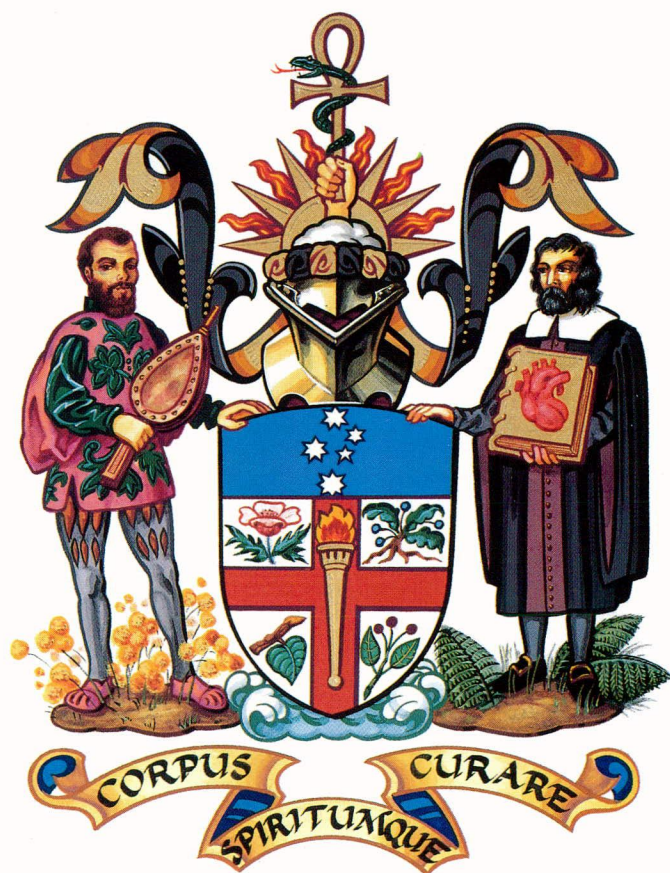


# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852



## B U L L E T I N

VOLUME 2 NUMBER 4

NOVEMBER 1993

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## EDITORIAL

Mrs J.M. Sheales, *Editor*

Prof. J.M. Gibbs

Dr I. Rechtman

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## PRESIDENT'S MESSAGE



The past two years have seen some of the most significant changes in the history of the College/Faculty. The formation of the Australian and New Zealand College of Anaesthetists has now been consolidated by the significant support of its Fellowship, by establishing ANZCA representation on multiple medical and government organisations and its recognition by similar organisations in other countries.

The physical separation from the Royal Australasian College of Surgeons is occurring following our purchase of the Melbourne Headquarters. The new Headquarters is about to undergo some renovation as we do not have to physically move from the Royal Australasian College of Surgeons' building until June 1994. This time offers us an excellent opportunity to refurbish our new building prior to its occupation.

Planning for our first independent Annual Scientific Meeting continues to occur. The Tasmanian Organising Committee has been significantly innovative and it is believed that these initiatives will further strengthen the College.

The College Examinations are undergoing the biggest changes in their evolution. The Final Examination was recently carried out in its new format which was a significant success. The

magnitude of these changes needed to be seen and practised to be completely appreciated, although clearly there is some fine-tuning required. The overall assessment by Examiners and Examinees was that these changes were for the better. The Primary Examination is about to undergo a review that may also result in substantial changes in the format of this Examination.

The establishment of the Faculty of Intensive Care at the recent Council Meeting represents another historical change. The Faculty will have a similar relationship to ANZCA as the Faculty of Anaesthetists had with the Royal Australasian College of Surgeons. This will result in greater recognition, independence and representation of this speciality in the future. The formation of the Faculty of Intensive Care is another big step in the evolution of the speciality.

More changes are contemplated. They include the development of Clinical Indicators, Certification of the Maintenance of Standards, In-Training Assessment, mandatory subspecialty training and workforce initiatives.

All these activities are the result of a considerable effort by your Council, its Committees and many Fellows, to ensure that the College is well placed for the future.

Finally, I hope that all Fellows have a very happy Christmas and that 1994 has a similar bright outlook for you as it does for your College.

MICHAEL J. DAVIES  
President

**DIPLOMA OF FELLOWSHIP**  
**ENDORSED IN**  
**INTENSIVE CARE**  
**BY ELECTION**

D.N. Cunningham, SA  
G.R. Cutfield, NSW  
G. Downward, NZ  
P.O. Older, Vic

**DEATHS**

Council noted with regret the death of the following Fellows:

*Dr D.J. Molomby, Qld, FFARACS 1981,  
FANZCA 1992*

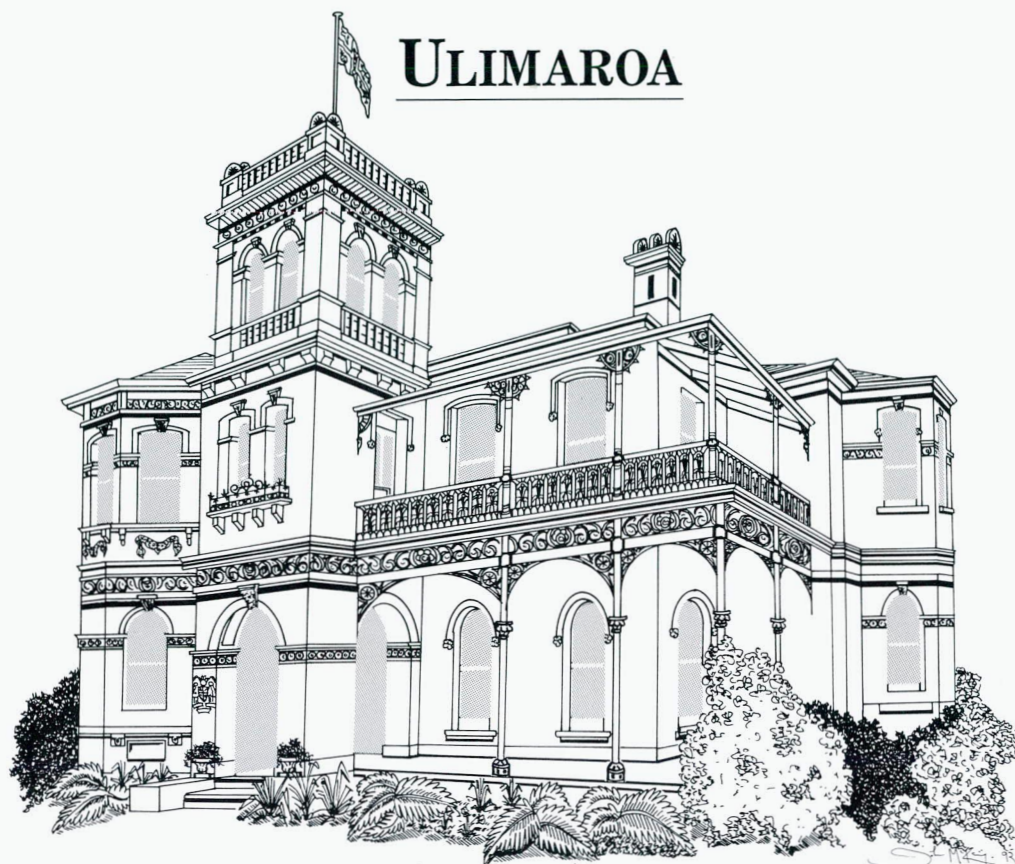
*Professor M.A.E. Rex, Qld,  
FFARACS 1977, FANZCA 1992*

*Mr Bernard O'Brien, AC, CMG, FRACS*

**ADMISSION TO FELLOWSHIP**  
**UNDER ARTICLE 12(c)**

Jeffrey Luey, NZ  
Stuart Macgregor Shepherd, SA

Soosaipillai Mary Donald Valentine, HK



"Ulimaroa"

