

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

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EDITORIAL

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

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PRESIDENT'S MESSAGE

To be elected President of your College creates many emotions, but essentially the thought is of the daunting task ahead and of the achievements of previous Deans and President.

My reaction on being elected to the Presidency by Council is recorded in the Council Minutes as follows:

"I do thank the Council for its decision and appreciate the honour you have bestowed upon me and I totally understand the obligations that I have in this position. I am going to do my utmost to promote the aims of this College and in the next 12 months which I believe are extremely important, I will require the College to determine its real direction and consolidate its position. So, outside that objective I don't believe I will be pushing many new initiatives. We want to consolidate and work out where our direction is going to be."

This remains my view.

The first thing I would like to do in this Message is to thank our past President, Associate Professor Peter Livingstone on behalf of all Fellows for his efforts over the past two years. Peter has worked extremely hard and has with skill and diplomacy steered this College to the secure position it is now in. He has laid the foundation for a great future.

We have a new College, a new President and a new Council with a slightly different approach to things, but we do not have a new course.

What is this course? It is one which continues to develop our identity, independence and credibility, to establish our future as a specialty up with and leading other specialties in health care. To achieve this will require many things but primarily commitment, good communication, consultation and co-operation both within and outside our College.

It will require some changes and as with any change will create some problems in the short term. There will be disagreements but it is essential that we keep these in house and show unity in public. There is no place for division.

With independence we will gain many things but we must also realise we will lose others. We have enjoyed a good relationship with our Surgical Colleagues and the Royal Australasian College of Surgeons over the past forty years and to maintain this we will need to keep working at it.

One of the first decisions to be made will be in regard to our future home.

As has been noted in this column before, the Royal Australasian College of Surgeons wished to purchase the Spring Street Headquarters and has indicated that in the future they would wish us to move out. This purchase occurred in June and creates many uncertainties for us.

Council has resolved that it supports the principle of the purchase of suitable Headquarters for the College in Melbourne, that it obtains appropriate professional advice and assistance and that a Search Committee be established to seek an appropriate building. This Committee has been established and has already inspected several properties. If any Fellow is aware of any property in Melbourne that they believe may be suitable for our Headquarters please contact the Registrar.

The elections for Council and for Regional Committees are now over and I would like to congratulate all those who were successful and hope that those who were not will continue to be active in College affairs.

Competition is healthy and it was pleasing to see that there were six candidates presenting for three Council positions. It was perhaps not so pleasing to note that several Regional Committees did not require an election in that the number of candidates did not exceed the number of positions.

Council and Regional Committees were elected by you to make decisions on your behalf. To do this they need to know your views. Communicate with them, speak to individual members, attend meetings.

The College is yours and there are many ways that it can assist individual Fellows. Use your College, use the facilities provided such as the Library, Museum and Archives, use the policy documents to improve the facilities and standards in your Hospital and use the educational activities developed for your benefit.

Policy documents have changed anaesthetic practice significantly in Australia and New Zealand. One of my current concerns is the budgetary constraints now being placed by Governments on health services and the consequent ability of Hospitals to comply with our standards because of this. Times will be difficult and I believe we can serve our specialty best by insisting that we get a fair share of the health budget.

Many people work for the College and many receive little recognition and acknowledgement for it. I would like to thank them, particularly those who are Examiners, those who are involved in educational and training activities whether as Supervisor of Training, Education Officer or organiser of educational courses, those involved in organising Scientific Meetings, those on Committees and many others not identified.

Also I would like to thank all those Fellows who stay at the work face whilst others of us involve ourselves in College activities.

The year ahead will be hard. I will tackle it with enthusiasm and commitment. It will be an exciting time, a time for unity and striving to achieve our aims.



MICHAEL HODGSON

DR JOHN BENNETT VONWILLER

Eulogy address delivered at funeral service for the late John Vonwiller on Wednesday 8th July 1992, by his brother, Christopher Vonwiller.



It is both easy and difficult to talk of John's life. Easy, because of his strong personality and obvious achievements; difficult, because those achievements, and John himself, encompassed so many separate dimensions — who could do justice in describing them?

- The dimension of John as a father and husband.
- John's work as a doctor, and in particular his passion for the care of the newborn.
- John's contribution to his profession in various roles within the Australian and New Zealand College of Anaesthetists.
- His contributions as a teacher in the Faculty of Medicine in the University of New South Wales, and as the author of some twenty published research papers.
- John the soldier, rising to the rank of Colonel and Commanding Officer of the 1st General Hospital and 1st Field Ambulance; his being honoured by appointment as Honorary Surgeon to His Excellency the Governor General.
- John's community service and counsel to all who sought it. His many positions of trust in State and community organisations.
- Finally, John as a friend, with his love of conversation and debate, and his sense of humour.

John was born on 4 June 1940, the eldest in our family of three children. By the time my sister Virginia and I were old enough to talk, John was ready to argue with us. He called it debating, and he was very good at it. I discovered later in life that if you chose to debate with John, you took your life in your hands.

But already in those days, the qualities of leadership and organisational skill were already apparent. As an older brother, he was a strong role model, and always prepared to catch you if you stumbled.

By the time he had left Shore School, the prizes and scholarships behind him, he had already made up his mind what to do in life. The law or the Bar held no challenge for him. He could already fix the family car or wire the house, so no need to study engineering (although he was to retain his keen interest in technology for the rest of his life). Medicine it was to be, and he enrolled at the University of Sydney.

National Service in the Army interleaved with John's medical studies. He was commissioned in the CMF in 1961 and graduated in Medicine in 1965.

These two separate strands — the Army and the medical profession — then converged in 1968, when he volunteered for active service in South Vietnam, as an anaesthetist in the 1st Field Hospital at Vung Tau. He returned to Australia in 1969, with service decorations.

Marriage to Julie Anne Knight followed in 1970. In due course the family grew to three with the arrival of a large brown dog called Fang, of which John was extraordinarily fond.

With Laura and Damien born in the early 1970s, and after a year in Edinburgh as Senior Registrar in Anaesthetics at the Royal Infirmary, John and the family settled in Coogee. Why Coogee? Possibly because it was Julie Anne's parish. Maybe so he could march to work at nearby Prince of Wales Hospital. More likely because of the proximity to Sydney Cricket Ground, so he could catch an hour or two at the cricket when his busy schedule permitted.

The children were now at St. Brigid's School, a primary school of traditional church values, and supported by a vigorous Mothers' Club. Here John perceived injustice and discrimination – why no Fathers' Club? The result was the formation of St. Brigid's Parents & Friends, and John, although not a Catholic, was invited to become its President.

He continued a close and strongly supportive relationship with this church and its community, and the Christian principles for which it stood, throughout his married life.

John's career was bounding ahead, and he progressed to positions of greater and greater responsibility at the hospital, with his particular interests now established in paediatric anaesthesia. After appointment as Staff Specialist Anaesthetist in 1973, he became Director of Paediatric Anaesthesia and the Children's Intensive Care Unit at Prince of Wales in 1976. By 1991 he served as Chairman of the Department of Anaesthesia and Intensive Care at Prince of Wales and Prince Henry's Hospitals; visiting Specialist Anaesthetist, The Royal Hospital for Women; and Honorary Consultant in Paediatric Anaesthesia at Sydney Eye Hospital.

Meanwhile, he assumed more and more responsibility on behalf of his professional body, the Faculty of Anaesthetists of the Royal Australasian College of Surgeons, and became a member of the Board of the Faculty and of several committees. Of particular note was John's contribution in education and as Chairman of the Primary Examination Committee.

If you want something done, ask a busy person. So it was with John. He played an active role as a Council Member and President of the NSW Public Medical Officers' Association. He contributed service to a number of

Government Committees, in particular since 1985 as a member of the NSW Minister for Health's Special Committee investigating deaths under anaesthesia.

Army life continued unabated, with John achieving the red hat of full colonel in 1984.

There are some of the achievements, but what of John's values? What did he stand for, and in what did he believe?

- Honesty, and integrity of the highest order, recognised by the many positions of trust given to him by his peers and professional colleagues.
- Loyalty and teamwork; John would seek to work with others and through others, and to share credit rather than work alone.
- A highly developed sense of responsibility, and of service to others; a willingness to contribute at no personal gain; his enormous energy and commitment when he accepted any assignment.
- Finally, his love of family, the foundation on which he built all his achievements, and which ultimately was always the centre of his life.

His values supported the qualities which he brought to his work – strong leadership, intelligence and quickness of mind, organisational abilities, sense of humour, and finally a strong commitment to any job he took on.

Fate seems unjust when someone like John dies young. There is so much he has missed: the chance to see Laura and Damien blossom into adulthood; the golden years of retirement with Julie Anne. But equally, there is so much John has done and left behind to leave the world a better place.

