


AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852



B U L L E T I N

VOLUME 1 NUMBER 2

MAY 1992

Registered by Australia Post - Publication No. VBQ91 4964

CONTENTS

| | |
|------|--|
| Page | |
| 1 | President's Message |
| 2 | Report on Inaugural Scientific Meeting |
| 2 | Admission to Fellowship by Examination |
| 3 | Toast to College - Prof. Tess Cramond |
| 5 | President's Response |
| 6 | Toast to College - Mr J.K. Clarebrough |
| 8 | President's Response |
| 9 | Australasian Visitor's Lecture - Geoff Cutfield |
| 14 | Staff Profile |
| 14 | Deaths and Honours |
| 18 | Research Awards |
| 19 | Douglas Joseph Professorship |
| 20 | Robert Orton Medal - Citation - Dr T.C.K. Brown |
| 29 | Admission to Fellowship Under Article 49(a) |
| 34 | Section of Intensive Care - Now a "Faculty of Intensivists" ANZCA? |
| 37 | Medical Ethics |
| | Euthanasia - What are our Rights and Responsibilities? |
| 40 | Active Euthanasia - The Current Debate |
| 43 | Future Meetings |
| 44 | Forthcoming Overseas Meetings |
| | Policy Documents |
| 45 | Protocol for the Use of Autologous Blood |
| 45 | Sedation for Endoscopy |
| 48 | Index of Policy Documents |

EDITORIAL

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

The Australian and New Zealand College of Anaesthetists *Bulletin* is published four times per year by the Australian and New Zealand College of Anaesthetists, A.C.N. 055 042 852, Spring Street, Melbourne, 3000, Victoria.
 (03) 662 1033.

Copyright 1992 by the Australian and New Zealand College of Anaesthetists, all rights reserved. None of the contents of this publication may be reproduced, stored in a retrieval system or transmitted in any form, by any means without the prior written permission of the publisher.

Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the author's personal observations and do not imply endorsement by, nor official policy of, the Australian and New Zealand College of Anaesthetists.

PRESIDENT'S MESSAGE

This is my last opportunity as President of the College to write to you all and there are a number of points I wish to raise for your information, consideration and also your contribution.

The transformation of what was for forty years the Faculty of Anaesthetists, within the Royal Australasian College of Surgeons, into the Australian and New Zealand College of Anaesthetists has been a remarkable development for anaesthesia and intensive care in Australia and New Zealand.

In the short time since establishment of the College, in February, the first Primary and first Final Examinations of the College were conducted. An election for the Council has taken place. This new Council, which takes office on 6 June, is charged with the responsibility of developing the plans which will guide our College into the 21st century. The future of our College is very exciting and full of interest to all Fellows, and I would like to briefly address some aspects of that future which I think are very important indeed.

First is the matter of a new Headquarters for our College. Since the lease on the present site in Melbourne expired ten years ago, successive Deans and Boards of Faculty, Presidents of the RACS and their Councils, have been endeavouring to resolve the question of our continued occupation of the Spring Street site. The Board had always indicated our interest in participation in the purchase of the site, if the price was suitable. It now appears that the RACS will purchase the site alone, and whilst we have been assured of a tenancy on a short term basis, it seems clear that we must begin a search for a new Headquarters.

In selecting a site for our Headquarters, the Council will need to take into account the contribution to the present site made by Fellows of the Faculty over many years as well as continued access to the facilities such as the Great Hall, and Education Centre at the RACS, but also providing for the continued development of our independence as a College and the display of the priceless Geoffrey Kaye Museum of Anaesthetic History.

A new Headquarters will not come cheaply and must be spread over the whole Fellowship and also well into the future. The current Fellowship cannot be expected to bear this cost alone.

The next matter I wish to discuss is the continued involvement of our College in Singapore, Malaysia and Hong Kong. All three regions have now developed their own qualifications, as they were encouraged to do by the Faculty, but there still appears to be a very strong desire to have the ability to take the Fellowship.

I believe that such an exercise would allow us to continue to have a very strong presence and influence on the further development of anaesthesia and intensive care in the region, to the great benefit of our College and our international reputation, both as a College and a nation.

Continued demonstration of qualifications, call it what you will, is certain to be a major item of consideration by the Council and the Fellowship in ensuing months.

The forum at the recent GSM provided a useful opportunity to exchange views and stimulate discussion among Fellows. It is important that as many Fellows contribute to the discussion on this topic as wish to do so. I know the Council will welcome your input on this important aspect of College affairs.

The question of the continued involvement with the RACS in the GSM will also need to be addressed by Council. Whilst we are certainly committed to participation in the 1993 Meeting in Adelaide, there are a number of ways in which our College involvement could be varied with good effect for our College.

In conclusion, I would like to thank all the Fellows, staff and friends who have been so strong in their support during my time as Dean and then President. This great new College of ours has the potential to become even more influential in the areas of training, examinations, certification and standards with your continued support which I am sure will be forthcoming.



P.D. LIVINGSTONE

INAUGURAL SCIENTIFIC MEETING

CANBERRA 1992

The Inaugural General Scientific Meeting of the College was held in Canberra in conjunction with the Royal Australasian College of Surgeons from the 12th to the 15th May, 1992.

Concurrent sessions on "*Right Ventricular Failure*" chaired by Dr Michael Davies and "*Day Care Anaesthesia*" chaired by Dr Glenda Rudkin opened the College's Scientific Programme.

The College's Inaugural Dinner was held at the High Court where Emeritus Professor Tess Cramond, AO, OBE, proposed the Toast to the College. Professor Cramond's Toast is published in this *Bulletin* with the response by the President, Associate Professor Peter Livingstone.

The GSM Dinner was held in the Great Hall, Parliament House at the conclusion of the Meeting. Mr John Clarebrough, AM, OBE, proposed the Toast to the College at this function and his Toast together with the President's response is included in this *Bulletin* for your interest.

During the Business Meeting the President explained the details of the sketch of the College proposed Crest which had been displayed throughout the week, and sought comments from the Fellows.

The College of Heralds will complete the final drawings, define colours, style and content. The College of Heralds has very definite requirements which must be adhered to for a Grant of Arms and following submission of our College's thoughts and suggestions, we will be advised of any required changes.

Comments received included:

- *Inclusion of a book in the hand of one supporter — reflecting knowledge and learning*
- *Preference for use of opium poppy seed pod — flower had been used to provide colour*
- *Concern at use of opium poppy and possible confusion with the Flanders poppy*
- *Datura for its striking colour*
- *Unnecessary to have personalities and use of Latin*
- *Alternative suggestion for laryngoscopes.*

In addition to a crest it was suggested a logo also be designed which is easily identifiable with our College for such purposes as CME Meetings and publications.

Fellows are invited to forward their suggestions and comments with regard to a Crest to the Registrar, at the earliest possible opportunity.

JOAN SHEALES
Registrar

ADMISSION TO FELLOWSHIP BY EXAMINATION

ANAESTHETICS

Michael Anthony Abbott, SA
Riccardo, Bergesio, WA
Paul Bertolino, NSW
Michael Anthony Bujor, Vic
David Bruce Christie, Vic
Premjeet Singh Dhillon, SA
Paul James Graziotti, WA

Bernard John Hanrahan, NSW
Rowan Rustem Molnar, Vic
Michele Anne O'Brien, NSW
Janice Powell, NZ
Craig Sims, WA
John Maxwell Storey, WA

Toast Proposed at the College Dinner

*by Emeritus Professor Tess Cramond, AO, OBE
held in the High Court, Canberra, on 13th May, 1992*

Thank you, Mr President for the honour you afford me by the invitation to propose the toast to our new College at this, its Inaugural Dinner. My appreciation of that honour is deep and sincere.

When I was a very junior Fellow of the Faculty, I looked with awe and admiration when Mary Burnell spoke at similar functions — I can't claim Mary's elegance or ability to find the correct word, but I am happy to follow in the role she played in supporting and encouraging younger colleagues.

Nearly 150 years ago, Isaac Aarons, Editor of the *Australian Medical Journal*, made a determined effort to manipulate public and professional opinion with the following remarks about the introduction of anaesthesia:

"For minor operations in surgery we could consider any such measure unnecessary; in the more important ones, we think it will be found conducive to secondary consequences of a grave character, even if it did not in many constitutions produce effects of a mischievous nature. We have no hesitation in predicting for this process a transient popularity; it will have its day, ultimately to be abandoned as useless and/or injurious"

This was surely the most inaccurate prophecy of the century, as our predecessors demonstrated while establishing anaesthetics as a respected specialty, and we ourselves have extended its influence from pain relief in the operating theatre, to post-operative recovery rooms, resuscitation both in the community and in hospitals, intensive care units, pain clinics and palliative medicine, and during this time the organisation of, and training for, the specialty have evolved, setting a standard which has been followed by many other colleges.

It is almost forty years since the first general meeting of the Faculty of Anaesthetists, the precursor of this College, was held in August 1952, so it is appropriate tonight that we reflect on the past, as we also look to the future, for as Sir William Osler said:

"What the future has in store for me, I cannot tell, or do I care much, so long as I can carry with me, as I shall, a memory of the past you have given which nothing can take that away"

As we look back we see that the Medical Royal Colleges can trace their foundation to the craft guilds of Europe in the 12th and 13th centuries. The earliest surgeons were the barbers who date their origin to 1492 — 500 years ago!

Originally these craft guilds had only two functions — one to celebrate the feats of their patron saints and the other to provide support in hour of need for their members.

Medical Benevolent Associations have taken over this latter role, but we can still claim that anaesthetists have a select band of patron saints. In the United Kingdom, John Snow would stand supreme together with John Clover, James Young Simpson, Henry Hickman, Sir Robert Macintosh and Sir Ivan Magill.

This afternoon Professor Barry Baker expressed the view that we have no saints to venerate in the Southern Hemisphere, but perhaps with my background, my acknowledgement of sainthood is more liberal. In Australia, I would nominate William Russ Pugh and John Belasario, together with Harry Daly, Robert Orton, Douglas Renton, Lennard Travers, Ellis Gillespie, Gilbert Brown and Stuart Marshall.

In New Zealand, a Mr Marriott gave an anaesthetic to a prisoner in the morning and a Maori chief in the afternoon, in Wellington on 27 September, 1847. And those Foundation Fellows — Eric Anson, Alf Slater, Jim Church, Margaret Smith, John Ritchie and Charles Morkane.

And while we are reflecting on the contributions of those early anaesthetists, I learnt something very interesting at the meeting of the Section of Surgery and Anaesthesia today — that the first operation for the repair of a tracheo-oesophageal fistula in the Southern Hemisphere was done by Cam Barrett's father in New Plymouth, and that a Foundation Fellow

Jim Church, gave the anaesthetic to the neonate, predating the first repair in Melbourne by Russell Howard by one year.

Jim Church's son-in-law, David Wright, also made an outstanding contribution to New Zealand anaesthesia.

But back to the craft guilds. Early in their formation these European craft guilds made a determined effort to exclude untrained and unskilled craftsmen. They determined the standards of practice by organising apprenticeship training and examinations.

The licensing of medical practitioners in the United Kingdom was introduced by Henry VIII who placed it under the control of the Archbishop of Canterbury who can still award the M.D. Lambeth — the last recipient was Dame Cicely Saunders, to recognise her contribution to the care of the terminally ill.

Mr President, I doubt that the Lambeth M.D. would be recognised as a specialist qualification by our new College, by the State Medical Boards or by the National Specialist Qualifications Advisory Committee.

Tonight, as we celebrate our new collegiate status, it is appropriate that we pay tribute to and acknowledge publicly the support of our surgical colleagues, through the Council of the Royal Australasian College of Surgeons. They provided the administrative and financial infrastructure, without which we could not have attained our objectives and developed our independent and autonomous educational, administrative and financial structure with absolute academic autonomy.

I was the first Dean of the Faculty to attend the full College Council meetings in 1972 and I have watched with great pride and satisfaction the progressive and continued harmonious relationship of the Faculty and College to the betterment of both surgery and anaesthesia. I trust this co-operation will continue and flourish.

As a woman in medicine, I pay particular tribute to our male colleagues in both the A.S.A. and the Faculty. From the establishment of the A.S.A. in 1934 and the Faculty in 1952, women have held office at regional and national levels and been appointed as examiners. Provided the women were prepared to work hard and contribute to the professional organisations, they have been accepted and made welcome — attitudes not seen in other specialties, nor to the same degree in the United Kingdom and the United States — and I have worked in both countries.

As I have said on many occasions, anaesthetists have the nicest wives. My life has been enriched by the friendship extended by them, not only in Brisbane and interstate, but in New Zealand and South-East Asia and I thank them with sincerity and affection.

As anaesthetists we can stand tall. The Faculty has led the way in so many areas — the publication of its objectives in both anaesthetics and intensive care, the accreditation of training posts and rotational training programmes, hospital inspections and the publication of policy statements. And it is a source of great pride that our Faculty qualifications in both anaesthetics and intensive care have been acclaimed internationally.

In the spirit of continuing education, the Faculty has supported committees to investigate deaths associated with anaesthetics; what other professional groups have established such voluntary peer review?

With this background of achievement, it is not surprising that many anaesthetists felt the urge to demonstrate independence by achieving collegiate status as has been done by many other specialties since World War II.

For some the achievement of independence was painfully slow. For others, it was too precipitate. No Board or Council can satisfy all its Fellows.

But now the Australian and New Zealand College of Anaesthetists is a reality and we rejoice with you and your Council, Mr President, that this has been achieved in an atmosphere of goodwill and continuing support from the President and Council of the College of the Royal Australasian College of Surgeons.

Prestige and status are earned not demanded — earned by the high standards of patient care of every Fellow in day to day practice and ethical relationships with patients and colleagues.

You emphasised the contribution of individual Fellows in your President's Message in the first *Bulletin* of the College.

Finally, Mr President, I congratulate you on your achievements as Dean and now as President of the College. For me as a senior member of the profession, the satisfaction of medicine is to see those juniors whose potential was apparent early in their careers do better than us. You have commanded by leadership and respect.

Mr President, Fellows and guests, as a Past Dean of the Faculty and now a Fellow of the Australian and New Zealand College of Anaesthetists, I give you the Toast:

"The Australian and New Zealand College of Anaesthetists — may it flourish and extend its influence".

PRESIDENT'S RESPONSE

Mr Chairman, Fellows and guests, it is with great pleasure that I rise to respond to the toast to our new College. Before responding, I would like to take this opportunity to welcome all Fellows, the guests, our Foundation Visitors, Australasian Visitors, President of the Australian Society of Anaesthetists, President of the New Zealand Society of Anaesthetists, and also Mr Terry Gallagher of the Boots Company (Australia), a company which has very generously sponsored our Australasian Visitors for some years. We gratefully acknowledge your support.