*Following Council's decision not to proceed with the proposed extensions to Ulimaroa, a permit from the Historic Buildings Council has now been issued for the refurbishment and general maintenance of Ulimaroa. An interior designer has been appointed to advise and co-ordinate the work in a number of areas, however, at this stage it is impossible to anticipate when the building will be ready for occupancy by the College.*

## **ADMISSION TO FELLOWSHIP BY EXAMINATION** **ENDORSED IN ANAESTHESIA**

Richard Kelly Barnes, Vic  
Linda Jane Cass, Vic  
John Victor Green, SA  
Alison Margaret Hill, Vic  
Neil Frederick Maycock, SA  
Eric Michael Moyle, NSW  
Robert Marwood Mules, SA

Maury Scharf, Vic  
Mervyn Harold Shapiro, SA  
Peter Hamilton Sharley, SA  
Adrian Sultana, Vic  
Yung Van Tran, NSW  
Stephen Frederick Woodford, NSW  
Murray Lesley Williams, NZ

## **DIPLOMA OF FELLOWSHIP ENDORSED IN INTENSIVE CARE**

David Alan Galler, NZ

Roderick John McRae, Vic

# REPORT ON 1992 CONFIDENTIAL CME SURVEY

Compiled 21/9/93 by Mike Martyn, FANZCA

## 1412 Questionnaires returned.

1. ACTIVE 1318 93% (These only reported below)

### 2. PERSONAL CME DURING 1992

	Frequent	Sometimes	Never	No Answer
Anaesthetic journals	1082 82%	227 17%	1 0%	8 1%
Anaesthetic texts	347 26%	847 64%	23 2%	74 6%
Medical journals	410 31%	780 59%	64 5%	64 5%
Medical texts	110 8%	916 69%	141 11%	151 11%
CECANZ	312 24%	715 54%	208 16%	83 6%

### 3. REGULAR QUALITY ASSURANCE PARTICIPATION DURING 1992

Clinical Audit	795 60%
Morbidity/Mortality	937 71%
AIMS/NZ	786 60%
Other	471 36%

1149 (87%) indicated that they undertook some form of QA

### 4. TEACHING ANAESTHESIA/INTENSIVE CARE DURING 1992

Clinical	1088 83%
Tutorials	752 57%
Faculty courses	340 26%
Other	1046 79%

1241 (93%) indicated that they were involved in some form of teaching

### 5. SCIENTIFIC MEETINGS ATTENDED DURING 1992

#### MEETINGS < ONE DAY

	Number	Aver.
Hospital	904 69%	9.4
State	659 50%	2.4
Other	169 13%	2.4

1096 (81%) indicated that they attended at least one of these

1221 (93%) indicated that they attended a scientific meeting

#### MAJOR MEETINGS

Hospital	285 22%	1.5
State	662 50%	1.6
National	624 47%	1.4
Overseas	402 31%	1.5

932 (71%) indicated that they attended at least one of these

### 6. NATIONAL MEETINGS IN LAST TWO YEARS (1991-1992)

	Number	Aver.
Faculty/ANZCA GSM	458 35%	1.3
ASA AGM	457 35%	1.3
NZ CM	118 9%	1.3
ANZICS	166 13%	1.6

689 (52%) attended either GSM or ASA  
736 (56%) either GSM, ASA or NZCM  
804 (61%) GSM, ASA, NZCM or ANZICS

### 7. "RECERTIFICATION" RELEVANCE OF ACTIVITY (RATED 1-5)

	1	2	3	4	5	Aver.	No reply
Reading Journals	19	34	216	503	509	4.1	37
Scientific Meetings	41	71	256	414	485	4.0	51
Quality Assurance	84	165	364	382	266	3.5	57
Clinical Teaching	100	136	310	444	278	3.5	50
Peer Review	115	178	438	334	179	3.2	74
Self-Assessment Program	101	247	464	297	148	3.1	61
In-Service Attachments	279	222	325	259	135	2.8	98
Clinical Research	472	344	235	127	75	2.2	65
Site Visits	470	278	256	129	50	2.2	129

NOTE: This has been ordered by decreasing average.

# **STOP PRESS**

## **FACULTY OF INTENSIVE CARE**

### **— THE INAUGURAL BOARD MEETING**

On November 4, 1993 the inaugural meeting of the Interim Board of the Faculty of Intensive Care, Australian and New Zealand College of Anaesthetists, was held in Melbourne. Members of the Board and their state or country of origin are listed below as are the offices they hold:

- Dr G.M. Clarke (Dean), Western Australia
- Dr R.V. Trubuhovich (Vice Dean), New Zealand
- Assoc. Prof. W.G. Parkin (Censor), Victoria
- Prof. G.D. Phillips (Education Officer), South Australia
- Dr R.F. Whiting (Treasurer), Queensland
- Dr A.W. Duncan (Chairman of Examination), Western Australia
- Dr F.H. Hawker, New South Wales.

The final meeting of the Education Committee (Intensive Care) and the Executive of the Section of Intensive Care have been held and those bodies disbanded. Their functions have been taken over by the Board of Faculty. Further refinements must be made to the Regulations. Administrative Instructions and policy documents are being reviewed as are a host of other documents affecting intensive care.

I am pleased to report that Fellows of the College with endorsement in intensive care were admitted to Foundation Fellowship of the Faculty at the Inaugural Meeting, and letters of notification and congratulations are being forwarded.

Matters affecting Fellows of ANZCA not endorsed in intensive care but participating in the practice of

intensive care and having an interest in the functions of the Faculty are being addressed.

It is the expressed intention of the Board to keep its Fellows fully informed of its activities through regular publications in the *Bulletin*. Until our numbers support the formal establishment of Regional Committees in Intensive Care, lines of communication from the Board to individual Fellows will either be direct or through Board Members in individual States or New Zealand. Input from Fellows into the affairs of the Faculty is strongly encouraged. The Board is seeking a preliminary meeting between its representatives and those of the Royal Australasian College of Physicians to explore all matters affecting training and certification in intensive care in Australia and New Zealand.

The Launceston Annual Scientific Meeting of the ANZCA will be the first meeting our College has held independent of the Royal Australasian College of Surgeons. It will also be the first Scientific Meeting of ANZCA at which the Faculty of Intensive Care is represented. Though modest, our contribution to the meeting will be significant. Approaches are to be made to Council and the organising body of the 1995 Annual Scientific Meeting to be held in Townsville, for a much expanded Faculty contribution. Several interesting concepts of how Faculty Scientific Meetings should be structured have already been put forward. Ideas from all Faculty Fellows are invited.

GEOFFREY M. CLARKE  
Dean

### **INTERIM BOARD OF FACULTY**



*Pictured, left to right:  
Professor Garry Phillips,  
Dr Bob Whiting, Dr Felicity  
Hawker, Dr Ron Trubuhovich,  
Dr Geoffrey Clarke (Dean),  
Dr Alan Duncan, Dr Michael  
Davies (President), and  
Dr Geoff Parkin.*

# ITEMS OF INTEREST FOLLOWING THE OCTOBER 1993 COUNCIL MEETING

## WELCOME

The President welcomed Dr Mike Martyn as a Co-Opted Member of Council representing the Region of Tasmania. In welcoming Dr Martyn, the President advised that he was entitled to exercise all the same rights and privileges at the Meeting as the Elected Members, including the right to vote, except for voting for Office Bearers or for the Officers of the Council.

## EDUCATION

### *In-Training Assessment*

Council agreed in principle to a protocol for In-Training Assessments to be carried out at regular intervals within Departments of Anaesthesia approved by the College for Anaesthetic Training. This document has been referred back to the Education Committee for further editing when it will be then forwarded to Regional Committees for comment.

