melbourne from April 29 to May 1 under the auspices of the Australian Resuscitation Council. The Meeting was convened by Professor John Pearn under the Chairmanship of Professor Don Harrison. The Organising Committee comprised the entire Council of the Australian Resuscitation Council and the Convention Organisers were Kevin and Coralyn Wickham. Executive Secretary was Mrs Carol Carey.

In many ways this was an extraordinary meeting as this was the first major Meeting on Cardiopulmonary Resuscitation and associated resuscitation topics held in Australasia. The Hilton Hotel was stretched to the limit with 1100 registrants and over 200 late registrants were not able to be accommodated.

The Conference commenced with a series of Workshops on Thursday 29th April held at various venues. These Workshops were filled soon after registration opened and future Meetings will place greater emphasis on these Workshops. The Workshops included basic life support, advanced life support, anatomy and physiology of the cardiopulmonary system, water rescue and early management of trauma.

The Conference was opened with much pomp and ceremony by His Excellency, The Honourable Bill Hayden, AC, Governor General of the Commonwealth of Australia. Presidents or representatives of the fifteen major organisations represented on the ARC were present. The Convener introduced a representative

from each member organisation who took their position beside its flag. Proudly, I can report that this was the first public display of the new Australian and New Zealand College of Anaesthetists' Flag. Following a warm reception Ms Fiona Coote, representing the Australian public, lit the Spark of Life. The opening Plenary Address was delivered by Dr Allan Braslow from Marylands, Virginia on **"Cardiopulmonary Resuscitation — a Skill for Everyone"**.

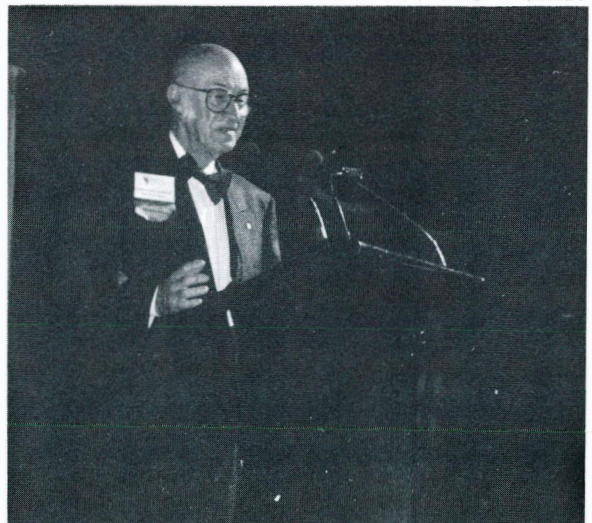
Other international guests included Dr Bill Montgomery from Hawaii and Dr Colin Robertson from Edinburgh who represented the European Resuscitation Council.

Many papers were presented over the next two days on a variety of topics including the choking controversy, envenomation, teaching of BLS and ALS, Guidelines for BLS and ALS, the use of the Laryngeal Mask Airway in resuscitation, and many other topics.

Anaesthetists, including Tess Cramond, John Williamson, Fred Gilligan, Don Harrison, David Komesaroff, Merv Alan, Jim Tibballs and Harry Oxer made presentations.

There is considerable pressure for the Australian Resuscitation Council to repeat "Spark of Life". Considerable discussion will take place at our next Council Meeting to determine the time, place and form of the next Conference.

IAN RECHTMAN



Professor Don Harrison, Chairman of the Australian Resuscitation Council.

NH & MRC WORKING PARTY ON ANAESTHETIC MORTALITY

Since September 1991, there have been three "face-to-face" meetings of the above Working Party and three telephone conferences. Difficulties which were evident early have been greatly eased and the Meetings of January 1993 made considerable progress.

Unfortunately, a misunderstanding with respect to classification led to an inconclusive telephone conference in late March. The following summarises the activities of the Working Party to date.

1. The Value of Anaesthetic Mortality Studies

Differences of opinion exist on the continuing value of mortality studies in view of the rarity of deaths attributable entirely to anaesthesia. However, there are still 60 to 70 deaths occurring annually in Australia to which anaesthesia has made some contribution.

The Working Party does not doubt that the continued collection of data on deaths due to anaesthesia is important, and the material has great potential value for anaesthetists and their patients. A low incidence emphasises the need to compile as large a database as possible, and hence the pooling of national statistics is supported in principle.

2. Standardisation of Data

The pooling of national statistics at this time produces a flawed database due to the differences which exist between the methods by which data are captured and analysed from State to State. Partly for reasons which were given earlier, standardisation of methodology has got off to a slow start.

Basically, standardisation has three elements:

- 2.1 a uniform *reporting* system
- 2.2 standardisation of clinical data-collection
- 2.3 a uniform classification system.

Progress towards a uniform reporting system is unanimously seen by the Working Party as being dependent on common coronial legislation across Australia where deaths in relation to anaesthesia are concerned. So long as Coroners' Acts differ in detail over the statutory obligations of anaesthetists, there will be significant variations in the capture rates from State to State. This fundamentally affects the comparability of results from each Mortality Committee.

A proposed uniform wording, for insertion in the appropriate place of each State Coroner's Act was agreed at the meeting of 28th January, viz:

"dies within 24 hours, or as a result of, anaesthesia or sedation administered for a medical, surgical, dental, diagnostic or like procedure."

This wording fulfils the aim of capturing those cases in which sedation for endoscopy has led to disaster. Its use of 24 hours as the cut-off point was recognised as the most practical approach since the majority of State legislation specifies this period now. Furthermore, extension to 48 or 72 hours multiplies the number of cases reported to Coroners without significantly increasing the yield of genuine anaesthetic mortality.