Tess, thank you most sincerely for your words in support of our new College. It is particularly significant that these words came from such a greatly respected and well known figure and a former Dean of the Faculty.

I think it is timely that we reflect upon and acknowledge the great debt which we all owe to Members of past Boards of Faculty, Deans and Fellows who have contributed so much to this maturation process which has now resulted in the formation of our College.

I think it is also timely that we should acknowledge the support which has been provided by the Royal Australasian College of Surgeons to the Faculty and there are some here this evening who would be able to expand on this far better than myself. In the early days of the Faculty when numbers were small, the security and support of the Royal Australasian College of Surgeons provided great comfort to the Faculty. It is often said that Colleges and their Faculties resemble families and this has certainly been true of the arrangement between the Royal Australasian College of Surgeons and

the Faculty of Anaesthetists for 40 years now. Forty years is a pretty long "growing up" process in the view of most people, but at last it has happened. Of course, as often happens in such circumstances you will have appreciated from my remarks and those of the President of the Royal Australasian College of Surgeons at the Inaugural Ceremony, not only have we now "grown up" but it looks as if we might have to "leave home" as well - but such is life.

I know that some of you are perhaps concerned that at a time when the medical profession is under immense pressure from many quarters, that our move to independence may create in the eyes of some yet another split in the profession. After 11 years of serving the Fellowship of the Faculty and College, I do not support such a premise. I believe that our independence will now strengthen the bonds between the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists and will also create bonds with all Medical Colleges.

I must confess that to me, unity requires that unmistakable and precious feature of "equality". I think that speaks for itself.

I believe we now have "equality" and I ask you all to do your utmost to support our new College. The framework now exists, but the real work to carry our new College into the 21st century should begin now but in so doing, we should remember and acknowledge the strong traditions of our past, preserve and enhance them so that in another 40 years, the Fellowship may look with pride upon our efforts as we now look with pride upon the efforts of the Founding Fathers and Foundation Fellows of the Faculty.

COLLEGE TOAST AT GSM DINNER

*Proposed by Mr J.K. Clarebrough, AM, OBE
in the Great Hall, Parliament House, Canberra,
Friday, 15 May, 1992*

Mr President,

It was firstly an honour and secondly a pleasure to receive your call asking me to propose a toast to the College of Anaesthetists, of Australia and New Zealand, on this auspicious occasion and in this great setting. What better place to celebrate the birth of this new College than in the cradle of the nation.

It is auspicious too, because it is taking place in the presence not only of anaesthetists, but also surgeons, administrators, their wives and other valued guests, all of whom share with you, Mr President, your pleasure in the recognition of this new venture.

Speaking of such august branches of the profession as surgeons, anaesthetists and administrators puts me in mind of the story of the surgeon, the anaesthetist, and the administrator who each were especially proud of their dogs which they had owned and trained. One day by coincidence, they found themselves walking their dogs in the park together. The surgeon was challenged to show his dog's prowess. Upon command, the surgeon's dog ran around the park collecting bones and eventually rapidly built them into a magnificent skeleton.

The anaesthetist's dog, not to be outdone, began collecting old pieces of metal and then constructed a modern anaesthetic machine, complete with monitoring equipment. The administrator, with a wry smile on his face, said to his dog "Go boy", whereupon the administrator's dog ran over and ate the skeleton, following this he relieved himself on the anaesthetic machine, and then took the rest of the day off!

Great institutions are built not of stone, but arise out of the energies, strength of purpose and foresight of far-seeing men, dedicated to the concepts of excellence, maintenance and improvement of standards, research and the training of the young.

Time does not permit the recounting of the history of anaesthesia, but I will tonight devote a few moments to developments in this country, not denying for one moment the important role played by the United Kingdom Colleges, the American Colleges and other sources in the training of our anaesthetists. Such training and advice was generously given and clearly showed the way.

New Colleges, like new babies, require forebears and it has been by a combination of the Royal Australasian College of Surgeons and the Faculty of Anaesthetists that life has been given to the infant College of Anaesthetists.

To go back in history a little, 1888 marked the establishment of anaesthesia as a specialty in this country. Before that time, there was no organised teaching, training, or supervision. In that year the first "Chloroformist", Dr De Lambert, was appointed to St Vincent's Hospital Sydney and as Gwen Wilson says in her history of the Faculty, "The long hard road to the organisation of anaesthesia and resuscitation in Australia and its neighbours had begun".

Specialisation in anaesthesia was late to develop in Australia, but in 1888 Dr Robert Todd announced in the Medical Gazette that he had "*given up General Practice and had determined to work at the Administration of Anaesthetics for the Profession*" - so the great tradition of specialisation in anaesthesia had begun just 104 years ago.

Again Dr Gwen Wilson, the doyen of anaesthetic history, believes that in addition to the specialisation the growing realisation by surgeons that teaching and supervision made for better anaesthesia and safety for their patients. "Such was engendered the close association of surgeons and anaesthetists not only in the operating theatre but also in the symbolic development of the College of Surgeons and the Faculty".

In December 1950 the Board of the Faculty was formed in association with the College of Surgeons. So the wedding occurred and this marriage has done extremely well when compared to many such other arrangements.

As time passed interests of anaesthetists and surgeons were fostered by their close association. Of equal importance was the gradual achievement of a sense of identity by the Faculty – the gradual achievement of a separate and important status. At the same time, however, similar goals were achieved by close, friendly and productive associations at personal, practical and communication levels brought about by joint occupation of the College Headquarters, joint representation at Senior Council and Committee levels.

Tonight we pay tribute to the product of this great association between the College of Surgeons and the Faculty, the Birth of the College of Anaesthetists of Australia and New Zealand.

When Professor Claude Welch, Forum President of American College of Surgeons, Professor of Surgery at Harvard, visited this country some years ago to open a new hospital, his opening remark was, “*It is not the bricks and mortar that count. It is the people you put in them that count*”. And so it is with Colleges.

This toast could not be completed without mentioning some of the “Greats” early in the Faculty – Renton, Travers, Gillespie and Watt of Auckland, after whom prizes have been named, scholarships endowed; and of the early surgeons, Hurley, Searby, Smith, who together with many other Presidents and Deans have contributed to the development of the necessary background and cooperative nurturing which led to the happy day of the birth.

It would be invidious to mention many more for fear of omitting great contributors, but finally Mr President, the ultimate question, after much labour arrives – Do we form our own College? You, Mr President, encouraged by your surgical and anaesthetic colleagues adopted the role of acoucher and the College was born, but not until after a great deal of work, deliberation and discussion had determined the method. Fortunately, no forceps were required.

As defined by the Oxford Dictionary, a College comprises an organised society of persons performing certain common functions and possessing certain rights and privileges. It is these special rights and privileges which must be nurtured, developed and protected against the vicissitudes of the day and the changing mores of our times. They must be above all, handed to our successors without taint or tarnish.

In the hands of the Council and the Fellows of your young College lie this awful responsibility.

I personally, and I am sure that all associated with you in this celebration have the utmost confidence that such will be achieved and that modern anaesthesia will be shown to know no bounds and be developed for the safety and treatment of our patients.

I always look to my favourite poet for a word of advice and Robert Burns never fails me . . .

*But human bodies are sic fools
For a'there colleges and schools
That when nay real ills perplex them
They make enow themselves to vex them.*

I do not want to end on a cautionary tale, but on a tale of hope and encouragement to those who will steer the College through its future years, and again, as Robert Burns would say . . .

*But let us pray that come it may
As come it will for a' that
That strength and worth oe'r the earth
May bear the griz and a' that.*

Mr President, it gives me a great deal of personal pleasure and a feeling of enormous satisfaction which I am sure is shared by all at this great event this evening, to be able to address you in that role as President of the Australian and New Zealand College of Anaesthetists and I would like to ask all of those present to rise and drink a toast to your new College.

PRESIDENT'S RESPONSE

Mr President, Royal Australasian College of Surgeons, Distinguished Guests, Presidents, and Fellows of all Colleges and their guests.

It gives me great pleasure to respond to the Toast to the Australian and New Zealand College of Anaesthetists. Before doing so, however, I believe that we should acknowledge the great contribution to the success of this Meeting from Fellows of the Australian Capital Territory. In particular, I should like to acknowledge the efforts of David McCuaig, our Scientific Programme Convener, who is not able to be with us this evening. Gerald and Miriam Flynn, Ray and Deanne Cook, George and Anna Jerogin, Helen Bidstrup and many others.

Mr Clarebrough, thank you most sincerely for your good wishes on this most wonderful evening and on the formation of the Australia and New Zealand College of Anaesthetists.

It is a matter of great delight and pleasure, to the Members of our College Council and all Fellows of the new College that you, Sir, as a past President of the Royal Australasian College of Surgeons, former College of Surgeons Councillor to the Board of Faculty and, above all, an Honorary Fellow of the Faculty, and now an Honorary Fellow of the Australian and New Zealand College of Anaesthetists, should be able to propose this Toast.

I believe that the forty years of being a Faculty within the Royal Australasian College of Surgeons have in many ways been most beneficial to Anaesthesia and to Surgery. But forty years is a long gestation in the view of most people, and though this arrangement has so often been looked upon as a family arrangement, we all know that offspring have that disarming habit of growing up. Now, after the events which have come about in recent weeks, it looks like we may have to leave home as well.

Ladies and gentlemen, much is said these days about the fragmentation of our profession and, indeed, whilst the Board of Faculty and the Royal Australasian College of Surgeons Council were discussing the Board of Faculty decision to incorporate as a separate legal entity and then move to Collegiate status, this aspect was given very serious consideration. I am sure we all know the pressures facing us as a profession have never been greater and that beneath all the differences and unique situations which abound in medicine, we must be careful to retain a basic strong and cohesive force between all disciplines, to withstand these pressures. It is for this reason that I believe the bonds which currently exist between our two Colleges will not be weakened, but by our independence will be strengthened.

Mr President, Fellows of the new College are grateful for the support and security afforded to our Faculty, especially in those early days, when Fellows of the Faculty were few in number. Also for the progressive achievement of independence within the College, which came with time.

I would also like to take this opportunity to formally and publicly thank you, your Council, former Presidents and Council Members for the unanimous support for the Board of Faculty in this great step forward for Anaesthesia and Intensive Care in Australia and New Zealand. This support has been in no small measure responsible for the smooth transition to our present state.

On behalf of the Council of the Australian and New Zealand College of Anaesthetists, all Fellows and administrative staff, I thank you, Mr Clarebrough, Mr President, your Council and the Fellows of your College.

Australasian Visitor's Lecture

Delivered in Canberra by

Geoff Cutfield, D.Phil.(Oxon.), FFARACS, FANZCA

'Critical Care of the Specialty'

1. INTRODUCTION

Thank you Mr President,

Colleagues and friends; I am honoured to have been invited to participate in this Inaugural Scientific Meeting of the College as the Australasian Visitor. I acknowledge, with gratitude, the sponsorship of this position by the Boots Company.

To tell you the truth, I was extremely diffident about accepting the invitation from Professor Livingstone and I hope that you will bear with me because I am no less diffident about the task which now befalls me. To follow in the tradition of the Foundation Visitors at this Meeting, and to attempt to match the excellence of their contributions is a very difficult task. Sir Winston Churchill, faced with a similar predicament, was heard to remark that it is as difficult as it would be to "... climb a wall which is leaning towards you, or to kiss a girl who is leaning away from you...!"

About the time of Professor Livingstone's invitation, two significant things happened to influence this lecture: The first was a comment overheard in our hospital corridor. A patient's wife and her friend were leaving our Unit, unaware perhaps that their conversation could be heard. The comment was: "*They certainly know what they're doing, but they don't really seem to care*".

The second significant event was that Professor Livingstone himself wrote a leader article in the *Faculty Bulletin*, forewarning us of the then Board's resuming discussions on the issue of 'recertification'.

My lecture today began its gestation as an essay in response. As this not-so-immaculate conception passed through several near miscarriages, however, its progenitor began to experience doubts about its future viability and never mailed it! Recent events have stimulated resuscitative efforts and I hope to present to you, not too wrinkled with post-maturity, this essay: '*Critical Care of the Specialty*'.

What is my position?

I stand before you, not as an expert on educational or social philosophy, but as a Morris Minor league academic anaesthetist with intensive care preference, concerned

for the welfare of our specialty and, clearly, in need of retraining. I had failed to communicate a sense of care in a clinical setting, and as an academic anaesthetist I would score very few *cognate points* in a system such as our gynaecological colleagues have for 'recertification'.

What is my message?

My message this morning is that I believe that the Specialty of Anaesthesia and Intensive Care is indeed in need of "critical care" – certainly not in the sense of needing resuscitation, though life support perhaps – and I am convinced that there are several important things that we must do, whether or not we embrace recertification, to best achieve this.

What do we mean by "Critical Care"?

If we consult the dictionary, we find three definitions for "critical". The first definition incorporates meanings like: "... censorious, or fault-finding ..."; perhaps referring to find system malfunction in the very ill patient, or finding so-called 'bad apples' in our profession, or even referring to judicial interference in professional activities?

The second definition is: "... pertaining to crisis, involving risk or suspense, ... decisive, ... crucial". This might apply to the immediacy of decision-making in response to urgent problems in anaesthesia or intensive care, maybe "CRISIS: A SWIFT CHECK", the algorithm given us by the Adelaide group, or it might apply to a "crisis of public confidence".

The third definition is, as in physics, "... marking a transition from one state to another ..." for example from vapour to liquid at critical pressure, or perhaps from Faculty to College at critical mass!

"Care" of course means "... having concern for, anxiety about, ... interest, ... regard, ... affection, ...".

I mean to suggest a blend of all of these definitions. They are all pertinent.

2. WHAT IS THE PLACE OF RECERTIFICATION?

The process of critical care, as we practice it in our Specialty, comprises three phases: **resuscitation** or restoring to life, **rehabilitation** or restoration of organ system function or function of the organism as a whole, and – equally importantly – **reassurance**.

I personally believe that as a Fellowship, we will come to accept some form of 'recertification', and that its place will be in the sphere of **reassurance**: Reassurance to patients and the community, reassurance to the "authorities", and – not least of all – reassurance to ourselves.

2.1 Motivating Forces for 'Recertification'

Let us for a moment consider the perceived motivating forces justifying such a process. We might list them in order, from the most compelling to the least compelling, as follows:

- i. As a means of maintaining the self-educating process, and with it standards of care;
- ii. As a means of demonstrating accountability (to which the remaining factors are subsidiary);
- iii. "Others are doing it, so should we".
- iv. As a means to preventing further public scandals;
- v. "If we don't do it ourselves, it will be inflicted on us".

Taking these in turn:

i. As a means of maintaining the self-educating process, and with it, standards of care.