### *Primary Examination as a Pre-Requisite for Approval of Third Year of Training*

At its October meeting in 1988, the Board of Faculty agreed that if a trainee had not passed the Primary Examination by the end of the second year of training, that the third and subsequent years of training cannot be commenced until after the Primary Examination has been passed. However, an implementation date for this policy was not set.

At its recent Meeting, Council reconsidered this resolution and resolved that the resolution passed by the Board of Faculty at its meeting in October 1988 be implemented for trainees who commence approved vocational training during the 1994 Hospital Year.

### *Minimum Assistance Required for the Safe Conduct of Anaesthesia*

Council agreed to support a plan to develop a National Associate Diploma for Anaesthetic Assistants.

## FACULTY OF INTENSIVE CARE

1. Council approved the formation of the Faculty of Intensive Care within the Australian and New Zealand College of Anaesthetists.
2. Council approved Regulations under which the Faculty of Intensive Care will operate which are a simplified version of the Regulations under which the Faculty of Anaesthetists operated within the Royal Australasian College of Surgeons.

### *Interim Board*

Council appointed an Interim Board of the Faculty of Intensive Care, pending the election of a Board of Faculty early in 1994. The Interim Board comprises:

*Dr G.M. Clarke, WA*  
*Dr A.W. Duncan, WA*  
*Dr F.H. Hawker, NSW*  
*Dr W.G. Parkin, VIC*  
*Professor G.D. Phillips, SA*  
*Dr R.V. Trubuhovich, NZ*  
*Dr R.F. Whiting, QLD*

All Regions are represented on this Interim Board with the exception of Tasmania, in which Region at present, there is no Fellow endorsed in Intensive Care.



**FINANCE**

There are two Representatives from Western Australia, Dr Geoff Clarke and Dr Alan Duncan as Chairman of the Final Examination Committee (Intensive Care).

**Annual Subscription:**

That the Annual Subscription for 1995 due and payable on 1st February 1994, be A\$800 and payable to the Melbourne Office.

**Register of Training Fee for 1994**

A\$400 and payable to the Melbourne Office.

**Examination Fees for 1994:**

A\$1,500 and payable to the Melbourne Office.

**The Annual Training Fee for 1994:**

Australia and Hong Kong	A\$700.
New Zealand	NZD700 plus GST (payable to the Wellington Office)
Singapore and Malaysia	\$700 (local currency converted into Australian Dollars and remitted to the Melbourne Office).

**CONTINUING  
EDUCATION AND  
QUALITY ASSURANCE**

**Annual Scientific Meeting — 1995**

Council resolved that the Annual Scientific Meeting for 1995 be held in Townsville.

**Australasian Visitor**

Dr John Russell, South Australia, has accepted the appointment of Australasian Visitor for the 1995 Meeting.

**Annual Scientific Meeting — 1997**

Council resolved that the 1997 Annual Scientific Meeting be held in New Zealand.

**Maintenance of Standards**

Following the recommendations from the Working Party for the Maintenance of Standards, the Chairman has agreed to incorporate Council's deliberations into a document for circulation to Regional Committees and Specialist Societies for comment.

**INTERNAL  
AFFAIRS**

**Physical Facilities**

**New Zealand**

Council agreed to affix the College Seal to a Lease of the Ground Floor of the New Zealand College Office for a period of two years.

**Melbourne — Headquarters**

Council carried out a comprehensive tour of Ulimaroa following the Vendor's vacation of the premises.

**Articles of Association**

The Constitution Review Committee has been requested to review the Articles of Association following the establishment of the College, the disbandment of the Faculty of Anaesthetists, Royal Australasian College of Surgeons and the establishment of the Faculty of Intensive Care.

## PROFESSIONAL

***National Health and Medical Research Council — External Review***

Council has been requested to nominate three representatives for consideration of the appointment of one representative for the triennium 1994-1996 on the NH&MRC Healthcare Committee.

Council has nominated Professor Garry Phillips (SA), Dr Brian Horan (NSW) and Dr Moira Westmore (WA).

***Policy Documents — Disclaimer***

Following advice from the College's Honorary Solicitor, Council has resolved that the following Disclaimer be included on all new and reviewed Policy Documents:

***“This policy document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this policy document in each case.***

***Policy documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Policy documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.***

***Whilst the College endeavours to ensure that policy documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.***

***Promulgated:***

***Reviewed:***

***Date of current document:”***

***Minimum Assistance Required for the Safe Conduct of Anaesthesia***

Following a review of Policy Document P8 “Minimum Assistance Required for the Safe Conduct of Anaesthesia” Council accepted the amended document which is published elsewhere in this *Bulletin*.

***Informed Consent***

Council accepted a Policy Document “Guidelines on Informed Consent” which document has been approved by the College's Honorary Solicitor and forwarded to Regional Committees for comment.

***AIDS and Hepatitis***

Council resolved that the College promulgate a Policy Document on AIDS and Hepatitis.

***Paediatric Anaesthesia***

Council also resolved to develop a Policy Document for Paediatric Anaesthesia in non-paediatric hospitals.

## **HONOURS AND** **APPOINTMENTS**

Council extended its congratulations to the following recipients of Honours, Appointments and Award:

*Associate Professor P.D. Livingstone, Qld*  
— *RACS Court of Honour*

*Associate Professor V.I. Callanan, Qld*  
— *Chairman, Australian Resuscitation Council*

*Professor Gai G. Harrison, South Africa*  
— *D.Sc. (NUD) University of Capetown*

*Professor G.R. Cutfield, NSW*  
— *Professor of Anaesthesia and Intensive Care,*  
*University of Newcastle, Director of Education,*  
*Department of Anaesthesia and Intensive Care,*  
*John Hunter Hospital*

*Dr Ronald Lo, Hong Kong*  
— *President, Hong Kong College of*  
*Anaesthesiologists*

## **1994** **RESEARCH AWARDS**

Details of College Research Awards for 1994 are:

Dr Harry Owen, SA was awarded a grant of \$57,367 to support his project "*Comparison of Variable Dose Patient Controlled Analgesia to Fixed Dose PCA*".

Dr Mark Schneider, WA was awarded a grant to the extent of \$6,630 towards his project: "*A Comparison of the Effects of Fixed and Tailored Cardiopulmonary Bypass Flow Rates and Dopamine on the Gastrointestinal Tract*".

Dr Owen was also awarded the Harry Daly Research Fellowship for his project.

# THE ROYAL SOCIETY OF MEDICINE

*The College has now been accepted for membership of The Royal Society of Medicine, London. The following letter has been received from the Society offering Fellows of the College membership.*

October 1993

## **To members of the Australian and New Zealand College of Anaesthetists**

With the agreement of your Council, I extend an invitation to you to apply to become, by virtue of your Fellowship of the Australian and New Zealand College of Anaesthetists, a Fellow of the Royal Society of Medicine, an historic medical society based in London.

Formed under another name in 1805, the Royal Society of Medicine is today one of the foremost multi-disciplinary, international medical organizations in the world. It has a membership of some 18,000 doctors, dentists, scientists and others, approximately 11,000 of whom are home-based and the rest overseas.

The Society's magnificent headquarters building is located in the heart of London's West End, near to the Oxford Street and Bond Street shopping centres and convenient for the capital's theatres. It houses conference and lecture facilities; one of the finest medical libraries in Europe with over 50,000 books and 2,000 journals; meeting rooms, sitting rooms, a members' bar and a restaurant all built around an imposing conservatory; and a "Domus Medica" which provides hotel accommodation at £47 per night for a single room and £85 for a double room each with its own telephone, T.V. and bathroom. When in the UK, you would be able to

use all these facilities: even only a brief stay at the Domus Medica can effectively recoup the annual subscription to the Society by the savings made on many London hotel charges. In addition, you would receive the Society's monthly journal free of charge and would also be entitled to attend any of the 500 academic meetings arranged each year by the Society and its 40 specialty Sections, including a Section of Anaesthetics.