ADMISSION TO FELLOWSHIP BY EXAMINATION

ANAESTHETICS

John William Bremelen, Vic
Maree Anne Burke, Qld
David Dunbar, Vic
Adrian Cumming Hall, Vic
Chi Kwan Koo, HK
Calum McClymont, NZ
Roger Norman Raymond, WA
Patricia Adrienne Thompson, NSW

Frances Margaret Ware, Qld
Andrew David Lawrence Warmington, NZ
Linda Susan Weber, ACT

INTENSIVE CARE

David George Clayton, SA

AUTOLOGOUS BLOOD TRANSFUSION

New South Wales Red Cross Blood Transfusion Service

The transfusion of autologous blood has become the standard of transfusion practice in elective surgery and should complement techniques that are aimed to conserve blood and to minimise the use of homologous blood.¹ An assessment of the risks and benefits to each patient is of primary importance in the context of blood transfusions. Whenever possible, techniques of blood conservation that have been established should be utilised.

The NSW Blood Transfusion Service, in association with the major hospitals in Sydney, has established a network for the collection of predeposited autologous blood. It is to be hoped that this network will override some of the logistical and practical difficulties of establishing predeposit, autologous blood collection programmes.

All units of predeposited autologous blood undergo the same testing as for homologous blood; blood group, antibody screen and virology testing for presence of infective markers. To minimise errors, all blood should be handled identically in the hospital laboratory. The cross-matching of predeposited autologous units identifies the patient as having units of autologous blood in stock, serves as an important ABO group and clerical check and cross-links any additional units of homologous blood that may be required. If unused, autologous blood should not be used for other patients.

The use of autologous blood virtually eliminates all the hazards that are associated with transfusions of homologous blood.^{1,4} For example, the risks that are associated with disease transmission and with immunisation to foreign cells or plasma components are reduced or significantly eliminated. The immunomodulating effects of blood transfusion are currently under intense scrutiny.^{5,6} The evidence is far from clear, however, it would be prudent to use predeposited autologous blood if medically possible and to minimise the use of homologous blood.

However not all patients who require cross-matched blood for elective surgery are suitable candidates for a predeposit autologous blood programme: 50% of patients are excluded because of anaemia, poor general health, the presence of infection or inadequate time before surgery.

The controversies about the use of predeposited autologous blood in "high-risk" donors — that is, in children, in elderly persons, in pregnant women and in cardiac patients — largely have been resolved. Predeposited autologous blood transfusions in children have been shown to be safe and effective⁷ and both children and elderly persons are well-represented in orthopaedic programmes that involve the transfusion of autologous blood.⁸

Predeposited autologous blood can be used safely in third-trimester pregnancy, and a pilot study had shown that fetal monitoring was unnecessary. However, the prevalence of blood transfusions at delivery is low^{9,10} and the identification of subgroups of pregnant women who are at a higher risk for blood transfusion is needed as a focus for predeposited autologous blood programmes.

Cardiac-surgery patients who have undergone cardiopulmonary by-pass grafts, valvular replacement or the correction of congenital heart lesions have participated safely in predeposited autologous blood programmes.¹¹ The major contraindications to participation in programmes of predeposition of autologous blood are considered to be disease of the left main-stem coronary-artery, tight aortic stenosis, and unstable or preinfarction angina.¹¹

The responsibilities that are associated with the transfusion of blood must be accepted. Excuses such as a lack of knowledge or of availability of autologous services, the lack of evidence about donor requirements and safety, logistical difficulties and the often-quoted inconvenience of blood-centre protocols no longer are valid. In this era of informed consent and medicolegal ramifications, the options for the transfusion of autologous blood and for blood conservation should be discussed and pursued as far as is possible medically for each patient.

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DEATHS, HONOURS AND APPOINTMENTS

DEATHS

The following deaths were noted with regret:

- Dr J.E. O'Donnell**, Qld – Fellow 1960
- Dr W.K. Peacock**, WA, Foundation Member,
Fellow 1966
- Dr N.W. Bartrop**, NSW, Foundation Member,
Fellow 1956
- Dr J. Loughman**, NSW, Fellow 1960
- Dr F. McK Whan**, Vic, Fellow 1974
- Dr J.A. Lawson**, Vic, Fellow 1969
- Dr J.B. Vonwiller**, NSW, Fellow 1971

HONOURS

Council noted the following Honours and Appointments:

Professor A.B. Baker, NZ – Elected to the Court of Honour, Royal Australasian College of Surgeons

Dr Lim Say Wan, Malaysia – Elected President World Federation of Societies of Anaesthesiologists

Professor Teik Oh, Hong Kong – Elected to Fellowship Royal College of Physicians of Edinburgh

Professor W.B. Runciman, SA – Foundation Fellow of the Hong Kong College of Anaesthesiologists

Professor Gracie Ong, Malaysia – Professor of Anaesthesia, University of Malaya.

ITEMS OF INTEREST FROM THE JUNE 1992 COUNCIL MEETINGS

EDUCATION - INTENSIVE CARE

Faculty of Intensive Care

Council agreed to the establishment of a Working Party to be Chaired by Associate Professor G. Phillips to explore the development of a Faculty of Intensive Care within the College.

EDUCATION - ANAESTHESIA

Qualification in Pain Management

A series of Motions relating to the development of a Post Fellowship Diploma in Pain Management incorporating both acute and chronic pain management and open to Fellows of other Postgraduate Medical Colleges were agreed to.

Regional Committees are to be asked for input and a Working Party will be established later to consider the matter further.

CONTINUING MEDICAL EDUCATION AND QUALITY ASSURANCE

Future GSM Involvement

Following consideration of a discussion document, it was resolved that

- the aim of Australian and New Zealand College of Anaesthetists is to have its own annual scientific meeting.
- we appoint a convention organiser, and
- we meet periodically with the Royal Australasian College of Surgeons and other specialty groups.

GSM Canberra 1992

The report on the scientific programme was considered and the entire General Scientific Meeting was regarded as a great success.

ASC Adelaide 1993

The College will retain its usual involvement with the ASC in Adelaide.

ASC Hobart 1994

It was agreed that we would separate from the ASC in 1994 and have our own annual scientific meeting. This would be at the same time as the ASC and would be in Hobart if facilities and accommodation were adequate.

Continued Demonstration of Clinical Competence

Council resolved:

1. That the College Council supports the principle of a formal mechanism of demonstration of continued maintenance of standards for its Fellows.

2. That a Working Party be established to consider how such a programme be offered to Fellows and report to Council.
3. That the Membership of the Working Party should be:
 - (a) The Chairman of the Continuing Medical Education and Quality Assurance Committee.
 - (b) The Chairman of the Education Committee (Anaesthesia)
 - (c) The Chairman of the Education Committee (Intensive Care)
 - (d) A representative of the Section of Intensive Care
 - (e) Such other Councillors as the Council may appoint.

Council to appoint the Chairman.
4. That this Working Party should be asked to consult with and request input from Regional Committees and the Fellowship.
5. That the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists, the Australian and New Zealand Intensive Care Society and the Royal Australasian College of Physicians be kept informed of the progress of this Working Party.

CME Meeting – Retrieval Medicine

Special Interest Group in Rural Anaesthesia

Council agreed to establish a Special Interest Group in Rural Anaesthesia and invitations will be extended to interested Fellows.

INTERNAL AFFAIRS

Invitation to Observers to Council

The President of the ASA and the NZSA and the Chairman of the Section of Intensive Care were invited to attend the Council Meetings. Dr Ron Trubuhovich, Chairman of the Section of Intensive Care Executive and Dr John Richards, President of the Australian Society of Anaesthetists attended the Meeting.

Air Travel

It was resolved that domestic and Trans Tasman airline travel should be at discounted economy rates for all Fellows travelling on College business.

Regulations and Administrative Instructions

As a result of the incorporation as a College and some former Regulations being encompassed within the Articles of Association, the Regulations and Administrative Instructions were reviewed and consolidated into one set of Regulations. College affairs are now administered under the Articles of Association and Regulations.

EMST Course

The Regulations were amended to require that trainees complete the EMST Course or an equivalent course approved by the Council before training is complete.

College involvement in South East Asia and the South Pacific

Council resolved that

- the Australian and New Zealand College of Anaesthetists as a policy, determine to improve its relationship and involvement with "anaesthesia" in South East Asia and the South Pacific.
- the Australian and New Zealand College of Anaesthetists specifically develop a relationship with anaesthetic organisations in these countries.
- the representatives of anaesthetic organisations in these countries be invited to a General Scientific Meeting in the near future and involved in informal/formal discussion on our future relationship specifically in matters relating to training and examinations
- the above principles be extended to intensive care when appropriate.

Risks associated with endoscopic surgery

Council accepted a request from the Royal Australasian College of Surgeons to participate in a Working Party on this matter.

