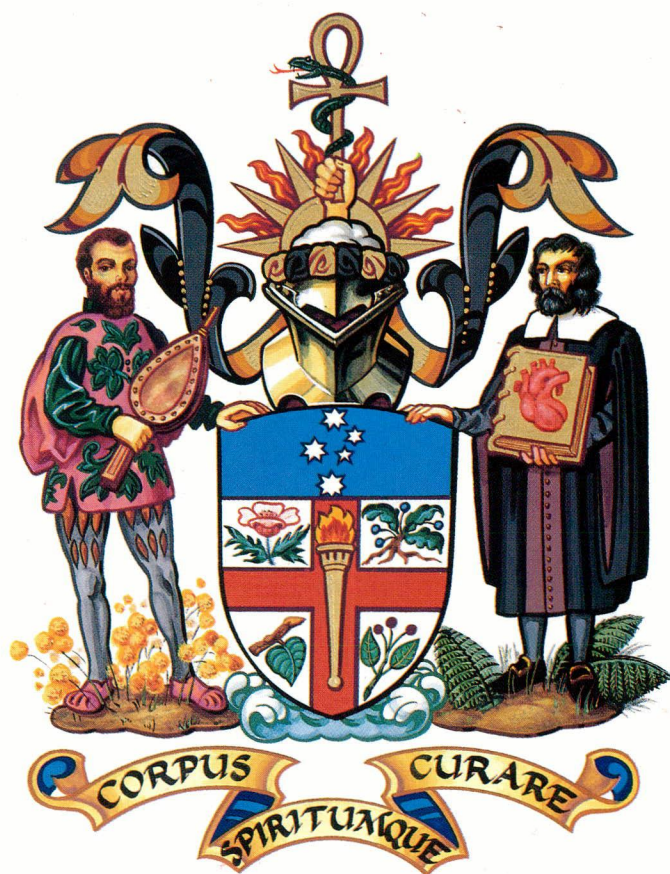


AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852



B U L L E T I N

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EDITORIAL

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

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PRESIDENT'S MESSAGE



My election to the Presidency of the Australian and New Zealand College of Anaesthetists has occurred at a very important time. This is because of two major events soon to occur which are the occupancy of our College new Headquarters and our first Independent Scientific Meeting in Launceston. The Fellows who have seen our College new Headquarters have been very excited about the purchase. Many other Fellows have seen photographs or a video tape of the building and have also been impressed. The Building was purchased for \$1.462 M — a very attractive price in the depressed property market of Melbourne. We will take possession of the building on September 1, but some renovations are required prior to our occupancy which will hopefully be early next year. At that time we will plan an appropriate opening and invite all Fellows to visit this very impressive home.

Plans for the Launceston ASM are progressing very well. Dr Mike Martyn and his Committee are finalising the plans and I believe that the Meeting will be a great success befitting of our first Independent Annual Scientific Meeting. Papers are being called for in this Bulletin so please consider your contributions. Townsville has been chosen as the site for the 1995 ASM — another exciting venue for our Scientific Meeting.

The Council Election resulted in the election of Dr Moira Westmore and Dr Brian Horan to the Council. Both of these Fellows have impressive backgrounds in College affairs and will add significantly to the quality of the team working together on the Council. Associate Professor Peter Livingstone and Dr Michael Hodgson completed their twelve years on the Board/Council and

both contributed significantly to ANZCA's affairs. Peter Livingstone lead us to the formation of the Australian and New Zealand College of Anaesthetists from the Faculty and Michael Hodgson's Presidency was crowned by the purchase of the new College Headquarters.

The Council has agreed to review the Constitution of the Australian and New Zealand College of Anaesthetists and it is currently considering the Articles of Association that require amendment. All Fellows have received copies of this information in the past and should consider writing to me regarding revisions.

The Final Examination is about to be carried out in its new format. Barrie McCann and his Final Examination Committee have worked very hard on these changes and now await the first new Examination with confidence. There is no doubt that the Examination will be more searching but should also be fairer and more relevant for candidates.

Progress is being made in the establishment of the Faculty of Intensive Care. Professor Garry Phillips has worked tirelessly to produce draft Regulations and to consider all aspects of the formation of the new Faculty. The Faculty will be organised in a similar way to the Faculty of Anaesthetists, and will take over all the functions of the Australian and New Zealand College of Anaesthetists Committees related to Intensive Care.

The Fellows' response to the Programme for the Maintenance of Standards has been very supportive. The concerns about Recertification have declined since the publication of the intended Programme which is practical and non-threatening. Further work is being done by Garry Phillips and his Working Party to complete the details of the Programme which we anticipate will be introduced by 1995.

MICHAEL J. DAVIES
President

ITEMS OF INTEREST FOLLOWING THE JUNE 1993 COUNCIL MEETING

HONORARY FELLOWSHIP

Professor M A Denborough, Professor John Curtin School of Medical Research, Australian National University, was invited to accept Honorary Fellowship of the College.

EDUCATION

Overseas Trained Doctors

Overseas trained doctors who have completed training in Australasia to the satisfaction of this College and have passed the Final Examination will be eligible for admission to Fellowship of the College.

Workshop on Distance Learning

Council supported in principle, the CPMC involvement in discussions on distance learning.

PROFESSIONAL

Representation on Standards Australia

The College Council and the Australian Society of Anaesthetists Executive agreed that anaesthetic representatives on Standards Australia will in the future represent both the College and the Society, the costs of such representations to be shared equally between the College and the Society.

Policy Documents

Council approved a policy document on "Minimum Standards for Pain Management Units". Publication of this document is printed elsewhere in this *Bulletin*.

Continuous Intravenous Analgesic Infusions

Following a review of policy document P16, Council agreed that in view of the joint Australian and New Zealand College of Anaesthetists/Royal Australasian College of Surgeons Statement on the Management of Acute Pain that some aspects of P16 have been superseded and that the document should be withdrawn.

Standards for Clinical Perfusion

Council resolved to establish a Working Party to produce Standards for Clinical Perfusion and that the Working Party comprise two representatives of the Australian and New Zealand College of Anaesthetists and the National Association of Medical Perfusionists of Australia. Dr Richard Walsh (NSW) and Dr David Scott (Vic) will be the College representatives on this Working Party.

FINANCE

Council agreed that the Australian and New Zealand College of Anaesthetists co-host the 1996 ISRA Meeting in Auckland with the New Zealand Society of Anaesthetists.

Reinstatement of Fellowship

Council approved a Regulation to provide for Fellows in subscription arrears of the Faculty of Anaesthetists as at the date of incorporation of the College to be considered for admission to the College upon payment of such arrears.

**INTERNAL
AFFAIRS*****Australian Resuscitation Council***

Council resolved:

1. *That the Royal Australasian College of Surgeons be informed that the Australian and New Zealand College of Anaesthetists would seek to be a joint sponsor of the Australian Resuscitation Council with the Royal Australasian College of Surgeons.*
2. *That the Australian and New Zealand College of Anaesthetists would be prepared to consider facilities for the Australian Resuscitation Council in the College new Headquarters.*
3. *That the Australian and New Zealand College of Anaesthetists will pay the expenses of the current three representatives on the Australian Resuscitation Council.*
4. *Following a review of the ARC Constitution, that the Australian and New Zealand College of Anaesthetists will be seeking to have two representatives on the Australian Resuscitation Council.*

Qualification in Pain Management

Council resolved to establish a Working Party to consider the Curriculum and a programme of qualification in pain management with a preliminary report to be forwarded to the October Council Meeting.

Recognition Award

Council requested the Executive to consider the development of a Certificate of Appreciation for award under appropriate circumstances.

Articles of Association

Council requested the Constitution Review Committee to review the Articles of Association and recommend any amendments.

Faculty of Intensive Care

Council endorsed the proposal to establish a Faculty of Intensive Care within the Australian and New Zealand College of Anaesthetists and that the Working Party proceed to develop a full proposal regarding the proposed Faculty for presentation at the October Council Meeting.

College Diary

Council agreed to distribute the 1994 College Diary with the November *Bulletin*.

AMA — Draft Policy on Sexual Harassment

Council supported the general approach of the Australian Medical Association's preliminary draft policy on Sexual Harassment.

Patients' Access to their Medical Records

Council supported the Australian Medical Association's Draft Guidelines regarding patients' access to their medical records.

**INTERNAL
AFFAIRS**

Committee of Presidents of Medical Colleges Review of Policies

Council supported the re-endorsement of the CPMC resolution regarding Education Aspects of Working Conditions in Hospitals.

Continuing Education and Quality Assurance

Council resolved that following the 1994 Annual Scientific Meeting in Launceston, Foundation Visitors Dr Carl Hug will visit Western Australia, New South Wales and the Australian Capital Territory, and Dr Jose Carvalho will visit New Zealand and Victoria. The Australasian Visitor, Professor Laurie Mather, will visit Regions as invited during his year of appointment.

Australasian Anaesthesia

Dr John Keneally has been appointed Editor of the 1994 Edition of Australasian Anaesthesia. A representative in each Region has been appointed to assist in the provision of articles for this publication.

Combined Meeting between the Academy of Singapore, the Academy of Malaysia, the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists

Council agreed to discontinue the College's involvement with the 1994 Joint Meeting in view of the numerous Anaesthetic Meetings already planned for that year.

Certificate of Participation in a Programme of Maintenance of Standards

Council resolved that Fellows who complete a Programme of Maintenance of Standards satisfactorily be awarded a Certificate of Participation in a Programme of Maintenance of Standards. Further information relating to this matter is published elsewhere in this *Bulletin*.

1994 Younger Fellows' Conference

Dr Lachlan Doughty has been appointed the Convener for the 1994 Younger Fellows' Conference.

Special Interest Group

Council resolved to establish a Special Interest Group for Anaesthetic Research.

1995 Visitor — ASM Townsville

Dr John Sear, Reader in Anaesthetics and Honorary Consultant Anaesthetist, University of Oxford, Nuffield Department of Anaesthetics, the John Radcliffe Hospital has accepted the invitation to be a Foundation Visitor at the 1995 ASM in Townsville.