It would therefore be possible for a Fellow of the Australian and New Zealand College of Anaesthetists, on a visit to London, to be 'based' at the Royal Society of Medicine for the duration of his or her stay; to eat in the restaurant or Buttery here; to arrange to meet British colleagues here; to perhaps register for a meeting being held here by one of the RSM Sections; and to do research in the Library.

If you are interested, please contact your College Registrar Mrs Joan Sheales for more information and an application form.

We look forward to welcoming as members many new friends from the Australian and New Zealand College of Anaesthetists.

Sincerely,

Sir George Pinker KCVO FRCOG  
President, Royal Society of Medicine

## LETTER TO THE EDITOR

Madam,

I read Mr Colin Smith's article on the ANZCA/RACS Archive in the August *Bulletin* with great pleasure. It is wonderful that we now have people to take proper care of our historical artefacts. However, Mr Smith is in error when he describes the reproduction on page 21 as Dr G.F.V. Anson's Certificate of Fellowship. This, in fact, is the Exordium which was signed by the five Founder Fellows, namely Drs Daly, Gillespie, Renton, Travers and Troup. A copy was then sent to each of the forty Foundation Fellows who signed their copies and returned them to signify their agreement with the objects set out. The Faculty of Anaesthetists was then formally established. This particular copy of the Exordium is the one signed by Dr G.F.V. (Eric) Anson, who indeed received the No. 1 Certificate of Fellowship, presumably because of his alphabetical primacy!

Dr Anson's Diploma of Fellowship (dated 25th August 1952) actually hangs in the Ernest and Marion Davis Medical Centre at Auckland Hospital, on loan from the Anson family. A photo of this diploma can be seen on page 15 of my treatise "Eric Anson - an Appreciation" (1983), a copy of which is held in the College Library. This form of our Diploma was still in use at the time I gained my Fellowship in 1966 and I believe it did not change to the larger certificate with coloured coat-of-arms until some years later.

B. R. HUTCHINSON  
Auckland

# AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

## MAINTENANCE OF STANDARDS WORKING PARTY

### REPORT TO FELLOWS ON DRAFT PROPOSALS TO BE CONSIDERED BY COUNCIL

Over the past two years, the MOS Working Party has developed a proposal to enable Fellows to demonstrate that they are participating in a program aimed at maintaining clinical standards. The rationale behind the MOS program has been outlined in *Bulletin* articles in November 1991 and 1992 and March and May 1993. The proposal is now circulated to all Fellows, Regional Committees, ASA, NZSA and ANZICS for comment. A revision of the document will then be carried out and final recommendations made to Council and Board of Faculty in June.

The program will be called "*Maintenance of Standards*" and Fellows completing it satisfactorily will be awarded a Certificate of Participation in the program.

It is anticipated that the program will be available from January 1995 and that Certificates will be issued at five yearly intervals. Participation is voluntary.

The program will require Fellows to record annually their participation in CME, Teaching, Research and Quality Assurance activities chosen by them as being compatible with their particular type of practice.

Credit points will be allocated for each activity, and it will be necessary to accumulate a total of 500 points chosen from different activities over each five year period. As the program is aimed at maintenance of clinical standards, the weighting of the various activities reflect this.

The program has three components:

1. Credentialling, consisting of provision to the College of a copy of the current registration or practising certificate from the relevant Medical Board or Council, and evidence of accreditation at an institution of practice. This is a prerequisite for completion of the program.
2. Provision of evidence of regular involvement in some or all of the activities outlined in the table opposite, achieving a total of 500 points each five years.
3. The third component which is not yet available, and which may be introduced following pilot studies, includes:
  - evidence of personal participation in clinical audit;
  - assessment of response to critical situations by participation in simulation exercises;
  - Peer Review based on use of clinical indicators.

We have opted for a voluntary, flexible and simple system which is relevant to Fellows, yet comparable to programs of other Colleges. Data will be collected by the individual and provided to the College each five years. Administrative arrangements for the program will be as cost efficient as they can be made.

Provision will be made for the program to be made available to Specialists who are non-Fellows of ANZCA.

## MAINTENANCE OF STANDARDS PROGRAM

### CREDIT POINTS ALLOCATION

#### 1. QUALITY ASSURANCE

(Min 100 points/5 years, Max 300 points/5 years)

Activities outlined in Policy Document E9 (evidence required). (Examples: AIMS participation, National ICU outcome participation, regular participation in morbidity and mortality reviews.)

**50 points/annum**

#### 2. CONTINUING MEDICAL EDUCATION

(Min 200 points/5 years, Max 300 points/5 years)

2.1 Accredited Meetings – Regional, National and International (College, ASA, CANZ, ANZICS Meetings automatically accredited. Others require accreditation. Evidence of attendance required).

**10 points/day**

2.2 Accredited Workshops/Seminars (EMST automatically accredited. Others to be accredited must have focussed education with small groups, registrant participation and evaluation.)

**20 points/day**

2.3 Accredited Self Assessment (HELP automatically accredited if answer sheet returned for marking).

**20 points/package**

2.4 Practice related CME (includes journals, journal clubs, rounds, tapes, videos). (Log book required for >100 points).

**1 point/hour**

2.5 Participation in postgraduate medical examinations, including EMST Course instruction.

**10 points/day**

#### 3. TEACHING AND RESEARCH

(Max 200 points/5 years)

3.1 Teaching (Formal undergraduate or postgraduate evidence required for >100 points).

**5 points/hour**

3.2 Presentation (At an accredited Meeting (see 1.1.). Evidence required).

**5 points/presentation**

3.3 Publication (Evidence required).

**5 points/publication**

#### 4. OTHER ACTIVITIES

(Points not yet assigned)

Suggestions from Fellows welcomed.

GARRY D. PHILLIPS  
Chairman, Working Party

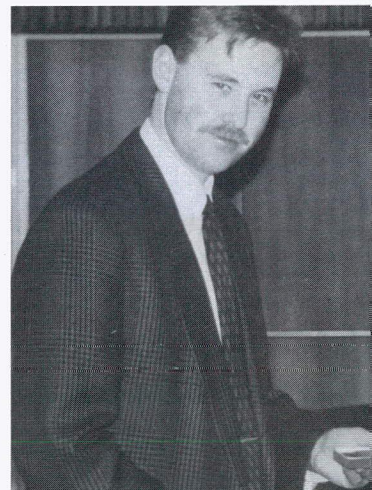


## **COURT OF EXAMINERS, FINAL**

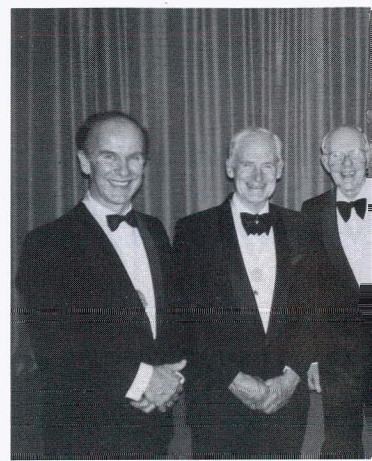
*(Left to right): Drs W G Peskett, D J Sage, D A Power, C D Scheinkestel, Sandra Taylor, W J Russell, J Associate Professor V I Callanan, Drs E P Ward, E B Hewett, A M Weeks, P G Habersberger, Miss M W R Thompson, Lee Coaldrake, D A Scott and Glenda Rudkin. Front Row: Drs R J Willis, K D Cronin*