PROFESSIONAL MATTERS

Policy Documents

The following policy documents were reviewed, amended and approved:

Guidelines for Care of Patients Recovering from Anaesthesia
Related to Day Surgery
Endoscopy of the Airways
Protocols for the use of Autologous Blood.

A Statement on Entrepreneurial Medicine was also approved.

These documents are published in this Bulletin.

Hazard Alerts

Hazard alerts relating to Dangers Associated with the Higher Filling Pressure of Gas Cylinders supplied by one company and of Canda Equina Syndrome associated with Small Bore Continuous Anaesthesia Catheters were approved and despatched to all Fellows, Health Departments and relevant organisations.

Epidural Pethidine

The matter of product labelling relating to the issue of pethidine in the epidural space was referred to the Special Interest Group in Pain for consideration.

ADMISSION TO FELLOWSHIP UNDER ARTICLE 49 (a)

30th June 1992

- Richard Hugh Acland, NZ
 Bin Data Abdullah Ahmad, Brunei
 Eustace Emanuel Alfred, NSW
 John Allt-Graham, UK
 Robin Lorraine Amerena, Vic
 Thomas George William Baker, Vic
 Edwin Roger Barker, Vic
 Robert James Barnett, Canada
 Kanag Baska, NSW
 Maureen Anne Bassili, NZ
 Peter Graeme Bendixen, Qld
 Paul Randolph Berry, NZ
 Stephen Victor Bianchi, S.Arabia
 Julien Francois Biebuyck, USA
 Tarun Krishna Biswas, NSW
 Simon Christopher Body, USA
 John MacKillip Bolton, SA
 Richard John Geoffrey
 Bonham, NSW
 Alan Guibal Bradford, NZ
 Kerry James Brandis, Qld
 Stephen Thomas Brazenor, Vic
 Frederick Anthony Brough, Vic
 Christina Margaret Brown, NZ
 Warren Edward Bruce, NSW
 Leon Richard Alfred Bryan, Vic
 David Errol Bullen, SA
 Peter Caldwell, NZ
 Isavel Carija, WA
 Preston Craine Calvert, NZ
 Robert David Carpenter, NZ
 Harold Wah Kim Chan, S'pore
 Marta Clarke, NSW
 Paul Douglas Cochrane, NSW
 Rosemary McVeigh Coffey, NSW
 Anthony David Cohen, Vic
 Debra Sara Anne Coleman, WA
 Thomas Kentigern
 Collingridge, UK
 Don Bertram Mahendra Collure, NZ
 Barbara Phyllis Coppen, Vic
 Frederick Henry Peter Arthur
 Cox, NSW
 Rosemary Ann Craen, Canada
 Brian John Crichton, NZ
 Kieran Joseph Crowley, Ireland
 Leslie Emery Csenderits, NSW
 Anthony John Andrew
 Cunningham, Ireland
 Stewart Charles Dabb, Vic
 John Davenport, SA
- Mary Therese Dufficy, NSW
 Robert Oliver Edeson, WA
 Elizabeth MacDonald Feeney, NSW
 Frank Fisher, NSW
 John David Fisher, NSW
 Leonard David Fisher, Vic
 Dennis Lloyd Fitzsimmons, Qld
 John Jeffrey Flachs, NSW
 John Lester Foote, SA
 Colin James Friendship, NSW
 David Alan Galler, NZ
 Dawn Marilyn Giltinan, Vic
 D. David Glass, USA
 Lucia Glumac, NSW
 Robert Alister Godkin, WA
 John Charles Goldsmith, NSW
 Ronald Wellesley Greville, ACT
 Robert Mager Gray, Vic
 Ross Alan Grieve, Qld
 Joanne Frances Groom, NSW
 Allan Metcalfe Hall, Vic
 John Scott Hamilton, NSW
 William Hamilton, USA
 Carol Joy Harding, NZ
 Robert Graham Hay, NZ
 James Kia Song Heng, SA
 Joerg Zinner Hickman, NSW
 Geraldine Hill, NSW
 Paul Hng, WA
 Soon Hean Ho, S'pore
 Terence Mark Hoolahan, NSW
 James Murray Hunter, Qld
 Ian Leslie Graham Hutchison, NZ
 Margaret Innes, NZ
 Ross Malcolm Ireland, WA
 Mark Raymond Janson, Vic
 Christopher John Joyce, NZ
 Philip Juno, USA
 James Patrick Dalton Keaney, ACT
 Bernard Xavier Kehoe, Qld
 Geoffrey Peter Keller, NZ
 Siew Tuan Khoo, S'pore
 Robert John Killalea, NSW
 Judith Clare Killen, NSW
 Choo Kok Koay, S'pore
 Man Chiu Kung, HK
 Francis Xavier Lah, NSW
 Mohan Parbhu Lala, NZ
 John Lander, NSW
 John Edward Dennis Lane, Vic
 Lilian Lai-Lin Lau, HK
- Mary Dianne Lewis, Vic
 Boon Tock Lim, WA
 Kim Seong Lim, S'pore
 Peter Ronald Lindberg, NSW
 Kyaw Nyunt Lwin, HK
 Kenneth William Macleod, NSW
 Eike Martin, Germany
 Peter Richmond McCall, Vic
 Graham Roy McCleary, NSW
 Alan Maxwell McDonald, Qld
 Lawrence Edward
 McDonnell, NSW
 Desmond Patrick McGlade, Vic
 Paul Martin McGrath, SA
 Graeme Alistair McLeay, SA
 David Roderick McLennan, Qld
 Peter Laurence McNicol, Vic
 Paul Mead, Qld
 Leela Menon, Malaysia
 Kevin Moriarty, Vic
 Jean Oakes, Tas
 Kerry Anne O'Connell, SA
 Thomas Leonard O'Connell, NSW
 Elizabeth Eily O'Hare, NSW
 Roger Stanley Packer, SA
 Chee Ping Edward Pang, S'pore
 Robert David Paton, Hobart
 Bodiabaduge Camillus Leonard
 Annesley Perera, NZ
 Richard Song Phin Pok, NSW
 John Henry Pratt, WA
 Anthony Norman John
 Prendergast, Vic
 James Walker Prescott, NSW
 Michael Anthony Radley, NZ
 Thirunavukarasu Rajasingham, NZ
 Balendra Wyrmuttoo Rasiah, NZ
 Prem Narain Rastogi, NSW
 Kunarathy Ratnavadivel, NZ
 Pia Karen Raudkivi, NZ
 Edward Glyndwr Richards, NZ
 Terence Bryan Rushford, Vic
 Mark Joseph Ryan, NSW
 Win Min San, S'pore
 Mark William Murray Sandford, Vic
 Mark Schneider, WA
 Keith Richard Searle, NZ
 Ashim Kumar Sen, SA
 William Arthur Joseph Shearer, Vic

Vallipuram Sivagnanaratnam, S'pore
 Mark Skacel, NSW
 Warwick Mayne Smeeton, NZ
 Matthew Spence, NZ
 Miriam Stocks, Qld
 Bruce Lindsay Taylor, UK
 Brian Meredith Teviotdale, NZ
 Donald Henry Theobald, NZ
 Rowan David Thomas, Vic
 Peter John Tralaggan, NSW

Jovina Tze Hsing Tseng, S'pore
 Kenneth Tweedale, NSW
 James Edward Clive Twentyman, UK
 Annie Winifred Wall, SA
 Naham Warhaft, Vic
 Barbara Mary Watson, WA
 Evan Charles Watts, NZ
 William Munro Weightman, WA
 Drew Cecil James Wenck, Qld
 John Benedict Williams, WA

John Bruce Williams, NSW
 John Henry Agnew Wills, USA
 Alon Palm Winnie, USA
 Gerald Wong, NZ
 Kai Cheung Wong, NSW
 John Woodley, Vic
 David Govett Romaine Wright, NZ
 Patricia Margaret Yelavich, NZ
 Christopher Laurence Yeo, NSW
 Graham Andrew Yule, NSW

Dr Gwen Wilson Honorary Historian 1966-1992



At the June Council Meeting, Council acknowledged the retirement of Dr Gwen Wilson as the First Honorary Historian to the Australian and New Zealand College of Anaesthetists. Dr Wilson had held this position and the antecedent one of Honorary Historian to the Faculty of Anaesthetists, RACS, for 26 years, during which time she had established herself as the foremost historian of anaesthesia in Australasia and one of the doyens of world historical research into anaesthesia.