FACULTY OF INTENSIVE CARE

The Faculty of Intensive Care Working Party has agreed that a proposal be presented to the Council of the Australian and New Zealand College of Anaesthetists at its next Meeting in October. The proposal recommends that:

1. A Faculty of Intensive Care be established within the Australian and New Zealand College of Anaesthetists (and therefore subject to the Memorandum and Articles of Association of the College).
2. Foundation Fellowship of the Faculty will be offered to Fellows of the Australian and New Zealand College of Anaesthetists endorsed in Intensive Care.
3. Council be requested to appoint an Interim Board of the Faculty to cover Faculty affairs until an election for the Board has taken place, this to be within 12 months of the appointment of the Interim Board.
4. The Faculty would operate under the Regulations and Administrative Instructions modelled on those of the former Faculty of Anaesthetists Royal Australasian College of Surgeons. Such Regulations and Administrative Instructions will include:
 - 4.1 Formation of the Board which will consist of eight Fellows elected for a term of three years but eligible for re-election for three further terms with a maximum of twelve years. The composition of the Board must include one Fellow resident in New Zealand. The Board could invite a representative from a State which was not represented by an elected Board Member to act as an Observer. The Board of Faculty would include a College Councillor and the Board of Faculty would nominate a Board Member to the College Council.
 - 4.2 The Board would elect annually a Dean and Vice-Dean.
 - 4.3 A Faculty Administrative Officer would be appointed and the ANZCA Registrar would be an adviser to the Faculty.
 - 4.4 The Board would appoint each year a Chairman of the Fellowship Examination.
 - 4.5 The Fellows of the Faculty shall be persons admitted to Fellowship by examination and training, conferment of Honorary Fellowship and admission by election to Fellowship pursuant to the Regulations.
 - 4.6 The Regulations relating to training and examinations would be in line with the existing Regulations. The Faculty Board would approve

training positions following review of Intensive Care Units utilising the current ANZCA Policy Documents.

The examinations would be the ANZCA Primary and the Faculty Fellowship Examination which would be unchanged in content and format from the current Final Examination (Intensive Care).

- 4.7 Subscriptions would be identical to that of the College and continued to be paid to the College. This would allow continuation of existing financial and administrative arrangements and provide a clearer understanding of the financial requirements for the Faculty to be financially independent.
- 4.8 The headquarters would be at the new ANZCA headquarters which would allow continuation of existing administrative support.

It is envisaged that the Interim Board would take over the functions of the Section Executive, the Education Committee (Intensive Care) and the Final Examination Committee (Intensive Care).

The College Council would be requested to delegate to the Board of Faculty, responsibility for the conduct of intensive care activities provided that the Board did not make any decisions which were in conflict with the Memorandum and Articles of Association of the College.

Evolution of the role is anticipated just as the Faculty of Anaesthetics evolved.

The main implications of formation of the Faculty of Intensive Care as outlined above are that the Board would be composed of intensivists governing intensive care matters; training and examinations would continue unhindered; there would be no additional subscription; the Faculty would have a home and administrative support. The Board would be able to deal with all matters referred to it and could enter into discussions about such issues as liaison with the College of Physicians regarding training and examinations.

Fellows of the College should appreciate that those not endorsed in Intensive Care would not be eligible as Foundation Fellows of the Faculty.

GARRY D. PHILLIPS
Chairman — Working Party

FACULTY OF ANAESTHETISTS
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS



OFFICE OF THE PRESIDENT
 David E. Theile

Patron: H. R. H. The Prince of Wales

**ROYAL AUSTRALASIAN
 COLLEGE OF SURGEONS**

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7th July 1993

Dr. M. J. Davies
 President
 Australian and New Zealand College
 of Anaesthetists
 Spring Street
 MELBOURNE Vic 3000

Dear Dr. Davies,

The Annual General Meeting of the Royal Australasian College of Surgeons of 24th June 1993 altered its Article of Association and the Faculty of Anaesthetists of our College no longer exists. At this time our College remembers with pride the forty years during which the development of anaesthesia in Australasia was steered by the Faculty of Anaesthetists of the Royal Australasian College of Surgeons.

Our Council again wishes ANZCA well for the future. The intimate administrative association of anaesthesia and surgery has been loosened but there is no doubt that there will be continued close professional inter-relationship and friendship between the Fellowships of Surgery and Anaesthesia.

A letter from our Secretary will have conveyed to you the results of deliberations of our Council regarding the separation of the two Colleges. It also contains our resolve to present to ANZCA a Ceremonial Mace. We hope the symbolism of this presentation will serve as a long lasting reminder of the administrative history of anaesthesia and of the ongoing professional respect.

Yours sincerely,

David E. Theile
 President

LAW REPORT

Michael Gorton, LLB — College Honorary Solicitor — Partner, Abbott Tout Russell Kennedy

SURGERY, ETHICS AND THE LAW

(An excerpt from introductory remarks made during the Session on this topic at the recent College Annual Scientific Meeting in Adelaide — May 1993)



It is interesting that a lawyer has been asked to comment on ethics in the course of a Medical Conference. Some would question what a lawyer would know about ethics.

However, it is clearly a recognition of the close relationship of the development of ethical codes of conduct in the medical profession, and the relationship and linkages to our legal and legislative framework. Certainly not the least reason for the linkage is because a failure to meet ethical standards may involve litigation and other sanctions.

Codes of ethics for the practice of medicine are not new —

- the Hippocratic Oath established some basic ethical and practice guidelines that have influenced many fundamental principles for medicine today.
- the modern “Hippocratic Oath” is reflected in the Declaration of Geneva (as modified in 1968).
- there is an International Code of Medical Ethics approved by international medical organisations.
- the Tokyo Declaration (1975) provides a statement on torture and other cruel, inhuman or degrading treatment or punishment.
- the Oslo Declaration (1970) gives a statement on therapeutic abortions.
- the Helsinki Declaration (revised in 1975) gives recommendations on bio-medical research involving human subjects.
- the AMA has, as recently as 1993, issued its own statement on Ethics for medical practitioners.

There are a wide range of codes and guidelines developed by the Colleges, the AMA and the NHMRC on various subjects. There is the influence of particular legal and legislative requirements (such as the High Courts formulation on Informed Consent, and the legislative sanctions applied to manslaughter). In recent times, there has been the development and increasing influence of “patients’ rights”.

Statements on ethics and practice will never remain static, since they are required to meet constantly changing circumstances arising from medical advances, changing community attitudes and demands, and ever changing and more pervasive reach of legislation of our governments.

Ethical considerations in the 1980’s and 1990’s involve a range of significant and often controversial areas:-

The Beginning of Life

- Abortion
- IVF procedures
- Embryo experimentation

During Life

- Informed Consent — the duty to warn patients.
- Capacity to consent to medical treatment (children/mentally impaired).
- Resource allocation (choosing patients and treatments in circumstances where resources and treatment options are limited).
- Confidentiality of patient information.
- Experimentation on human subjects and approval procedures for new drugs and treatments.
- AIDS/HIV issues.

The End of Life

- Passive Euthanasia.
- Active Euthanasia.
- Treatment of brain-death and the vegetative state.
- Organ transplants/organ donation and autopsies.

In all of these issues, many important questions are raised such as —

- What role for doctors? Parliament? The Courts? The Patient?
- Who should decide?

- How and when should ethics be taught and promulgated?
- What penalties or sanctions should there be for a breach of ethical standards?

There is clearly no comprehensive answer.

However, if doctors and lawyers expect to continue to claim the privileges of being "professionals", then part of the concomitant obligations of being a "professional" includes the need for self-regulation/training/education. "Professionals" must adopt, enforce and promote ethical codes and ethical practices. The "professions" should ensure that standards, once determined, are maintained, and sanctions imposed for a breach of standards.

The standing of the legal profession and, to some extent, the standing of doctors, in the eyes of the community in recent years has diminished. This has not been for any lack of code of ethics or behaviour (there are clearly many, either by self-regulation or supported by legislation). It may have arisen because, in part, there is a perceived failure to observe or failure to enforce such codes, practices or standards.

There is a clear warning to professions that, if they do not regulate, there will always be the risk that government (with all its slow ham-fisted and bureaucratic methods) will regulate the professions for them.

Workcover

A new scheme of workers compensation known as "**WORKCOVER**" has been introduced in Victoria. The scheme has been modelled on the work cover system of compensation in New South Wales and commenced operation in Victoria on 1 December, 1992.

The emphasis under **Workcover** is expressed to be to create a "return to work" culture, rather than a "compensation" culture, with greater emphasis being placed on rehabilitation in consultation with the employer. Early indications are the **Workcover** is succeeding in reducing the high level of unfunded liabilities which existed under the old "Workcare" system. This reduction is expected to flow through to a drop in the levies employers are required to pay.

The main changes under the **Workcover** legislation are as follows:-

1. Employment must now be a "**significant**" contributing factor to an injury or disease before compensation is payable.
2. A new benefits structure with only seriously injured or totally and permanently incapacitated workers entitled to weekly payments of compensation after two years.

3. Common law claims for negligence are only available where the worker suffers a "**serious injury**".
4. Medical Panels of independent doctors are to adjudicate on disputes relating to diagnosis, treatment and/or capacity to work.
5. Medical Certificates can now only be issued by medical practitioners and no longer by chiropractors or osteopaths, thus restoring parity with physiotherapists.
6. Abolition of the Accident Compensation Commission with claims now being heard in the Administrative Appeals Tribunal, Magistrates' Court or County Court, after a conciliation conference.
7. Injuries whilst travelling to and from work are now covered under the Transport Accident Act.

Generally speaking, the benefits available to injured workers will be greater for the first six months, but will then be reduced to encourage return to work. One aim of **Workcover** is to increase compensation for those suffering more serious injuries, whilst reducing compensation payable for partially injured workers.

It is likely that there will be disputes as to whether or not employment was a significant contributing factor (see item 1 above) to the injury or disease. It will be difficult, for example, for a medical practitioner to assess whether a significant contributing factor of a back injury is work-related, or is merely caused by a degenerative spinal condition.

A key factor in determining the level of benefits a worker may receive is whether a serious injury is suffered. A "**serious injury**" is defined in the **Workcover** legislation to have occurred when an assessment as to permanent impairment has been carried out in accordance with the "**American Medical Association's Guide to the Evaluation of Permanent Impairment**" (Second Edition) ("**the Approved Guide**") and the level of impairment is 30% or more.

Motor Vehicle Accidents

The **Workcover** structure of compensation is of a similar nature to the compensation structure applicable to motor vehicle accident claims in Victoria.

A no-fault scheme of compensation was introduced in Victoria on 1 January, 1987. Increased benefits are available through the issuing of a common law claim for damages on the grounds of negligence. These claims are, however, only available where a "**serious injury**" is suffered.

The definition of “**serious injury**” under the governing Transport Accident Act is slightly broader than the relevant provisions of **Workcover** and include:-

1. Serious long-term impairment of loss of a body function; or
2. Permanent serious disfigurement; or
3. Severe long-term mental or behavioural disturbance or disorder; or
4. Loss of a foetus.

A permanent impairment assessment of 30% or more (as assessed under the Approved Guide) will deem an injury to be a “**serious injury**”. The Transport Accident Commission is also given a discretion to allow a claim for damages if the Commission is satisfied that the injury is a “**serious injury**”. Alternatively, a person injured in a motor vehicle accident can apply to Court for a determination that the injuries suffered are “**serious injuries**”.