1



2





## EXAMINATION — SEPTEMBER 1993

*J Hammond, N J Radford, Associate Professor I D Caterson, Drs E Loughman, Wilma Beswick, Lynch (Admin. Assist. Exams), Drs A R White, K W Sleeman, A A Bishop, P A Hales, P L Klineberg, (Deputy Chairman), B T McCann (Chairman), I Rechtman.*



③



⑤



④

- ① *Dr Michael Davies (President) presenting Ms Nirupa Sachithanandan with the Bill Crosby Prize. Professor Charles L Gibbs is pictured in the background.*
- ② *The Inaugural recipient (Ms Nirupa Sachithanandan) of The Bill Crosby Prize for Physiology awarded by Monash University together with Mrs Jean Crosby and Mr Stuart Crosby following the presentation.*
- ③ *Dr Andrew Patrick (Victoria) being presented with his Renton Prize Medal by Dr Ian Rechtman.*
- ④ ***Past Deans and Presidents** — Drs Michael Hodgson, Noel Cass, Ralph Clarke, Professor Barry Baker, Assoc Prof Peter Livingstone and Professor Ross Holland at the Dinner hosted by the Council of the Royal Australasian College of Surgeons in the Hughes Room at the College Headquarters on 25 June, 1993, following the RACS AGM where the Faculty of Anaesthetists was disbanded.*
- ⑤ *Dr Barrie McCann, Chairman, Final Examination Committee (Anaesthesia), presenting Dr Bill Peskett with a Certificate of Recognition of his contribution to the Final Examination.*



## LAW REPORT

Michael Gorton, LLB, BComm — College Honorary Solicitor — Partner, Abbott Tout Russell Kennedy  
Damien Coleman, LLB (Hons), BEc (ANU)

### MEDICAL MANSLAUGHTER IN AUSTRALIA



The conviction of a number of medical practitioners in New Zealand and the United Kingdom for manslaughter in recent years has caused a considerable degree of concern among members of the medical profession in those countries, not the least, Fellows of the medical colleges. This article examines some of the implications of these developments for the medical profession in Australia.

#### The New Zealand Cases

There have been three well publicised medical manslaughter cases in New Zealand.<sup>1</sup> In two of these cases the doctor involved administered the wrong drug to a patient because they had relied, without checking, on their assistants.<sup>2</sup> The third case involved an anaesthetist who failed to realise that he had supplied a patient with carbon dioxide instead of oxygen.<sup>3</sup> It is interesting to note that in the cases of **Morrison** and **Yogasakaran** no sentence was imposed on either doctor once the conviction had been recorded.

In each of these cases the doctor involved was prosecuted under s155 of the Crimes Act 1961 (NZ). This provides:

- 155 **Duty of Persons Doing Dangerous Acts** – Everyone who undertakes (except in case of necessity) to administer surgical or medical treatment, or to do any other lawful act the doing of which is or may be dangerous to life, is under a legal duty to have and to use reasonable knowledge, skill, and care in doing any such act, and is criminally responsible for the consequences of omitting without lawful excuse to discharge that duty.

The courts of New Zealand have interpreted this provision so that criminal liability attaches to acts of “simple” negligence.<sup>4</sup> That is, a breach of the standard of care which is sufficient to establish civil liability is also sufficient to render the doctor in question criminally liable for negligent treatment.

This interpretation was not disturbed by the Privy Council in Britain when one of the cases was considered on appeal.<sup>5</sup> The matter was viewed as a policy decision of the New Zealand courts, and the Privy Council was, for this reason, not prepared to interfere. The Privy Council did not, however, endorse the New Zealand approach as a matter of general principle. The effects of the New Zealand approach should, therefore, remain confined to that country.

#### The Position in the United Kingdom

In the United Kingdom, there have been four practitioners convicted of manslaughter in recent years. Two of these, Doctors Prentice and Sullman, were convicted as a result of one incident where a 16 year old leukaemia patient was administered a chemotherapeutic drug intrathecally which ought to have been administered intravenously.<sup>6</sup> Dr Prentice administered the lumbar puncture and Dr Prentice had agreed to supervise the procedure. The other two cases involved anaesthetists, one of whom failed to notice the disconnection of a ventilator at the patient’s end, and another who connected a high pressure oxygen source directly to a tube inserted into a patient’s throat instead of via the appropriate machinery.<sup>7</sup>

The case of Prentice and Sullman has generated the greatest concern as these junior doctors were found guilty of manslaughter because they were judged to have been **reckless**, that is, because they had created an obvious risk of serious injury without giving any thought to the possibility of there being such a risk.<sup>8</sup> It appears that neither of them were fully aware of the problems associated with chemotherapeutic drugs.

The application of this **recklessness** test does not, however, constitute the imposition of liability on medical professionals for mere negligence as has been the case in New Zealand. It is clearly the law in England, as it is in Australia (see below), there mere negligence is insufficient to generate criminal liability.<sup>9</sup> In conceptual terms, the failure to advert to the possibility of what is,

on any objective view, an obvious and serious risk of causing physical injury goes beyond mere carelessness. However, it could be argued that, in practical terms, it may be difficult to distinguish between recklessness and mere carelessness where inexperienced practitioners are thrust into situations with inadequate training and support, as appeared to be the case in Prentice and Sullman.<sup>10</sup>

### The Australian Position

There do not appear to have been any reported cases of doctors being convicted for manslaughter arising out of negligent medical treatment in Australia. The legal position in Australia is similar to that in England, in that mere carelessness is not sufficient to justify a finding of manslaughter. The extent of the difference between the position in Australia and that in New Zealand is borne out by a separate examination of the states in which the common law applies and those in which the criminal law has been legislated.

### The Common Law States – Vic, NSW & SA

The common law in Australia is that mere carelessness or “simple” negligence is insufficient to warrant conviction for manslaughter.<sup>11</sup> The requirement of gross negligence is encapsulated in the following passage:

**“Negligence which is essential before a man can be criminally convicted must be culpable, exhibiting a degree of recklessness beyond anything required to make a man liable for damages and civil action. It must be such a degree of culpable negligence as to amount to an absence of that care for the lives and persons of others which every law abiding man is expected to exhibit.”<sup>12</sup>**

### The Code States – Qld, WA & Tas.

Each of these jurisdictions has a provision in its Criminal Code which is virtually identical to s155 of the Crimes Act 1961 (NZ). The Queensland and Western Australian provisions read:

**“It is the duty of every person who, except in a case of necessity, undertakes to administer surgical and medical treatment to any other person or to do any other lawful act which is or may be dangerous to human life or health to have reasonable skill and to use reasonable care in doing such act; and he is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty.”<sup>13</sup>**

It has been held by the High Court of Australia that mere negligence is not sufficient for a person to be convicted of manslaughter under this type of provision.<sup>14</sup> The court

was of the view that the expressions used in the predecessor to the present Queensland provision must be viewed in light of the fact that they appear in a Criminal Code dealing with major crimes involving grave moral guilt.<sup>15</sup> For this reason it was said that the civil standard of negligence was inapplicable and that the common law as to when negligence amounts to manslaughter must apply.<sup>16</sup>

The authority of this decision is such that the New Zealand experience of criminal liability for mere inadvertence is unlikely to be transported across the Tasman. If anything, good sense would suggest that the transfer be in the other direction. The common law’s traditional insistence on a greater degree of blameworthiness where criminal sanctions are to be imposed would seem to be firmly entrenched in the public morality of western society. For the New Zealand court of appeal in *Yogasakaran* to have ignored this and to have preferred its earlier view<sup>17</sup> of the statutory wording, a view which has been authoritatively interpreted to the opposite effect, is, with respect, inconsistent with the tradition of the common law and the apparently accepted norms of western society.