Dr Wilson researched over many years and published in 1988 the landmark resource edition on the Bibliography of References to Anaesthesia in Australian Medical Journals 1846-1962. This book which is the only one of its kind in the historical literature on anaesthesia is a great work of scholarship and the Faculty of Anaesthetists, RACS, awarded Dr Wilson its Faculty Medal in 1988 in commemoration of this great work. During her time as Honorary Historian,

Gwen Wilson also produced the definitive history of the Australian Society of Anaesthetists entitled "The First Fifty Years of the A.S.A." This book is again a first in anaesthesia and has led to Societies of Anaesthetists in other countries publishing their own histories with advice on how to research the topic and with help to locate definitive references, freely given by Gwen Wilson. During the major part of her long tenure as Honorary Historian, Gwen Wilson has been writing the definitive history of anaesthesia in Australia from its introduction in 1847 to the present day including the history of the Faculty, and the College, and entitled "One Grand Chain". This history is nearing completion and Dr Wilson believes that by retiring from her formal commitment as Honorary College Historian that she will be able to devote more time to the speedy completion of this most important task. No one knows the history of Australian anaesthesia better than Gwen Wilson and this knowledge must be harnessed to complete this History which will remain for evermore as a grand memorial to her work as Honorary Historian to the Faculty and College.

Gwen we salute your scholarship, applaud your authorship skills, and thank you for your sterling work recording the history of anaesthesia in this region, and for recording and archiving the history of the Faculty and College.

A.B. BAKER

OBJECTIVES OF TRAINING, EXAMINATIONS AND CONTINUING MEDICAL EDUCATION

All Fellows will be aware that the Objectives of Training in Anaesthesia have been updated recently. The equivalent Intensive Care document is currently being reviewed. The documents will be circulated to all Regional Committees, Supervisors of Training, Examiners and registered trainees.

The importance of the latest Anaesthetic document lies in the fact that it is an educational statement of the objectives of training and of the standard to be reached by the trainee by the end of training. It will be the guide to both primary and final examiners of the breadth and depth of knowledge and understanding required of trainees. It will indicate to Supervisors of Training the areas to be covered in training which may not be examined currently such as personal attributes, exposure to administration, quality assurance and research. It will thus be a useful guide to trainees.

But the Objectives of Training are more than that — Fellows wishing to review where they stand in their current practice could not do better than to use the Objectives of Training as a reference document. Continuing Medical Education is directed at keeping Fellows up-to-date with all aspects of consultant practice relevant to them.

Some aspects of the document are relevant to all practising anaesthetists — e.g. preoperative preparation, principles of general anaesthesia, management of postoperative pain, cardiopulmonary resuscitation, initial management of malignant hyperthermia, the ability to critically appraise a scientific article. Other aspects of the document may be of no relevance to some — e.g. most anaesthetists do not need to have any detailed knowledge or understanding of areas they never see, such as anaesthesia for heart surgery or liver transplantation.

The following pages reproduce the forward to the second Edition, the content and the Introduction to the document.

FOREWORD TO THE SECOND EDITION

Originally published in 1976, these Objectives of Training have provided a definitive statement of the standards to which trainee anaesthetists must aspire if they are to be awarded the Diploma of Fellowship of the Australian and New Zealand College of Anaesthetists. They have also provided guidance for College teachers and examiners.

Revision for this Second Edition has been undertaken by the College Council and has been supervised by Dr John Vonwiller, Chairman of the Primary Examination Committee. The Objectives defined in the First Edition remain equally relevant today and with minor alterations are retained in this Edition. New or expanded Objectives have been formulated in some areas, particularly for Pain Management, Day Surgery, Safety, Retrieval and Transport, Research, the Scientific Method, Administration and Quality Assurance.

It is the Council's view that these areas are all extremely relevant to anaesthetic practice in the late 20th Century and that training programmes should include appropriate emphasis and experience in these areas.

Recent governmental inquiries and reports on aspects of medical practice in both New Zealand and Australia and their impact on anaesthetic training have also been taken into consideration in this revision.

With the increasing emphasis now being placed on Continuing Medical Education and ongoing assessment of clinical competence of practitioners, the Council now believes that this revised document can provide guidance not only for trainees but also for specialist anaesthetists in defining what the College expects of competent practitioners, particularly in the relatively new or changing areas of bioethics, consent, teaching opportunities and patient rights.

These Objectives of Training are supplemented by the "Manual on Training" which should be consulted for detailed information about subject matter in Physiology and Pharmacology, and reading lists in these topics and in anaesthesia and its many areas of specialised care and service.

The Objectives are necessarily written in general terms as College policy may change with time in some areas. College Policy Statements provide information on current College policy. Trainees and specialists alike should study these Policy Statements in conjunction with the Objectives in order to define currently accepted standards of attitudes and behaviours in these areas.

The Council thanks those Fellows of the College who contributed to this revision and Mr Neil Paget of the Higher Education Advisory and Research Unit, Monash

University for his advice and guidance, and commends the Objectives of Training to trainees, teachers and examiners and Fellows.

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INTRODUCTION

It is pertinent to review the reasons for a document on the objectives of training. The education of an individual who wishes to attain the status of a specialist anaesthetist, has two major components:

1. Training in accredited Departments of Anaesthesia in a rotational training scheme.
2. Assessment at the F.F.A. Examination.

Throughout training, the trainees and the teachers need to be able to assess progress in the attainment of knowledge, practical skills and attitudes. A Statement of Objectives facilitates both this assessment and training, and assists the College Examinations to become more relevant to the overall aims of training. The need for such an approach has been echoed increasingly by Fellows in the expression 'Put more emphasis on training and less on Examinations'.

Both trainees and teachers are sometimes uncertain as to what should be learnt. Much difficulty arises from the nature of the specialty which has advanced in many different directions, because the skills of the anaesthetist

are also suited to many differing types of patient care. Further definition of the objectives and content of the training period is desirable.

After the decision was made to do this, two major difficulties became apparent. Firstly, if the skills were stated as those required to pass the examination, there would have been a sudden increase in the emphasis on the examination, possible panic amongst trainees, and discouragement to those who like to explore some areas of the work in greater depth. Such an examination oriented syllabus also would have prevented definition of practical skills and attitudes.

Secondly, if the skills were stated in the form of a detailed syllabus with reference sources, the document would have discouraged the active search for knowledge, decreased interest in clinical learning, impeded the acquisition of skills outside the content of the document and would have rapidly become outdated.

To overcome these problems 'The Objectives of Training in Anaesthesia' defines the skills in the form of learning objectives which are sufficiently detailed without being unduly restrictive.

The document is an education statement. Its impact on the content of training programmes has been profound. It is of increased importance that this statement be available at a time when the medical profession and the general public are making their concerns known through recent committees, commissions and reports throughout Australasia. Of particular significance are the Cartwright Report (The Report of the Cervical Cancer Inquiry, Auckland, New Zealand: Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters, July 1988) and the Doherty Report (Australian Medical Education and Workforce into the 21st Century, Canberra: Committee of Inquiry into Medical Education and Medical Workforce, April 1988). The relevance and credibility of this document is enhanced through its concern for those recent issues being debated. The College has noted changes and addressed these in its present revision, consistent with the Doherty Report recommendation 9(ii) which states

"Colleges make trainees aware of trends in health policy and in community attitudes that relate to their future role as specialist practitioners, and take account of those trends, as well as of professional, scientific and technological developments, in updating college training programmes."

The document is not meant to be read in a single sitting, but it should be consulted regularly. It will not remain

static and changes will continue to be made as the specialty takes on new directions. The Objectives will also be modified in the light of experience gained in their use.

Detailed definition of the standard of performance in achieving objectives is often recommended, but an attempt to do so would have been unduly restrictive. However, in training programmes which lead to assessment as the basis of specialist certification, appropriate standards must be reached. Information regarding these standards will be disseminated by the College.

The most important purpose of the document is to define the skills which an anaesthetist should acquire during the training period, and which should be maintained and improved thereafter. It is therefore a statement of the minimal level of competency expected at the end of the formal training period. Thereafter, the specialist anaesthetist would be expected to maintain similar levels of competency in those areas relevant to the nature of practice undertaken.

The document is not designed to be a specific syllabus for examinations, but these objectives influence changes in the examination system because there must be a relationship between assessment and objectives of training. Trainees can use the objectives as the basis of self-assessment of their preparation for the examination. Successful learning is substantially dependent on the students' own efforts.

As the quality of teachers and trainees in the future will depend not only on their natural ability, but also on their understanding of the principles of education and research, the objectives in relation to education and research are stated separately as they are common to the use of the whole document. Some resources involved in attaining these objectives are not readily available at the moment; but this deficiency is recognised and the College Council is investigating ways and means of providing them. Nevertheless the study of these sections is to be encouraged, and some of the objectives are already a required part of the training.

Where appropriate throughout the document there are lists which contain examples of possible special learning experiences. These do not constitute a syllabus. Nor do they restrict the nature of the skills required by an anaesthetist.

There is, of course, a **general** learning experience which is implicit in the whole document. This includes:

(i) Clinical Experience

This is most important. As well as developing manual dexterity and reinforcing the knowledge gained from

other learning experiences, it contributes to the development of diagnostic and problem solving skills and it fosters the acquisition of attitudes appropriate to the role of a specialist consultant. A broad based experience and knowledge of general medicine and surgery is an important prerequisite for specialist anaesthetic practice.