Both the **Workcover** and the Transport Accident Compensation Scheme’s use of the Approved Guide provides for an objective assessment of permanent impairment. It is the permanency and ongoing nature of the injury, and not the seriousness of the initial injury suffered, which is important in assessing permanent impairment. For example, a person involved in a motor vehicle accident who suffers *inter alia* numerous broken bones, but who recovers well from the injuries, whilst having all loss of earnings paid “**for up to a maximum of 3 years**”, along with all medical expenses paid, is unlikely to have suffered “**serious injury**” and may not recover any common law damages.

A graduated lump sum benefit is payable for a permanent impairment assessment in excess of 10%. A lump sum benefit is also payable under **Workcover**, together with pain and suffering benefits for some injured workers who receive an impairment lump sum of, at least, \$10,000.

The use of the Approved Guides takes no account of a patient’s disability, being the alteration of a patient’s capacity to meet personal, social or occupational demands. The permanent impairment assessment is, instead, an objective assessment of the health status of the person at the time of the assessment.

Not all medical practitioners will have a close working knowledge of the Approved Guide and this often leads to wide diversions in assessments, therefore, leading to disputes in the benefits payable.

Summary

It is hoped that, through this brief synopsis, medical practitioners will have a better understanding of the medical questions important when determining the level of benefits to which their patients may become entitled. This will, we believe, assist medical practitioners in providing their written opinions in medical reports.

Questions such as –

Are the injuries suffered **serious injuries**?

Is the worker totally incapacitated?

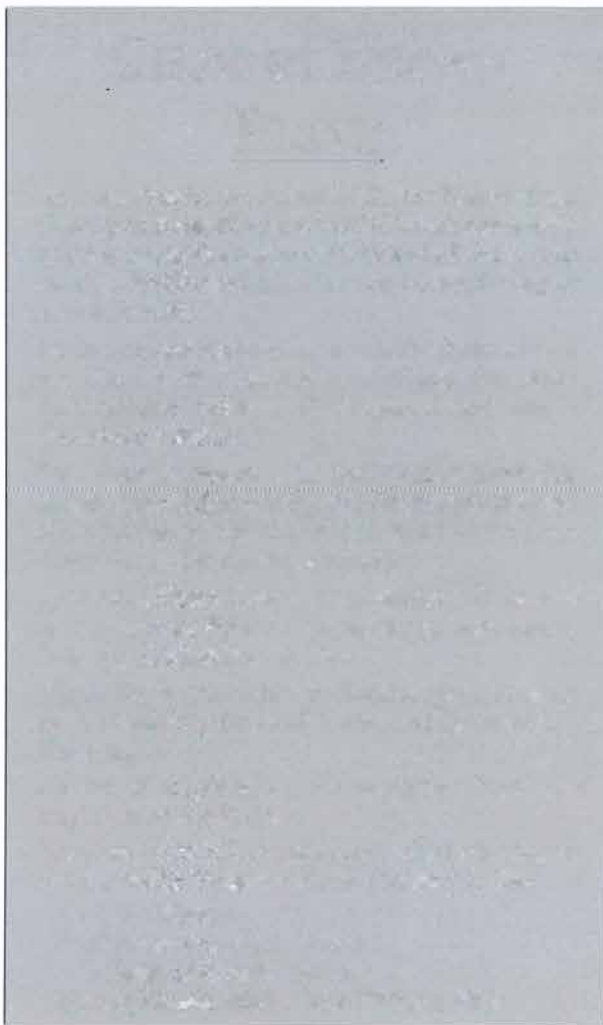
Was employment a **significant** contributing factor?

What is the level of permanent impairment?

can obviously be of vital importance in providing medical assessments under these compensation schemes.

The role of the medical practitioner is a vital one, not only in providing the necessary advice and treatment to a patient, but also, when requested, accurately assessing the precise nature and extent of the injury suffered according to legislative guidelines.

Often, the patient’s recovery from injury will be accelerated when accurate advice regarding compensation entitlements is given to the patient. Patients may, therefore, also be encouraged to obtain professional legal advice in appropriate cases to reduce the prospect of stress, worry and anxiety which may hinder recovery.



HONOURS AND APPOINTMENTS

Associate Professor Peter D. Livingstone, Qld	Elected to the Court of Honour, Royal Australasian College of Surgeons
Professor Gai G. Harrison, South Africa	Doctor of Science in Medicine, University of Cape Town
Associate Professor Vic I. Callanan, Qld	Chairman, Australian Resuscitation Council
Professor Geoff R. Cutfield, NSW	Professor of Anaesthesia and Intensive Care, University of Newcastle; Director of Education and Research, Department of Anaesthesia and Intensive Care, John Hunter Hospital.

ADMISSION OF FELLOWSHIP BY EXAMINATION

ENDORSED IN ANAESTHESIA

David Hugh Binney, NZ	David Bruce Hays, Vic
Elsbeth Bright, NSW	Ruth Mima Matters, Tas
Tony Di Florio, WA	Gregory David Raper, NSW
Ross Callum Freebairn, NZ	David Alan Shaw, NSW
Deborah Joy Goodall, NZ	Richard Alexander Crichton Sorby-Adams, SA
Kerry Nevyne Gunn, NZ	Robert Scot Tayler, NSW
Elizabeth Anne Hampson, Qld	Susan Barbara Voss, NSW

DIPLOMA OF FELLOWSHIP

ENDORSED IN INTENSIVE CARE

Jonathen Neil Buckmaster, Vic	Peter Dalton Cook, NSW	Robert Charles Gazzard, Vic
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ADMISSION TO FELLOWSHIP UNDER ARTICLE 12(c)

Stella Lea Alexander, NSW	Catherine Geraldine Mary Flynn, Ireland
Christopher Ian Elias, NZ	Margaret Faith Nicholson, NZ

CASEMIX FUNDING AND AUSTRALIAN DRGs

Over the past few years much effort has been made at the Federal and State level to develop a system which permits payment for health services on the volume of services delivered.

This "output" based funding is in sharp contrast to the current method which funds healthcare "inputs" (usually on an historical cost basis with adjustments for inflation — previously an increase but more recently a decrease in real terms). In order to fund on an "output" basis it is necessary, through improved information technology, to define various "outputs" and this has led to the concept of Diagnostic Related Groups (DRGs).

Casemix Funding

The "DRG" system provides a method of documenting the service delivery by a hospital. It allocates to groups patients, who based on their diagnoses at discharge, are expected to have cost similar amounts during their hospitalisation. Each Diagnostic Related Group (DRG) has a "weight" assigned to it which is a relative value of expected hospital cost. Payment to the health care provider is based on the "casemix" (the number of patients of each DRG treated).

It should be noted that the DRG weights from the United States do not include the costs of the medical practitioners who provide patient care. At the recent meeting of the ACCC (Australian Clinical Casemix Committee) it was still unknown whether or not the Australian DRG (AN-DRG) will include medical costs.

AN-DRG's

There are 527 AN-DRGs in the Australian version compared with 473 in the Maryland version. The number of DRGs is a balance. A greater number of groups makes each group more homogeneous but increases the difficulty in determining an appropriate weight.

Calculations have been based on Maryland weights because Australian weights have not yet been determined. A further difficulty is that nowhere in Australia does a hospital have a sufficiently detailed accounting system to be able to accurately assign costs to patients and so determine an appropriate dollar figure to place against the service weight. It is necessary to have several hospitals contribute. Any derived weights will only be valid for the type of hospital in which they are derived.

The "validation workshops" have been little more than discussion groups because of the lack of useful Australian data on which to base any reasonable validation.

Changes in Victoria

Victoria has recently become the first Australian State to fund healthcare on Casemix. The change to health care funding in Victoria has two major components. The first, and perhaps more important component has been described as the "Goodbye Experiment". This relates to a memorandum which cancels previous Health Department circulars relating to hospital funding. Hospital Boards are responsible for their own management. The Department of Health and Community Services will not close hospitals: Boards of Management will.

The second component, Casemix funding, has been used elsewhere and is a management tool for controlling expenditure on health care. It places direct pressure on institutions to compete on cost for the work to be done. Additional payment is based on casemix — the number of patients times their service "weight".

Implications for Hospitals of Casemix Funding

Various criticisms of the initial discussion paper stated that it would disadvantage large teaching hospitals. Others stated that it would disadvantage small hospitals. The following comments are restricted to general principles.

Although not an essential feature of casemix funding, it is obvious that the rate of payment from government will be less than the services cost some providers. Hospitals in this situation will therefore be faced with the choice of dropping that service or subsidising the loss from another service which it can provide at a profit. This will impose several changes on the way in which hospitals are managed internally and the way they position themselves in the market.

Department Budgets

All departments will be required to define the service they provide and be able to be competitive with comparable Departments in other hospitals. We have already seen major impact of this on pathology services in teaching hospitals with rationalisation so one large department will service several hospitals.

Doctor Costs

It is important to note that the U.S. DRG payments do not include the cost of medical staff. Any development of a system for Australia needs to recognise that costs in Anaesthesia have a very high proportion of doctors costs. We use relatively little in the way of nursing staff and disposable equipment when compared with many other groups. The anaesthesia service weight will need to be examined closely to ensure that if medical staff costs are included, the increase is sufficient to cover the true cost.

Departments of Anaesthesia will be expected to justify their staff on the basis of service provided. Balance between clinical service, teaching, research, maintenance of personal education and quality assurance will be challenged. The long term necessity for such activity is threatened by acute budget reductions.

Recent statements from the VHA attest to the reality of such threats. Anaesthetists, particularly staff specialists, are asked to justify why they do not spend 10 sessions per week in an operating room. Some people feel at liberty to suggest we should be restricted to such easily defined activity from 7.30 a.m. to 6.00 p.m. from Monday to Friday on the basis of a 38 hour week. Nowhere to be heard are suggestions that physicians should spend 10 sessions per week in outpatients on ward rounds, or that surgeons should be operating or be in outpatients for all of their 10 sessions.

Teaching and Research

There is no allowance made for these activities within casemix funding. These activities are funded separately. Funds specifically directed to these activities will be vigorously contested and it is likely that departments with a strong academic track record will attract a large share.

In this context it is prudent to continue to argue the need for non-clinical time on the basis of standards of care and the need to make staff positions attractive. The hospital managers will be under immense pressure to seek short term solutions to a cash crisis. If the non-clinical time is argued on the basis of teaching and research alone, it leaves open the option for hospital managers to say that they do not pay for such activity.

Product Line Management

Hospital structures may adapt to make changes of direction faster when funding patterns change. "Clinical Clusters" may replace traditional "Divisional" structures. Each clinical cluster would be responsible for the provision of a range of services within a group of DRG's. Anaesthesia could, like nursing, be divided up as a component of each cluster or could remain a central service, selling services to the relevant clusters.