I believe that this is the most valid, if not the **only** valid statement justifying or motivating the adoption of a process of 'recertification'.

Intuitively, we recognise that we shape our knowledge base to suit our practice needs. In my own practice, for example, the physiology of ventricular contractility is in memory but please don't ask me to discuss pseudopseudohyperparathyroidism without letting me look it up! We recognise also (and Professor Jones has reinforced this beautifully in his Ellis Gillespie Lecture on the mind and anaesthesia), that we have finite memories.

Educational theory tells us that the basis of our competence and our performance is a blend of **relevant knowledge, skills** (technical skills, professional skills and interpersonal skills) and **attitudes**. We cannot get away from the fact that these, all three, are **learned** and enhanced by further or continuing **education**. Admittedly, there **is** conflict in research data concerning decline in competence with time. In medical education research, however, much of the early work was done in a climate where continuing education was lacking or rudimentary to say the least. This begs the question though if we are aiming to **enhance** rather than merely **retain** a level of competence and performance.

In relation to **skills**, there is compelling evidence from experience in educational research in the aviation industry – with which our Specialty shares many performance characteristics – that "recency" is important in maintaining skills. In other words, frequency of exposure to situations is directly correlated with skill levels and ability to perform.

Guidelines for such educational activities are needed, together with some form of self-appraisal of the adequacy of the process . . . reassurance? . . . or 'recertification'?

ii. As a means of demonstrating accountability.

Demonstrating accountability to our patients and to the community is important, if we are to present the Specialty as caring in the sense of being forward-looking, community-sensitive, cost conscious, and wise to impact in its approach to challenges and developments.

I believe that one of the biggest concerns we all share is about the gulf between advances in medical science and public perception, awareness and education. This is amplified by modern approaches to news and current affairs reporting, such that emotions are generated in society ranging from adulation at one end of the spectrum to deep suspicion at the other. When such advances are accompanied by failure or misadventure of course this gulf is widened. The history of our own Specialty is peppered with examples of situations where grievances have been championed by the media, subjected to a public laundering of emotionally-charged views which reflect little credit on the profession, and ensuing bureaucratic or even legislative restrictions – some good, some bad. We may cite as examples:

- Spinal anaesthesia and the Wooley and Rowe cases: following which public confidence in this safe and valuable anaesthetic technique was all but destroyed, and many departments "outlawed" its use.
- Epidural dexamethasone in the management of chronic pain syndromes: a very recent example of misrepresentation in "trial-by-media" which has resulted in government agencies and defence societies withdrawing support for a pain management strategy of significant benefit to some patients.
- Organ donation and the debate on criteria of brain death: an example of helpful public airing of views from the profession, legal advisors, philosophers, theologians and others which cleared the way forward for organ donation and transplantation.

iii. "Others are doing it, so should we".

iv. As a means to preventing further public scandals.

Public confidence in the profession demands our accountability and it is the view of many that 'recertification' procedures will help in this regard. Whilst agreeing in part with this view, I have grave reservations that currently working 'recertification' procedures in other countries, or in sister Specialties, that we have heard about this week, will prevent so-called public

scandals. For example, the National Women's Hospital "unfortunate experiment" had nothing to do with the *knowledge base* or *clinical skills* of the practitioners concerned – which is all we can get at with whatever imperfect system of recertification we devise. It had to do with prevailing **attitudes** of the people concerned and in the whole profession, together with the self-determination of the patients involved. The subsequent Inquiry went far beyond its terms of reference in its demands for "preventive" legislation, even in the view of the mildest contemporary commentators.

This inevitably leads on to the last – and one observer has qualified "saddest" – motivating factor towards 'recertification':

v. **"If we don't do it ourselves, it will be inflicted on us"**:

Whilst we might wish that this statement was able to be ascribed simply to paranoia, the fact is that legislation incorporating time-limited 'recertification' in revised Medical Practitioners' Acts is already in Committee stages in both New Zealand and Australia.

In New Zealand, this legislation has been drafted by the Government, in consultation with the Medical Council of New Zealand which is the registering body. This action has been taken largely in response to the unfavourable publicity received by the medical profession in New Zealand following (i) the Commission of Inquiry into the management of the National Women's Hospital cervical cancer research programme, presided over by Judge, now Dame, Sylvia Cartwright, and (ii) the criminal proceedings (principally charges of manslaughter) brought – mostly unsuccessfully – by the New Zealand Police against a number of practitioners since 1987 under the new Crimes Act of New Zealand.

In Australia the focus of current legislative review is on means to establish minimum levels of competence to practice, in the first instance for immigrating doctors. It is recognised that in time this process will extend to new graduates from Australian Medical Schools, and subsequently to all registered practitioners. This conforms to the Commonwealth Government's desire to establish national competency standards for all trades and professions.

Our best action, therefore, is to show that we are developing procedures which will be credible, and which will meet the likely requirements of the revised Medical Practitioners' Acts.

2.2 Potential Benefits of 'Recertification'

On the brighter side, there are undoubtedly benefits which will follow with the introduction of some form of 'recertification' procedure, properly devised and implemented:

Safety

The application of **practical** audit procedures might provide a means of demonstrating to us as practitioners that we may have developed "short cuts" for the sake of expedience. Whilst such actions may be safe in our hands at this time, they deviate from ideal patterns of practice which we hope are inculcated in training. If not checked, we may progress, unwittingly perhaps, along a spectrum towards the brink of being downright dangerous. We need to be appraised of such tendencies at an early stage to avert problems.

In the aviation industry, this is exemplified by the 'Quick Access Recorder' programme used by QANTAS in association with the Airline Pilots' Association. Data from the on-board computer, which is capable of logging all of the instruments, every action on the flight deck and every response from the aircraft are fed continuously to a recorder rather like the "black box" flight recorders.

The tapes, so produced, are analysed promptly and deviation outside specified range from operational guidelines are identified. These are reviewed by a Pilots' Association representative and any significant incidents are reviewed with the pilot concerned. As a concrete example, the recorder on board Boeing 747 flights bound from one international airport to Sydney recently identified a departure from training protocols. Because of the geography, the route entails climbing out from this field and effecting a slow 180 degree turn. This can be more easily accomplished, and faster, with flaps withdrawn, but risks diminishing controllability of the aircraft in the event of turbulence. The practice was a departure from guidelines, a short-cut for the sake of expedience, and regarded as unsafe. As a consequence of something like our "hazard notice" in the professional journal, the practice has now ceased.

Work environment

In a similar fashion, demonstrations of hardship or inconvenience for the theatre or intensive care unit staff, which might have a detrimental effect on patient care, will become obvious in audited practice. This data is very useful evidence to substantiate claims for improvements or modifications to the work environment. This is, if you like, a positive attribute of 'recertification' turned outward, to benefit the practitioner and the patient.

Work practices and rules and regulations

Demonstrations from audited practice may also provide hard data in support of improvements or modifications to standards of practice as we teach them. In some situations this may require "tightening up" as it were; in others relaxation. As an example, again from the aviation "Quick Access Recorders", the textbooks and manuals all indicate that at the point of take-off, the rate of elevation of the nosewheel – or "rotation" – of aircraft

must be exactly four degrees per second. The recorders identified that the experienced pilots achieved superior performance from aircraft on take-off – i.e. airspeed and rate of ascent – with slower “rotation”. The rule books have now been rewritten!

Defence and Protection

One further benefit arising from a well-developed programme of ‘recertification’ would be the tangible evidence that continuing education and safety in practice are being pursued and that widely agreed guidelines are in place and adopted.

In the aftermath of recent cases in New South Wales; one related to cardiac surgery and transfusion-acquired AIDS, and one related to informed consent for ophthalmic surgery and subsequent sympathetic ophthalmia, two judges have rejected the view that a doctor is not negligent if he acts in accordance with the practice accepted at the time as proper by a responsible body of medical opinion, even though the majority of practitioners may have ascribed to a different practice. Such judgements, preserving for the Courts the prerogative to determine the reasonableness of medical treatment by their own standards, without reference to the profession, are a matter for grave concern. Expert legal opinion confirms, however, that compliance with the published Faculty Guidelines, which have not been tested at law (as far as I am aware) would constitute very weighty evidence in defence in such cases.

This highlights the benefits of remaining demonstrably up-to-date and fully conversant with such practice guidelines, not to mention contributing actively to their development.

3. IMPLEMENTATION OF ‘RECERTIFICATION’:

We are all agreed, I feel sure, that whatever the pattern of assessment procedures put in place to achieve ‘recertification’, it must be relevant to the educational objectives of the continuing education **process** and not geared to penalty. We should be focussing on improving competency and performance by self-management and self-determination. In other words, the process must be flexible enough to be tailored to our individual patterns of practice, and within our own limitations. I believe that our priorities as a Fellowship should be to fully support every effort to:

1. Revise our initial certification procedure, that is the Final Fellowship Examination, at least to the point of incorporating valid assessment of **competency**.
2. Enhance our continuing medical education process, including more exercises in problem-solving and practical skill training and practice.

3. Establish a protocol, just like a well-designed scientific research study, to **validate** whatever system we might choose to implement. The components would ideally cover the relevant knowledge base, the practical skills, and performance.

We have many relevant and affordable options;

(i) aids such as the ‘HELP’ modules from CECANZ, for the knowledge base;

(ii) simulations and training aids together with local peer review (i.e. in Hospital Departments or group practice locations) for skills, and

(iii) personal practice audits, e.g. using modified ‘clinical indicators’, or self-appraisal of video-taped sessions for performance.

Measurement parameters of major importance must include markers of improvement in outcome, the degree of rigour to be applied, and population performance statistics.

4. Run a voluntary pilot study.

5. Thoroughly review the results of the pilot study.

Before proceeding further to implementation, we will need to overcome the understandable fears about ‘de-certification’. There are a number of ways to do this. One possibility might be to explore the place for a legal agreement between the College as the “Authority” and the Fellowship, limiting the availability of data used for recertification, controlling its destruction within some minimal time frame (e.g. eight days, since it takes ten days to raise and serve a subpoena!), and limiting the powers of the “Authority” to use the data for anything but to suggest retraining. There are precedents for just such agreements.

Regardless, we should strive to encourage a broad-minded approach to the process. As an aside, I was very amused recently to hear an exasperated observer of the debate about the Ordination of women to the Priesthood in the Anglican Church of Australia – an issue which is every bit as divisive as that of ‘recertification’ – comment that *‘Broadmindedness is the result of flattening highmindedness out.’!!*

4. OTHER STRATEGIES IN “CRITICAL CARE”:

Are there other measures, quite apart from ‘recertification’ that we might be overlooking in our “critical care” exercise? I personally believe that there are, most certainly. Some of these we might consider more significant, or more urgent than the rush to ‘recertification’. Most of these measures already exist in some form, however, they all need our more active support and involvement.

At the personal level:

1. Public education

Our physical presence in the clinical sphere does much to enhance confidence. The sympathetic preoperative assessment visit and postoperative follow-up are as important for patient reassurance as they are a form of personal practice audit. Some would say that the rapid expansion of day-stay and outpatient surgery has done much to limit such exposure. If this is so, then we need to ask whether this is a **reason** or an **excuse**, and take steps to remedy the situation. Related also to this concept of the "human face" of anaesthesia and intensive care we should consider the advantage of retaining a degree of socialised medicine, which removes the philosophical tie-up between care and service on the one hand, and the fee on the other. We must regard our system as at least one step better than parts of the United States, where the anesthesiologist is virtually anonymous: the CRNA deals with the conscious patient, and the bills come from a faceless corporation. Such behaviour completely invalidates the covenantal basis of medical practice and is to be deplored.

We should also recognise and applaud the efforts of the Societies of Anaesthetists, and the Faculty, in the preparation of information leaflets for patients faced with the prospect of anaesthesia, perhaps for the first time in their lives.

2. Our involvement in public affairs

Being seen and known: Our Specialty does have a public profile outside the operating theatres and intensive care units in which we work, thanks to the marvellous examples of colleagues who are prepared to devote some of their precious free time to community involvement, either within our employing institutions, the College and Societies, but even better in the community at large . . . from the kiddies' school PTA or P&C Committee or Board of Trustees, to running for Member of Parliament! (both of which, I know, have historical anaesthesia precedents!)

3. Back to School

Very few of us have come to our present positions with any formal training in management or business administration. Whether we like it or not we are faced with having to deal with other professionals who have these skills and are in positions of influence over us. We become painfully aware that the "languages we speak" and the "currency we use" have different meanings and values in these circumstances.

As one of my colleagues, with whom I share stimulating theological debates from time to time, recently observed: "*You know, Geoff, administrators and bureaucrats share*

much in common with Judas Iscariot: They all know the essential Truth, yet they are prepared to deny it. The big difference is that Judas at least had the grace to go out and hang himself!"

There is a real need for taking time to learn more about management and administration so that we can speak to these people on an equal footing, and work in cooperation.

As groups of practitioners:

4. The medico-legal interface

We must foster mutual respect between the professions. There are a number of important issues which need co-operative study and growth. We need to place emphasis on recognition of scurrilous litigation. We also need to pay particular attention to courtroom performance of 'expert witnesses'; we are unlikely ever to be experts as witnesses, we need to become witnesses who are experts in anaesthesia and intensive care medicine. Nothing is more destructive to the public face of our Specialty than nationwide reporting of a divisive clash between two so-called 'experts' in the conduct of a criminal or civil trial. None of us is trained for, neither are most of us temperamentally suited to adversarial activity of this type. We must either learn, or adopt an effective strategy for preparing those faced with this prospect.

5. Media liaison panels

This is an important consideration – ideally with College and Society backing, so preserving public credibility and a sense of unity of both. Such panels could be charged with the tasks of

- (i) maintaining an output of news-worthy positive developments in the Speciality, and
- (ii) giving well-informed commentary in response to media reports where matters of fact or balance need correction.

6. Matters medico-political

I have not mentioned our involvement in medico-political matters. This is a sensitive issue at the overlap between the College and professional Society activities and best left for discussion in other forums. Most assuredly however, continued representation with wise counsel contributes enormously to the process of safeguarding standards of patient care and the welfare of the Specialty. We owe a debt of gratitude to those of our Fellows who willingly and effectively take this on.

5. CONCLUSION

In a delightful and thought provoking article, entitled "Down with Dogma", Alan Gilston has recently written:

"In general, medicine, including intensive and critical care, is slow to implement new concepts and often clinical practice is up-to-date only in leading centres, and then maybe only in specific contexts. This reflects both the slow spread of new ideas and the fundamental conservatism of [doctors]. It is not entirely an undesirable situation, even in the life-threatening context of the critically ill, for often new, fashionable concepts are swiftly and justifiably discarded. On the other hand, medicine is littered with examples of dogma becoming heresy through the impact of scientific evidence. The hostile reception often afforded those who threaten cherished beliefs in any sphere demonstrates our human need for certainty".