The proposal must be endorsed by the NH & MRC Health Care Committee, as well as NH & MRC itself, which would then transmit its recommendation to AHMAC (Australian Health Care Ministers' Annual Conference). If it is agreed to there, each State Minister would have to enlist the co-operation of his Attorney-General colleague, who would then ask his Chief Coroner for an opinion etc etc. The change, optimistically, could not occur in less than 2 years. This time-frame impacts on the urgency of other measures to achieve standardisation.

Standardisation of Clinical Data

Although a common form was originally envisaged as the means whereby such standardisation could be achieved, the Working Party now believes that for the purposes of national pooling, it is necessary only to agree on certain specific data being collected, rather than the actual means whereby they are recorded. Hence the patient's age and sex could be simply requested, or boxes provided for ticking: the age groups could be broken down into decades, with once again a "tick box" type form. Thus, provided the patient's age and sex are known, variations in the form are irrelevant.

This concept was an important break-through, and ready agreement was forthcoming on the ingredients of a common databank. State Committees will still use their own forms, with only slight modifications where necessary.

Standardised Classification

A standardised classification was to have been endorsed at the telephone conference in March, but it is evident that there are still some differences of opinion to be reconciled. It is anticipated that another face-to-face meeting will resolve these issues.

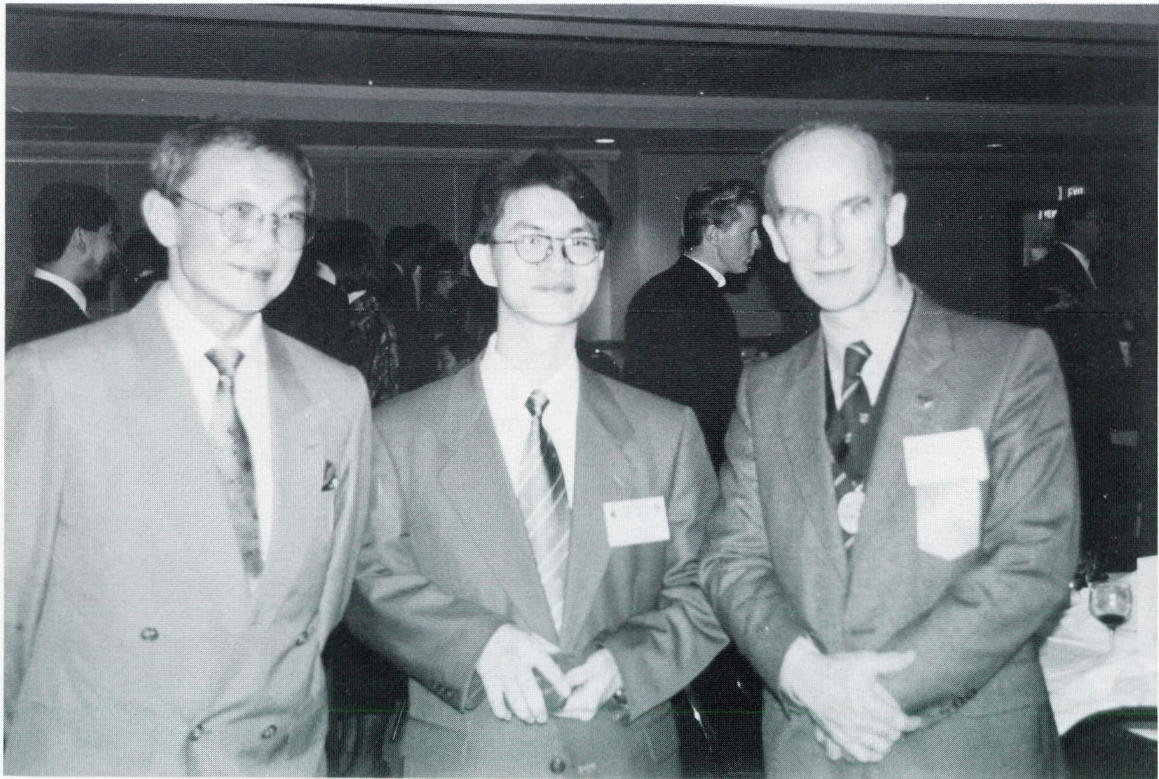
In conclusion, I feel optimistic that this Committee will achieve positive and useful results. There remains, however, the problem of the Report which the NH & MRC issues and which has now twice given rise to unfair and adverse publicity, with predictable outrage from the anaesthetic community.

There was a certain clumsiness in the wording of the first Report and its release to the media was done in such a way that senior representative members of the specialty had no opportunity to prepare adequate responses. Conscientious attempts were made to ensure that the second Report was worded in such a way that it could not give rise to misunderstanding and misrepresentation.

However, the problem on the last occasion arose from the fact that the NH & MRC meetings are now open to the media. Presentation of the Health Care Committee's Report on Anaesthetic Mortality were followed by comments from members of Council. The Report itself received less attention, in some media reports, than loose, ill-informed and off-the-cuff comments which had been made in Council.

The NH & MRC has now decided that the responsibility of endorsing reports like the report on deaths associated with anaesthesia will rest with the Health Care Committee. Only matters concerning policy in this area will be dealt with by the NH & MRC.