The changes in alliances within hospitals will pose a significant challenge to each department.

Hospital Specialisation

The result of product line management is that hospitals will of necessity move away from specialties in which they cannot be competitive. Initially, competition will be based on price but one must count on professionals to maintain standards and as the Market becomes more sophisticated, competition will move to quality and price. Demographic

factors will also be important. Hospitals will only be able to do the work where they have a sufficient patient base.

Implications for the College of Anaesthetists

1. Financial pressure on hospitals coupled with changes to the industrial relations legislation in Victoria will place pressure on Departments of Anaesthesia. There may be advantage in increasing the frequency of College inspections to monitor the standards of training and staff levels.
2. One of the challenges is to maintain standards of care. Increased emphasis on quality issues is likely to be the most effective tool in arguing the case for appropriate staff and capital equipment budgets.
3. One possible scenario includes development of major private hospitals in very close association with public hospitals. The opportunities for training in these hospitals will need to be seriously considered. The structure of training positions may need to change to make best use of available opportunities.
4. Pressure will be placed to reduce expenditure on registrars by reducing their number and the hours they work. Although it is appropriate to confine our concerns to issues of professional standards and training, we must recognise the impact of industrial issues on these professional issues.
5. Training in sub-specialty areas may not remain possible within traditional training rotations. Several options are available to address this problem and each has advantages and disadvantages. A key issue is to resolve the extent to which trainees must have exposure to sub-specialties.

Conclusion

Casemix funding is a reality of the 1990's. Individual Fellows and Departments must be aware of its impact on clinical practice and adjust their strategies so as to gain any benefits it may provide. Currently though it is important to minimize any negative impact on quality, staffing, training, remuneration and conditions of service in Anaesthesia and Intensive Care.

A.M. WEEKS
P.A.S. GERMANN

June 1993

REPORT FROM THE PRESIDENT TO FELLOWS OF THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS AS AT THE 11TH JUNE, 1993

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

AWARDS, HONOURS AND APPOINTMENTS

It is noteworthy the number of important appointments made and numbers of awards and honours conferred upon Fellows of the College in the past year. This indicated the significant involvement in, and recognition of the contribution of Fellows of the College in many activities, both within the specialty and medicine and within the community both in Australia and overseas.

The Robert Orton Medal was awarded to **Professor Ross B. Holland**, New South Wales.

Appointments

Professor A.B. Baker, NZ — RACS Court of Honour and Nuffield Professor of Anaesthetics in the University of Sydney at the Royal Prince Alfred Hospital.

Dr T.C. Kester Brown, Vic — Vice Chairman of the World Federation of Societies of Anaesthesiologists Executive Committee.

Dr Hugh J. Clarkson, NZ — President, New Zealand Society of Anaesthetists.

Dr John Hains, QLD — President Australian Society of Anaesthetists.

Dr Cedric H. Hoskins, NZ — a Vice President of the World Federation of Societies of Anaesthesiologists.

Dr Douglas Jones, HK — Chair of Anaesthetics, University of Queensland, Royal Brisbane Hospital.

Dr Saywan Lim, Malaysia — President of the World Federation of Societies of Anaesthesiologists.

Dr Gracie Ong, Malaysia — Professor of Anaesthesia, University of Malaya.

Professor Garry Phillips, SA — Chair — Professor of Anaesthesia and Intensive Care, Flinders University of South Australia, Flinders Medical Centre.

Honours

Dr M.D. Cobcroft, QLD — Member of the Order of Australia

Dr N.M. Dilworth, WA — Member of the Order of Australia

Dr Gerald J.L. Flynn, ACT — Elected to the AMA Roll of Fellows

Dr W.M. Smeeton, NZ — Order of the British Empire, New Year's Honours List

Professor Teik Oh, HK — Elected Fellow of the Royal College of Physicians of Edinburgh and Fellow of the Royal Australian College of Physicians.

Deaths

It is with regret that I report the death of the following:

Dr A.J. Gyngell, Vic

Dr I.L.G. Hutchison, NZ

Dr J. Lawson, Vic

Dr A.L. Nathan, Vic

Dr V. Rees, SA

Dr J.B. Vonwiller, NSW

Dr G.B. Westmore, Vic

RESEARCH GRANTS FOR 1993

In the past year the College received applications for Research Scholarships and Grants totalling \$357,320. College funds available for distribution in 1993 were \$115,000 for Research in addition to the \$65,000 for the Inaugural Douglas Joseph Professorship, and \$75,000 for the Anaesthetic Chairs Establishment Grant.

Scholarships were awarded to:

Dr S. McG. Barratt (NSW) \$22,000
Project: "Multi-Modal Pain Control and its Impact on Post-Operative Nutritional Support".

Dr K.H. Hall (NZ) \$22,000
Project: "Analysis of Ethical Principles of Intensive Care Decision Making".

Grants were awarded to:

Dr W.J. Burnett (Vic) \$3,114
Project: "Clonidine and Cerebral Protection During Carotid Endarterectomy".

Dr N.M. Gibbs (WA) \$5,723
Project: "Natural Anti-Coagulant Levels and Post-Operative Coronary Artery Thrombosis".

Dr J.H. Reeves (Vic) \$10,000 for 1 year
Project: "Plasmafiltration in Sepsis".

Dr R.K. Webb (SA) \$30,000 for 1 year
Project: "Incident Monitoring in Anaesthesia".

The **Harry Daly Research Fellowship** was awarded to Robert Webb from South Australia.

Professor Laurie Mather was appointed the **Inaugural Douglas Joseph Professor** for research into his project: "Consequences of Using Mixtures of Left and Right Handed Stereoisomers for Anaesthesia and in the Management of Pain".

AWARD OF ESTABLISHMENT GRANT

The Establishment Grant was awarded to the Department of Anaesthesia, **Royal Melbourne Hospital in the University of Melbourne**.

THE COUNCIL 1993-1994

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

PRIMARY EXAMINATION

The Renton Prize was awarded to Dr Andrew Patrick of Victoria for the half year ended 31st December 1992 but was not awarded for the half year ended 30th June 1993.

Examinations were held in Melbourne and Hong Kong.

July/September 1992

Total No. Candidates	Invited to Oral	Approved
129	67	40

March/April 1993

Total No. Candidates	Invited to Oral	Approved
Melbourne 95	64	25
Hong Kong 16	06	02

FINAL EXAMINATIONS

Endorsed in Anaesthetics

August/September 1992

Examinations were held in Melbourne and Auckland.

Sixty eight candidates presented in Melbourne and thirty six were approved.

Eighteen candidates presented in Auckland and ten were approved.

Names of the successful candidates who had not completed their training are:

Dr C. Buchanan, SA	Dr R. Connolly, NSW
Dr C. Butler, Qld	Dr D. Cook, Qld
Dr A. Chan, NSW	Dr J. Cormack, Vic
Dr A. Chee, NSW	Dr J. Derrick, NSW
Dr Cheng Woon Ming, HK	Dr A. Donald, SA
Dr A. Clapin, WA	Dr R. Duffy, Qld

Dr D. Eugster, Tas	Dr M. Parkinson, NZ
Dr F. Georgiakakis, NSW	Dr L. Paterson, Qld
Dr P. Goggin, Vic	Dr A. Pembroke, NSW
Dr G. Handley, Qld	Dr R. Price, Qld
Dr P. Hebbard, Vic	Dr M. Priestley, NSW
Dr C. Hill, NZ	Dr T. Pryor, Qld
Dr Hiong Yee Tian @Peter, Malaya	Dr D-G Raiz, NSW
Dr D. Jackson, NZ	Dr D. Riley, NSW
Dr K. Khor, NZ	Dr M. Robinson, NZ
Dr Kwan Sai Wing, HK	Dr J. Torrie, NZ
Dr E. Leslie, Vic	Dr B. Trytko, NSW
Dr A. Lew, Qld	Dr R. Wall, NZ
Dr F. Liskaser, Vic	Dr D. Watts, NZ
Dr H. Madder, Vic	Dr A. Wild, WA
Dr B. Marks, Vic	Dr A. Williams, NZ
Dr M. Morris, NSW	Dr S. Winter, NSW

The Cecil Gray Prize was not awarded for the half year ended 31st December 1992.

Geographical distribution of candidates was as follows:

	No. Presenting	No. Approved
Queensland	9	8
New South Wales	27	12
Northern Territory	1	—
South Australia	3	2
Tasmania	1	1
Victoria	15	9
Western Australia	5	2
New Zealand	13	9
Hong Kong	10	2
Kuala Lumpur	1	1
Singapore	1	—
	<u>86</u>	<u>46</u>

March/May 1993

The following candidates were successful at the May 1993 Final Fellowship Examination and had not completed training requirements:

Dr C. Hill	Dr J. Torrie
Dr D. Jackson	Dr R. Wall
Dr K. Khor	Dr D. Watts
Dr M. Parkinson	Dr A. Williams
Dr M. Robinson	

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30th June 1993 be awarded to Dr Gerard Handley, Queensland.

Endorsed in Intensive Care

August/September 1992

An Examination was held in Melbourne. Fourteen candidates presented and seven were approved.

The name of the successful candidate who had completed training is:

Dr G. Eruini-Bennett, NSW.

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

Dr D. Galler, NZ	Dr B.C. Smith, NSW
Dr I.R. Jenkins, WA	Dr So Hing Yu, HK
Dr M. Skacel, NSW	Dr P.V. van Heerden, WA

April/May 1993

At the Final Fellowship Examination in Intensive Care held in Sydney in May 1993, a total of seven candidates presented and five were approved.

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

Dr J.N. Buckmaster, Vic
Dr R.C. Gazzard, Vic

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

Dr R.J. McRae, Vic
Dr W.J. O'Regan, NSW
Dr S.F. Woodford, NSW

ADMISSION TO FELLOWSHIP BY ELECTION

The Council was pleased to elect to Fellowship the following:

Under Regulation 6.2 pursuant to Article 22

Professor P. Foëx, UK
Professor M.F. Roizen, USA

Under Regulation 6.3 pursuant to Article 23

Dr G.J. Dobb, WA
Dr P.J.C. Houlton, NSW
Dr K. McLeod, Qld
Dr R.A. Sharp, Vic
Dr J.D. Villiers, Vic

Endorsement in Intensive Care

Dr A.R. Burrell, NSW

ANNUAL SCIENTIFIC CONGRESS

The Annual Scientific Congress of the College was held with the Royal Australasian College of Surgeons at the Adelaide Convention Centre from the 9th to 14th May 1993.

The Meeting was well supported by Fellows and was a great success from every point of view.