Dr Gilston makes many relevant and valid points in short order in this brief communication. He also hails scepticism as vital for medical progress. In this spirit, I trust that you will consider my thesis that the Specialty is indeed in need of critical care, but I trust that you will also endure my scepticism about the predominating role of formal declarations of continuing clinical competence as the sole means of providing this.

Ladies and Gentlemen, we stand on the brink of a new generation. Let us take up these challenges and continue to work as a Fellowship of a live and vital College to guarantee our own "preferred future".

DEATHS AND HONOURS

DEATHS

Council noted with regret the death of:

Dr N.W. Bartrop (NSW)
Foundation Member, Fellow 1956

Dr J.E. O'Donnell (Qld) Fellow, 1960

Dr W.K. Peacock (WA)
Foundation Member, Fellow 1966

HONOURS

Council noted the following Honours:

Professor W.B. Runciman (SA) -
First Honorary Foundation Fellow
of the Hong Kong College of
Anaesthesiologists.

Dr Paul Rainsford (Vic) -
Elected to AMA Roll of Fellows.



● Registrants at the Cardio Vascular and Thoracic SIG Meeting on Perioperative Myocardial Ischaemia, held at North Head Quarantine Station, Sydney, in November, 1991.



ROBERT ORTON MEDAL

Citation – Thomas Christopher Kenneth Brown

'The Orton Medal is given at the discretion of the Council of the Australian and New Zealand College of Anaesthetists, the sole criteria being distinguished service to anaesthesia.'

Mr President,

I have the honour to present to you, Dr Thomas Christopher Kenneth (Kester) Brown for the Award of the Orton Medal.

Mr President, Kester Brown, M.B., Ch.B. (St Andrew's), MD (Melbourne), Fellow of the Faculty of Anaesthetists, Royal Australasian College of Surgeons and Fellow of the Australian and New Zealand College of Anaesthetists, has spent a significant and formative part of his life in four countries – Kenya, Scotland, Canada and Australia. Fortunately for Australian Anaesthesia he settled in and has spent his professional life here.

Kester was born in Kenya, undertook his secondary schooling in Nairobi and following completion of his National Service in the Kenya Regiment, commenced medical studies at the University of St Andrews, Scotland, from which University he graduated in 1960.

Following his intern year in London, Ontario, he spent in the best traditions of the day, 18 months of general practice in Yellowknife, North West Territories, Canada.

His future career in anaesthesia for children and research must have been evident to him early, since his first anaesthetic training in Canada involved work in the Vancouver General and Children's Hospital and as Research Fellow in the Department of Medicine at the University of British Columbia.

Kester moved to Australia in 1966 when he accepted an anaesthetic registrar position at the Royal Melbourne Hospital.

In 1967 his career was finally moulded when he moved to the Royal Children's Hospital where he was sequentially Medical Officer and then Uncle Bob's Fellow in the Intensive Care Unit, Anaesthetic Perfusionist and then finally Director of Anaesthesia in 1974, a position which he currently holds.

Kester is a quiet family man who has friends all over the world.

He can be gentle and tolerant, independent, persuasive and stubborn, all ingredients for success.

He can do the unusual and unexpected. As a student he worked as a grouse beater to Her Majesty the Queen Mother during University summer holidays and once he appeared dressed in a bear outfit whilst part of a panel discussion at a national anaesthetic meeting.

He was a sportsman of note in his student days obtaining a Blue in hockey and being Captain of his University and the Scottish Universities Teams. He was also involved in the administrative side of sport, being President of the Athletics Union and on the Scottish Universities Sports Board.

Mr President, the Orton Medal is awarded for distinguished service to anaesthesia and I wish to indicate to you why the Board of Faculty believed this is deserved.

Two words could best describe Kester's achievements as an educator and teacher. His activities have been directed and acknowledged at the local, national and international levels.

His publications have never ceased since his early days in anaesthesia and now total almost one hundred in some twenty different journals. They have been on topics of a general nature directed at all medical practitioners, on topics directed to a purely anaesthetic readership and to other specialty groups.

He has been a forerunner in the anaesthetic world in this country at least in the development and use of teaching aids such as films, videos and anatomical dissections.

He is well known for his text book written with Dr Graham Fisk, *'Anaesthesia for Children'*, which is published in three languages and for *'Anaesthesia and Patient Care'*.

Kester has lectured in over 40 countries, has had many lectureships worldwide and has given several named lectures in his own country which is a rare honour.

His research interests have been many and varied and again, like his publications have never ceased since his early days in anaesthesia. They have been at both basic science and clinical levels. Within his Hospital he was



Presentation of the Orton Medal by the President to Dr Brown.

for many years on the Board of Research and Chairman of the Animal Research Laboratories Committee and Animal Ethics Committee.

He is a stimulating teacher and many an anaesthetist in the country and overseas are indebted to the work of Kester.

He has not been one to shun administrative and professional activities, having been involved at Hospital, University and professional levels.

Involvement with the Faculty has been significant. He was an Examiner in Pharmacology for twelve years, was a member of the Victorian Regional Committee, being its Education Officer for five years and Chairman for two.

Kester is one of only six Fellows of the Faculty in this country to have been appointed to the Lennard Travers Professorship.

Within the Australian Society of Anaesthetists he has been actively involved at Committee levels in continuing medical education and peer review and is currently Chairman of its Scientific Programme Committee and Overseas Aid Sub-Committee.

One of Kester's abiding interests has been the assistance to overseas anaesthetists. This has been both through his involvement in the World Federation of Societies of Anaesthesiologists, where he has been involved with the

Paediatric Anaesthetic Committee, its Education Committee, of which he is currently Chairman and its Scientific Programme Committee, of which he is Convener for the 1996 World Congress in Sydney.

His involvement is very personal and regularly he has overseas trainees in his Department, is involved in overseas training courses and has assisted with the establishment of their own examination systems.

He has previously been awarded the Gilbert Brown Medal of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, the Gilbert Brown Award of the Australian Society of Anaesthetists, he is an Honorary Member of several overseas anaesthetic societies, he is a Life Member of the Australian Society of Anaesthetists and was recently elected a Fellow of the Royal College of Anaesthetists.

Some years ago when introducing Kester to an anaesthetic audience in Tasmania I described him as a friend of Tasmanian anaesthesia for the help and assistance he had given us. I truly believe today I can describe him as **the friend of anaesthesia** for the distinguished service he has given.

Mr President, may I present to you Dr Thomas Christopher Kenneth Brown for the award of the Orton Medal.

Michael J. Hodgson



Participants in the Right Ventricular Failure Session. Assoc. Prof. Geoff Cutfield, Dr Michael Davies (Chairman), Professor Roberta Hines and Dr Charles Domaingue.



Mr Graham Grant, Managing Director, Mallinckrodt Australia Pty Ltd, and Ms Lynda Holdsworth (National Sales Manager), recently presented a cheque for \$10,000 as the first instalment of Mallinckrodt's pledge for \$30,000 to the Victorian Chairs of Anaesthesia Appeal to Dr Patricia Mackay (Deputy Chairman) and Dr Peter Lowe (Committee Member).



Left: Participants in Day Care Anaesthesia Session with the President. Left to right: Drs Bruce Burrow, John Zelcer, Richard Kelly, Assoc. Prof. Peter Livingstone, Drs Arne Schimmelfeder, Glenda Rudkin (Chairman) and George Osborne.



Pictured above: Assoc. Prof. Geoff Cutfield following his Australasian Visitor's Lecture with the President and Mr Terry Gallagher, Business Manager, Anaesthetic Products, Boots Company (Australia).



Presentation of the Gilbert Brown Prize by the President, Assoc. Prof. Peter Livingstone to Dr Neil Warwick, NSW.

COLLEGE PROPOSED CREST

THE SUPPORTERS

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

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

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

THE COMPARTMENTS

The supporters stand on land separated by water signifying their two different countries, but also the separation of the New World of Australasia from the Old World of Europe and the significance of sea travel in the transmission of the introductory message about anaesthesia around the world and the separation of Australia and New Zealand by sea.

THE CREST

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

The hand of the carer rising from the Lord's Cloud representing Almighty guidance links back to the Parisian medical influence and symbolises the Fellow's hand guided by the Lord caring for the patient's life. The hand holds an



ankh, the Egyptian symbol of life, linking the major responsibility of the College Fellows with the roots of Western medicine in Egypt. The snake of Aesculapius entwines the ankh to symbolise the medical links as well as the heritage to Greek medicine.

THE SHIELD

The **chief** of the shield contains the Southern Cross indicating the College position in the Southern Hemisphere. The five stars are represented with the number of points representing their brightness. This representation is also that taken by the Victorian State representation of the Southern

Cross, and, as no other State nor New Zealand represent the Southern Cross in this form, it symbolises the College founding in Victoria and the College Headquarters in that State.

The lower part of the shield contains the St George Cross indicating the links to the English Faculty (now Royal College of Anaesthetists) and the Christian heritage of the College. The torch of glory indicates the link to the Royal Australasian College of Surgeons and their motto '*fax mentis incendium gloriae*' - 'The torch of glory inflames (inspires) the mind'.

The Macintosh laryngoscopes signify the integral part this instrument has in the specialty and its traditional representation of the specialty.

The **charges** in the upper left/lower right quadrants contain the opium poppy flower (*papaver somniferum*) signifying analgesia, together with the mandrake plant (*mandragora officinarum*) signifying sedation or anaesthesia. These charges also symbolise the Old World plants.

The **charges** in the upper right/lower left quadrants contain the cocaine leaf and fruit (*erythroxylon coca*) signifying local anaesthesia together with the curare vine (*chondrodendron tomentosum*) signifying neuromuscular paralysis. These charges also symbolise the New World plants. All these plants together form the basis for the pharmacology fundamental to anaesthesia and intensive care.

THE MOTTO

'*Corpus curare spiritumque*' is translated 'To care for body and life' and aptly summarises the main aim for Fellows of the College.

ADMISSION TO FELLOWSHIP UNDER ARTICLE 49 (a)

14th March, 1992

HONORARY FELLOWS

Arthur Barclay Bull, S.Africa
David Mervyn Davies, UK
Gaisford Gerald Harrison, S.Africa
William Woolf Mushin, UK
James Gordon Robson, UK
Malcolm Keith Sykes, UK

FELLOWS

Ruth Margaret Aaskov, Qld
Malcolm Edward Agnew, NSW
David Beverley Angliss, WA
Peter James Armstrong, NSW
Peter Douglas Arnold, Vic
John Winter Ashton, Vic
Francis John Augustus, NSW
Margaret Ruth Bailey, SA
Philip James Barnes, SA
John Campbell Barrett, NZ
Susanna Monica Bedford, Qld
Jonathan Leonard Benumof, USA
Neroli Lyndall Best, NSW
Andrew McLaren Spiers Black, UK
John Edward Blackburn, NZ
Christopher Leonard Borton, NSW
Ross John Boulter, WA
Alan Geoffrey Bowers, NZ
Gavin John Atlee Bowra, WA
Geoffrey Robert Braimbridge, WA
Peter Brine, WA
David Alan Robert Brown, NSW
Philip Jeffrey Brown, USA
Mark Robert Buckland, Vic
Paul Robert Buncle, Vic
Janet Leuwin Cade, NSW
John Francis Cade, Vic
Anne Margaret Canty, Vic
Michael Thomas Carlton, NSW
Margaret Helen Hunter Chacko, NZ
Christopher John Wesley
Chambers, NZ
Chee Wah Chan, Malaysia
Edmund Bernard Chan, HK
Ling Hong Chan, NSW
Peter Nang-Sang Chang, NSW
Mark Henry Chapman, NZ
Fun Gee Chen, S'pore
Tuck Pew Chen, Malaysia
Roderick Hanbury Chisholm, NZ
David Tak Wai Choy, HK
Tak-Chiu David Choy, HK
Catherine Mary Clark, Vic
Richard Campbell Clark, NZ
Graeme Leslie Turner Clarke, Vic

Richard Martin Clarke, WA
Christopher Dudley Clay, WA
Colin Richmond Climie, NZ
Mervyn David Cobcroft, Qld
Russell Geoffrey Cole, Vic
Raymond David Colman, NSW
Raymond William Cook, ACT
Vernon Bruce Cook, NZ
Charles Frederick Corke, Vic
Terence Graham Coupland, UK
Gary John Creighton, NSW
Frederick George Dally, WA
Anavangot Damodaran, Malaysia
Gavin Robert Dawson, Tas
Brian Edgar George D'Bras, NSW
Alexius Ernald Delilkan, Malaysia
Roy Edwin Dennis, NSW
Philip Lindsay Dey, NSW
John William Doncaster, Vic
Mark Charles Donnelley, NSW
Kenneth Erskin Downnes, ACT
John Watson Downing, USA
Mark John Duncan, NSW
Lillias Joan Dunn, Qld
Kenneth Royce Elms, Qld
Malcolm Evans, Vic
Robert Lindsay Eyres, Vic
Piotr Fast, NSW
Edwin Robert Fawcett, NZ
Basil Eric Talbot Fergus, NZ
Lionel Clarence Fernando, NZ
James Anthony Ferris, SA
James Edward Field, Vic
Jeremy Aylwin Foate, NZ
Deborah Jane Forsyth, UK
Donald Ivor Alexander Fraser, NSW
William Rayner Fuller, SA
Malcolm Edward Futter, NZ
Susan Patricia Gathercole, NZ
David Brunton Gibb, NSW
Alison Jean Gilroy, NSW
Tony Gin, HK
Kay Wah Goh, Malaysia
Peter Daniel Gold, NSW
David Bruce Goodie, USA
Ian Donald Graham, NSW
John Robert Mager Gray, Vic
Keith Benjamin Greenland, Qld
Max Adderly Griffith, NSW
Cary Victor Griffiths, NZ
Richard William Grutzner, Vic
Geoffrey Alan Gutteridge, Vic
Peter Alan Hales, NSW
John Leonard Handsworth, SA