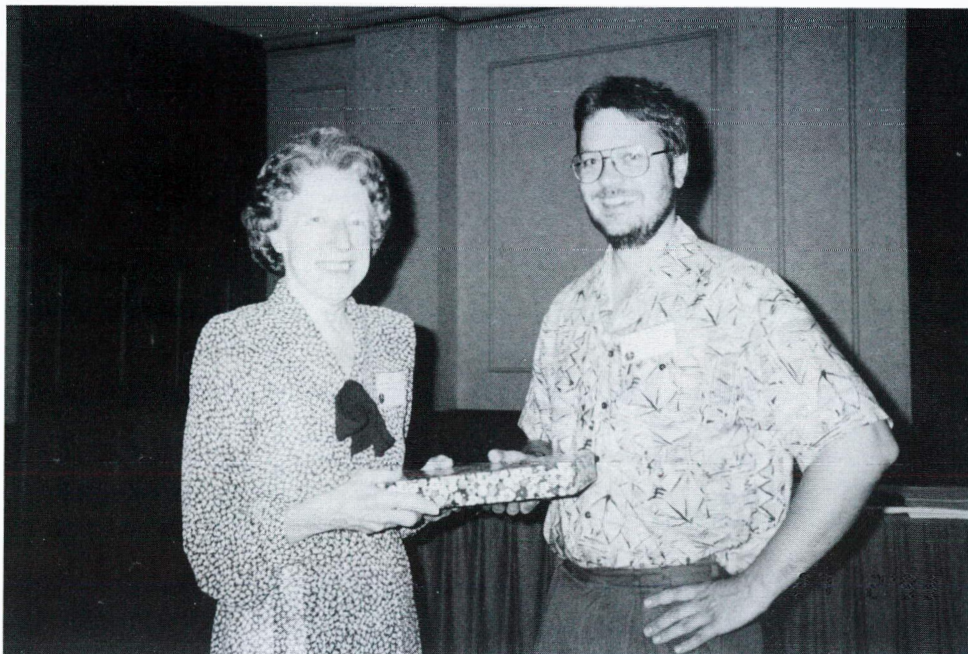
R.B. HOLLAND
February 1993



*Left to right:
Professor Teik Oh with Dr Suen Ka Lok (Tommy) following the presentation of the Gilbert Brown Prize by
Dr Michael Hodgson.*



*Dr Brian Spain accepting the
1992 Renton Prize Medal from Dr Moira Westmore.*



*Dr Nerida Dilworth presenting the Nerida Dilworth Prize
(a Littman's cardiology stethoscope) to Dr Mark Whitby.*

Australasian Visitor's Lecture

Delivered in Adelaide by

Vic I. Callanan, MBBS, FANZCA

CPR — An Exercise in Futility?

In this lecture I will discuss cardiopulmonary resuscitation including both basic life support (BLS) and advanced life support (ALS). Although this may not be core anaesthesia I believe it is important for anaesthetists to keep abreast not only of technical developments in this field but of current discussion of its place in society.

Anaesthetists were leaders in the development and implementation of modern CPR. Roger Bennett and Tess Cramond were pioneers in Australia in selling CPR to medicine and the public and introducing widespread education programmes. The Australian Resuscitation Council was founded in 1976 with the Royal Australasian College of Surgeons and its Faculty of Anaesthetists as sponsors. Its aim was to standardise and improve the practice and teaching of resuscitation within Australia. It has achieved these ends largely due to the input of anaesthetists such as Harry Ozer and Don Harrison, the last two Chairmen of the A.R.C., as well as Tess Cramond, Merv Allan and others who have served for many years on this Council. As well, many anaesthetists are involved in teaching programmes both in hospital and to groups such as paramedics, ambulance officers, lifesavers and lay persons. Hopefully anaesthetists will continue to be at the forefront of CPR development even though other groups such as the Australasian College for Emergency Medicine are playing a rapidly increasing role.

There are many situations in medicine which evoke emotional debate, but the use of aggressive universal resuscitation is probably the most anxiety and debate producing. Resuscitation is virtually never planned, but is a spur of the moment happening and therefore rational, calm, informed decisions are not possible. Because any delay greatly worsens the outcome or ensures non-survival, most patients, at least in hospital, are resuscitated without hesitation or discrimination. Often the difficulties occur after the resuscitation has begun and involve questions such as, "When should we stop?", "Should we have started?" and "What now?"

Often practitioners (medical, nursing or emergency medicine personnel) are reluctant to start CPR. Intuition tells them it is futile in the sense that it will never succeed even in the short term. The reluctance is increased by humane considerations; for example, it is better to die

from sudden cardiac arrest than from complications while bedridden and suffering indignities in an Intensive Care Unit or Rehabilitation Ward. Interference with the natural progression of life to inevitable death is not the proper thing to do and persons should have the right to "die with dignity".

On the other hand, some argue that no-one should be allowed to determine who should die and who should live. They say that no-one has the right to play God. Where is the balance between these views? How is the decision to be made? How is the decision made between the right to live and the right to die well?

The answer is never clearcut and decisions involve moral, ethical, religious, legal and medical factors as well as patients' rights, families rights and availability of medical and financial resources. The latter two are rarely a problem in the individual case in this country but that does not mean that they are not important nor should they be ignored in the overall scheme of health care provision.

Decisions must involve the probabilities of success and this requires good clinical data from well conducted outcome studies. However this needs to be combined with practical experience and good judgement by the clinician involved, because it is the knowledge of the literature, clinical experience and judgement of the clinician which best determines the course of action.