The potential for cases similar to the United Kingdom decisions discussed above in Australia is somewhat greater. While aspects of the law relating to negligent manslaughter in the United Kingdom are in a state of some uncertainty, the test which was applied in the Prentice and Sullman case is consistent with Australian authority. In light of this, Australian doctors and health administrators would do well to heed the warnings which have appeared in the British literature as a result of this case.<sup>18</sup> The unsupervised administration of treatment by inexperienced practitioners who have been inadequately briefed and are insufficiently supported by senior staff should be regarded with alarm by both practitioners and administrators in light of the potential criminal consequences. This is especially so where junior staff are routinely expected to work long hours.<sup>19</sup>

Some comfort can, however, be taken from the fact that the recent convictions in the United Kingdom appear, at least in the eyes of some commentators, to have been the result of an aggressive prosecution policy.<sup>20</sup>

### Conclusion

In contrast to the position of their New Zealand counterparts, Australian medical professionals are not subject to criminal liability for mere carelessness. While it would appear that there are good policy reasons for a change of approach on the part of New Zealand courts, it seems that the only prospect for change in that country lies in an amendment to s155 of the Crimes Act 1961 (NZ). Recent developments in the United Kingdom provide somewhat greater cause for concern although there is,

as yet, no evidence of prosecutions being instituted in Australia in cases of the type discussed above.

### References

- 1 See Collins, DB NZ Med J 1991: 104:318-9.
- 2 R v Morrison unreported, High Court, Dunedin, S7/91; R v Yogasakaran (1990) 1 NZLR 399
- 3 R v McDonald (unreported), High Court, Christchurch, T24/82
- 4 See generally on the New Zealand position, Collins, D B, *Medical Law in New Zealand* 1992.
- 5 R v Yogasakaran, 30 January 1991
- 6 R v Prentice & Sullman. See Korgaonkar, G & Tribe, D (1992) 47 BJHM 147 & Dyer, C (1991) 303 BMJ 1218.
- 7 See Brahams, B, *The Lancet*, August 18, 1990, 430-31.
- 8 See R v Lawrence (1982) AC 510 at 526E, per Lord Diplock; R v Caldwell (1982) AC 341 at 354C, per Lord Diplock.
- 9 Andrews v DPP (1938) 26 Cr. App. R. 34, HL.; R v Stone & Dobinson (1977) 64 Cr. App. R. 186, 192, 193 C.A.; see generally Archbold, *Pleading Evidence & Practice in Criminal Cases*, 1992. London, Sweet & Maxwell.
- 10 See Dyer, C (1991), 303 BMJ 1218.
- 11 See generally Gillies, P (1990) at pp 603-06.
- 12 R v Gunter (1921) 21 SR (NSW) 282.
- 13 Qld s288; WA s266. See also Tas s149.
- 14 Callaghan v The Queen (1952) 87 CLR 115 at 124; see generally Carter, R F, *The Criminal Law of Queensland*, 1988.
- 15 Callaghan v The Queen (1952) 87 CLR 115 at 124.
- 16 This is also the position in Canada - see Collins, D BNZ Med J 1991; 104, 318-19.
- 17 R v Dawe (1911) 30 NZLR 673 (CA); R v Storey (1931) NZLR 417 (CA).
- 18 See Korgaonkar, G & Tribe D (1992) 47 BJHM 147; Dyer, C, 1991 303 BMJ 1218.
- 19 See Korgaonkar, G & Tribe D (1992) 47 BJHM 147; Dyer, C, 1991 303 BMJ 1218.
- 20 See Korgaonkar, G & Tribe D (1992) 47 BJHM 147.

## 1993 COUNCIL



*Pictured, left to right (Back row): Drs Moira Westmore, B F Horan, D H McConnel, R S Henderson, R J Willis, D R Kerr, Professor J M Gibbs, Mrs Joan Sheales (Registrar). (Front row): Dr R G Walsh, Associate Professor N J Davis (Vice-President), Dr M J Davies (President), Dr I Rechtman, Professor G D Phillips.*

## **FACULTY OF INTENSIVE CARE**

### **AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS**

The Council of the College at its October Meeting established the Faculty of Intensive Care and appointed an Interim Board to manage the affairs of the Faculty until the first elected Board takes office in June 1994. The Interim Board Members are Dr Geoff Clarke, Dr Alan Duncan, Dr Felicity Hawker, Dr Geoff Parkin, Professor Garry Phillips, Dr Ron Trubuhovich and Dr Robert Whiting. The Interim Board will meet for the first time on November 4 to elect Office Bearers and to begin the business of managing intensive care affairs within the College.

Following the establishment of the Faculty of Intensive Care the President congratulated the Working Party on its achievement and in wishing the Faculty well, the President offered the support of the Council and Fellows of the College.

It may be of interest to recount briefly the history of formation of the Faculty of Anaesthetists as recorded by Dr Gwen Wilson.

The Interim Board of the Faculty of Anaesthetists held its first Meeting on 31st January 1951. Members of the Board were Dr Douglas Renton, Dr Lennard Travers and Dr Ellis Gillespie from Victoria, Dr Harry Daly of Sydney, Dr Gilbert Troup of Perth and two RACS Councillors. There were 40 Foundation Fellows and 69 Foundation Members. The first Board Election was held in May 1953, and that Board met on August 28 1953. The Faculty rapidly grew to 170 Fellows by 1960, 515 by 1970, 1151 by 1980 and 1818 by 1987. The Diploma of Membership was closed in 1960.

The Section of Intensive Care was established in May 1975 and the first Final Examination in Intensive Care was held in 1979. Progress has been

rapid since then, despite predictions by some that there was no future for the specialist intensivist. At the Annual Business Meeting of the Section of Intensive Care held in Adelaide on May 13 1993, it was noted that there were 240 Members of the Section, of whom 141 were endorsed in Intensive Care, 57 by election and 84 by examination – a larger body than the Faculty of Anaesthetists when it was formed.

**What of the future?** The section on *“Foundation of the Faculty”* in the 1988 Handbook of the Royal Australasian College of Surgeons noted that the new Faculty *“needed, sought and received in full from the College the necessary advice and administrative and financial support to achieve its objectives.”* Progressively the Faculty developed its own traditions, independent structure and autonomy, culminating in formation of the Australian and New Zealand College of Anaesthetists on 7 February 1992.

There are some who believe that there should be one College representing Intensive Care in Australia and New Zealand, with one training program and one examination system. Early attempts to achieve the latter two objectives, as far back as 1975, were unsuccessful.

The future is always uncertain. Careful negotiation may yet see a common training and examination system for intensive care specialists, and perhaps even an independent College. However, formation of the Faculty of Intensive Care is a big step forward in the recognition of the speciality of Intensive Care in Australia and New Zealand.

GARRY D. PHILLIPS  
Working Party Chairman

## A WORKFORCE SURVEY

The College has a responsibility to the community at large to ensure that there are adequate appropriately trained anaesthetists and intensivists to service community needs.

This statement implies the necessity for appropriate geographical distribution of anaesthetists and intensivists, adequate staff in teaching hospitals to provide guidance and supervision for trainees and a workload which, on the one hand will give sufficient practical experience to maintain skills, and on the other, give sufficient time to indulge in continuing education, research, learning of new skills and techniques, and necessary relaxation.

In addition the College, along with other medical institutions, is under increasing pressure from external groups to justify perceived restrictions in training numbers and these criticisms must be answered.

In order to address these problems, a multifaceted approach is required. The College already has information on ages of Fellows and likely levels of retirement from practice. Further information in demographic trends both national and regional will need to be obtained.