It gave me great pleasure at the Convocation Ceremony to present Professor Ross B. Holland of New South Wales with the Orton Medal.

The Organising Committee has been congratulated and thanked for their efforts.

I wish to thank the College Scientific Programme Convenor, Dr Harry Owen, for producing a high quality Scientific Programme.

The visiting speakers were excellent and were ably complemented by many good local speakers.

Our two Foundation Visitors were Professor Michael Roizen from Chicago and Professor Pierre Foëx from Oxford.

Professor Roizen delivered a stimulating Ellis Gillespie Lecture, "Pre-operative Evaluation: Improving Quality of Care and Reducing its Cost" whilst Professor Foëx for his Foundation Lecture spoke impressively on "What's New in Anaesthesia".

The Australasian Visitor, Associate Professor Vic Callanan, for his formal presentation spoke on "CPR — A Futile Exercise?" which was clear, thought provoking and timely.

All three Visitors contributed significantly to the Meeting both in quantity and quality, delivering many interesting papers and participating in discussions.

The Gilbert Brown Prize was awarded to Dr Suen Ka Lok Tommy from Hong Kong for his presentation "Ondansetron 4MG IV for the Prophylaxis of Nausea and Vomiting after Gynaecological Laparoscopic Surgery".

COLLEGE AFFAIRS

The year has been one of consolidation following incorporation of the College and there was a need to resolve the many issues that were consequent to our separation from the Royal Australasian College of Surgeons.

There have been Meetings between representatives of the two Colleges considering the implications of the separation and the matter of compensation.

College Armorial Bearings have been granted by the College of Arms in London. A Diploma of Fellowship incorporating the Coat of Arms is currently being prepared for every College Fellow and will be despatched as soon as possible.

The College has a new home. On the 25th May an offer by the College to purchase a Victorian mansion at 630 St Kilda Road, Melbourne was accepted. An exchange of contracts occurred on the 3rd June and settlement is in ninety days. The building is ideal for our purposes and more details will be provided shortly.

A College Foundation has been established and following tabling of Regulations in Parliament, tax deductibility will apply to all donations to the College.

In accordance with the provisions of the Articles of Association nominations were called for two vacancies on the Council. Five nominations were received and the results of the ballot is attached to this report.

Retiring Councillors

Associate Professor Peter Livingstone and I retire from the Board of Faculty and College Council this year.

Associate Professor Livingstone is the last Dean of the Faculty of Anaesthetists, RACS and Inaugural President of the College. He has completed twelve years on the Board and his term of office has included sixteen months on Council. During this time he has held the following offices:

Honorary Treasurer
Chairman of the Executive
Vice-Dean
Dean
and President of the College

Professor Livingstone has been a great contributor to the Faculty and College during his time on the Board and Council. He has been an outstanding Inaugural President of the College. His enormous and untiring personal sacrifices and efforts on behalf of the Fellows guided and led the College to its establishment.

He was the Treasurer of the Faculty of the time of the introduction of the subscription in advance which has provided the Faculty and College with opportunities to develop a very sound financial footing. His wise and considered counsel has always been most valuable and much sought after.

On behalf of all Fellows, I wish to record our gratitude to Peter for his enormous contributions to our specialty, Faculty and College.

College Administration

Following Miss Cheryl Clarke's resignation to return to Sydney, Mrs Carolyn Handley was appointed to the position of Administrative Assistant and at the recent Executive Meeting her appointment as Deputy Registrar was ratified.

Mrs Allison Burger's role has been made responsible for Continuing Education and providing the secretariat for the Special Interest Groups and Mrs Veronica Quetglas the secretariat for the Victorian Regional Committee.

Miss Janelle Ware has recently joined the staff as Secretary and has already proved to be a most valuable member of our team.

I wish to express my sincere thanks to all who have contributed and assisted the College over the past 12 months.

I thank the President of the Royal Australasian College of Surgeons and his Council for their support and assistance in the time of change.

I thank Fellows who contribute as members of Council, Regional Committees, Examiners and as representatives on the increasing number of external and Government Committees and I thank the College staff who, with ever increasing demands made on them, quietly and efficiently go about their work.

It is these combined efforts which ensure the College succeeds in its role in teaching, training and standards.

M.J. HODGSON

1993 YOUNGER FELLOWS COURSE – WIRRINA, S.A.



A. Gin, P. Tesar, M. Berce, G. Laney, F. Frizelle, P. Ridell, W. McLeay, P. Smith, M. Young, T. Semple, B. Tulloh, S. Fraser, S. Tobin, J. Myburgh, G. Clarke, P. Ragg, G. O'Sullivan, A. Newton, M. Cowling, L. Lipsett, J. Garney, L. Yeaman, J. Chambers, R. Lea, S. Towler, K. Kyngdon. Absent: G. Benveniste.

THE ANZCA/RACS ARCHIVE — A BACKWARD LOOK AND A FORWARD LOOK

Over the past three years the Archive has received enough records to fill a shelf 72 metres long. We also reprocessed 54 shelf metres of existing holdings — improving and computerising control documentation, and culling.

About 15% of the records dealt with in this period belong to FA/ANZCA. About 25% of accumulated holdings belong to FA/ANZCA.

Quite a lot of the processing led to destruction of records. Total holdings have grown by only 30 metres — from 120 to 150 shelf metres — over the three years — and current holdings include about 8 shelf metres (mostly financial records) that are scheduled for future destruction, plus an estimated 46 shelf metres that will ultimately be found destroyable in the course of reprocessing.

This means that we have close to 100 shelf metres of records that are considered to be worthy of permanent retention. They include the original file on every Fellow there has ever been in either RACS or FA/ANZCA (except that quite a few files are missing — thanks to poor control of them before we had an Archivist); minutes and agenda papers of Council, the FA Board etc; lots of correspondence, files and lots of photographs.

Growth in the use of our holdings has been remarkable. We received 222 reference enquiries during the year 1992-1993 — up from 103 in 1988-1989. That is to say, the pace of reference and research work has more than doubled in the past four years. And most of that growth has been on account of RACS and FA/ANZCA developing the habit of using the Archive as an organisational memory. (To cite an example on the FA/ANZCA side — we have several times revisited the records to find out how the Faculty of Anaesthetists came into being, and to find the bases of various aspects of its complex relationship with RACS).



Photo 1

The enquiries represent the use of about 1000 record items per annum. In addition, we made over 300 routine file retrievals (requiring no search by the Archive — because the administrative staff give us the file reference. The lion's share of these, interestingly, have always come from FA/ANZCA).



Photo 2

This is an extraordinary amount of use by the general standards of archives in Australia — more so considering that the holdings are almost entirely of twentieth century origin, and thus have had less time to gain the greater historical interest which generally attaches to nineteenth century records.

The Australian Council of Archives has compiled some statistics from returns supplied to it by the leading archival institutions in Australia, relating to the year 1989. The total holdings of some 25 institutions (including all the Federal and State government archives) amounted to some 660 shelf kilometres of records including over 300 shelf kilometres considered to be of permanent value. The institutions dealt with some 80,000 reference enquiries in 1989, and issued over 300,000 items.

These numbers make ours seem quite Lilliputian. However, they represent a rate of enquiries per unit of record holdings that was about 1/4 of what the RACS/ANZCA Archive had in 1989, and about 1/8 of what we have now.

Again, the 25 institutions retrieved for use, in 1989, about one file from every 2 shelf metres of their holdings. We were then retrieving 6 per shelf metre (that is, making 12 times more intensive use), and are now retrieving 9 per shelf metre.

Dr. G. F. V. Anson
(Anson, George Frederick Vernon)

FACULTY OF ANÆSTHETISTS
ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

Cert. N^o 1
Elected 25.8.52

EXORDIUM

WHEREAS it is advisable, in the interests of the community, in the interests of Surgeons, and in the interests of those who practise the profession of Anæsthetics that—

1. The high traditions of that profession should be upheld and developed.
2. The intensive study of the science and art of Anæsthesia should be promoted by means of research.
3. Facilities should be provided for the higher education and advanced technical training of Anæsthetists.
4. The standards of anæsthetic practice in hospitals should be elevated.
5. A high moral standard of conduct should be demanded from all who accept the responsibilities of an Anæsthetist in their relations with patients and members of the medical profession.

WE, the undersigned, of our own free will, bind ourselves together for the fulfilment of the aforesaid objects and hereby form ourselves into The Faculty of Anæsthetists within the Royal Australasian College of Surgeons; and we pledge ourselves to obey all such by-laws, regulations and ordinances as may be adopted from time to time by the Faculty (with the approval of the Council of the College) or by its governing body or duly delegated authority (with the approval of the Council of the College) and we will submit to any penalties including that of expulsion from the Faculty that may be imposed by the governing body (with the approval of the Council of the College) for violation of any of the said by-laws, regulations or ordinances.

AND we resolve that the Constitution of this Faculty shall be as follows:

1. That the name of the proposed Association of Anæsthetists should be the Faculty of Anæsthetists of the Royal Australasian College of Surgeons.
2. That the objects of the Faculty should be—
 - (a) To cultivate and maintain the highest principles of anæsthetic practice and ethics.
 - (b) To promote the practice of Anæsthesia under proper conditions by securing the improvement of hospitals and hospital methods.
 - (c) To arrange for adequate post-graduate training in Anæsthetics.
 - (d) To promote research in Anæsthesia.
3. That the qualifications for admission to the Faculty shall be such special training in Anæsthetics and such standard of conduct as shall be considered satisfactory to the governing body under the regulations.
4. That the governing body shall be the Board of the Faculty and shall include such representatives of the Council of the Royal Australasian College of Surgeons as that Council shall from time to time determine.

Signature.	Address.	Date.
<i>H. J. Daly</i>	143 Macquarie Street, Sydney. N.S.W.	20.7.51
<i>J. W. Sullivan</i>	85 Spring Street, Melbourne. C.1.	26/7/51
<i>Langford Rubin</i>	12 Meadow Street, East St. Kilda. S.2.	25/7/51
<i>Richman</i>	28 Jolimont Road, East Melbourne. C.2.	25/7/51
<i>G. R. Tomp.</i>	194 St. George's Terrace, Perth. W.A.	9.8.51
<i>G. F. V. Anson</i>	31 Monona Road, Green Lane, Auckland. N.Z.	26.8.51

M.R.C.S.(Eng). L.R.C.P.(Lond) 1916.

The intensity of use is reflected in our time allocation. About a thousand person-hours of work — about half of all the hours we have per annum — are now being spent on reference and retrieval work — mostly for the administration of the Colleges, and to a lesser extent for Fellows and their families and other medicos with questions and interests to pursue, plus a few members of the general public, academia etc.