To make sound decisions we must know which are the irreversible conditions. Many are obvious — rigor mortis, dependent lividity, decapitation, incineration and overwhelming trauma. In other cases death is a continuum over a varying period of time which starts with oxygen deprivation to essential organs and proceeds to membrane failure and ATP depletion to the start of decay, but there is no finite point. No-one has yet seen the soul leave the body despite the depictions of Hollywood in recent movies such as "Ghost". Therefore we need clear pointers to irreversibility on the one hand and undesirability or inappropriateness on the other.

The former can be gleaned from careful inspection of the medical data, but the latter measures involve the concept of futility and must be sought elsewhere.

OUT-OF-HOSPITAL ARRESTS

Results

Sudden cardiac death causes about 50 to 65% of the mortality attributable to cardiovascular disease. Most of these deaths occur outside hospitals in the presence of family, friends, workmates or other bystanders. Despite this most do not survive their cardiac arrest outside hospital and of those who reach hospital to be resuscitated most do not survive to hospital discharge.

Survival from out-of-hospital arrests

Summary of 6 studies with 3,362 patients

Standard Ambulance	<1-5%
2 tier E.M.S. paramedic	9-42%
Defibrillation only	12.5-23%

Predictors of Poor Outcome

Out-of-hospital arrests: predictors of poor outcome

■ fate	— cardiac rhythm
	— presence of a witness
■ response time	— time to commence BLS
	— time to commence ALS

The likelihood of survival in out-of-hospital arrests is known to be related to several factors, some due to fate and some related to the rapidity of the emergency system response. The factors governed by fate include the cardiac rhythm at the time of collapse and whether or not the arrest is witnessed. The predictors governed by the speed of response are the time to commencement of CPR and the time from collapse to defibrillation. If all factors are not favourable successful resuscitation is very unlikely.

Initial Rhythm

In 80 to 90% of adults who suffer a sudden non-traumatic cardiac arrest the initial cardiac rhythm is found to be V.F.

Less than 5% of victims whose cardiac rhythm is found to be asystole or electromechanical dissociation (EMD) survive to be discharged from hospital. Asystole and EMD are found in two situations. The first is when catastrophic problems strike the heart, such as rupture, pulmonary embolus, global ischaemia or prolonged respiratory arrest. The second situation is when an initial ventricular fibrillation degrades to asystole or EMD. There is now ample evidence that an initial VF rhythm degrades to asystole or EMD in a matter of minutes. The time for this to happen can be prolonged by CPR.

Presence of a Witness

No-one should be surprised that a strong predictor of failure of resuscitation is a non-witnessed cardiac arrest. Unfortunately having a witness present is not as strong a predictor of survival. For a witnessed arrest to be of value, the bystander must initiate both a call for help and CPR.

Studies conducted in the last 20 years all showed benefit from bystander CPR. Unfortunately, these studies failed to control many of the variables which can affect survival rates such as arrest aetiology, cardiac rhythm, whether the arrest was witnessed, the response time and time to initiation of advanced life support. Cummins as part of his 1985 review of 1,297 witnessed arrests were 579 received bystander CPR showed that 32% survived with bystander assistance and only 22% without. These studies demonstrated ventricular fibrillation to be more common rhythm when bystander CPR was performed than when it was not. Cummins attributed this to the ability of bystander CPR to help maintain VF as the rhythm.

In certain circumstances, bystander CPR has been shown not to affect survival. Kowalski from Milwaukee and Bossaert from Belgium in large series have shown that if advanced life support was instituted in less than 8 minutes from collapse, bystander CPR did not improve the survival. In these studies the first response time was less than 5 minutes, a time unlikely to be matched in many parts of Australia.

Response Time

Cummins' important study concluded that bystander CPR was effective if started within 4 to 6 minutes and if followed by advanced life support within 10 to 12 minutes. Beyond 12 minutes, survival was so unlikely that bystander initiated CPR conferred no advantage. No-one now debates the importance of shortening the time to availability of BLS and ALS.

IN-HOSPITAL ARRESTS

Most people now die in hospital in Australia despite programmes designed to allow patients to die with dignity at home. Because of speed of response and ready availability of trained primary responders and ALS services, one might expect results of cardiac arrests to be considerably better in hospital than out of hospital. The difference is not dramatic. Most studies show a survival to discharge rate of about 15%.

Survival from in-hospital arrests

Summary of 17 studies with 5,412 patients

Immediate R.O.S.C.	26-53%
At 24 hours	13-33%
At discharge	3-24%

Published studies demonstrate that while the initial resuscitation rate is better than for out-of-hospital arrests, the final outcomes are not as good as one would hope.

The problem with these figures lies in the fact that standard reporting methods are not used. Many resuscitations claimed as successful were not cardiac arrests. The figures often include critical care areas which should report good outcomes. In the wards, the figures are less rosy.

Some studies actually demonstrate worsening results when current outcomes are compared with earlier data collections. Peter Dans and co-workers from Johns Hopkins showed a fall from 24 to 14% survival to discharge. The obvious explanation for this is the widespread unselective use of CPR in the hospital environment. The inclusion of more severely ill patients must make the results worse. This indiscriminate use of CPR was never intended, is ethically wrong and makes the results appear worse than they should be. If we were to eliminate cases where CPR is futile, a more realistic evaluation of outcome would be possible.

Predictors of Poor Outcome

Predictors of a poor outcome for in-hospital arrest victims have been established by most studies.

In-hospital arrests: Predictors of poor outcome	
■ severe underlying disease	
■ unwitnessed arrest	
■ severe neurological impairment pre-arrest	
■ asystole as first diagnosed rhythm	
■ CPR longer than 15 minutes.	