Ian Harley, Vic
Philip Charles Harris, NSW
Dennis Reginald Hayward, WA
Edward Holbrook, USA
Charles John Perry Hollings, NZ
Alison Mary Holloway, Qld
Charles McKinnon Holmes, NZ
Geoffrey John Hool, Qld
William Charles Stanley
Houghton, USA
Rae Arden Howard, Qld
Maurice Cedric Hudson, UK
Chee Keong Roger Hung, HK
Kanapathipillai Inbasegaran,
Malaysia
Susan Jane Inglis, NSW
Brendan Patrick Ingram, Vic
Peter Ralph Isert, NSW
Robert William Jefferis, NSW
Craig Alexander Johnston, Qld
Cecil Stanley Jones, S.Africa
David Jones, NZ
Franciscus Junius, NSW
Antony Hannay Kaines, SA
Harry Kay, NSW
Robert Ross Kennedy, NZ
Michael John Kent, WA
Ross Kenneth Kerridge, NSW
Gary Thomas Klopfer, NSW
Roman Kluger, USA
Rodney Neville Knight, Vic
John Stewart Knox, NSW
Ralph Michael Krippner, Qld
Bee Hua Kwa, S'pore
Merrick Howard Laforest, NSW
Choong Koon Lai, SA
Chuen Shun Lam, HK
Mark David Landy, Qld
Penelope Anne Laskey, Qld
Andrew Douglas Lawson, NSW
Bin Bin Lee, NSW
Choong-Keet Lee, NSW
Shing Cheung Lee, S'pore
William Norman Lee, NSW
Denis William Leech, Vic
Roger Kenneth Levy, NSW
Reginald Abbot Lewis, Tas
George Lim, S'pore
Maxwell Lindsey, Vic
Thomas George Lithgow, ACT
David Allen Lloyd, Vic
Charles Anthony Loader, Vic
Seck Poh Loh, Malaysia
Edward Loughman, NSW

- Christopher John Lowry, NSW
 Joseph Cho Ze Lui, HK
 Shi-Sheung Lui, HK
 Catherine Jane Mackenzie, Vic
 John Phillip Madden, Tas
 Michael Martyn, Tas
 David Vincent Mawter, NSW
 Donald Charles Maxwell, NSW
 Peter Simon Mazur, Vic
 Rupert David Ashforth
 McArthur, SA
 Terence Michael McAuliffe, WA
 Barrie Thomas McCann, Qld
 Colin Hopper McCulloch, NSW
 Robert Thomas McGuinness, NSW
 Robert Gordon McLellan, Qld
 David Hugh McLeod, SA
 Peter Jerome McQuillan, UK
 Colin MacDonald Melville, Vic
 Leslie Mendel, UK
 John Dunstan Mercer, NZ
 Sonya Megan Miller, NSW
 David Michael Milliss, NSW
 Daniel James Molombo, Qld
 David Edward Dudley Moon, NT
 Peter Gordon Moore, USA
 Peter John Moran, Qld
 Theodore Richard Morley, WA
 Peter John Glasgow Morris, Qld
 Muniswami Yuganthan
 Mudaliar, NSW
 John Ian Munchton, SA
 David John Murchison, NZ
 Gabriel Jacobus Myburgh, WA
 Johan Alexander Myburgh, SA
 Leela Nair, S'pore
 Anton Lindley Neilson, Qld
 Anthony John Newson, NZ
 Lai Ping Pinky NG, HK
 Bich Van Ngo, SA
 Timo Lasse Mortimer Nyman, SA
 Mary Alice O'Callaghan, Qld
 Shenton Min Yueh Oh, USA
 John Joseph O'Leary, NSW
 Rosemary Anne O'Meeghan, USA
 Gracie Siok Yan Ong, Malaysia
 James Gordon Opie, NSW
 John William Orton, NSW
 George Anthony Osborne, SA
 Irene Sophia Palgan, Vic
 Philip Ralph Palmer, NZ
 Sulabha Vijay Panjratana, NSW
 Andrew Peter Randell Parsons, USA
 Timothy John Glover Pavy, Canada
 Umanath Vittalrao Pawar, Vic
 Philip Hugh Piers Pearce, Vic
 Gail Christine Pearson, NZ
 David Perlman, WA
 Isobel Alice Ann Perry-Keene, Qld
 Maureen Joan Peskett, NZ
 William Geoffrey Hogan Peskett, NZ
 Roger Anthony Picone, Vic
 Anthony Noel Plowman, Vic
 Christopher James Pottinger, NZ
 Keith Leslie Prest, Vic
 Franz Josef Pribil, WA
 Barry John Pitt, Qld
 Richard Eric Priddy, NSW
 Catherine Anne Prior, NSW
 Frederick Geoffrey Prior, NSW
 Anthony Walker Quail, NSW
 Bronwyn Ruth Rae, NSW
 Philip Richard Courtenay
 Randall, WA
 Robert Bruce Rattray, Vic
 Noel Vincent Roberts, Vic
 Nigel Niven Robertson, NZ
 George David Robinson, Vic
 Howard Philip Roby, NSW
 Frederick Arthur Rosewarne, Vic
 Robin Wayne Rowley, Qld
 Donald George Runcie, NSW
 Venera Carmel Russo, Qld
 James Miller Saunders, SA
 Margrid Schindler, NSW
 Richard Gibson Francis Lloyd
 Seed, S.Arabia
 Eva Ruth Seelye, NZ
 Roslyn Anne Seeney, Qld
 Timothy James Semple, SA
 Ivan Paul Sergejev, USA
 Jonathan Malcolm Shagrin, USA
 Richard James Simmie, Vic
 Barbara Leonie Slater, NSW
 Peter Julian Slattery, SA
 William David Sloss, Vic
 Alfred Graham Smith, Qld
 John Andrew Stanley Smith, SA
 Paul Bernard Smith, WA
 Peter Bernard Snider, Vic
 Andrew Duncan Spiers, NZ
 Vilim Stanisich, Vic
 Raymond Clifton Starr, NSW
 Ian Matheson Steven, SA
 Anthony John Stevens, UK
 Gregor Mitchell Stewart, Vic
 Paul Anthony Stewart, NSW
 John William Stokes, NZ
 Yvonne Helen Stokes, WA
 Martin Kinman Street, UK
 Ian Douglas Buchanan
 Sutherland, NSW
 Joanna Rae Sutherland, NSW
 Mary Felicity Sutherland, SA
 Damon Clive Sutton, USA
 Stephen Keith Swallow, Qld
 William Edmond Sweetapple, NSW
 Lee Choo Tan, Vic
 Soon Kiam Tan, S'pore
 Thomas Swee Hock Tan, Vic
 Hoong-Yee Tang, USA
 Kah Hey Tay, Malaysia
 Donald John Taylor, Vic
 Geoffrey Terrence Taylor, UK
 Nicholas Mark Thackray, WA
 Ravinder Thadaka, NZ
 Easaw V.E. Thomas, S'pore
 Stephen J. Thomas, USA
 Walter Ross Thompson, WA
 William Foster Thompson, NSW
 John Andrew Thornton, UK
 Michael James Tisdall, Vic
 Timothy Welbourne Trott, SA
 Ronald Valentine Trubuhovich, NZ
 Kenneth Kai-Yan Tsui, NSW
 Susan Udall, NSW
 Weng Koon Van, S'pore
 Euahna Varigos, Vic
 Paul Robert Wajon, NSW
 Stuart Anthony Walker, NZ
 Geoffrey Hamilton Wall, NSW
 Wen Cheng Wang, S'pore
 Anne-Maree Warman, Qld
 Michael John Waterfield, Vic
 Joan Valerie Webster, Qld
 Douglas Graeme Wells, Vic
 Martyn Christopher
 Westerman, NSW
 Bruce White, NSW
 Paul Frederick White, USA
 Anthony Edmund Williams, NSW
 Henry Edward Martyn Williams, NZ
 Mark Williams, SA
 Jane Sumner Willoughby, SA
 Bevan Thomas William Wilson, Qld
 Geoffrey Ashton Wilson, NSW
 Trevor John Wilson, NSW
 John Spencer Windeyer, NSW
 Kenneth John Wishaw, Qld
 Annie Kam-Ying Wong, HK
 Jimmy Wing Fatt Wong, WA
 Kai-Kong Wong, HK
 Ronald David Woodey, NSW
 David Malcolm Wright, Qld
 Deidre Isobel Wright, NSW
 Ho-Yuen Wu, HK
 Kwok-Keung Anthony Yau, HK
 Mathew Zacharias, NZ

23rd March, 1992

HONORARY FELLOW

Douglas Geoffrey Lampard, Vic

FELLOWS

Neil Abrahams, NSW
 Mervyn Richmond Allen, SA
 Arthur Julius Anderson, Vic
 Rudolf Duncan Anderson, WA
 Yick Chor Au Yeung, HK
 Richard John Bailey, NSW
 Glen Bakyew, Vic
 James Neil Barson, Vic
 Lucille Christine
 Bartholomeusz, Vic
 Christopher Paul Bellhouse, NSW
 Francis Robert Berry, NSW
 Janie Una Blacker, NSW
 George Mario Boffa, NSW
 Carmel Emanuel Borg, SA
 James Palmer Bradley, Qld
 Bernard John Brandstater, USA
 Geoffrey David Brown, Qld
 Thomas Pendreich Brown, NZ
 David Cranleigh Thomson
 Bush, NZ
 Jeremy Ben Buttsworth, WA
 Julia Mary Byatte, Qld
 John Theodore Cantor, SA
 Grant Thomas Carr, SA
 Ham Long Chang, Malaysia
 Douglas Ian Chisholm, NZ
 Mun Wai Amy Cho, HK
 Yeen Yoong Chong, S'pore
 Po Tong Chui, HK
 Elizabeth Jane Coates, Vic
 Peter John Cooke, NZ
 Gavin Conrad Coppinger, WA
 Jonathon Andrew Cross, NZ
 Alfred Charles Day, NZ
 Ian Thomas Dicks, NSW
 John Joseph Dieckmann, Qld
 Trevor Lancelot Dobbinson, ACT

George Downward, NZ
 Brian Leonard Duffy, SA
 Francis John Michael Edwards, WA
 Stephen Christopher Ellis, USA
 Peter William Fay, Tas
 Robert Murray Fergusson, NZ
 Paul William Glover, NZ
 Lung-Cheung Goh, Qld
 Roger Michael Owen Hall, NZ
 Hamish MacGregor Holland, NT
 Philip Rowan Hyde, NZ
 Neil Scott Jacobs, Vic
 John Gareth Jones, UK
 Michael Emlyn Jones, SA
 Michael Richard Reece Jones, NSW
 Michele Ann Joseph, NSW
 Richard Winton Kelly, SA
 Joanne Fiona Kilpatrick, WA
 Bengt Korman, WA
 Geoffrey Evan Laney, NZ
 David Victor Laurence, Vic
 Vaughan Gilbert Laurenson, NZ
 Hugh Maxwell Lawrence, ACT
 Mun Yee Grace Lei, HK
 Khoi Seong Leong, WA
 Chung Cheung Leung, Qld
 Anthony Kevin Long, NSW
 Michael John Lorimer, Tas
 May Ervin Lothringer, WA
 Seow Jing Ma, S'pore
 Anthony Haydon Mark, NZ
 John Melville McDougall, NZ
 Ellison James McInnes, NZ
 Nanda Kumar Menon, WA
 Colin George Merridew, Tas
 Ian Richard Metcalf, Canada
 Lars Jorgen Koefed Molving, NZ
 John Francis Murray, Qld
 Khay Hua Ng, NSW
 Scott Ian James, Nicolson, Vic
 David Powell Palethorpe, Qld
 Rex Lindsay Pearlman, SA

Bruce Leonard Perks, SA
 Susan Kathleen Phillips, WA
 Walter Podolakin, Vic
 Ashley Neil Pollock, NZ
 David Gordon Postle, Qld
 Joseph Adriano Pracilio, WA
 Prudence Mary Pullar, NZ
 Christopher Kym Purser, WA
 Richard Rigby, NZ
 John Raymond Archdall Rigg, WA
 Gavin Joseph Brian Robinson, Vic
 Paul John Rodoreda, WA
 Lucia Victor Rodrigues, NSW
 Anthony William Russell, SA
 Robert Francis Salamonsen, Vic
 Brian John Shaw, NSW
 Kenneth Watson Sleeman, Vic
 Alison Jane Sloan, Vic
 Raymond Harry Spitz, NZ
 Donald Stenhouse, NZ
 Alan Strunin, Vic
 Colin Thomas Knox Stuart, Vic
 Philip David Sturrock, Vic
 Janis Henriks Svilans, SA
 Anthony William Swain, SA
 Yew Peng Tan, Qld
 William Owen Hugh Thomas, NSW
 Roderick Joseph Bramston
 Tiernan, Vic
 John Brodribb Finn Tucker, Vic
 Ian Geoffrey Wall, SA
 Robert John Wall, NZ
 Mark Livingstone Walsh, Qld
 Edward Ward, NZ
 Brian David Warman, NSW
 Trevor John Watkins, NSW
 William John Watt, NZ
 Stanley George Webster, WA
 Rodney Neill Westhorpe, Vic
 Gregory Paul Wotherspoon, NSW

30th March 1992

HONORARY FELLOWS

Lucien Ellis Morris, USA
 John Francis Nunn, UK
 Carlos Parsloe, Brazil

FELLOWS

Christopher John Acott, SA

Kenneth Patrick Ahmat, WA
 Karl Douglas Alexander, Vic
 Brian Joseph Anderson, NZ
 Michael Bernard Anderson, Tas
 Wah Keong Boey, S'pore
 Terence Desmond Bourke, WA
 Michael Paul Burt, ACT

Richard Stephen Witherington
 Bruce, WA
 Graham Bruce Cannon, Vic
 Gavan John Carroll, Qld
 Fook Ying Chiew, NSW
 Michael Charles Chittleborough, SA
 Lee Son Choong, Vic

Jeanne Margaret Collison, NSW
 Michael John Cousins, NSW
 Geoffrey Cameron Darby, Vic
 Lachlan Douglas Barr Dickson, SA
 Richard Alan Dinsdale, NZ
 Brenton Dale Donovan, WA
 Lawrence Andrew Doolan, Vic
 Brian Eric Dwyer, NSW
 Lillian Lai Lan Fong, HK
 Suzanne Kathleen Frisk, NSW
 Duncan Charles Galletly, NZ
 Robert Charles Gazzard, Vic
 Alastair James Gibson, NZ
 John Eugene Gilligan, SA
 Leo Gothelf, NSW
 Charles Roger Goucke, WA
 David Michael Griffiths, Tas
 Michael Hunter Harpur, NSW
 Patricia Harrison, USA

Robert Tom Harrison, WA
 Daniel Brodie Hogg, Qld
 Hamish McKinlay Horton, NZ
 Patrick Kwing Shing Hung, SA
 John Anthony Jaccarini, SA
 Peter John Keast, Vic
 Gavin John King, NZ
 Kie Tjong Kwa, S'pore
 John Frederick Lodge, Qld
 Peter Michael Mahoney, Qld
 Colin James McArthur, NZ
 Joanne Penelope McDougall, Vic
 William Joseph McMeniman, NSW
 Serge Merzliakov, NSW
 Gerard David O'Connor, NSW
 Michael Edward O'Loughlin, Qld
 Duncan Ross Phillips, Vic
 Sook-Han Poon, NZ
 Peter John Pryor, NZ