Photo 3

A word, finally, about the pictures. The photo on page 21 shows Fellowship Certificate No 1 of the Faculty of Anaesthetists — the certificate of Dr G.F.V. Anson. It was a rather oddly improvised document, signed by the five Founders of the FA — Daly, Gillespie, Renton, Travers and Troup — and the new admittee.

Photo 1 is the evidence of how RACS was storing its most basic early records in the mouldy vault under the stairs when the first Archivist was appointed some 11 years ago.

Photos 2 and 3 are two views of the RACS/ANZCA repository — illustrating an Archivist's idea of how records ought to be kept in the long term — with the first Archivist (Mr Tam Best) and the present Archivist, in view.

ANZCA has shared in the costs and the benefits of the RACS/ANZCA arrangement for over ten years. Consequently, virtually all its significant past records are now safe, retrievable and available. This is an enviable and unusual situation for an organisation to be in.

The continuance of the situation will require, however, that active curatorship and disciplined digestive and disposal practices are sustained.

Colin Smith, RACS/ANZCA Archivist, 6 July 1993

References

- ▶ Crush 'Australian Archival Statistics — an important if not Glamorous Task' *Archives and Manuscripts* Vol 20 No.1 May 1992, pages 9-18.
- ▶ Photos from RACS/ANZCA Archive, T91/016 and Series 5.

LETTERS TO THE EDITOR

To the Editor of the Bulletin

Associate Professor Vic Callanan presented a most interesting and very thorough review of cardiac resuscitation in the May 1993 issue of the "Bulletin". On page 43 he commented on the results reported by the Perth Ambulance service.¹ He quotes a success rate of 23%. However if one reviews the original article¹, the abstract reports that 40 out of 231 cases survived to hospital discharge and they add in brackets 22.7%. This is later extrapolated to 23%. However on a calculator 40/231 would appear to be 17.3%. Readers may wish to check this. A 17.3% survival rate is still very good. The confusion may arise because further in the article the authors comment that 180 patients were transported, and that 40 survivors from 180 transported is 22.2%. Different papers use different denominators (and numerators), and this is surely why the Utstein recommendations² should be used in future papers that report the outcome of attempted resuscitation from cardiac arrest.

References

1. Jacobs I.G., Oxer H.F. A review of pre-hospital defibrillation by ambulance officers in Perth, Western Australia. *Med J Aus* 1990; 153:662-4.
2. Cummins R.O., Chamberlain D.A., Abramson N.S., Allen M. et al. Recommended guidelines for uniform reporting of data from out-of-hospital cardiac arrest: the Utstein style. *Ann Em Med* 1991; 20:861-919.

Yours sincerely,
 Dr P.D. Crone FANZCA,
 Medical Director, Auckland Ambulance Service.

Madam,

Last night I filled in the questionnaire which arrived a few days ago, but I wonder how many other anaesthetists will do so, because it is a badly flawed document. It is titled "A day in the life of an anaesthetist" but provides space for description of anaesthetic drugs only, let alone techniques. There is no provision for entering other activities such as pre and post-operative visits, anaesthetic clinics, work in the pain clinic or intensive care unit, teaching, learning or administration. I wonder what purpose this will serve? Will it perpetuate the myth that all anaesthetists do is administer anaesthetics?

B.R. Hutchinson,
 Auckland



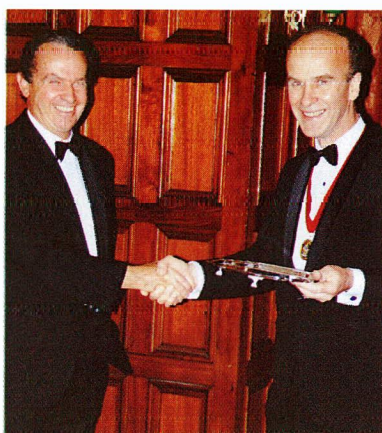
The President acknowledged the support of Mrs Allison Burger towards the success of the recent C,TAG "Value Disease and Anaesthesia" meeting.



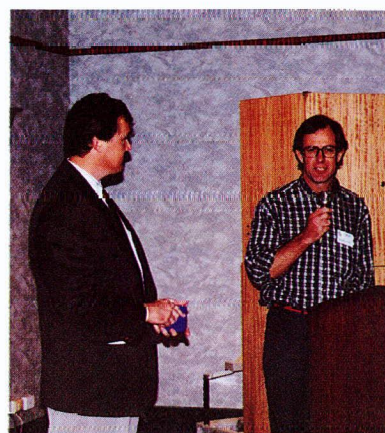
Dr Michael Hodgson, President, presenting Assoc. Prof. Peter Livingstone with a crystal platter commemorating his term on the Board and Council.



Left to Right: Dr I. Robinson (Boots representative) with Professor Alan Lisbon (Boston), the President and Mr David Stephens (Managing Director The Boots Company (Australia) Pty Ltd).



Dr Michael Hodgson, President accepting a silver salver on behalf of the College from Assoc. Prof. Peter Livingstone.



The President, Dr Michael Davies, presented Dr Doug McEwan (Queensland) with the Cecil Gray Prize at the May 1992 Final Examination.



Dr Micheal Davies (Vice President) presenting Dr Michael Hodgson with a crystal decanter bearing the College Coat of Arms commemorating his term on the Board and Council.



Executive members of the Day Care Anaesthesia SIG met recently at the Group's second continuing education meeting conducted at Noosa, Queensland. (Left to right:) Dr Mark Chapman (NZ), Dr Andrew Bacon (National Day Surgery Committee), Dr Linda Weber (ACT), Professor David Gibb (NSW), Dr Bruce Burrow (Qld) and Dr John Zelcer (Vic).

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

SUMMARY OF FELLOWS DATABASE

Total Number of Fellows —	2210	Special Interest Groups —	CTAG:	329
Male —	1849		Day Care Anaesthesia:	501
Female —	362		Medical Education:	5
Average Age —	45.15		Neurosurgical Anaesthesia:	160
			Pain:	402
			Rural Anaesthesia:	143
Age Range of Fellows —	< 30 years: 25			
	30-40: 653	Fellows Geographical Distribution —		
	40-50: 762	Australia: 1674	NSW/ACT:	608
	50-60: 459		Victoria:	426
	60-70: 228		Queensland:	254
	> 70 years: 83		South Australia:	190
Anaesthesia Fellow Type —	Honorary: 17		Western Australia:	151
	Elected: 287		Tasmania:	39
	By Exam: 1881		Northern Territory:	5
	Total: 2185	New Zealand:	244	
Intensive Care Fellow Type —	Elected: 59	Hong Kong:	66	
	By Exam: 87	Singapore:	45	
	Total: 146	Malaysia:	40	
Section of Intensive Care —	254	United Kingdom:	47	
		Ireland:	5	
		Canada:	13	
		USA:	39	
		Other:	38	

SPECIAL PURPOSE FINANCIAL REPORT FOR THE YEAR ENDED 31 JANUARY 1993

The Councillors of the Australian and New Zealand College of Anaesthetists submit herewith the Balance Sheet as at 31st January 1993 and the Revenue and Expenditure Statement for the financial year then ended.

The Revenue and Expenditure Statement shows the combined results of the Faculty of Anaesthetists (a division of the Royal Australasian College of Surgeons) and the Australian and New Zealand College of Anaesthetists. (Refer point 2 below for a more detailed explanation). The Councillors report as follows:

1. The names of the Office Bearers and the Councillors in office at the date of this report are:

President: Dr M J Hodgson, FANZCA
Vice-President: Dr M J Davies, FANZCA
Honorary Treasurer: Dr R G Walsh, FANZCA

Elected Members of Council:

Associate Professor N J Davis
Associate Professor P D Livingstone
Dr D H McConnel
Professor G D Phillips
Professor J M Gibbs
Dr R S Henderson
Dr D R Kerr
Dr I Rechtman
Dr R J Willis

Co-opted Representatives:

Mr R L Atkinson, Royal Australasian College of Surgeons
Mr J McK Watts, Royal Australasian College of Surgeons

2. **Special Purpose Financial Reporting Period**

From 1 February 1992 to 6 February 1992 the entity operated as a division of the Royal Australasian College of Surgeons, as the "Faculty of Anaesthetists". On 7 February 1992 the entity was incorporated as the "Australian and New Zealand College of Anaesthetists".

As the Faculty of Anaesthetists had been operationally independent from the Royal Australasian College of Surgeons, the change in legal status did not affect the entity's continuity of operations.

Therefore, these Special Purpose Financial Statements show the combined results of the two entities, covering the period from 1 February 1992 to 31 January 1993.

3. The principal activities of the College in the course of the financial period were promoting the study of anaesthetic and intensive care practice and clinical and scientific research. During the financial period there was no significant change in the nature of those activities.

4. The net surplus for the year as shown in the Revenue and Expenditure Statement was \$608,476.

5. During the financial year there was no significant change in the College's state of affairs other than referred to in the Accounts or Notes thereto.

6. There has not been any matter or circumstance, other than that referred to in the Accounts or Notes thereto, that has arisen since the end of the financial period, that has significantly affected, or may significantly affect, the College's operations, the results of those operations, or the College's state of affairs in financial years after this financial period.

7. The College intends to purchase a building for occupation as the Melbourne headquarters, when a suitable premises to fulfill the requirements of the College has been located. The purchase price will be affected by the actual building, its location and many other factors, but is expected to be within \$1.5-\$3.5 million.

8. The College has budgeted for a surplus on the Subscription Account for the year ending 31st January 1994 which includes significant allocations to the Development and Foundation Funds. Current activities and operations are continuing as planned.

9. During or since the financial period, no Councillor of the College has received or become entitled to receive a benefit because of a contract that the Councillor or a firm of which the Councillor is a member or an entity in which the Councillor has a substantial financial interest made with the College or an entity that the College controlled, or a body corporate that was related to the College, when the contract was made or when the Councillor received, or became entitled to receive the benefit other than:

(i) a benefit included in the aggregate amount of emoluments received or due and receivable by Councillors shown in the Accounts; or

(ii) the fixed salary of a full-time employee of the College or an entity that the College controlled or a related body corporate.

Signed in accordance with a resolution of Councillors.

On behalf of the Councillors

M J Hodgson
PRESIDENT

R G Walsh
HONORARY TREASURER

J M Sheales
REGISTRAR

11th June, 1993

TREASURER'S REPORT

INTRODUCTION

The Annual Financial Report of our organisation for the year 1 February 1992 until 31 January 1993 is presented. The Report encompasses all revenue and expenditure realised during that year and all assets and liabilities as at 31 January 1993. The establishment and incorporation of the Australian and New Zealand College of Anaesthetists on 7 February 1992 and the transfer of financial assets from the Faculty of Anaesthetists, RACS, to the new College on 2 March 1992 has particularly complicated the process of reporting the full financial year to Fellows.