I am sure that no-one with experience in in-hospital cardiac arrests would be surprised by this list. Survival rates in various groups of severely ill patients are similar in several studies and the indicative rates are shown below. Again these results are not surprising.

Approximate survival rates with severe underlying disease	
■ Cancer with metastases	0%
■ GIT bleeding	0%
■ CCF, cardiogenic shock	0%
■ Pneumonia	1%
■ Sepsis	1%
■ Renal failure needing dialysis	0%
■ Stroke causing coma	0%

Age of itself is a poor predictor of outcome, but serious concomitant disease is very common in patients over 70 years of age in hospital and therefore the elderly have low survival rates.

INHIBITORS OF BETTER OUTCOMES

To make changes which will improve outcomes we need to be aware of the factors inhibiting good results.

Inhibitors of better outcomes	
1. Late start—	early access
	— no bystander CPR — reluctance
	— availability of ALS — education
2. Technical factors.	
3. "Hearts too poor to live".	
4. Inappropriate CPR.	

Bystander CPR

Bystander CPR does have an important role to play, but it is only initiated in 10 to 40% of cardiac arrests. Why are bystanders so reluctant? The most important factors are:

- (i) lack of knowledge in performance of CPR. A trained person is more likely to recognise the significance of a collapse and to respond quickly while the untrained will hope that others will help the victim;
- (ii) the aesthetics of resuscitation;
- (iii) fear of disease.

Availability of ALS

Early defibrillation is the action most likely to improve survival. For good results it must be available within 12-15 minutes. Beyond this time survivors are rare. Providing this response may be possible in urban centres, but in many rural areas it is manifestly impossible.

Full ALS from paramedics may not be necessary.

Acceptable results can be achieved by training first responders, like most Australian ambulance officers, to use automatic or semi-automatic defibrillators. The 23% survival to hospital discharge reported by Ian Jacobs and Harry Ozer from the St John's Ambulance in Perth is an example most of the country should follow. Two-tiered paramedic systems are beyond the manpower and financial resources of many centres within Australia so the Perth system is being duplicated elsewhere in Australia with similar results.

Technical Inhibitors

There are limitations to the effectiveness of CPR. Animal and human studies have demonstrated that blood flows generated by closed chest CPR are well below the minimal levels thought to be necessary to maintain myocardial and neuronal viability.

The addition of drug therapy improves the flows only a little.

Poorly performed bystander CPR adversely affects outcome. An Auckland study showed that with no CPR, 5% of victims survived, with poor CPR 8% survived and with good CPR 17% survived.

ALS as a more technical exercise, might be expected to vary in quality, but the trend to international standards should help eliminate this. As ALS should only be undertaken by professionals they should have regular recertification as to their continued competence. This certainly applies to emergency medicine personnel, but the majority of doctors, and most probably anaesthetists, do not undergo regular education in ALS. Although anaesthetists' technical skills will be good, theory is as important as new developments come and go. Regular updates are essential for one to be aware of current concepts.

Hearts too Poor to Live

There are obviously preordained failures from catastrophic events. These victims will probably never be saved despite any future advances in resuscitation techniques.

Inappropriate CPR

It must be remembered that CPR was originally developed for victims of sudden cardiac or respiratory arrest. The introduction to a monograph written by Jude and Elam in 1965 stated "the techniques described in this monograph are designed to resuscitate the victim of acute insult, whether it be from drowning, electrical shock, untoward effects of drugs, anaesthetic accident, heart block, acute myocardial infarction or surgery." The application today has become much more widespread and it is standard practice to attempt CPR on any patient in a hospital who has a cardiac arrest. This is often regardless of the underlying illness from which the patient suffers.

All anaesthetists would recognise the futility of CPR in many cases where it is instituted, at least in hospitals.

HOW TO IMPROVE SURVIVAL

How to improve survival

- Adopt the Chain of Survival
- Technical advances
- Reject futile CPR

Adopt the Chain of Survival

The American Heart Association (AHA) has developed the concept of a Chain of Survival without which victims of out-of-hospital arrests will not achieve an optimal outcome. If one link in the chain is weak, survival rates will be poor. While its principal thrust is at out-of-hospital resuscitation the principles apply equally to the hospital situation.

Early Access

This first link is essential to ensure the third link is not delayed. In adults, "call first" ie. before starting CPR. In children where respiratory causes of cardiac arrest are more likely, one minutes of CPR is recommended before "call fast" is instituted.

Improvement in this link depends on education of the public to recognise warning signs of problems and to notify the ambulance system without delay. As well, the emergency medical system must be able to respond quickly, with well trained and well equipped staff. They must carry on Automatic External Defibrillator (AED), oxygen and airway equipment appropriate to their level of expertise.

Early CPR

In all out-of-hospital arrests and most in-hospital arrests as well, bystander CPR has a significant effect on survival. It is able to buy a few minutes time while the ALS personnel arrive. It rarely causes injury to the victim even if the heart is still beating, albeit ineffectively.

Community wide education must be developed wherever possible and barriers to learning and performing CPR must be diminished. At present, the principle factor causing reluctance to perform CPR is the risk of cross infection and this is engendering considerable discussion at present.

INFECTION RISKS

Table 1 indicates diseases which are likely to be transmitted by mouth to mouth resuscitation of a victim or by practice on a mannequin.