Christine Ann Quin, NZ
 Michael George Scarf, NSW
 David Anderson Scott, Vic
 Kurt Singer, NSW
 Margaret Stuart Smith, NZ
 Hugh McLaren Speirs, WA
 Jane Marie Stahl, Switzerland
 Robert Ernest Steele, SA
 Robert John Storer, WA
 Andrew Douglas Temperley, NSW
 Peter David Tennent, Qld
 Kenneth James Thompson, NZ
 Mark Robert Upton, SA
 Neil Raymond Warwick, NSW
 Frank McKenzie Whan, Vic
 James Francis Wilkinson, NSW
 Peter David Yorke, ACT
 Clement Yuan, HK

7th April, 1992

FELLOWS

Jean Avery, Qld
 David John Benson, NSW
 Fedor Max Serge Bodlander, NSW
 Robert John Hugh Boughton, NSW
 Victor Brand, Vic
 Robert John Brooks, SA
 Colin Ernest Busby, Qld
 Maura Anne Carroll, Qld
 Paul Champion, Vic
 Hock Heng Chiu, S'pore
 Kwok Wah Chu, NZ
 Robert Milton Chung, NSW
 Richard Stuart Cohen, NSW
 Bernard Cresswell, WA
 Mark Jacob Fajgman, Vic
 Luis Gallur, NSW
 San San Gan, S'pore
 Alexander Leslie Garden, NZ
 Karen Michele Grey, NZ
 Philip Antony Guise, NZ
 Richard Chaworth Hallows, Vic
 John Owen Hancock, SA
 Vasudev Srinivas Hatangdi, NZ
 Michael James Hellings, WA

John Radford Horne, NSW
 Quintus Leopold David
 Kalpage, NSW
 Louis Klein, NSW
 John Kohn, Vic
 John Berend Lauritz, Qld
 Peter John Lawrence, NSW
 Gordon William Leckie, Vic
 Leonard Keith Lightfoot, WA
 Gail Elizabeth Littlejohn, Vic
 Anthony Alban Lynch, Qld
 Laurence Edward Mather, NSW
 Kevin McCaul, Vic
 Glyn Robert McHutchison, Vic
 Jacqueline McLeod, NSW
 Barbara Jean McLucas, NSW
 Angela McLuckie, UK
 Eric Jack Micklethwaite, NSW
 Kin Pong Ng, HK
 Breton John O'Mahony, WA
 John Neil Osborne, NSW
 Pauline Joy Paton, NSW
 Michael David Pemberton, NSW
 Daryl MacKinnon Salmon, NSW

Carl Brian Scott, NSW
 Peter Reginald Skinner, NSW
 Brian Martin Smith, Qld
 Alec Kumar Sodhy, WA
 Ian Ford Stevenson, NSW
 Paul Kenneth Swan, Vic
 David Hock Seng Tay, S'pore
 Malcolm Rigg Tyers, Vic
 Ian Paul Macdonald Unsworth, NSW
 Robert William Ure, NZ
 Alnis Ernst Vedig, SA
 Peter John Vidler, NSW
 Warren David Walker, NSW
 Geoff Wallich, NSW
 Robert William Whiting, Qld
 David Whatton Wilkie, NZ
 Anne Wills, NZ
 Monica Lai Har Woo, S'pore
 Helene Mary Wood, NSW
 Peter Charles Woodhouse, SA
 Leslie George Wright, Qld
 Man Lee Yeung, HK

15th April, 1992

FELLOWS

Ian Lintern Airey, Qld
 Richard Anthony Barker, Canada
 Sean Jeremy Beehan, NSW
 Ronald Ernest Benson, NSW
 Robert Leonard Bown, Tas
 Neil Thomas Bradburn, NSW
 John Benjamin Chapman, NSW
 David Alan Cherry, SA
 Sook Leung Chew, S'pore
 Pamela Julie Coats, Vic
 David Bruce Frederick Cottee, USA
 Maurice Paul Coutanceau, Vic
 Agnes Mary Daly, Qld
 Robert John Ebert, NZ
 Robert Murray Edwards, SA
 Bradley Michael Fawkes, NSW
 Francis Ferenc Foldes, USA
 Michael Thomas Gleeson, NSW
 Rajpal Sarath Gooneratne, NZ
 Genevieve Anne Goulding, NSW
 Douglas Nicholson Gow, NSW
 Richard Stanley Grenfell, NZ

Richard Michael Thomas
 Halliwell, NSW
 Paul Richard Hanson, Vic
 Colin Angus Heinz, NZ
 Vicki Kay Hoggard, NZ
 Stanley Regnault Hunt, NZ
 Michael Anthony Jackson, Tas
 Sinnathamby Jenagaratnam,
 Malaysia
 Anthony John Kelly, NSW
 Christopher John Kelly, SA
 Peter Charles Laussen, Vic
 Donn Grantley Ledwidge, NSW
 Brendan Vincent Lyne, NZ
 Pamela Elizabeth Macintyre, SA
 Barton John McKenzie, Qld
 Alan Gordon McLean, SA
 Richard Philip Middleton, Vic
 Karis Bin Misiran, Malaysia
 Peter Joseph Moran, NSW
 Robert Scott Murray, SA
 Judith Nella Nicholas, NSW

Paul Ormond Older, Vic
 Keith Attwood Payne, S.Africa
 Janice Elizabeth Peeler, Vic
 Mary Elizabeth Plant, S.Africa
 David Andrew Pybus, NSW
 Ajit Chandran Richards, Qld
 Terry George Richardson, NZ
 Bruce Frederick Rounsefell, SA
 John Roy, NZ
 Philip Inman Rylands, ACT
 Amarjit Singh Sandhu, NSW
 Gregory Durham Spark, NZ
 John Milton South, SA
 Christopher Lyall Thompson, NSW
 Anthony Richard Thorne, Qld
 Thomas Andrew Gabriel Torda, NSW
 Richard Barry Wansey, NSW
 Poleon Yee, NZ
 Boon Hun Yong, Malaysia
 John Zelcer, Vic

27th April, 1992

FELLOWS

David Colin Elly Begg, NSW
 Colin Robert Brown, NSW
 Barbara Gwenyth Burrows, Vic
 Hean Wai Chan, Malaysia
 Russell Jonathan Cook, Vic
 Jeremy Ormond Cooper, NZ
 Graeme Edward Morris Correll, Qld
 Peter George Courtney, Vic
 Graeme Andrew Crooks, NZ
 Graham Errol Dutton, Qld
 Ingrid Ellen Dzendolet, NSW
 Nancye Eunice Edwards, Vic
 Richard Edward Fear, NSW
 Michael James Fong, Qld

John Bruno Fortunaso, NSW
 Nicholas Duncan Gemmell-Smith,
 ACT
 Robert Bruce Gillies, NSW
 John Allan Griffiths, NSW
 Venkatraman Subramania Iyer, SA
 Frederick Cecil Donald Jollow, NSW
 Richard Jeyarajasingham
 Kanagasundaram, NZ
 Christopher David Lavis, WA
 Tat-Leang Lee, S'pore
 Eng Siong Lim, S'pore
 Angus James Ross Maclellan, NSW
 Harold Michael Marsh, USA

John Nicol Matheson, NSW
 David Murrell, NSW
 Rachael Pereira, S'pore
 Michael Sam Rozen, Vic
 Paul Norman Rozental, Vic
 Victor Sereda, Vic
 John Sgouromallis, NSW
 Terence Adrian Shanahan, WA
 Felix Tin-Yau Shin, USA
 Robert Stuart Simons, UK
 Frances Evelyn Smith, NSW
 Susan Joyce Wong, HK

2nd May, 1992

FELLOWS

Philip Roger Ainley, NSW
 David John Bassin, NSW
 Sinnadurai Duraisingam, Malaysia
 John Frederick Gillies, NSW
 Raphael Zeev Glaser, NSW

Robert Darien Henning, Vic
 Mary Ann Holland, Vic
 Kai Chung Li, HK
 Ee Koon Lim, S'pore
 Edward Hunter Morgan, NSW

Duraiyah Thangathurai, USA
 Pamela Anne Tonkin, SA
 Jennifer-Jane Trinca, Vic
 John Manning Wynter, NSW
 Mi Yee May Yuen, HK

SECTION OF INTENSIVE CARE

NOW, A "FACULTY OF INTENSIVISTS" ANZCA?

Within the last year the Australian and New Zealand College of Anaesthetists has attained legal identity by completion of the process of incorporation. Legal advice received was to achieve that as a matter of urgency, which left little opportunity for issues other than incorporation itself to be considered over that time. The Dean and Board did anticipate however, that further reassessments could possibly lead to modifications in the Articles of the College.

The Section received an invitation to initiate some discussion and express views about where the Section of Intensive Care and its intensive care specialists would fit into the new College. This opportunity enables us to reconsider and redefine the whole position of the organisation of Intensive Care within the College.

The President has emphasised that the College welcomes the continued presence of the Section and endorsed intensive care specialists within the College. He has confirmed that the College will maintain the same high academic, scientific and philosophic aims and the same exacting standards of training, examination and certification as the former Faculty of Anaesthetists, in (both anaesthesia and in) intensive care.

As the President has indicated, one option would be quite simple: for the present structure of the Section to be continued as it is constituted and functions at present. However, it would not be unfair to describe some aspects of that organisation as the object of voiced disquiet in recent years.

It is obvious from informal opinions expressed to Section members that currently there is a groundswell of opinion for change. The idea of a College of Critical Care Medicine has come to the forefront, to provide for both Faculty-endorsed intensivists and physician intensivists. Nonetheless, despite any proposal for such a separate College of Critical Care Medicine being a relevant related issue, it does not affect the present need to optimise the place of intensive care within the College of Anaesthetists. Recognisably, the bonds between Faculty intensivists and physician intensivists must in no way be undone, and those links can be seen as a role of ANZICS.

Your Chairman's Newsletter which was distributed with the Agenda for the Business Meeting of the Section of Intensive Care at the GSM in Canberra, was largely

concerned with preliminary comments on a proposed "Faculty of Intensivists". An invitation was made to endorsed Fellows to return any representations they might wish to make to the Executive on these matters. In the event no written comments were received. The invitation still holds, particularly for Section members who were unable to attend the Business Meeting (necessarily, in terms of definition in the current Constitution, held at the Intensive Care "Day" at the Canberra GSM).

The future of intensive care within the College was an official Agenda item for the Business Meeting in Canberra and enabled those able to be present to discuss the issues in open forum. The consensus of opinion achieved was that this needed defining within its own right, that steps should be undertaken to initiate the process formally in negotiations with the Council, and that notwithstanding any undeniable indication for a College of Critical Care Medicine in the future, the current time was too premature to initiate such a stand-alone College. Recognisably of course, representation at the meeting was with quite a minority of the approximately 150 endorsed Fellows (but this is the nature of the Intensive Care Day, which primarily is an occasion for anaesthetists with an interest or role in intensive care: it is difficult for full-time intensivists, apart from those present for occasions of the day itself, such as presentation of papers, committee attendances etc, to attend this meeting). Nonetheless, a highly informed opinion was expressed.

In culmination a motion from the floor to the effect that the Section make a formal proposal to the Council to initiate discussions re the formation of a Faculty of Intensive Care was passed without dissent. This first step, if accepted, will be followed by gathering of appropriate data, producing proposition, submitting that to endorsed Fellows for comment, then going back to the Council.

The proposal for a "Faculty of Intensivists" within the College is to provide intensive care with autonomy in its own affairs. This goes along with maintaining close links with the College, including representation in its own right on the College Council. Costs and economies must be carefully considered; thus, joint committees will continue to operate where the interests are mutual (e.g. for continuing medical education and in clinical review).

However, there are very many issues to consider, for example, Faculty Officers and Board membership, the extent for which the Faculty will take responsibility for standards of training and education, the kind of examinations, whether certification will come from the Faculty or from the College, Policy Documents, research, future GSMs, etc.

There is warmth toward the need for a recognisably distinguishing diploma, for instance, Fellow in Intensive Care of the Australian and New Zealand College of Anaesthetists (FICANZCA), or Fellow of the Faculty of Intensive Care ANZCA, i.e., FFICANZCA.

The President, speaking personally, has reminded us concerning reorganisational planning, that “a pretty good working model about to be dismantled” can help to provide the framework for structuring a new Faculty. (In pursuing this notion, on recourse to my copy of the RACS Handbook — for the year 1977 — two features struck me: 1. The very close similarity of the Constitution of the Section of Intensive Care to the Constitutions of the subspecialty Sections of the RACS; and, 2. The emphasis on the happy coincidences whereby Surgery was the Royal College with which anaesthesia originally linked up in the establishment of the Faculty of Anaesthetists, in 1949-50: see pp217-218. The background links between intensive care and anaesthesia are closer than those of anaesthesia and surgery then).

A new Faculty would expect to be able to meet the needs of ANZCA Fellows endorsed in intensive care (but obviously has no applicability for “physician intensivists”). Membership of the Faculty would be offered to the FICANZCA “endorsed Fellows”. These are typically full-time intensivists or near-fulltimers with a smaller side practice in anaesthesia. The position of non-endorsed Fellows may present some problems.

The Section recognises the tremendous obligation owed to such Fellows who do provide intensive care services in our hospitals, usually in country towns and cities and usually on a basis that is part-time with anaesthetic practice, because of the work demands for both specialties. The Section has been exercised over the most appropriate way of producing satisfaction for the needs of such Fellows.

The new Section Executive to take office at the conclusion of the Business Meeting was announced and will consist of Dr Felicity Hawker; Geoff Clarke (Secretary), (appointed to the Education Committee for Intensive Care), Robert Whiting (appointed to the Continuing Medical Education and Clinical Review Committee) and myself, Ron Trubuhovich (continuing in second year as Chairman and appointed to the Education Committee for Intensive Care).

As the election produced only four nominations for the four Executive positions, no ballot was required. The members of the Executive thank Section members for the support expressed for them thereby and declare their intention of providing a stewardship which they trust will warrant that confidence. This will be a busy year.

Finally, I wish to express my appreciation of the supportive approach of our President, Associate Professor Peter Livingstone. Also to farewell and thank Ian Pearson after his years on the Executive and particularly to thank our Secretary, Felicity Hawker for her dedication and hard work. Welcome to Geoffrey Clark who will be a valued Executive member.

R.V. TRUBUHOVICH
 Chairman, Executive
 Section of Intensive Care, ANZCA

MEDICAL ETHICS

(Repeated with permission of RACS Bulletin).

The days when a surgeon or anaesthetist was able to practise his or her art and science in the secure knowledge that right actions were their own reward, are long gone. There are now fundamental changes to how doctors practise medicine with pressures from new technology and research, community expectations and diminished resources, all contributing to a variety of important issues.

The College believes that Fellows should address these challenges and join the debate where the issues impact upon their professional lives and conduct.