(ii) Appropriate Source Material

Books, monographs, references, tapes, films, tutorials, lectures etc., which are relevant to any of the objectives. Further assistance is available from the 'Guide to Study'. College Policy Statements provide advice on currently accepted standards of practice.

(iii) Basic Sciences

Throughout the document it is assumed that trainees will study the related basic sciences. e.g., pharmacology, physiology, mathematics and physics.

(iv) History of Anaesthesia

All aspects of Anaesthesia should be viewed in their historical context.

(v) General Attitude

Trainees should desire to learn and acquire practical skills to the best of their ability. They should work and learn with the patient's welfare foremost in their minds.

(vi) General Features

Even when not stated, the objectives apply to all patients taking into account age (from the premature infant to the very elderly), gender, and genetic make-up.

The modification and adaptation of the objectives in hospital departments is strongly encouraged. The document is reviewed regularly, and such reviews will be made by consensus in the light of the experience of the users.

The progress of the trainees towards the ideal will take place only if their teachers and senior colleagues continue to be energetic and enthusiastic. In particular, the attitude of being active in one's own education is the most important of all. Thus the use of these objectives can be the foundation of continuing education throughout the anaesthetist's professional life.

Copies of the document are available from:

Ms C. Cunningham-Browne
Australian and New Zealand College of Anaesthetists
Spring Street
Melbourne, Victoria, 3000.

G.D. PHILLIPS

STATEMENT ON ENTREPRENEURIAL MEDICINE

This statement is intended to assist Fellows with the sometimes complex professional and ethical situations which can arise from involvement with commercial organisations.

In the current economic climate in both Australia and New Zealand, Fellows are heavily reliant on funds from commercial groups to aid with research, with educational endeavours and with other professional activities. Some – but by no means all – of this support is given with commercial objectives in mind. The guidelines which follow are intended to assist Fellows who negotiate with commercial organisations in relation to clinical, teaching and research activities. Senior officers of the College are very prepared to give advice on matters presenting difficulties.

GENERAL PRINCIPLE

The College of Anaesthetists strongly affirms that a formal acknowledgement of the support given by a commercial organisation is a necessary part of any report of research, educational activity or other professional function. Fellows should not allow their names to be associated with any form of direct advertising. Unequivocal evidence of professional benefit to patients and/or to colleagues must be the yardstick by which associations with commercial organisations are judged.

COLLEGE MEETINGS

1. The nature and extent of commercial support for meetings must be negotiated by the organising committee. That support should be acknowledged appropriately and should form a part of the report and the accounts of the meeting.
2. Identifiable profits associated with the meeting but resulting from commercial support should be devoted to further educational or research activities.
3. Normal College guidelines for control of the meeting should be observed. The Medical Industry Association of Australia Technical Exhibition Guidelines (Appendix A) will be of value in negotiations related to a Trades exhibition.

TRAINING PROGRAMMES

1. Commercial support should be directed to the programme as a whole and should be under the control of the Fellow(s) responsible for its organisation.

2. Where a prize is awarded for work performed by a Fellow or trainee, the selection of the prize-winner should be entirely under the control of an appropriate and independent Committee.

WORKSHOPS, SEMINARS AND MEETINGS SPONSORED BY COMMERCIAL ORGANISATIONS

1. Ideally the activity should be under the control of a College based organising Committee with representation from the commercial organisation(s). It is always appropriate that support be fully acknowledged in an unbiased manner.
2. If a commercial organisation is responsible for the setting up of the meeting and its programme, it is more appropriate for them to handle all arrangements and for the College not to be formally associated with that meeting.
3. Fellows and trainees may be invited to attend commercially sponsored dinners or social activities with a varying amount of associated educational activity. A decision whether to attend such a function must relate to the General Principle and remains a matter of individual choice.

RESEARCH PROJECTS

1. Fellows who are asked to take part in commercially sponsored research or development should establish a written contract with the organisation concerned. Ideally the contract will involve a 'neutral' third party such as a University or a Research Foundation. The contract would then be subject to the rules of that third party.
2. Normal Ethical Committee procedures and approval must always be followed and must include disclosure of the commercial association with the proposed project. In such cases, a recognition of the potential benefits and risks to the patient is essential and normal ethical committee procedures for a new treatment should be followed.
3. As implied above, all financial arrangements are best channelled through the third party.

TRAVEL

1. There are unlikely to be difficulties where travel is part of a research grant properly administered through a 'neutral' third party.
2. Money granted on a personal basis for attendance at meetings should be carefully considered using the General Principle as it has the potential to compromise a Fellow's or a trainee's independence. Such funding should always be disclosed in any presentation to the meeting or in a report from the meeting. A 'thank you' for the support is always appropriate.
3. Travel and tour expenses on a commercially sponsored educational visit to other centres should be considered in terms of the likely professional benefit to all involved. The Fellow should ensure that talks or lectures are presented and reported in an unbiased manner. The same guideline is necessary in respect of retrospective reports of the visit.

TRAINEES

Support for trainee activities is best handled through an organising group of senior colleagues who are in a position to help the trainee(s) with maintenance of their independence. Full acknowledgement of such support must always be made.

RELATIONSHIP WITH PATIENTS

1. In research areas, all normal clinical and ethical protocols in respect of patient oriented research must be followed.
2. In clinical activities, any commercial interest in a technique or activity must be prospectively disclosed when obtaining treatment consent from the patient. It is recognised that during the early stages of a development, the commercial association may not have been formulated. In such cases, a recognition of the potential benefits and risks to the patient is essential and normal Ethical Committee procedures for a new treatment should be followed.

June 1992

Letters to the Editor should be no more than 300 words, shorter letters would be preferred.

All letters must be signed and the author's name and address clearly written.

A letter may be edited for reasons of space or clarity, unless the writer specifies it must be published in full.

APPENDIX A

M.I.A.A. TECHNICAL EXHIBITION GUIDELINES - SUMMARY

Technical Exhibitions held in conjunction with conferences, seminars and other professional meetings are an important means by which industry disseminates information on new and existing products. Additionally, the revenue generated by such exhibitions is often critical to the success of the meeting.

The Medical Industry Association of Australia Inc. (M.I.A.A.), whose members include companies involved in manufacture and/or distribution of medical devices and diagnostic reagents, presents the following information as a guide to conference organisers to assist in the conduct of technical exhibitions.

A well run exhibition which enables industry representatives to reach the maximum number of attendees will attract (and keep) sponsors. Conversely, an exhibition which does not deliver value for money is less likely to be supported in future years.

To ensure that your technical exhibition is organised with the needs of industry in mind, it is suggested that an industry nominee be appointed to serve on the Conference Planning Committee. MIAA would be pleased to provide names of suitably qualified persons to assist in this capacity.

The following information will serve as a guide for conference organisers; further information is available on request from the Membership Services Manager, MIAA (02 415 1151).

1. **VENUES** – to be chosen with the Exhibit in mind (cost of transport of staff and equipment/location of exhibit within or adjacent to conference area).
2. **SITE ALLOCATION** – terms to be identified "up front", e.g. allocated according to predetermined price schedules; prime sites reserved for major sponsors, etc. Where site costs are equal, allocation to be on "first come, first served" basis.
3. **COSTS** – to be determined according to the "exposure" the industry is likely to get (number of delegates, duration of conference etc.)
 - to be clearly identified "up front"
 - deposit to be made on booking; balance to be payable immediately prior to the exhibit

4. **ACCESS TO EXHIBIT AREA** – setup and pull down times to be advised at least 1 month in advance. Adequate time to be allowed for these activities.
5. **STORAGE** – storage space for packing, etc to be made available.
6. **SECURITY** – adequate provision to be made for security of the exhibit area when unattended (to protect equipment, etc) and during opening times (to limit attendance to conference attendees).
7. **POWER SUPPLY** – medical equipment often places a significant load on available power supply. Power resources to be identified “up front”; participating companies to be given the opportunity to identify their particular needs when booking their display site, and told as soon as possible if their requirements cannot be met.
8. **CONFERENCE REGISTRANTS** – where possible, a list of conference registrants to be made available to all participating companies at the Conference.
9. **DELEGATE ATTENDANCE** – delegates to be actively encouraged to attend the exhibit. The following suggestions may be helpful:
 - tea/lunch breaks served within exhibition area
 - registration desk and other services located within exhibition area
 - exhibition prominently featured in programme
 - delegates frequently reminded to attend exhibition (e.g. announcement at end of sessions)
 - official function held to open the exhibition.
10. **INDUSTRY ATTENDANCE** – representative/s of sponsoring companies to be permitted to attend all conference sessions as full participants (excluding meetings called for the purpose of transacting the business of the organisation). Travel and accommodation concessions available to delegates to be extended to industry participants. Sponsoring companies which purchase additional exhibition space to receive a commensurate increase in facilities for company representatives.
11. **MEALS** – the cost to company representatives of meals and other conference amenities (additional to those covered by the stand fee) to be advised on booking. Consideration to be given to providing ‘split sittings’ for lunch.
12. **EXHIBIT NOTIFICATION** – to include full details, and to be forwarded to companies at least 6 months in advance of the conference.
13. **PROGRAMME** – Provisional programme/Final programme (including lists of speakers and topics) to be forwarded to companies as soon as possible, to enable companies to plan their display.
14. **PUBLIC LIABILITY INSURANCE** – to be the responsibility of the Conference organising body.
15. **DEBRIEFING MEETING OF EXHIBITORS** – to be held at the close of the Conference and to include exhibit convenor for following year’s meeting.