TABLE 1
Cross Infection in Resuscitation

Infective Agent	Likelihood of transmission	Availability of Data
rhinovirus	††††	0
herpes virus	††	†
meningococcus	††	††††
T.B.	†	††
syphilis	†	†††
HIV	0	†
Hept B	†	†

HIV is the infection propelling this subject into the limelight. In 97% of cases in the USA, transmission has been by sexual contact, blood inoculation in its various forms and perinatal transmission. However, there are now over 30 reported cases of medical and laboratory workers becoming infected in the workplace.

HIV and AIDS have focussed attention on infections risks in countries with lay person CPR programmes and on willingness to perform CPR. This is despite the lack of any documented incident of HIV transmission from victim to rescuer or vice versa during resuscitation of a victim or from practice on a mannequin. That there is a real fear among many sections of the community has been documented several times.

In 1985, Lawrence and Sivaneswaran from Concorde Hospital in Sydney surveyed 70 hospital staff and obtained the results shown below.

Attitudes to resuscitation	
	(from Lawrence & Sivaneswaran, 1985)
70 Hospital Staff	
<i>In Community</i>	
Mouth to mouth – never	7%
– selectively	23%
<i>In Hospital</i>	
Mouth to mouth – clean case	51%
– ‘dirty’ case	13%
Mouth to mask	59%
Mouth to mask & filter & valve	100%

There is little evidence that attitudes have changed since 1985 and a public opinion survey in the United States produced similar figures. Against this must be placed the fact that most arrests from cardiovascular disease occur in the home. This means that if a bystander is present it is likely to be a close relative and willingness to perform mouth to mouth ventilation in such a case should be over 90%. To be effective the close relative must be trained in CPR, although dispatcher CPR is becoming more widely adopted in the United States. Only about 1% of the Australian population has attended a First Aid Course. As a worthwhile community service it would seem that the teaching of resuscitation in schools should be part of every curriculum. Despite urging from several bodies, including the Australian Resuscitation Council, this has not occurred.

With aids to CPR (these should probably be called devices to assist) such as masks and face shields improve these very worrying statistics? Intuitively one would expect them to decrease the risk of disease transmission, but there is no proof. Further questions remain unanswered. Is a valve necessary if a mask is used? Are face shields helpful? Certainly they are becoming very widely available, but are they effective? Problems have been shown in testing and these include high flow resistance in each direction, and valves and filters blocking or failing with saliva and/or vomitus. There exists no testing

standards and so commercialism is running away with large sales of untried devices. Even with this occurring, will the general public accept them and become more willing to institute bystander CPR? Will the population carry one of these devices for the once in a lifetime arrest which they may witness?

Carrying a device may be less necessary in the future. On the 2nd January, 1992 New York City passed Bylaws making it mandatory for specified places (bars, health clubs, theatres and restaurants) to have resuscitation equipment (which must be discarded after a single use) consisting of adult and paediatric exhaled air resuscitation masks and latex gloves readily accessible with notices of its location displayed. Importantly rescuer liability is limited such that liability is only incurred by gross negligence. If this practice becomes widespread the manufacturers of resuscitation equipment will make a lot of money, but there is no evidence that the incidence of bystander CPR will increase or that people will be saved. If we were to see an AED beside every fire extinguisher the costs would be enormous.

In the U.S.A. it is acceptable for a rescuer confronted with a collapsed victim to call first, clear the airway and then perform only external cardiac compression. If ECC only is performed for the first few minutes until the emergency medical personnel arrive, is outcome effected? There is no data on this but the American Heart Association has given its tacit approval by recommending this course of action as the minimum requirement.

So it seems that there is a new breed of leper in the community – and it is every one of us. Each of us is a stranger to all but family and very close friends. Does this mean that the good samaritan joins the ranks of those who will participate in personal contact only if he happens to have a protective device readily available? Has CPR had its day?

Perhaps CPR developed in a “window of opportunity” which is now closing. Up until the turn of the century and probably well into the 20th century, mouth to mouth resuscitation would not have gained much acceptance because of the risk of transmission of TB, small pox, leprosy, plague and other infectious diseases. Even before the turn of this century, will mouth to mouth resuscitation be discarded as a bystander response because of similar infection risks?

This is a very serious dilemma because it is expired air resuscitation which people are reluctant to perform, but in many cases this is the most important aspect of resuscitation as it prevents arrest progressing to cardiac arrest which carries a very much worse prognosis.

Early Defibrillation

This is the link in the Chain most likely to improve outcome in the patient with VF and AED's should make a large contribution in this area.

Automatic external defibrillators can diagnosis VF with a reliability equal to that of trained Cardiologists and better than that of other groups of medical practitioners or of paramedics. One study, the time to defibrillation was shortened by 1.5 minutes when standard defibrillators were changed to the automatic variety. With minimal training they are simple to use. Therefore AED's should have a significant part of play in improving survival from out-of-hospital and in-hospital arrests. In the out-of-hospital scenario there is debate about their use.

Few would deny that they should be available in hospitals and to ambulance personnel. Argument arises over other suggested sitings where they may be used by lay personnel, perhaps with minimal or no training in their use. Aeroplanes, office buildings, high density dwellings with a preponderance of inhabitants over 50 years old, in homes of high risk patients and at large public gatherings are just some of the suggested sitings for AED's. There is little numerical data to support any of these.

When Expo was held in Vancouver in 1986 there were six cardiac arrests to which emergency paramedical personnel were called. This was from the 22 million visitors. Three of the six arrests were in VF when the emergency medical personnel arrived and two survived. The widespread availability of AED's at Expo would have had the potential to save one extra person in 22 million visitors. Even allowing that higher risk patients may not have attended the Expo, these figures suggest that widespread availability of AED's will probably not be cost effective.