In March 1991, the College and Faculty held a National Ethics Seminar at the Wesley Hospital in Brisbane as a Continuing Education activity. It was here that a number of important Ethical issues were discussed.

EUTHANASIA

WHAT ARE OUR RIGHTS AND RESPONSIBILITIES?

Michael L Walsh

Director, Centre for Bioethics and Healthcare, University of Technology, Sydney

I have put the words rights and responsibilities together in the title, because I think they are correlative terms that need to be used together. I also have problems with the simplistic use of rights — language that is a feature of many discussions these days. Clearly, human rights are of vast importance, but unfortunately, all too frequently rights are just asserted, not carefully examined to make sure they are really well grounded. Often times, the simple statement that I have a right to something, seems to be used to close off further discussion. Claims and counter-claims abound in the area of rights and frequently the complexities of the issue get submerged.

A simple example might be the ongoing debates about the rights of smokers and non-smokers and the stresses both claims cause for the restaurant owner. More complex claims about rights to life and rights to die are the constant source of debate in the media and at ethics conferences. Rights need to be carefully argued, and their correlative responsibilities and obligations or duties need further examination. When we start to use the language of rights, we need to be clear precisely what kind of rights we are talking about. The first distinction to be made is between **negative** rights and **positive** rights.

Negative rights — the rights not to be interfered with in the exercise of our freedom and autonomy. These are

the rights we appeal to when we wish to be able to go about our business free of let and hindrance by others. They are negative in the sense that no-one else has to do anything for us. They simply demand that we be let alone to exercise the particular right concerned.

Positive rights on the other hand, imply that someone has the duty to give us our rights, to make it possible for us to exercise our rights. An example of a positive right that people claim in this country is the right to education — this implies that the government has a duty to provide the possibility of education for us. If we are speaking of positive rights, we are making a claim on others, not just that they let us alone to pursue our rights, but that they provide us with the wherewithal to exercise our rights.

In the context of this debate, then, are we claiming the 'right to die' as a positive right or merely a negative right? If negative, then we are saying that others should leave us alone with our choice to be allowed to die. If, however, we are claiming a positive right, then we are saying that someone else has a duty to see to it that it is possible for us to achieve our aim. In other words, we are claiming a right that will impose a duty on someone else to kill us, if necessary. That is quite a heavy demand. Does the medical profession have a responsibility to answer such a demand? Let us have a look at some of these rights and responsibilities as they confront the medical profession

in the care of the dying patient. My comments will be from an ethical viewpoint.

Law and ethics do not always coincide, so I will leave the legal aspects to the lawyers to make their own careful statements. What ethical rights can we establish for patients and doctors and what are the relative responsibilities?

1. Refusal and Withdrawal of Treatment

The doctor-patient relationship is one that is based on at least an implied contract which begins when the patient approaches the doctor for treatment, or the doctor becomes involved professionally in the care of the patient. Such a contract involves rights and responsibilities. Normally they are clear enough. The doctor has a responsibility to offer treatment to the patient which is believed to be appropriate for that particular patient. The doctor cannot be obliged to give treatment which he or she believes to be futile or unethical. The patient also has rights, not only in requesting treatment, but also in its refusal. There continues to be debate about this point in Law Reform Commissions, as the various jurisdictions spell out more clearly the implications of the common law. The trend can be summed up in this way: the patient has a right to refuse unwanted treatment, or to request its withdrawal, if it has already begun. It is within the rights of the patient to decide if a particular treatment is too burdensome.

If treatment is refused or a request made for its withdrawal, the doctor has a duty to comply, on the presumption, of course, that the patient clearly understands the likely medical consequences of cessation of treatment. The debate from an ethical viewpoint focuses on the shift that has occurred from medical paternalism to patient autonomy. Nowadays, the emphasis is placed on the autonomy of the patient, and the competent patient's right to control what happens to his or her body. The patient may decide that a particular form of treatment is too burdensome and may prefer to forego treatment. If the patient persists in that judgment after properly informed discussion, then the doctor has a responsibility to respect the patient's decision.

But patient autonomy is not an absolute. Sometimes patients, or their relatives, demand treatments that the doctor judges to be futile. The doctor has a right to refuse such treatments. He or she has a responsibility to make appropriate medical decisions. To do otherwise would be an abdication of professional responsibility. In the care of the incompetent patient, the doctor may have the responsibility to order treatment abatement on the grounds of beneficence — basing this decision on the best interests of the patient.

2. Pain Relief

The dying patient, even in the case where he or she has

refused medical treatment against the advice of the medical professional, has a right to appropriate pain relief. But how do we estimate from an ethical viewpoint vigorous efforts at pain control, even though life may thereby be shortened? The discussion hinges on the importance of intention. It is not sufficient to judge the ethics of an action simply in terms of the action itself and its outcome. Intention plays a vital part and may well distort an otherwise worthy action. If one of my students were to offer me \$100 towards the end of the year — the action itself is indifferent (neither good nor bad); the outcome — an increase in my wealth and happiness seems good; but the intention (a bribe rather than a Christmas gift) would seriously affect it from an ethical point of view. So in the case of the pain killers — what is the doctor's intention: to relieve pain or bring about death? Perhaps he alone knows. But it is vital for a full evaluation of ethical responsibility.

I am not going to be rash enough to suggest to this professional body how pain ought to be managed or controlled. But I will risk the comment that it is an area that demands more attention. The decision to abate medical treatment does not imply that all care for the patient ceases to be a professional responsibility. It is simply that the focus shifts from treatment to care. Whether it be in the hospital or the hospice, the dying patient has a right to pain relief that is no less a professional responsibility than the more spectacular aspects of high technology medicine. The acts of care in such a setting do not aim at the prolongation of the patient's life, but strive to make the patient's remaining time as comfortable and meaningful as possible.

3. Assisted Suicide

The claim that there is a right to suicide, presumes that the decision to commit suicide is a rational one. This point is considerably debated, but it does seem that an argument can be made that some suicides are rational and not obscured by severe depression or intolerable pain.¹ Clearly those motivated by a religious understanding of life as a gift from God entrusted to their stewardship would not agree with this claim to a right, but such an argument does not necessarily close off the discussion for other members of our society.

Assisted suicide of the kind that is of concern to the medical profession involves 'helping to bring about the death of a patient who has intractable pain or is in some other intolerable condition, who is unable for psychological or physiological reasons to commit suicide without assistance, who prefers death to the continuation of intolerable life, and who requests aid in bringing about an end to his or her life.'² A point that needs consideration here is the degree of co-operation involved in assisting a suicide. At times it can be remote, e.g. when the doctor knows the line of thinking of the patient and when

prescribing a particular pain killer, advises: 'If you were to take all of these at once, it would be fatal'. It would be more proximate if the doctor were to give physical support to the patient who is taking the overdose. The level of responsibility would be in proportion to the degree of proximate or remote co-operation involved.

Dr Kervorkian of the suicide machine fame, has sharpened the focus of debate in recent times. As Colin Honey reminds us in that debate: 'In no case of justified killing do we normally kill for the presumed benefit of the victim'.³ Approval of assisted suicide would represent a paradigm shift in ethical thinking and hence would need to be carefully argued, not just asserted. Any doctor who takes on such responsibility, needs to be well aware of the step taken and its implications, especially the legal consequences.

4. Euthanasia

The claim to a right to voluntary euthanasia must be examined in some detail as it is much debated, often with more heat than light. It is vital to recall here the distinctions I made previously between negative and positive rights. A negative right is the right I have not to be interfered with in its exercise, e.g. my right to life. No-one has the right to stop me living. A positive right, on the other hand, implies much more. It means that I am claiming that others have a duty to see that I am enabled to exercise my right.

Clearly, in the area of our debate when we speak of rights, this distinction is important. The patient requesting the abatement of treatment is claiming a negative right — that the medical professionals do not interfere with the person's right to self-determination. The patient is claiming the right to be left alone, not to be impeded in the process of dying. In the case of euthanasia, the one claiming this right is by implication, imposing a duty on the medical profession to assist in his or her death.

The demand on the medical profession is to examine, not just what might be patients' rights, but what are the responsibilities of the profession. And it is on this point of an understanding of the responsibilities of the profession that much of the opposition to euthanasia and the claim of patients' rights to be killed, rests. The goals of medical treatment are to prevent sickness, restore health and prolong life. But to be ethical it must strive to achieve these goals in a manner consistent with the patient's value system and with the ethical standards of medicine. The duty of the doctor could be summed up as being to provide care for the patient which is beneficial, does no more harm than good, respects the patient's autonomy and is fundamentally respectful of the patient as a person. The doctor is not obliged to provide treatment he or she judges to be futile or unethical.

Once the decision is made by the patient or the doctor to

cease treatment a further question arises. Is it ethical for the doctor to proceed to active intervention to end the life of the patient? It is at this point that the debate about euthanasia heats up. Some would say that if it is ethical to omit treatment then one should also be able to act directly to end the life of the patient. The argument is that the outcomes will be the same — the death of the patient. They would describe omission of treatment as 'passive euthanasia' and would go on to argue that if we allow this form of euthanasia there is no logical reason why we should refuse to endorse 'active euthanasia'. They would further argue that there is no significant moral difference between an action or an omission. Their opponents would argue that the omission of treatment in these circumstances is not an example of euthanasia, but rather an appropriate medical decision in the case of a dying patient.

The distinction between killing and allowing to die, or between acts of commission and omission, is at the heart of the euthanasia debate. Despite a body of literature to the contrary,⁴ I believe that the distinction is significant. Time does not permit me to develop an argument here, so I will simply refer to an editorial by Ranaan Gillon in the *Journal of Medical Ethics*:

*'In analysing these issues it is important to distinguish between two quite different claims. The first is that there is a necessary moral **equivalence** between killing and letting die. The second is that there is a necessary moral **difference** between killing and letting die. Both claims are false but it is only the second to which contemporary philosophers have addressed themselves. The famous example offered by James Rachels in which one villain drowns his young cousin in order to inherit, while another, intending to do the same is spared the effort because his cousin falls in his bath, hits his head and drowns "naturally", is one of many that shows there can be no **necessary** moral difference between killing and letting die . . .*

However, from the conclusion that there is no necessary moral difference between killing and letting die it simply does not follow that they are necessarily morally equivalent; all that follows is that there are cases where letting die is morally equivalent to killing (and of course vice versa). Plenty of counter-examples are available to demonstrate that it would be equally absurd that killing is necessarily equivalent to letting die"=

When we apply this distinction to the question of euthanasia, we can see that there is a difference between killing and letting die. All acts of direct killing of the patient are wrong, so are some acts of letting die — when there is the possibility and the necessity of acting in a way to save life. But sometimes, it is moral to allow someone to die. It is clearly necessary to make distinctions

between killing, unjustified letting die and justified letting die. Sometimes there is no significant ethical difference between the act and an omission. But at other times there is. Sometimes a doctor may ethically refrain from treatment and allow his patient to die. But it is never ethical for him actively to kill his patient. Active killing is a clear violation of the fundamental principle of respect for human life.

Conclusion

In attempting to come to grips with the difficult questions of the rights and responsibilities of the medical profession in the question of euthanasia, we might be well advised to shape our questions in the following way. Is a doctor acting responsibly in allowing this patient to die, given the patient's diagnosis and prognosis? If the answer to this question is 'yes', either because the treatment is too burdensome, or offers no real benefit, or because the patient is reduced to mere physiological functioning and is deprived of any further opportunity to achieve the purposes of human life — then we can conclude that it is ethical to cease treatment.

Is a doctor acting responsibly in instituting a programme of vigorous pain control, even though the patient's life may thereby be shortened? If it is clear that pain control is the directly intended effect of the action and that any associated side effects are merely tolerated, then the doctor may proceed. We should be quite clear that such an approach represents sound medical practice and we should not allow ourselves to be persuaded that we are embarking on the path to euthanasia by those who fail to make the necessary distinctions and who may have their own agenda in shifting the focus of debate.

We should also be clear that any move to involvement in assisted suicide or euthanasia marks a paradigm shift in our understanding of the nature of the profession and its role in the care of the dying. Previously the focus has always been on cure, treatment and care, never active involvement in the death of a patient.

We should also be clear that any move to involvement in assisted suicide or euthanasia marks a paradigm shift in our understanding of the nature of the profession and its role in the care of the dying. Previously, the focus has always been on cure, treatment and care, never active involvement in the death of a patient.

What we owe patients is care, compassion and company through the process of their dying — not help to die by killing them — however mercifully.

References

1. Pieper, A. 'Ethical Arguments in Favour of Suicide' in Pohier J & Mieth D (eds), *Suicide and the Right to Die*. Edinburgh, T. & T. Clark, 1985, p39.
2. Weir, R. *Abating Treatment with Critically Ill Patients; Ethical and Legal Limits to the Medical Prolongation of Life*. New York, Oxford University Press, 1990, p299.
3. Honey, C. 'Simple Assistant and Difficult Issues' in *Medical Journal of Australia*, vol 154, Feb 4, 1991, p206.
4. Rachels, J. 'Euthanasia, Killing and Letting Die' in Ladd J (ed), *Ethical Issues Relating to Life and Death*. New York, Oxford University Press, 1979, pp146-63.
5. Kuhse, H. *The Sanctity-of-Life Doctrine in Medicine: A Critique*. Oxford, Clarendon Press, 1987.
5. Gillon, R. 'Euthanasia, withholding life-prolonging treatment, and moral differences between killing and letting die'. *JME*, 1988, 14:115.

ACTIVE EUTHANASIA THE CURRENT DEBATE

Dr Brian Pollard, FFARACS
Past President, Australian Society of Anaesthetists
Past President, Palliative Care Society of New South Wales

Euthanasia is the deliberate killing of an innocent person, for compassionate motives. It is voluntary, when the victim consents to be killed, or involuntary, when the victim is either not capable of giving an opinion, on account of immaturity or mental defect, or is capable of giving an opinion, but is not asked.

Euthanasia is a form of homicide and would remain so even if it were to be legalised. Though there can be accidental homicide, there is no category of passive

homicide. Homicide is committed whether intended death results from an action or an omission, since the law assesses an action by reference to the intention. Thus, whenever there is the intention to kill, euthanasia is always active, though it be brought about by withdrawing care. Conversely, when there is no intention to kill, there is no euthanasia. When unwanted, burdensome and futile life-extending treatments are ethically withdrawn, because they are needlessly prolonging the act of dying, there is no intention to kill. Such actions may be wrongly

labelled as passive euthanasia by doctors and others who do not understand the issues, or by those who wish to muddy the ethical waters. But passive euthanasia is a myth which we will perpetuate only to our professional cost.