REPORT FROM THE DEAN TO FELLOWS AND MEMBERS OF THE FACULTY OF ANAESTHETISTS, ROYAL AUSTRALASIAN COLLEGE OF SURGEONS AS AT 7TH FEBRUARY, 1992

It is my pleasure to present the Report of the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

HONOURS, AWARDS AND APPOINTMENTS

During the past month prior to the establishment of our College in February, many of our Fellows have been the recipient of awards, honours and appointments.

Dr Kester Brown, one of our best known anaesthetists in many parts of the world, was awarded the Orton Medal. Kester is well known for his dedication to teaching and encouragement of the development of anaesthesia standards in the less well developed parts of this world.

Mr John Clarebrough, former President of the Royal Australasian College of Surgeons, former RACS Councillor to the Board of Faculty and Honorary Fellow of the Faculty, was made a Member of the Order of Australia.

Professor Michael J. Cousins – Elected Fellow, College of Anaesthetists.

Professor Keith Sykes, GSM Visitor in 1979 was knighted.

Associate Professor Don Harrison and Dr George Davidson were invested as Members of the Order of Australia, while the title Emeritus Professor of Anaesthesia, University of Queensland, was conferred on Professor Tess Cramond.

Professor Teik Oh was elected President, the Hong Kong College of Anesthesiologists and Professor Paul White, GSM Visitor in 1990 was appointed to the Inaugural Milam McDermott Chair in Anesthesiology, University of Texas, South Western Medical Center, Dallas, Texas.

The Dean, Associate Professor Peter Livingstone was elected to Membership of the Academy of Medicine, Malaysia. Dr Neville Davis was appointed Associate Clinical Professor, University of Western Australia.

Other appointments include Professor Duncan Blake, Professor and Director of Anaesthesia, University of Melbourne, Royal Melbourne Hospital and Professor Malcolm Fisher, Clinical Professor within the Department of Anaesthesia and Medicine, in the University of Sydney at Royal North Shore Hospital.

DEATHS

It is with regret that I report the death of:

Dr W.M. Crosby, Vic Dr L. Feldman, WA

Dr H.M. Windsor, NSW Dr D. Young, NZ

RESEARCH GRANTS FOR 1992

In the past year, the Faculty was able to distribute over \$100,000 in research grants and awards and also an establishment grant of \$75,000 to the Foundation Chair of Anaesthesia and Pain Management, University of Sydney, Royal North Shore Hospital.

Scholarship – Dr C.J. Joyce, New Zealand \$22,000
third year, to continue support for his project:
“Lung Volumes and Inspired Oxygen”

Scholarship – Dr M.J. Chapman, SA \$22,000
Project: “The Role of Endothelial Leukocyte in
the Decrements in Cerebral Blood Flow and
Function after Arterial Air Embolism”

GRANTS

Dr R.W. Morris, NSW \$25,000
Project: “Effect of Aortic Cross-Clamping
on the Distribution of Blood Flow”

Dr N.M. Gibbs, WA \$5,203
Project: “Natural Anti-Coagulant Levels and
Perioperative Coronary Artery Thrombosis”

Dr D.P. Crankshaw, Vic \$7,050
Project: “Pharmacokinetics of Thiopentone Isomers”

Dr G.H. Beemer, Vic \$13,905
Project: “Reversal of competitive Neuromuscular
Blockade by an anticholinesterase”

Dr B. Silbert, Vic \$8,000
Project: “Prevention of Increased Pain Sensitivity”
(Subject to his obtaining significant funding
from elsewhere)

The Harry Daly Research Fellowship was awarded to:
Dr C.J. Joyce from New Zealand.

AWARD OF ESTABLISHMENT GRANT

The Establishment Grant was awarded to the foundation Chair of Anaesthesia and Pain Management, University of Sydney, Royal North Shore Hospital.

PRIMARY EXAMINATION

The Renton Prize for the half year 31st December, 1991 was awarded to:

Dr Rex A. Smith of New Zealand.

Examinations were held in Sydney, Melbourne and Christchurch.

	Total No. Candidates	Invited to Oral	Approved
Sydney	50	44	29
Melbourne	43	35	19
Christchurch	20	15	10
	<u>113</u>	<u>94</u>	<u>58</u>

FINAL EXAMINATIONS

Endorsed in Anaesthetics – September, 1991.

Examinations were held in Melbourne and Sydney.

Thirty candidates presented in Melbourne and nineteen were approved.

Thirty-two candidates presented in Sydney and twenty-one were approved. The names of the successful candidates who have completed their training:

Dr P.T. Barnard, NSW Dr I.R. McPhee, NSW
Dr J.M. Byatte, Qld

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

Dr M.R.J. Allen, Qld	Dr J. Lioufas, Vic
Dr K.S.R. Ang, NSW	Dr P.J. Longden, Qld
Dr Y.K.W. Au, NSW	Dr D.W.J. Mecklem, Qld
Dr R.K. Barnes, Vic	Dr G.E. Moloney, Qld
Dr A. Belessis, NSW	Dr W.D.N. Kee, NZ
Dr D.H. Binney, NZ	Dr B.J. Nunn, Vic
Dr M.S. Cardoso, SA	Dr A. Pearce, SA
Dr L.J. Cass, Vic	Dr L.M. Robinson, SA
Dr J.S. Christie, Qld	Dr G.M. Shaw, SA
Dr P.B. Cornish, NZ	Dr S.W. Simmons, SA
Dr J.K. Cruickshank, Qld	Dr G.S. Teoh, SA
Dr T.A. Edgley, Vic	Dr B.D. Todd, Qld
Dr T.I. Edwards, NZ	Dr S.R. Tomlinson, NZ
Dr R.C. Freebairn, NZ	Dr Y. Tran, Qld
Dr M.N. Gray, NSW	Dr R.J. Waldron, SA
Dr J.V. Green, SA	Dr M.B. Walker, SA
Dr I.P.C. Greenway, NZ	Dr D.J. Westbrook, NSW
Dr E.A. Hampson, Qld	Dr S.F. Woodford, Qld
Dr A.K. Hilton, NSW	

The Cecil Gray Prize for the half year ended 31st December, 1991 was awarded to:

Dr Richard K. Barnes of Victoria.

The geographical distribution of candidates is as follows:

Region	No. Presenting	No. Approved
Queensland	12	11
New South Wales	14	8
Australian Capital Territory	1	—
Victoria	9	5
South Australia	13	9
Northern Territory	1	—
New Zealand	9	7
Hong Kong	2	—
Singapore	1	—
	<u>62</u>	<u>40</u>

ENDORSED IN INTENSIVE CARE SEPTEMBER 1991

An Examination was held in Melbourne. Eleven candidates presented and four were approved.

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

Dr Peter W. Skippen, Qld.

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

Dr Peter D. Cook, NSW
Dr Peter C. Laussen, Vic
Dr David Y. Williams, Vic

ADMISSION TO FELLOWSHIP BY ELECTION:

The Board was pleased to elect to Fellowship, under Regulation 6.2 the GSM Visitors for 1992, Professor J. Gareth Jones (Cambridge) and Associate Professor Roberta Hines (Yale).

Under Regulation 6.3.1(b) Dr Michael E. Jones, SA.

Dr Peter Fay, of Hobart was elected to Fellowship under Regulation 6.3.1(e), the first Fellow to be elected under this category.

Endorsement in Intensive Care

Dr Anthony J. McDonogh, NSW
Dr Walter R. Thompson, WA
Dr Alistair M. Forbes, WA

FACULTY AFFAIRS

The latter half of 1991, was marked by great activities concerning the writing of the Memorandum and Articles of Association and selection of the name of the College. I travelled to all regions of Australia and New Zealand to address Fellows and invite their contribution to this process. The proposed Memorandum of Articles of Association which were prepared with the assistance of Mr Michael Gorton, Honorary Solicitor, were debated at great length, and after circulation to Fellows and consideration of suggested amendments, the Memorandum and Articles of Association were submitted to the Australian Securities Commission and accepted on 7th February, 1992 and the Australian and New Zealand College of Anaesthetists was formally established.