Currently a unit costs approximately \$10,000. If AED specifications were to be standardised and their use very widespread, the price may well fall to \$1,500 to \$2,000. Even at this price more effective use must be ensured and availability targeted appropriately. Prospective studies are awaited to guide these decisions and then politicians must be made aware of the appropriate use and where the necessary funding sits in the overall health dollar allocation.

Early Advanced Cardiac Life Support

The AHA sees this link as providing two first responders, rapidly followed by two rescuers trained in ACLS (ie. paramedics) at the scene. This is beyond the resources of most systems in Australia, however acceptable results can be obtained with only two responders as shown in Perth and other centres.

Once ROSC occurs, rapid transport to hospital care is part of this link in the Chain.

Technical Advances

Everyone would like to see a "magic bullet" break through which would in one stroke dramatically improve results in this life and death discipline. While the medical profession are realistic, we do tend to clutch at every promising development and want to immediately adopt it into our practice in the hope that it will save lives. In CPR we have seen all too often, such early promise evaporate to be replaced by the disappointment of reality.

"New CPR" was such a development, but simultaneous ventilation and compression has not improved outcome. Recent important research continues to try to improve blood flow during CPR. Interposed abdominal compression CPR, pneumatic vest compression CPR and active compression — decompression CPR are being evaluated, but despite commercial development of at least one of these, human data is limited. No changes in chest compression technique can be recommended at present.

As an anaesthetist the use of pharmacological techniques has appeal. Whether this be with new drugs or new applications or optimal dosing of familiar drugs, anaesthetists are familiar with this form of treatment. We must remember that the evidence for any drug improving outcome is weak and one study has shown that drug therapy may be harmful when other useful therapeutic manoeuvres are delayed waiting for drug delivery to its site of action.

The use of high dose Adrenaline is the latest adaptation of an old drug to be tested. Three recent large prospective comparisons of standard dose Adrenaline (1.0 mg IV) with 5, 7 or 10 times this dose failed to show any differences in survival to hospital discharge.

Another area subjected to considerable research has been brain resuscitation. The list of procedures and drugs tried in an attempt to ameliorate the damage from global cerebral hypoxia is large. Barbiturates and calcium channel blockers are just the latest from the list to fail the test of increasing survival to hospital discharge. Current contenders include:

- NMDA receptor antagonists
- free radical scavengers
- iron chelators
- monoclonal antibodies to leucocyte adhesion sites.

Having seen so many come and go I am not optimistic about the latest batch.

Another technique which may prove of limited usefulness and of very limited application is the use of cardiopulmonary bypass as a circulatory adjunct. While clinically feasible using new portable equipment, it will flounder on the rocks of expense and availability of expert operators.

Research will continue, as it should, to make small gains, but advances in technology are unlikely to make dramatic improvements in the ultimate outcome of CPR for the vast majority of victims.

Reject Futile CPR

Not starting CPR in cases with a low probability of success will obviously improve outcome figures. This must never be the justification for rejection of CPR in a particular case, but such rejection may be justified. Implementation of this principle is obviously much simpler in the hospital environment, but the wearing of a 'No CPR' bracelet has been introduced in some American States.

One special case needs discussion. Patients who are not resuscitated to a return of spontaneous circulation (ROSC) in the field do not do well. If a patient arrives in the Accident and Emergency Department needing CPR despite advanced life support in the field then their prognosis is almost hopeless.

**Survival in out-of-hospital cardiac arrest
Patients who reach hospital pulseless**

<i>Studies</i>	<i>Patients</i>	<i>Survivors</i>
9	2,911	45 = 1.54%

This raises the question of ceasing resuscitation in the field. Considering the results, all would agree that in certain circumstances it is futile to continue CPR during transport to hospital. Provided that good ALS is given at the site of the arrest outside the hospital should be seen as good practice to establish protocols to cease prolonged unsuccessful resuscitation at the scene, perhaps after consultation with a physician in a hospital. This concept deserves to be supported by suitable legislation in those States where it is currently not possible. Most authorities in the area of resuscitation agree that the doctor is not obliged to perform procedures when there is no expectation of medical benefit. This principle should be extended, with careful provisos and strict protocols, to the professional expert resuscitator in the field. Mechanisms need to be established for diagnosis of death in the field and for disposal of the body. Emergency personnel will need training in counselling of relatives and others at the scene.

"Resuscitation should be ceased if the patient has failed to demonstrate return of spontaneous circulation within 20 minutes, is over the age of 45 years and there is no evidence of immersion, overdose or hypothermia". This quote from Mark Fitzgerald's recent article in Emergency Medicine should be adopted as the standard.

We need to spend a moment discussing futility and what it means in this context. The notion of futility as applied to dying and medical attempts to thwart it is not new. Hippocrates allegedly advised "to refuse to treat those

who are over mastered by their diseases, realising that in such cases medicine is powerless". More recently, authors less often quoted than Hippocrates have espoused many opinions more specifically directed at CPR and futility. The best title was by Thomas Petty in 1979 entitled "Don't just do something — stand there!" In everyday usage futility means "a waste of time" or "doomed to failure" but this is no help in the present context and in fact its use in medical decision making is hard to define.

When doctors make decisions regarding rejection of CPR without consultation, they are justified only if the CPR is futile in a strict sense.

I believe that the following situations justify a unilateral decision that medical futility exists.