The public debate on euthanasia is conducted almost wholly in the media at a superficial and emotional level, in cycles which respond to passing interest in a current story of killing, thought to be compassionate. Today's deep and meaningful issue is forgotten next week. From my experience, I can say that the media, with few exceptions, have no interest beyond presenting a contrived spectacle of controversy, which may be as well, because generally, I believe they have little capacity to do more. When it is possible to get to the truth of a case under discussion, it is commonly found to be a clear example of preventable medical neglect.

The 'right to die' is asserted, but not defined or argued. In discussion, this right becomes subtly changed into one's right to be killed, but absolutely never in those terms. Despite that, no code of law or ethics has ever, even vaguely, alluded to such a right! The call then is for reform of our outdated laws which are said to stand in the way of the application of mercy, and doctors regularly join in these calls.

This plea for law reform is not accompanied by specific proposals for change, except perhaps a vague suggestion that we might do worse than follow the good example of Holland. The inference is that the law remains as it is because of reactionary opposition to progress, and that if only someone would set his mind to it, the law could be suitably amended. It is not revealed that no country in the world has legalised euthanasia, and that this is because it has proved too difficult, and is not for want of trying. Attempts have been made in many places, all to no avail.

The reasons why these attempts have failed are:

- (a) the impossibility of determining in many instances the true intention of the provider. The claim of compassion could not always be tested;
- (b) the possibility of an error of diagnosis;
- (c) great difficulty in drafting descriptions of the disabilities which would justify killing, so as to cover all circumstances, while avoiding the possibility of abuse; and
- (d) difficulty in ensuring freedom in the matter of consent or dissent in the emotional context of dying, when fear, anxiety, confusion, paranoia, depression, feelings of worthlessness and coercion are either common or are likely. The outcome has been that no parliament has felt sure that the proposal before it could not be substantially abused.

The euthanasia lobby treats with total indifference the gross incompatibility between their proposals and the internationally accepted UN Declarations concerning human life and the human rights of a variety of disadvantaged persons, to which Australia is a signatory, and incompatibility too with codes of law and codes of medical ethics. To my knowledge, no medical code of ethics has ever allowed active euthanasia.

The call for euthanasia is based on the recognition of severe distress, often described as untreatable. What does 'untreatable' mean in a community whose professionals have never received organised education and training in care of the terminally ill? If the experts in palliative care who are now available were consulted, how much distress would remain untreatable? I do not know, but neither does any other person until we test it. The dynamic of the present position is that inadequate education leads to an inability to relieve distress in what may be difficult circumstances, which permits unnecessary suffering, which leads to more urgent calls for relief, which leads finally to a perceived need for euthanasia.

Killing those we cannot cure has never been part of a doctor's commission from the society he serves, and it would be a bankrupt gesture in that it would do nothing to prevent others from falling into the same pit. The universal application of the principles of palliative care would be positive and logical, would accord with beneficent principles of care, would respect human life and would be enthusiastically acclaimed by the community. Nobody could predict with certainty how effective it may be, but I think it would be more than adequate to defuse the issue of euthanasia, at least to the degree that the position could then be rationally assessed. Rationality is the most necessary component which is missing at present from discussion.

The hard cases, such as the severely disabled, possibly young, person with an illness which is not threatening life, but for which there is no prospect of cure, but perhaps the prospect of further deterioration, these evoke our extreme compassion. Their distress is emotional more often than physical. A great deal could be said on many aspects of their plight, but of one thing I am sure. If they were to be used to establish a law which could be invoked to allow killing on the grounds of severe mental anguish, its abuse would be certain and uncontrollable.

What of Holland, as an exemplar? Since a certain court ruling there in 1973, euthanasia has been practised ever more frequently, despite that it remains a crime under the Penal Code. Subsequent court rulings have widened the conditions for exemption from prosecution for euthanasia, so that active euthanasia is now common. Indications for it no longer require a terminal illness, consent no longer has to be in writing, even when that is possible, euthanasia may be carried out on minors without parental consent, and when doctors are probed

about their actions, which is uncommon, they may safely plead higher necessity under duress as their justification. Its incidence, certainly in the several thousands annually, is not known for sure because, in most instances, it is not reported to the authorities. Instead, the death certificate is falsified to indicate natural death. The government admits that it has no control over it.

Euthanasia is approved publicly by the Dutch Medical Association and government medical bodies, and a large number in the community, though that approval is not homogeneous. Guidelines for 'carefully' carrying out euthanasia have been issued by those bodies, in contravention of their charters, to ensure that the doctor who adheres to them is at no risk of prosecution. The startling development is that involuntary euthanasia is also approved by all the groups just mentioned, and it has been estimated that it is now two to five times more common than voluntary euthanasia. There have been at least two court cases where murder was proven, where the killing was without the victim's knowledge or consent, but where it was judicially excused and then rewarded, either by the awarding of damages or a suspended sentence.

A generation of doctors has arisen who have never known significant opposition to euthanasia and who have learned that, in some settings, they may either treat or kill. The Sanctuary Association exists to protect the interests of those who do not wish to have euthanasia, because the law, being captive to popular sentiment, is unable to do so. Medical associations in other European countries have isolated Holland, by their vigorous opposition to its practices.

I believe that the suggestion that we might kill some of our patients is outrageous and that it would invite many disastrous consequences. Whatever the community thinks, there is no role for doctors in euthanasia. I urge the Fellows and Council of this College to endorse and adopt the stand of those American doctors who declared in 1988: *'As doctors, we must say we will not deliberately kill. We must say to our fellow doctors that we will not tolerate the killing of patients and that we will take disciplinary action against doctors who kill. We must say to the broader community that if it insists on tolerating or legalising active euthanasia, it will have to find non-doctors to do the killing.'*

Reprinted with permission of RACS Bulletin.

POLICY DOCUMENTS

P13(1992) Review

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

ROYAL COLLEGE OF PATHOLOGISTS OF AUSTRALASIA

A.C.N. 000 173 231

PROTOCOL FOR THE USE OF AUTOLOGOUS BLOOD

This statement applies to autologous blood collected and admitted by anaesthetists at the time of the patient's operation.

1. A standardised label, used only for autologous blood, and clearly marked to this effect, should be securely attached to the collection pack. It should include a unique identification number.
2. The label should carry the signature and name in block letters of the person collecting the blood.
3. A label which includes the patient's name, medical record number and the date and time of collection should be attached to each pack. These details must match those on the patient's identity bracelet.
4. Autologous blood which is not for immediate reinfusion (within 6 hours of collection) should be stored under conditions identical to those required for homologous blood (and be subjected to the same screening tests*).
5. Checking procedures prior to infusion should be similar to those used for homologous blood, and the appropriate entries made in the patient record.

*Optional

May 1992

P24(1992)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

and

GASTROENTEROLOGICAL SOCIETY OF AUSTRALIA

A.C.N. 001 171 115

and

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

A.C.N. 004 167 766

SEDATION FOR ENDOSCOPY

1. INTRODUCTION

Sedation for endoscopy includes the administration by any route or technique of all forms of drugs which result in depression of the central nervous system. The objective of these techniques is to produce a degree of sedation of the patient, without loss of consciousness, so that uncomfortable diagnostic and minor surgical procedures may be facilitated. The drugs and techniques used should provide a margin of safety which is wide enough to render unintended loss of consciousness unlikely.

These techniques are not without risk because of:

- 1.1 The depression of protective reflexes
- 1.2 The wide variety of drugs and combinations of drugs which may be used
- 1.3 The possibility of excessive amounts of these drugs being used to compensate for inadequate local analgesia
- 1.4 The individual variations in response to the drugs used particularly in the elderly or infirm
- 1.5 The wide variety of procedures performed
- 1.6 The differing standards of equipment and

staffing at the locations where these procedures are performed.

Thus it is important to understand the variability of effects which may occur with sedative drugs, however administered, and that over-sedation or airway obstruction may occur at any time. To ensure standards of patient care, the following guidelines are recommended.

2. GENERAL PRINCIPLES

2.1 The patient should be assessed before the procedure and this assessment should include:

2.1.1 A concise medical history and examination and identification of risk factors. Patients should be assessed for risk prior to endoscopy. The American Society of Anesthesiologists classification system is convenient for this purpose (see Appendix 1). Patients in Grades III to V, including the elderly and those with severely limiting heart disease, cerebrovascular disease, significant lung disease, liver failure, acute gastrointestinal bleeding and cardiovascular compromise, severe anaemia, morbid obesity and shock require special attention during endoscopy.

2.1.2 Instructions for preparation for the procedure, the recovery period, and discharge of the patient.

2.1.3 Informed consent for the procedure and sedation.

2.2 Staffing — During an endoscopic procedure, a person who is trained in acute resuscitative measures must be present whose principal responsibility is to monitor the patient's level of consciousness and cardiorespiratory status and assist resuscitation if required. The use of pulse oximetry for every sedated patient will assist this monitoring process. Reliable venous access should be in place for all endoscopies. If major risk factors are identified (as in 2.1) or difficulties can be anticipated, involvement of an anaesthetist in monitoring and administering sedation is recommended.

2.3 Most complications of endoscopy are cardiopulmonary. Sedation should be kept to a minimum required for patient comfort, particularly in the elderly. Increasing the level of sedation to allow more forceful passage of the endoscope, particularly in colonoscopy, carries an unnecessary risk of iatrogenic

trauma; excessive pain during endoscopic procedures often signals poor technique and may mean impending perforation. It should be noted that the combination of benzodiazepines with an opioid increases the risk of cardiopulmonary complications. Opioids should be given first, then the benzodiazepine dose increased slowly according to clinical status. Benzodiazepine antagonists should always be available but these drugs are not for use just to allow greater sedation. Their duration of effect is less than the benzodiazepines and so late "re-sedation" may occur in recovery. The practitioner administering sedative drugs requires sufficient basic knowledge to be able to:

2.3.1 Understand and deal with the action of the drug or drugs being administered

2.3.2 Detect and manage appropriately any complications arising from these actions

2.3.3 Anticipate and manage appropriately the modification of these actions by any concurrent therapeutic regime or disease process which may be present.

2.4 Oxygenation

Degrees of hypoxia are not uncommon during gastrointestinal endoscopy. Oxygen delivered at 2-3 litres/minute diminishes hypoxaemia during endoscopy. At risk patients undergoing endoscopic procedures should have supplemental oxygen.

2.5 A written record of the dosages of drugs and the timing of their administration must be kept as a part of the patient's records. Such entries should be made as near to the time of administration of the drugs as possible.

3. FACILITIES

The procedures must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This should include:

3.1 Adequate uncluttered floor space to perform external cardiac massage on the patient should this prove necessary.

3.2 An operating table or trolley which can be readily tilted.

3.3 Adequate suction and room lighting.

3.4 A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.

3.5 A means of inflating the lungs with oxygen

(e.g. a range of pharyngeal airways and self-inflating bag suitable for artificial ventilation).

- 3.6 Appropriate drugs for cardiopulmonary resuscitation and a range of intravenous equipment (see appendix).
- 3.7 A pulse oximeter.
- 3.8 Ready access to an ECG monitor and defibrillator.
- 3.9 Drugs for reversal of benzodiazepines and opiates.
- 3.10 Equipment suitable for measurement of blood pressure.

4. RECOVERY

Recovery should take place under appropriate supervision in the procedure room or an adjacent area designated for this purpose and adequately equipped and staffed.

Prior arrangements should exist which enable transfer in an emergency to be accomplished smoothly and effectively with a minimum of delay and under adequate medical supervision.

5. DISCHARGE

The patient should be discharged only after an appropriate period of recovery and observation in the procedure room or in an adjacent area which is adequately equipped and staffed. Discharge of patients should be authorised by the practitioner who administered the drugs, or another qualified person. The patient should be discharged into the care of a responsible adult to whom written instructions should be given. Written instructions should also include prohibition of driving and the operation of machinery until the next day, and eating and drinking instructions.

REFERENCES

- 1. Faculty of Anaesthetists RACS and College Document: "Guidelines for the care of patients recovering from Anaesthesia".
- 2. British Society of Gastroenterology. Endoscopy Committee Working Party. Recommendations for standards of sedation and patient monitoring during gastrointestinal endoscopy. *Gut* 1991; 32:823-827.

APPENDIX I

The American Society of Anesthesiologists classification of physical status:

Class I

The patient has no organic, physiological, biochemical, or psychiatric disturbance. The pathological process for which surgery is to be performed is localised and does not entail a systemic disturbance. Examples: A fit patient with an inguinal hernia, a fibroid uterus in an otherwise healthy woman.

Class II

Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiological processes. Examples: non- or only slightly limiting organic heart disease, mild diabetes, essential hypertension or anaemia. The extremes of age may be included here, even though no discernible systemic disease is present. Extreme obesity and chronic bronchitis may be included in this category.

Class III

Severe systemic disturbance or disease from what ever cause, even though it may not be possible to define the degree of disability with finality. Examples: severely limiting organic heart disease, severe diabetes with vascular complications, moderate to severe degrees of pulmonary insufficiency, angina pectoris, or healed myocardial infarction.

Class IV

Severe systemic disorders that are already life threatening, not always correctable by operation. Examples: patients with organic heart disease showing marked signs of cardiac insufficiency, persistent angina, or active myocarditis, advanced degree of pulmonary, hepatic, renal or endocrine insufficiency.

Class V

The moribund patient who has little chance of survival but is submitted to operation in desperation. Examples: the burst abdominal aneurysm with profound shock, major cerebral trauma with rapidly increasing intracranial pressure, massive pulmonary embolus. Most of these patients require operation as a resuscitative measure with little if any anaesthesia.

APPENDIX II

Emergency drugs should include at least the following:

- adrenaline
- atropine
- dextrose 50%
- flumazenil
- naloxone

February, 1992

POLICY DOCUMENTS

E = educational. T = technical. P = professional. 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 (1987) Duties of Regional Education Officers
 E5 (1988) 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 Hospitals with Approved Training Posts
 E9 (1987) Clinical Review
 E10 (1990) The Supervision of Vocational Trainees in Intensive Care
 E11 (1989) 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 (1987) 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 (1989) The Pre-Anaesthetic Consultation
 P8 (1989) Minimum Assistance Required for the Safe Conduct of Anaesthesia
 P9 (1991) The Use of Sedation for Diagnostic and Minor Surgical Procedures
 P10 (1991) Minimum Standards for Intensive Care Units
 P11 (1991) Management of Cardio-Pulmonary Bypass During Cardiac or Major Cardio-Vascular Surgery
 P12 (1991) Statement on Smoking
 P13 (1982) Protocol for the Use of Autologous Blood
 P14 (1987) Guidelines for the Conduct of Epidural Analgesia in Obstetrics
 P15 (1987) Guidelines for the Care of Patients Recovering from Anaesthesia Related to Day Surgery
 P16 (1988) Continuous Intravenous Analgesic Infusions
 P17 (1987) 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

May 1992