During this time, the Board has also been conducting an evaluation process with respect to matters, commonly referred to as "Recertification". Seminars on the topic have been held in most regions in an attempt to reform Fellows of the serious aspects of the topic and also to seek their contribution to the consideration of what is certainly a most stimulating subject.

P.D. LIVINGSTONE
Dean

REPORT FROM THE PRESIDENT TO FELLOWS OF THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS AS AT 6TH JUNE, 1992

It is my pleasure to present the Inaugural Report of the Australian and New Zealand College of Anaesthetists.

HONOURS AND AWARDS

Dr Paul Rainsford, SA – elected to AMA Roll of Fellows.

Professor W.B. Runciman, SA – first Foundation Fellow of the Hong Kong College of Anaesthetists.

DEATHS

It is with regret that I report the death of:

Dr M.W. Bartrop, NSW Dr J.E. O'Donnell, Qld
Dr J. Loughman, NSW Dr W.K. Peacock, WA
Dr J.A. Lowson, Vic Dr F. McK. Whan, Vic

PRIMARY EXAMINATION

The first Primary Examination of the Australian and New Zealand College of Anaesthetists was conducted in March and April, 1992. The Renton Prize was awarded to Dr Brian Spain, WA.

This was the first examination to be held where the oral examination was conducted in one centre in Australia.

Examinations were held in Melbourne and Hong Kong.

	Total No. Candidates	Invited Oral	Approved
Melbourne	79	65	45
Hong Kong	<u>21</u>	<u>15</u>	<u>9</u>
	<u>100</u>	<u>80</u>	<u>54</u>

FINAL EXAMINATIONS

Endorsed in Anaesthetics – May, 1992

Examinations were held in Melbourne and Auckland.

Forty-nine candidates presented in Melbourne and thirty-five were approved.

Ten candidates presented in Auckland and five were approved.

The names of the successful candidates who have completed their training are:

Dr D. Dunbar, Vic
Dr C. McClymont, NZ

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

Dr A.J. Baker, Vic	Dr J.T. Moloney, Vic
Dr N.A. Barnes, NZ	Dr D.C. McEwan, Qld
Dr E. Bright, NSW	Dr Z. Nanavgati, NSW
Dr W.J. Burnett, Vic	Dr I. Oleinikov, Vic
Dr T. Di Florio, WA	Dr S.M. Pingel, SA
Dr R. Eadie, Vic	Dr G.D. Raper, WA
Dr B.T. Flanagan, Vic	Dr W.A. Richards, SA
Dr Goh Joo Lin, WA	Dr W.C. Russell, NZ
Dr J.L. Hall, Vic	Dr M.H. Shapiro, SA
Dr P.L. Hann, NSW	Dr P.H. Sharley, SA
Dr D.B. Hays, Vic	Dr D.A. Shaw, NSW
Dr Ho Kin Ming, HK	Dr R.A.C. Sorby-Adams, SA
Dr D.B. Kinchington, NSW	Dr A. Sultana, NSW
Dr E.L. Lee, NZ	Dr R.S. Tayler, NSW
Dr K.J. Liyanagama, NSW	Dr Jin Hui Teh, HK
Dr R.M. Matters, Tas	Dr M.V. Tuck, Vic
Dr N.F. Maycock, SA	Dr S.B. Voss, NSW
Dr N.S. Melhuish, NSW	Dr A.R. Walpole, Vic
Dr J. Mezzatesta, Vic	Dr A. Yusuf, NZ

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended 30 June 1992 be awarded to Dr D.C. McEwan of Queensland.

The geographical distribution of candidates is as follows:

Region	No. Presenting	No. Approved
Queensland	3	1
New South Wales	15	10
Western Australia	4	3
Victoria	15	12
Tasmania	1	1
South Australia	7	6
New Zealand	10	5
Hong Kong	3	2
Kuala Lumpur	<u>1</u>	<u>—</u>
	<u>59</u>	<u>40</u>

Endorsed in Intensive Care – May 1992

An Examination was held in Sydney. Five candidates presented and two were approved.

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

Dr D. Clayton, SA
Dr A. Mullens, NSW

GENERAL SCIENTIFIC MEETING

The Inaugural General Scientific Meeting of the College with the Royal Australasian College of Surgeons was held at the Convention Centre – Canberra from the 12th-15th May, 1992.

An excellent Scientific Programme was presented to a large number of Fellows with high quality papers and well-chosen panels of speakers.

I wish to congratulate the College's Scientific Convener, Dr David McCuaig for his excellent organisation of this Programme.

It gave me great pleasure to present Dr T.C.K. (Kester) Brown, Vic. with the Orton Medal at the Inaugural Ceremony.

Professor J. Gareth Jones, one of the College Foundation Visitors, delivered an excellent Ellis Gillepsie Lecture "*Plumbing the Depths of Anaesthesia*". Associate Professor Roberta Hines was the other College Foundation Visitor, whose main presentation "*Anaesthesia for the Patient after Cardiac Transplantation*" attracted many interesting questions from the floor.

Associate Professor Geoff Cutfield, the Australasian Visitor, selected "*Critical Care of the Specialty*" for his Lecture which was impressive.

All three Visitors worked extremely hard during the Meeting, contributing interesting papers and raising matters for discussion both from the floor and in smaller groups throughout the Meeting.

In recognising the anniversary of Crawford Long, Professor Barry Baker delivered a most interesting Lecture entitled "*Doctor's Day to Doctors' Day*".

The Gilbert Brown Prize was won by Dr Neil Warwick from New South Wales for the presentation of his paper "*Atracurium Kinetics Using a Dynamic-Kinetic Modelling Technique*".

COLLEGE AFFAIRS

On the 7th February, 1992 a Certificate of Incorporation was raised by the Australian and New Zealand College of Anaesthetists to continue the activities of the Faculty of Anaesthetists, Royal Australasian College of Surgeons.

The Inaugural Meeting of the Council took place on the 8th February, 1992 during which the subscribers to the Memorandum and Articles of Association were appointed as the first Council, Office Bearers and Executive Committee of the College.

Council

- Arthur Barrington Baker
- Stewart Thomas Bath
- Michael Joseph Davies Chairman of Executive, Treasurer
- Neville James Davis Assessor
- John Michael Gibbs
- Michael John Hind Hodgson Vice President
- Peter David Livingstone President
- David Henry McConnel
- Garry David Phillips Education Officer (Intensive Care) Chairman of Examinations
- Ian Rechtman
- Richard George Walsh
- Rupert Leigh Atkinson Co-opted Representative
- James McKinnon Watts Co-opted Representative

Office Bearers

- Peter David Livingstone President
- Michael John Hind Hodgson Vice President

Executive Committee

- Michael Joseph Davies
- Peter David Livingstone
- Michael John Hind Hodgson
- Neville James Davis
- Garry David Phillips
- Arthur Barrington Baker

On the 2nd March, 1992 the assets of the Faculty of Anaesthetists previously held in the name of the Royal Australasian College of Surgeons were assigned by deed of transfer by the Royal Australasian College of Surgeons to the Australian and New Zealand College of Anaesthetists.

In accordance with the provisions of the Memorandum and Articles of Association, nominations were called for six vacancies on the Council. Nine nominations were received. The following is the result of the Ballot:

Vote Count	885	
Less informal	26	
	859	x 6 = 5154
N.J. Davis	693	
R.G. Walsh	686	
D.H. McConnel	672	
R.J. Willis	625	
R.S. Henderson	563	
D.R. Kerr	543	
G.J. Purcell	486	
P.A. Lowe	450	
F.X. Moloney	436	

The College continues the process of consideration of recertification and the review of the examination systems.

Since the opportunity to purchase the Royal Australasian College of Surgeons site in Melbourne was exercised by the Royal Australasian College of Surgeons, it has become clear that the continued sharing of the present premises with the RACS will continue only on a relatively short term basis.

Whilst Council recognises the contribution to the building by Fellows of the Faculty, it is clear that we must find our own home. In so doing, we must optimise the goodwill and equity which I believe we have in the present building.

Since the establishment of the College, a small working party has been preparing a proposal for a Coat of Arms to be submitted to the College of Heraldry. The preparatory drawings and suggestions were presented to Fellows at the recent GSM in Canberra. Further contribution has been sought from the Fellowship.

RETIRED COUNCILLORS

Dr Stewart Bath did not seek re-election at the completion of four years service to the Board of Faculty and Council. Dr Bath has given many years of service to the Faculty of Anaesthetists as a Member of the Tasmanian Regional Committee from 1979-1988.

Dr Bath has filled the appointment of Pharmaceutical/Technical Officer during his term of office and been a great contributor to Faculty and College affairs.