1. Failure of BLS and ALS after an adequate trial. The best predictor of outcome is the response to initial treatment. Withdrawal of resuscitation in this situation is commonplace.
2. The expected chance of survival is zero, based on reports in the given circumstances. For example, when CPR is attempted in patients with metastatic cancer, no patients survive to hospital discharge.

Patients and surrogates should have no choice in these cases and patient autonomy must yield to the authority of the well informed member of the medical profession.

A less strict definition of futility requires the doctor to make value judgements. It has been said that ethics is a weighing of what is right, but what is right depends on value judgements and values change from place to place and time to time. In a multicultural society such as we have in Australia, a consensus on any one ethical value would be difficult to achieve.

Developments over the years have forced changes in our ideas. It used to be understood that a doctor's duty was to preserve life at all costs, despite Hippocrates, but newer technology has radically changed the meaning of "at all costs". The new ethic of the right to choose or autonomy has become strong and the living will and the durable Power of Attorney have been developed as an expression of this. For a patient to make the informed choice implied in these predeterminations, they need some realistic idea of the results of their decisions. One example clearly demonstrates that this is not the case.

The largest growing age group is the elderly. Medicine has not extended the natural lifespan of man only allowed more to reach it. A 1992 survey by Miller and associates from the Cleveland Clinic of 268 persons over 60 years revealed very unrealistic estimations of the success of CPR and subsequent resuscitation. They believed 62% of all the patients, 40% of patients with severe sepsis and 28% of patients with widespread cancer survived to

hospital discharge. This belief must have a major effect on how they will decide regarding consent to CPR in a pre-determined decision. If we are to follow the principle of autonomy we must ensure that patients have realistic expectations. This may not be easy as the same survey showed that 66% of participants received their knowledge from television while only 6% indicated a doctor as their source of information. This survey highlights the problem of letting the elderly decide the appropriate level of care for persons at the end of their natural lifespan. Obviously inappropriate decisions may be made which would be regrettable.

In Australia pre-determined orders are uncommon and in the area of CPR there is no time to consult family or surrogates once CPR is needed, so the doctor makes the decision.

With this knowledge it is important that "No CPR" orders are available within hospitals for responsible physicians to use. The protocols for No CPR orders are not easy to establish and in at least one Australian State, may be illegal. This should not deter us from collectively trying to change the law and from establishing guidelines for withholding CPR when it is manifestly futile. Doctors must not abrogate their role in decision making. Remember that despite the best will in informing patients and relatives, that with few exceptions, patients and surrogates cannot make fully informed decisions. This is not meant to be a cloak for paternalism or an excuse to play God, but an exhortation to doctors to be fully informed about:

- the chances of survival in differing circumstances;
- the patient's underlying disease and its prognosis;
- the patient's quality of life in the context of his present disease.

Then if there is nothing more to offer the patient, you owe it to the patient to desist from resuscitation or not to commence it.

If the doctor in any one case is to decide, we must be aware of his bias in remembering only the "miracles" or the "disasters" he has been exposed to. To avoid this, each doctor must be aware of the actual outcomes, some of which have been presented in this lecture.

There are cases of undoubted futility and these have been discussed but if they are not present the decision can only be to commence resuscitation. Once this has happened, the best guide to overcome is the initial response of the patient. Once 20 minutes of advanced life support has passed without a return of spontaneous circulation then, in the absence of hypothermia, the resuscitation effort is futile. This is not a long period of time and surely everyone is entitled to this amount of acute care.

IS CPR FUTILE?

If used as the *sole* means of resuscitation for the victim of an arrest from a cardiac aetiology the answer is most probably yes. In "cardiac" cardiac arrests the principal benefit of CPR is in preventing VF degrading to asystole until defibrillation is possible. Once asystole occurs the prognosis is very poor.

For many cases however CPR is certainly not futile and BLS and ALS will continue to save many victims who will live neurologically intact for long enough to have made the CPR a worthwhile endeavour.

There is considerable scope for improvement in the results and the challenge is to achieve this. Improving CPR mechanisms to increase blood flow may not occur in the near future, but more importantly systems for delivery of existing CPR mechanisms can be improved. No pharmacological agent will prove to be of as much benefit as improving the Chain of Survival.

The secret of better results is not really a secret. Commencement of BLS within four minutes of arrest and of ALS within eight minutes is the answer. Those who survive out-of-hospital arrests will have suffered witnessed arrests from a cardiac aetiology with VF as the initial rhythm, they will then have bystander CPR and early ALS and ROSC will occur at the scene. The Chain of Survival will have been implemented.

To increase the number of cases where this occurs will require an increased educational effort at several levels:

- (a) to the lay public in the importance of recognising the problem, calling for help early and thus obtaining early defibrillation;
- (b) to the lay public in the skills and theory of BLS to buy the time often needed for survival potential to be maintained until ALS arrives;
- (c) to ambulance officers and other emergency medical services in the use of AED's to complement their other skills;
- (d) to medical personnel to allow them to make good ethical decisions based on well validated data;
- (e) to administrators in the importance of medical supervision of emergency medical services;
- (f) to governments to ensure the funding is found to provide appropriate infrastructure establishment from within tight health budgets.

Finally, I would take issue with the Intensivist who said to me recently "CPR — that's just something to do until the defibrillator arrives". This narrow view, that CPR is futile apart from the one aspect of ALS must be quashed. It must not reach the general populace as it will further decrease their willingness to respond to the victim of a collapse.

Would you like to be the victim whose bystander had the attitude "CPR — just an exercise in futility!" I think not!

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 (1989)	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
P16 (1988)	Continuous Intravenous Analgesic Infusions
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

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