The impact of newer developments in anaesthetics and intensive care practice, such as pain services, will need to be assessed, and the significance of the entry of overseas trained doctors into the workforce needs to be determined.

Regional Committees of the College have been asked to provide information on a local basis on the level of

staffing in hospitals, and of notable demographic trends.

The College Council feels it is also extremely important to obtain information and opinion from individual Fellows regarding workload and patterns of practice, and has approved the distribution of a questionnaire with the annual subscription notice in early 1994.

The questionnaire has been designed with the aid of a statistician and is similar in layout to workforce questionnaires already distributed by some Medical Registration Boards.

Information will be sought on patterns of practice with regard to types of clinical activity, involvement in teaching, research and administration, and time commitment. Opinions will also be requested on levels of satisfaction of practice and individual assessment of the adequacy of numbers of both training and in the workforce.

The questionnaire is designed to be non-threatening and not time consuming to complete.

College Council earnestly requests all Fellows to complete the questionnaire. The information gained will be of great value in enabling the College to fulfil its requirements, both in numbers and distribution, to the ensure adequate staffing of anaesthetists and intensivists for community needs.

DAVID McCONNEL  
Chairman  
Workforce Committee

## EXAMINATION PRIZE WINNER

Council noted that the Renton Prize for the half year ending 31st December, 1993, had been awarded to Dr S.C. Townsend, Queensland, and that the Cecil Gray Prize was not been awarded for the September, 1993 Examination.

# HIGHLIGHTS FROM THE RACS COUNCIL MEETING HELD 28-29 OCTOBER, 1993

## WELCOME

The President welcomed the following visitors:

D M Sheldon, President — Australian Association of Surgeons.  
G S Merry, Chairman, RACS Committee on Trauma and RACS Road Trauma Committee.

The Minister for Health, Senator Graham Richardson, and author, Mr Thomas Keneally, addressed Council during the course of the meeting.

## AWARDS, ELECTIONS AND HONOURS

Council extended its congratulations to the following recipients of Honours and Awards:

### **Australian Achiever Award**

David J David AC

### **Clunies Ross National Science and Technology Award 1993**

G Ian Taylor

### **King of Nepal**

Frank H Garlick — King's Medal (Gorkha Dakshin Bahu Class IV)

### **Honorary Fellowship, Royal College of Surgeons of Edinburgh**

G Ian Taylor

### **Court of Honour**

Professor John Ham was admitted to the Court of Honour of the College.

### **RACS Medals**

Mr Tony Buzzard and Mr Gordon Low were awarded RACS Medals. The RACS Medal is awarded for distinguished service to the affairs of the College.

### **Previous Awards**

*The following awards were reported to the Executive Committee at meetings between the June and October meetings of Council:*

### **Medal in the Order of Australia**

D K Baird

### **President, Returned Services League**

W B James

### **Honorary Membership of the Academy of Medicine of Malaysia**

D E Theile

## CENSOR-IN-CHIEF

### **Part-time and Interrupted Training**

The College policy on Part-time and Interrupted Training is to be modified slightly to emphasise the availability of interrupted training for appropriate purposes.

**Academic Surgery and Advanced Surgical Training**

A review is to be undertaken to look at the current position with respect to the role of post-graduate surgical study and its availability within advanced surgical training.

**Research in Advanced Surgical Training**

Council accepted in principle a proposal from the Surgical Research Society whereby members of that Society will assist advanced surgical trainees in selecting research projects, undertaking them and presenting them orally or in written form.

**Guidelines for Surgical Boards and Regional Surgical Training Committees in Dismissing Advanced Surgical Trainees from the Training Programme**

Draft guidelines were approved in principle, with the final guidelines to be drawn up by the Censor-in-Chief in consultation with the College Secretary and the Honorary College Solicitor.

**Colon and Rectal Surgery Sub-Specialisation**

Council opposed a proposal from the Colorectal Surgical Society of Australia to the National Specialist Qualification and Advisory Committee (NSQAC) that Colon and Rectal Surgery be recognised as a sub-specialty of surgery by NSQAC.

**SCIENTIFIC MEETINGS****Annual Scientific Congress — Hobart 1994**

The Convenor, J McL Hunn, confirmed that Sir Edmund Hillary would deliver a President's Lecture at the Hobart ASC, and that the Syme Orator for the meeting will be Professor Adrienne Clarke, Head of the CSIRO.

**EDUCATION****Asia**

Discussions continue at Council on the role of the College in surgical education, training and examinations in Asia. There was a reaffirmation of the desire of the College to retain a positive presence in Asia.

Council did resolve, however, that the FRACS will be the only surgical qualification offered by the RACS, which effectively rules out the possibility of developing a particular qualification of the College for issue in Asia.

**Research Fellowships, Scholarships and Grants-in-Aid**

It was noted that \$418,000 had been allocated for Research Fellowships, Scholarships and Grants-in-Aid in 1993.

**PROFESSIONAL AFFAIRS****Recertification**

A Recertification Information Manual for Fellows was approved by Council and will be circulated to RACS Fellows.

**New Technology in Surgical Practice**

A policy on New Technology in Surgical Practice was approved by Council and is available from the College Secretary.

**HIV and Hepatitis B**

An amendment to the College policy on HIV and Hepatitis B was approved by Council. The College policy with amendments is to be reprinted and distributed to all RACS Fellows in the near future.

**National Urgency Ratings for Patients on Waiting Lists for Elective Surgery**

The establishment of Committees on Elective Surgery in each State based on State Committees was approved, these Committees to advise on and assist in the implementation of urgency ratings.

**RACS Committee on Trauma/RACS Road Trauma Committee**

The following three documents to do with trauma and road trauma were before Council and will be distributed selectively to Fellows, and are otherwise available on request from the Secretary:

- The National Road Trauma Advisory Committee Report on Trauma Systems.
- The RACS Policy on Trauma.
- Proceedings of the Seminar/Workshop on Trauma Care Systems in the '90s. Council approved in principle holding a seminar on Farm Injury in 1994.

**Laser Seminar**

It was agreed to support in principle holding a Laser Seminar in early 1994 concentrating principally on the physics of lasers.

**FINANCES****Fees and Other Charges for 1994 and 1995**

- 1. Annual Subscription for year commencing 1.2.95 to be invoiced 1.2.94:**  
A\$875 and NZ\$875.
- 2. Fellowship Entrance Fee for the year commencing 1.2.94:**  
Payable in full (10% discount applies) or over 5 years: A\$2500 and NZ\$2500.
- 3. Part 1 Examination Entry Fees for year commencing 1.2.94:**  
MCQ – Australia/New Zealand: A\$1500; South-East Asia A\$600.  
OSCA – Australia/New Zealand: A\$550; South-East Asia A\$100.
- Basic Trainees' Fee for the year commencing 1.2.94:** A\$250.
- Part 2 Examination Entry Fees for year commencing 1.2.94:**  
Australia: A\$1900; New Zealand NZ\$1900.
- Advanced Trainees' Entrance Fee for year commencing 1.2.94:**  
A\$600 and NZ\$600.
- Advanced Trainees' Annual Training Fee for year commencing 1.2.94:**  
A\$1000 and NZ\$1000
- 4. Provisional Fellows' Fee for year commencing 1.2.94:**  
(50% of Advanced Trainees' Annual Training Fee): A\$500 and NZ\$500.

**Funding for Chair in Urology**

Under its policy of providing support for new Chairs of Surgery in specialties where Chairs have not previously existed, Council approved a grant of \$50,000 to the recently established Chair in Urology, University of Western Australia, for the purpose of research.

**INTERNAL****Development Office**

Council resolved to establish a Development Office in the College responsible for public relations and the generation of resources and funding.