The College Auditors have therefore consolidated the statutory accounts into Special Purpose Financial Statements (incorporating records of both the Faculty and new College) to cover the full twelve month period for reporting purposes to Fellows. All references to the College therefore include the Faculty of Anaesthetists while it held assets, etc.

The Report is supplemented by a number of diagrams prepared by the College Head of Finance, Mr Ross Blain.

REVENUE AND EXPENDITURE STATEMENT

This statement is a general statement of all revenues and expenditure from all of the College funds. Careful reference to each of the Funds is necessary to fully understand this statement. There has, however, been a steady growth in the accumulated funds due to prudent budgeting and careful control of expenditure.

SUBSCRIPTION ACCOUNT

The subscription account provides for the daily running of the College's activities. These include the administration, all Committees and a 10% allocation to both the Development Fund and the Foundation Fund for research. Figure 3 shows the expenditure from the 1992 subscriptions and Figure 4 shows administration expenditure.

The surplus from operations is due to a slightly greater income from subscriptions than budgeted, a reduction in the budgeted costs of providing administrative services and expenditure restraint exercised by the Regional Committee Treasurers. The surplus also in part represents income that has been capitalised as assets purchased during the year, such as plant and equipment which will be depreciated over future years.

FELLOWS' FUND

This Fund has continued to grow in line with the increase in assets of the College, as together with the

Development Fund, it represents the Fellows' share of the net assets of the College.

That portion of these funds not reserved for other purposes, as represented by the asset "Investments", will be realised and applied towards the purchase cost of what will become an alternative asset "Property", namely the College new headquarters at 630 St Kilda Road, Melbourne.

FOUNDATION FUND

This Fund has been reduced in 1992 by the establishment of a Chair of Anaesthesia in Victoria, resulting in the transfer of \$1,250,000 to Monash University. The total amount represents funds raised from the Fellows and by public appeal for this purpose.

The effect of the reduction in overall interest rates is reflected in the reduced interest income. Due to imminent maturity of higher interest rate debentures, this source of income is expected to further reduce.

DEVELOPMENT FUND

As with the Fellows' Fund, the portion of this Fund not required for other projects will be applied towards purchase of a property asset, namely the College new headquarters.

CONCLUSION

In this, my first Annual Financial Report as College Treasurer, I have no hesitation in stating that the financial base of our new College is very sound. This has been achieved by continued prudent and successful management of College finances, particularly directed over recent years toward building up our reserves.

Fellows' subscriptions and Trainees' fees are acknowledged by all Councillors to be a substantial burden on individuals. We will now, however, be able to use our reserves to firmly establish our new College and in particular proceed with the purchase of a College headquarters. Relative to other specialty Colleges, our subscriptions and fees are very comparable and no levy is planned to raise funds for the College headquarters.

Trainees' fees, including examination fees, are always budgeted to cover projected direct costs and an estimated proportion of overall administrative costs. The latter estimated proportion is regarded as very generous to the training section, considering the many other College functions and assets which contribute indirectly to the College training and accreditation systems.

This Report reflects much groundwork laid by the previous Honorary Treasurer (now President), Dr Michael Davies. I am particularly indebted to Dr Davies for his hard work, advice and enthusiastic co-operation in ensuring a smooth transition to me of responsibilities as Honorary Treasurer. Thanks also go to Mr Kerry Haywood, Head of the Finance Department, RACS, and to the RACS financial advisers, Mr Doug Oldfield, Mr Tony Sallman and Mr Doug Larsson. Mr Sallman's advice and assistance with the acquisition of the College Headquarters has been of tremendous value and for which Fellows are most appreciative.

Most Fellows and Trainees would probably not readily appreciate the enormous amount of administrative effort, and therefore cost, which goes into running a specialty College such as ours, let alone the expertise, efforts and tremendous personal devotion of all our College staff. As Registrar, Mrs Joan Sheales deserves very special praise for her extraordinary ability to administer the College within our tight financial budgets. As Head of our College Finance Department, Mr Ross Blain has extended much time and extreme patience in assisting me to take over the reins as Honorary Treasurer. Mr Blain's special capabilities in expert financial management and advice have been a great asset to both me and particularly the College in general.

Finally, I invite all Fellows and Trainees to study the 1992 Annual Financial Report of the College, and to express (in writing to me) any queries or concerns. While I admit to personally finding previous such Reports of the Faculty and similar organisations somewhat daunting, I am now in a position to confirm both the accuracy and justification of the contents of this Report.

RICHARD G. WALSH
Honorary Treasurer

COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES 1993



*Pictured (from left), **Back Row:** Dr Richard Armati (Australasian College of Dermatologists), Dr Richard Ashby (Australasian College for Emergency Medicine), Professor Barry Baker (CPMC ESSC Sub-Committee), Dr Clive Wellington (Royal Australian College of Medical Administrators), Dr Peter Procopis (Australian College of Paediatrics).*

***Centre Row:** Dr Ian Favilla (Royal Australian College of Ophthalmologists), Dr Fred Hinde (Royal Australian College of Obstetricians and Gynaecologists), Dr Peter Stone (Royal Australian College of General Practitioners), Professor Robert Osborn (Royal College of Pathologists of Australasia), Dr Bruce Hocking (Vice-President, the Australasian Faculty of Occupational Medicine).*

***Front Row:** Mr David Burke (Australasian College of Rehabilitation Medicine), Dr Noel Wilton (Royal Australian and New Zealand College of Psychiatrists), Professor Alex Cohen (Royal Australasian College of Physicians), Mr John Hanrahan, Chairman (Royal Australasian College of Surgeons), Dr Michael Hodgson (Australian and New Zealand College of Anaesthetists), Professor Robert Bourne (Royal Australasian College of Radiologists).*

***Absent:** Professor Graham Ryan, Committee of Deans of Australian Medical Schools; Dr Nila Ellis, The Australasian Faculty of Occupational Medicine.*

HIGHLIGHTS FROM THE RACS COUNCIL MEETING HELD JUNE 1993

WELCOME

The President welcomed the following visitors:

B.H. Barraclough, Councillor-Elect
D.J. Colville, Councillor-Elect
R.L. Newcombe, Chairman — ACT Committee
W.R.B. McLeay, Convenor — Younger Fellows Conference 1993
M.J. Davies, President — ANZCA

The Member of the House of Representatives for Lalor, the Honourable Barry Jones and the Vice Chancellor of Monash University, Professor M.I. Logan addressed Council during the course of the meeting.

AWARDS, ELECTIONS AND HONOURS

Queen's Birthday Honours

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

RACS

Mr Brian Thomas Collopy, AM
Mr Ian Valentine Lishman, AM
Mr Brian Patrick Morgan, AM
Mr Louis Charles Anthony Ariotti OAM

Gold Medal of the Australian Medical Association

Mr Bruce Dalway Shepherd

Award for Excellence in Surgery

The RACS Award for Excellence in Surgery recognises the highest level of surgical achievement by world standards, leadership in surgery in Australasia, innovation and/or advancement in surgery, sustained highest standards and on-going innovation in surgery and the highest standards of surgical ethics.

Council resolved unanimously to award an RACS Award for Excellence in Surgery to Emeritus Professor Gerald White Milton.

Sir Arthur Sims Commonwealth Travelling Professorship

A Sir Arthur Sims Commonwealth Travelling Professorship was awarded to Professor Ian Constable.

Court of Honour

Mr John Hanrahan and Associate Professor Peter Livingstone were admitted to the Court of Honour of the College.

CENSOR-IN-CHIEF

Education Workshop

An Education Workshop to consider aspects of the Part 1 and Part 2 Examinations of the College and surgical training will be held in October 1993 and will consider, amongst other things, a conjoint clinical and research training program for selected trainees which may include a higher degree.

Entry to General Surgical Training

Except in special circumstances, applicants for entry to Advanced Surgical Training in General Surgery will only be eligible for appointment to a training post within two years of completion of the Part 1 package.

Job Descriptions for Advanced Surgical Trainees and Service Registrars

The College will develop guidelines to be included in job descriptions for Advanced Surgical Trainees and Service Registrars.

Educational Involvement of Medical Practitioners

Council endorsed the following policy of the Committee of Presidents of Medical Colleges:

“The Committee of Presidents of Medical Colleges strongly supports the principle that time should be available during the working week for continuing education, quality control, research, administrative and teaching activities for all medical practitioners. The percentage of the standard working week devoted to such activities will vary but should be of the order of 30%”.

FRACS with Suffix and Descriptors

Council resolved as follows:

“Fellows be encouraged to place ‘FRACS’ without any suffix in parenthesis following.

That on the following line, Fellows place in full the name of the specialty in which they are qualified to practise.

That the College cease to define the description of practise which Fellows may include on their letterhead.

Fellows be free to use descriptions of practise of their choice provided it is understood that Fellows may be legally and professionally accountable for the accuracy of that description”.

RACS Final Fellowship Examination outside Australia and New Zealand

Council recorded the reasons for its decision to discontinue the FRACS Final Fellowship outside Australia and New Zealand as follows:

“An inability to adequately verify and ensure the standards of training in overseas countries.

A belief that the development of surgery in other countries is best served by assistance in the development of their own training and examinations systems”.

OSCA Workshop

OSCA Workshops were held in Wellington, New Zealand and Melbourne in conjunction with the Part 2 Examinations in April/May 1993.

Further consideration of the incorporation of an OSCA style examination in the Part 2 Examination is to occur.

EDUCATION

Continuing Medical Education

A position paper on minimum standards for CME activities was approved.

Aid to Cambodia

It was accepted in principle that the RACS would, in collaboration with the RACOG, provide aid to Cambodia in the form of medical texts for medical staff and students.

**PROFESSIONAL
AFFAIRS**

Recertification

Information on Council deliberations and decisions with respect to recertification is available from the College Secretary.

Informed Consent

A draft policy document on Informed Consent was discussed by Council and following refinement, will be available to all Fellows.

Guidelines for the Management of Gastro-Oesophageal Reflux Disease using Laparoscopic Techniques

Guidelines were adopted by Council and are available as a resource document on request from the Secretary.

New Technology

A recommendation of the Advisory Committee on New Technology that in the future all candidates for the primary examination of the FRACS be required to have basic computing and telecommunications skills was approved.

HIV Aids and Hepatitis B

The College is to receive a Commonwealth Government grant of \$100,000 for the production of a video on the management of HIV/Aids and Hepatitis B and for the review, publication and distribution of the RACS policy on Aids and HIV.

INTERNAL

Elections

Council congratulated E.H. Bates and B.D. Shepherd on their re-election to Council and B.H. Barraclough and D.J. Colville on their election to Council.