# POLICY DOCUMENT

*Review P8(1993)*

## **MINIMUM ASSISTANCE REQUIRED FOR THE SAFE CONDUCT OF ANAESTHESIA**

The presence of a trained assistant during the conduct of anaesthesia is a major contributory factor to safe patient management. The assistant must have undertaken appropriate training to enable them to provide effective support to the anaesthetist. The duties of anaesthetists and thus of their assistants will range from the straightforward in the management of a minor case to the complex during some anaesthesia procedures. The guidelines that follow are therefore stated in general terms to establish both the practical and educational responsibilities of a competent assistant to the anaesthetist.

### **1. PRINCIPLES**

- 1.1 Trained assistance for the anaesthetist is essential for the safe and efficient conduct of anaesthesia.
- 1.2 This assistance requires:
  - 1.2.1 The presence of an assistant during preparation for and induction of anaesthesia. The assistant must remain under the immediate direction of the anaesthetist until instructed that their services are no longer required.
  - 1.2.2 The presence of an assistant at short notice if required during the maintenance of anaesthesia.
  - 1.2.3 The presence of an assistant at the conclusion of anaesthesia.
- 1.3 These principles apply wherever the anaesthetic is given.
- 1.4 Institutions in which anaesthetics are given must provide a service which ensures the availability and maintenance of anaesthesia equipment in accordance with College Policy Documents on recommended minimum facilities for safe anaesthetic practice. The relevant College Policy Documents are:
  - T1 "Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites"

- T2 "Protocol for Checking an Anaesthetic Machine Before Use"
- T3 "Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Units"
- T4 "Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro Convulsive Therapy (ECT)"
- T5 "Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries"
- T6 "Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites"

- 1.5 Staff employed for the above purposes must be trained as defined below for this role.

### **2. DEPLOYMENT OF ASSISTANTS**

- 2.1 The deployment of assistants in accordance with 1.2, should be specified by management protocols.
- 2.2 The nature and workload of the anaesthetic service will determine the number and status of assistants.
- 2.3 The duties of an assistant should be specified in an appropriate job description.
- 2.4 Whilst assisting the anaesthetist, the assistant is wholly and exclusively responsible to that anaesthetist.
- 2.5 The assistant is an essential member of the staff establishment in every area in which anaesthetics are given.
- 2.6 There must be appropriate staffing establishment and rosters for assistants. Assistance must be available for both elective and emergency anaesthesia in all locations where it is performed.

- 2.7 Where a number of assistants are employed, an appropriately trained member of their group should be designated as being in charge.

### 3. EDUCATIONAL REQUIREMENTS FOR ASSISTANTS

An adequately trained assistant to the anaesthetist must have attended and completed a training course which has as a minimum the following criteria:

#### 3.1 Eligibility

- 3.1.1 Those without previous health sector experience must have the Higher School Certificate or its equivalent.
- 3.1.2 Those with nursing experience must hold a certificate as an Enrolled Nurse or a Registered Nurse.
- 3.1.3 Registered Nurses and Enrolled Nurses must be in current clinical employment or have been so employed within one year of acceptance into a training course.

#### 3.2 Course of Instruction

At a minimum this will include:

- 3.2.1 A course of lectures of at least 150 hours, established by an appropriate and recognised Institution of Learning. A significant amount of the lecture material must be prepared and delivered by anaesthetists. A distance learning course is appropriate when conditions demand this.
- 3.2.2 Practical instruction supervised by trained anaesthetists which should be documented in a log book as a record describing the type of instruction received and experienced gained.
- 3.2.3 Completion of assignments appropriate to the curriculum which are suitable for presentation to trainees and supervisors.
- 3.2.4 Successful completion of internal assessments and designated examinations.

#### 3.3 Duration of the Course

- 3.3.1 For those without previous hospital experience, two years of full time study.
- 3.3.2 For those with Registered Nurse or Enrolled Nurse qualifications, one year full time or two years part time study.
- 3.3.3 For those employed as trainee assistants, two years part time study.
- 3.3.4 The course should not exceed three years.

An addendum sets out a potential course outline.

## RECOMMENDED CONTENT OF TRAINING COURSES FOR THE ASSISTANT TO THE ANAESTHETIST

### BASIC SCIENCES

Instruction will include appropriate elements of:

- Physics
- Chemistry
- Pharmacology
- Physiology
- Clinical Measurement
- Microbiology

as these apply to the practise of anaesthesia.

### ANAESTHESIA

**In the following areas, in depth understanding of the various topics is necessary. This must be reinforced by appropriate practical experience obtained while providing assistance to anaesthetists.**

- **Anaesthetic Equipment**

This will include the care, use and servicing of equipment in normal use.

- Anaesthesia machines and ventilators
- Monitoring equipment
- Airway devices
- Intravascular devices
- Cleaning and sterilization of equipment
- Infection control in staff, equipment and patients
- Pollution prevention

- **Electronics**

- Hazards in the Operating Theatre
- Patient safety
- Staff safety

- **Special Instrument Use and Care**

- Endoscopes
- Video equipment
- Microscopes

- **Anaesthesia Techniques** and requirements in all areas of practise in both theoretical and practical terms.

- **Invasive Techniques applicable to anaesthesia** including insertion of IV, central and arterial lines as well as their ongoing management. Other techniques such as intercostal tube drainage.

- **Local Anaesthesia** including all commonly used techniques for regional blockade.

- **All Therapeutic Substances** administered during anaesthesia.

- **Emergency Care** including provision and care of necessary equipment

Crisis Management including appropriate algorithms

Cardiopulmonary resuscitation

Airway management

Cardiac defibrillation

Blood transfusion

- **Postoperative Pain** including management and equipment required.

- **Management Skills**

Rostering

Budgetary matters

Anaesthesia standards and protocols

Workplace, Occupational Health & Safety Regulations

Interfaces with other workers

Legal responsibilities

Interpersonal relationships

*This policy document has been prepared having regard to general circumstances, and it is the responsibility of the practitioner to have express regard to the particular circumstances of each case, and the application of this policy document in each case.*

*Policy documents are reviewed from time to time, and it is the responsibility of the practitioner to ensure that the practitioner has obtained the current version. Policy documents have been prepared having regard to the information available at the time of their preparation, and the practitioner should therefore have regard to any information, research or material which may have been published or become available subsequently.*

*Whilst the College endeavours to ensure that policy documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.*

*Promulgated: June 1989*

*Reviewed: October 1993*

*Date of current document October, 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 (1993)  | Minimum Assistance Required for the Safe Conduct of Anaesthesia  |
| P9 (1991)  | Sedation for Diagnostic and Minor Surgical Procedures  |
| P10 (1991) | Minimum Standards for Intensive Care Units   |
| P11 (1991) | Management of Cardiopulmonary Bypass   |
| P12 (1991) | Statement on Smoking   |
| P13 (1992) | Protocol for The Use of Autologous Blood   |
| P14 (1993) | Guidelines for the Conduct of Epidural Analgesia in Obstetrics   |
| P15 (1992) | Guidelines for the Care of Patients Recovering from Anaesthesia Related to Day Surgery                         |
| P17 (1992) | Endoscopy of the Airways   |
| P18 (1990) | Monitoring During Anaesthesia  |
| P19 (1990) | Monitored Care by an Anaesthetist  |
| P20 (1990) | Responsibilities of Anaesthetists in the Post-Operative Period   |
| P21 (1992) | Sedation for Dental Procedures   |
| P22 (1990) | Statement on Patients' Rights and Responsibilities   |
| P23 (1992) | Minimum Standards for Transport of the Critically Ill  |
| P24 (1992) | Sedation for Endoscopy   |
| P25 (1993) | Minimum Standards for Pain Management Units  |