Australian and New Zealand College of Anaesthetists

Council resolved to present to the Australian and New Zealand College of Anaesthetists a suitably inscribed Ceremonial Mace to mark the dissolution of the Faculty of Anaesthetists, RACS and the incorporation of the Australian and New Zealand College of Anaesthetists.

Code of Ethics

Council approved a Code of Ethics. Copies are available from the College Secretary.

COUNCIL OFFICE BEARERS AND COMMITTEES

1993/94

President	M.J. Davies	Continuing Education and Quality Assurance Committee	
Vice President	N.J. Davis	Chairman	R.S. Henderson
Assessor	I. Rechtman	President	M.J. Davies
Assistant Assessor	B.F. Horan	ASM Officer	R.J. Willis
Education Officer (Anaes)	J.M. Gibbs	Section of Intensive Care	R.F. Whiting
Education Officer (IC)	G.D. Phillips	Representative from ASA	T.C.K. Brown
Chairman of Executive	N.J. Davis	Representative from NZSA	M.J. Harrison
Chairman of Examinations	R.J. Willis	Representative from ANZICS	F.H. Hawker
Treasurer	R.G. Walsh	Representative from APSF	W.B. Runciman
Pharmaceutical/Technical and Safety Officer (Australia)	D.R. Kerr	and such other members as the Council may appoint	R.G. Walsh
(New Zealand)	R.S. Henderson		D.R. Kerr
Protocol Officer	D.H. McConnel	Workforce Committee	
Library Officer	I. Rechtman	Chairman	D.H. McConnel
ASM Officer	R.J. Willis	President	M.J. Davies
Survey Officer	M.D. Westmore	Education Officer (Anaes)	J.M. Gibbs
		Education Officer (IC)	G.D. Phillips
		Survey Officer	M.D. Westmore
		Assistant Assessor	B.F. Horan
		and such other members as the Council may appoint	D.R. Kerr
Executive			
Chairman	N.J. Davis	Primary Examination Committee	
President	M.J. Davies	Chairman	P. Roessler
Assessor	I. Rechtman	Deputy Chairman	P. Kam
Treasurer	R.G. Walsh	Chairman of Examinations	R.J. Willis
and such other members as the Council may appoint	G.D. Phillips	and two members	R.L. Eyres
	J.M. Gibbs		
Education Committee (Anaesthesia)		Final Examination Committee (Anaesthesia)	
Chairman (Education Officer)	J.M. Gibbs	Chairman	B.T. McCann
President	M.J. Davies	Deputy Chairman	K.D. Cronin
Assessor	I. Rechtman	Chairman of Examinations	R.J. Willis
Chairman of Examinations	R.J. Willis	Council Representative	I. Rechtman
Education Officer (IC)	G.D. Phillips	and three members	P.L. Klineberg
and such other members as the Council may appoint	R.S. Henderson		C.A. Morgan
	D.R. Kerr		
	B.F. Horan	Final Examination Committee (Intensive Care)	
		Chairman	A.W. Duncan
Education Committee (Intensive Care)		Deputy Chairman	R.P. Lee
Chairman (Education Officer)	G.D. Phillips	Chairman of Examinations	R.J. Willis
President	M.J. Davies	Council Representative	G.D. Phillips
Education Officer (Anaesthesia)	J.M. Gibbs	and two members	J.W. Weekes
Section of Intensive Care	G.M. Clarke		J. Tibballs
	F.H. Hawker		
Final Exam IC	A.W. Duncan	General Examinations Committee	
ANZICS Representative	P.L. Byth	Chairman of Examinations	R.J. Willis
SAC Representative	D. Tuxen	President	M.J. Davies
		Education Officer (Anaes)	J.M. Gibbs
		Education Officer (IC)	G.D. Phillips
		Chairman Primary	P. Roessler
Hospital Accreditation Group		Deputy Chairman Primary	P. Kam
Assessor (Chairman)	I. Rechtman	Chairman Final (Anaes)	B.T. McCann
President	M.J. Davies	Deputy Chairman Final (Anaes)	K.D. Cronin
Assistant Assessor	B.F. Horan	Chairman Final (IC)	A.W. Duncan
Education Officer (Anaes)	J.M. Gibbs	Deputy Chairman	R.P. Lee
Education Officer (IC)	G.D. Phillips		

ASM Scientific Programme Committee

Chairman	R.J. Willis
Past Scientific Convenor (SA)	H. Owen
Present Scientific Convenor (Tas)	J. Madden
Future Scientific Convenor (Qld)	

Gilbert Brown Prize Adjudicators

Chairman (to select panel)	R.J. Willis
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Lennard Travers Professorship Electoral College**Computer Sub-Committee**

Chairman	D.R. Kerr
Treasurer	R.G. Walsh
Registrar	J.M. Sheales
Head Finance Department	R.A. Blain
Co-opted Member	C.A. Morgan

Section of Intensive Care Executive

Chairman	G.M. Clarke
Secretary and two other Members	F.H. Hawker R.F. Whiting R.V. Trubuhovich

Bulletin Editorial Committee

Editor	J.M. Sheales J.M. Gibbs I. Rechtman
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Academic Review Sub-Committee

Chairman	G.D. Phillips R.S. Henderson A.B. Baker
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Victorian Chairs of

Anaesthesia Advisory Committee	G.B. Donnan P.A. Lowe I. Rechtman T.C.K. Brown P.J. Keast R.N. Westhorpe
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EMST Board

Joint Advisory Committee	G.D. Phillips President or Vice President
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Australian Resuscitation Council	G.A. Harrison V.I. Callanan I. Rechtman
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College Historian and Assistant Historian

	M.G. Cooper A.J. Newson
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Geoffrey Kaye Museum of Anaesthetic History

Curator	R.N. Westhorpe
Assistant Curator	C.M. Ball

Representatives/Nominees to other outside Organisations**Australian Society of Anaesthetists**

Executive	President or nominee
Joint Liaison Committee	President Vice President

National Committee on Day Surgery

	D.H. McConnel A.K. Bacon
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Anaesthetic Co-ordinating Committee for AMA Federal Conference

	President Chairman of Executive
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Anaesthetic Industry Liaison Committee

	M.J. Davies D.H. McConnel R.J. Willis
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Joint Consultative Committee on Anaesthesia (JCCA)

	N.J. Davis D.H. McConnel F.X. Moloney
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Committee of Presidents of Medical Colleges

Educ. Standards Sub-Committee	President A.B. Baker
Workforce Committee	G.D. Phillips

ANZCA/RACS/RACP

President

Australasian Board of

Cardiovascular Perfusionists	A.B. Baker R.G. Walsh
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Observers on RACS Council Committees

Council	President
Finance Representative	Treasurer
House Committee	M.J. Davies
Library	I. Rechtman
Archives	M.G. Cooper R.N. Westhorpe

WORKING PARTIES**Establishment of the Faculty of Intensive Care**

Chairman	G.D. Phillips
Members of the Section Executive	G.M. Clarke F.H. Hawker R.F. Whiting R.V. Trubuhovich
Chairman of Educ. Committee (IC)	G.D. Phillips
Chairman of Final (IC)	A.W. Duncan
President	M.J. Davies
Registrar	J.M. Sheales

Diploma of Pain Management

Chairman	J.M. Gibbs P.D. Livingstone T.F. Little J.N. Ditton C.R. Goucke B.F. Rounsefell C.W. Free
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Certification of Maintenance of Standards

Chairman	G.D. Phillips
President	M.J. Davies
Education Officer (Anaes)	J.M. Gibbs
Treasurer	R.G. Walsh
Section Executive Member	F.H. Hawker
Registrar	J.M. Sheales

POLICY DOCUMENT

P25(1993)

MINIMUM STANDARDS FOR PAIN MANAGEMENT UNITS

1. INTRODUCTION

The following guidelines are intended as **minimum** standards for Pain Management Units seeking approval as training units for those practitioners wishing to obtain the Qualification in Pain Management of the Australian and New Zealand College of Anaesthetists.

The College recognises that the administrative and departmental arrangements may vary from one establishment to another eg. some Pain Management Units may be responsible for all pain management, (acute and chronic pain and palliative care), others only for the management of chronic pain and for the purposes of this document, acute pain services will be excluded.

2. CLINICAL STANDARDS

The Pain Management Unit must have:

- 2.1 A minimum number of two hundred new patients suffering chronic pain, per year, per trainee.
- 2.2 At least two regular outpatient sessions per week, which are separate from procedural sessions, together with involvement in the provision of an inpatient consultation service.
- 2.3 Involvement with patients who have cancer pain, chronic non-cancer pain and palliative care.
- 2.4 A range of treatments which include conservative as well as interventional techniques.
- 2.5 Quality Assurance activities.

3. STAFFING

The Pain Management Unit must have:

- 3.1 A Medical Director (who may be full time or part time) who is responsible for the overall organisation of the Unit.

- 3.2 Medical staff who have acceptable experience and training in management of chronic pain, in numbers appropriate to the workload of the Unit, to ensure the continuous availability of consultant advice and supervision of trainees.
- 3.3 Ready access to other disciplines such as psychiatry/surgery, diagnostic radiology, radiotherapy etc.
- 3.4 Registered nursing staff who are experienced in the management of patients with chronic pain problems. If procedures are performed within the Unit area, then additional staff appropriate to these needs will be required (for example, technical assistance).
- 3.5 Ready access to psychology, physiotherapy, occupational therapy and rehabilitation services.
- 3.6 Dedicated secretarial staff.

4. FACILITIES

The Pain Management Unit must have:

- 4.1 Adequate office space and equipment for the Director, other medical staff (including the trainees) and secretarial staff.
- 4.2 Convenient access to conference room facilities.
- 4.3 Ready access to adequately equipped procedure rooms if such facilities are not provided within the Unit area.
- 4.4 Equipment (including resuscitative drugs and equipment) appropriate to the range of procedures performed by the Unit.
- 4.5 Access to inpatient beds.

These guidelines should be interpreted in conjunction with the following Policy Documents of the Australian and New Zealand College of Anaesthetists:

- E6 "The Duties of an Anaesthetist in Hospitals with Approved Training Posts"
- E8 "The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts"
- E9 "Quality Assurance"
- P10 "Minimum Standards for Intensive Care Units"

June, 1993

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
P17 (1992)	Endoscopy of the Airways
P18 (1990)	Monitoring During Anaesthesia
P19 (1990)	Monitored Care by an Anaesthetist
P20 (1990)	Responsibilities of Anaesthetists in the Post-Operative Period
P21 (1992)	Sedation for Dental Procedures
P22 (1990)	Statement on Patients' Rights and Responsibilities
P23 (1992)	Minimum Standards for Transport of the Critically Ill
P24 (1992)	Sedation for Endoscopy
P25 (1993)	Minimum Standards for Pain Management Units

August 1993