Professor Barry Baker retires from the Board of Faculty and College Council this year. He was a co-opted Member of the Queensland Regional Committee from 1972-1973, elected a Member in 1974 and Regional Education Officer 1974-1975.

He was elected to the New Zealand Regional Committee in 1978 and appointed Regional Education Officer (Intensive Care) in 1980.

In 1975 he was appointed to the Panel of Examiners and is the only member of that Panel to examine in all three examinations of the Faculty of Anaesthetists.

Professor Baker was the Inaugural Chairman of the Section of Intensive Care. He was appointed a Member of the Education Committee of Intensive Care in 1977 prior to his election to the Board of Faculty in 1980. He has completed twelve years on the Board during which time he has held the following offices:

Education Officer (Intensive Care)	1984-1988
Vice Dean	1986-1987
Chairman – Workforce Committee	1987-1990
Dean	1987-1990

Professor Baker has been an outstanding contributor to the Faculty during his time on the Board; amongst many and varied contributions he has been responsible for the re-organisation of the Board's administrative structure to our considerable benefit and was the instigator for the Faculty conducting Management Courses for our Fellows.

In wishing these colleagues well in their retirement from Board and Council activities, we thank them most sincerely for their untiring contributions to both Faculty and College affairs.

COLLEGE ADMINISTRATION

Miss Raelene McGinty was appointed Administrative Assistant to the Registrar on the 10th February, 1992 and holds the honour of being the first staff appointment to the new College.

Following Mrs Jennie Jackson's resignation in April, due to her husband's overseas transfer, Miss Cheryl Clarke was appointed to the position of Administrative Assistant.

Already these appointees have proved to be most valuable staff members.

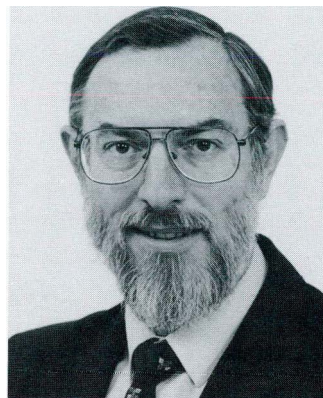
I wish to express my sincere thanks to all Fellows and their families who have devoted so much time and energy to the welfare of the Faculty and now our College, by their involvement in Committees in the education and examination of our trainees and generally contribute to the welfare of the College.

I would also like to record my sincere appreciation to the President of the Royal Australasian College of Surgeons and his Council for their co-operation and assistance over the past year and particularly with regard to the incorporation of our College.

Finally, to the Councillors and administrative staff both in Melbourne and the regions who contribute so willingly to the efficient running of the organisation and particularly, for their efforts in ensuring a very smooth and efficient transformation from the Faculty to the College, my sincere thanks.

P.D. LIVINGSTONE
President

NUFFIELD APPOINTMENT



Professor Barry Baker has been appointed the Nuffield Professor of Anaesthetics in the University of Sydney at the Royal Prince Alfred Hospital.

The Nuffield Chair of Anaesthetics, the first Chair of Anaesthetics in Australasia, was endowed by Lord Nuffield in 1962. The late Professor Douglas Joseph was appointed the inaugural Nuffield Professor of Anaesthetics and commenced his appointment in 1963, a position he held until his retirement in October, 1989.

Professor Baker is a graduate of the University of Queensland. He was admitted to Fellowship of the Faculties of Anaesthetists, Royal Australasian College of Surgeons and Royal College of Surgeons of England in 1968. His FFARACS was endorsed in Intensive Care, by Election, in 1981. Professor Baker was awarded his Doctorate of Philosophy from Oxford University in 1971.

Professor Baker has held the appointment of Professor of Anaesthesia and of Intensive Care in the University of Otago since its inauguration in 1975. This was the first Chair in Anaesthesia and of Intensive Care in New Zealand.

AUSTRALASIAN ANAESTHESIA

The 1992 edition of *Australasian Anaesthesia* has now been despatched to all Fellows. The College acknowledges the continued generous support by Abbott Australasia Pty Ltd towards the production of this publication.



The President, Dr Michael Hodgson, is pictured with Mr Mark Haywood, Abbott's Marketing Director, with Dr Dennis Kerr, Editor and Dr Jeanette Thirlwell, Sub-Editor of Australasian Anaesthesia.



Presentation of a photograph of Moreton House by Dr Stewart Bath to the Immediate Past President Assoc. Prof. Peter Livingstone.



Participants in the 1992 Younger Fellows Course held at Lake Crackenback Resort, near Thredbo.



Associate Professor Peter Livingstone with the Registrar and Professor Barry Baker following the presentation of a print from Banks Florilegium.

TREASURER'S REPORT 1991

INTRODUCTION

The annual financial report of the Faculty of Anaesthetists for the year 1st February 1991 until 31st January 1992 is presented. Once again the format of the Balance sheet and Accounts is set out according to the requirements of the Australian Corporation and Securities Regulations. The information is supplemented by a number of charts prepared by the Faculty's Head of Finance, Mr Ross Blain.

Figures 1 and 2 are charts of income and expenditure from all the Faculty's sources not just those from subscriptions.

REVENUE AND EXPENDITURE STATEMENT

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

SUBSCRIPTION ACCOUNT

The subscription account is the account which provides for the daily running of the Faculty's activities. These include the administration, all committees and a 10% allocation to both the Development Fund and the Foundation Fund for research. Figure 3 shows the expenditure from the 1991 subscriptions and Figure 4 shows administrative expenditure. The healthy surplus occurred as a result of a slightly greater income from subscriptions than budgeted and a decrease in the budgeted administrative expenses.

FELLOW'S FUND

This Fund continued to grow but it is anticipated that a considerable part of this Fund will be required for the purchase of the Headquarters for the newly formed Australian and New Zealand College of Anaesthetists.

FOUNDATION FUND

This Fund has again been boosted by the Victorian Chairs of Anaesthesia Appeal and a further \$99,000 from the bequest by the late Professor Douglas Joseph. The income from our investments was considerable this year, but lower interest rates will now have a significant effect. The income and expenditure of this fund are shown in Figures 5 and 6.

DEVELOPMENT FUND

The Development Fund continues to grow, but will also be required for the purchase of the new Headquarters.

TRAINEES' FUND

This fund is also growing because of the increase in investment income and the limitation of expenditure. It is also anticipated that part of this fund would be used for the Headquarters purchase. Figure 7 is a graph of the income and expenditure of this fund.

CONCLUSION

The Faculty's finances were in excellent condition and have now been transferred to the new Australian and New Zealand College of Anaesthetists. My thanks go to the College of Surgeons Financial Advisers, Mr Reg Nicholson, Mr Doug Oldfield and Mr Tony Sallman, for their general advice throughout the year.

All Fellows should continue to be aware of the hard work and high productivity of Mrs Joan Sheales and her staff who continue to make efficient use of our funds. Special thanks to Mr Ross Blain, Head of Finance Department who has continued to work hard and give good advice about the management of our finances.

MICHAEL DAVIES
Honorary Treasurer

Basic Surgical Training

Council resolved to establish a register of Basic Surgical Trainees and to develop formal training programs to teach basic surgical skills.

Assessment of Surgical Standards in Hospitals

A document outlining procedures for the assessment of surgical standards in hospitals was approved by Council and is available on request from the College Secretary.

Remote General Practitioners and General Surgeons

A report on training for remote General Practitioners in Surgery and for remote General Surgeons was approved by Council and is available on request from the College Secretary.

Future of General Surgery

There was broad general support by Council for a document on the "Future of General Surgery" prepared by the Chairman of the Board in General Surgery, B Barraclough.

A copy of the document is available on request from the College Secretary.

Endoscopy and Surgeons

The statement by Council on Endoscopy and Surgeons published in the Volume 12, Number 1 March 1992 edition of the *Bulletin* was amended by Council and is published elsewhere in this edition of the *Bulletin*.

Effects of Industrial Awards on Surgical Training

Council adopted a statement designed to ensure that Trainees and Supervisors are aware of the potential for adverse effects on Advanced Surgical Training as a result of industrial awards.

The statement is available on request from the College Secretary.

Recognition of Emergency Medicine as a Specialty by NSQAC

Having previously approved in principle, the recognition of Emergency Medicine as a specialty by NSQAC, Council resolved that it would be appropriate for such recognition to occur at this time.

Use of Live Animals in Surgical Training

Council adopted a statement on the use of live animals in surgical training which will be distributed appropriately and which is available on request from the College Secretary.

SCIENTIFIC MEETINGS**Future of GSM**

A number of recommendations were approved by Council, having been proposed by a special Working Party, which will make significant changes to the GSM.

The GSM will be renamed the Annual Scientific Congress: It will be a five day meeting with a central day for common activities allowing larger specialties to attend for five days and smaller specialties to attend for the first two days plus the central day or the central day plus the latter two days in the week. A Standing Scientific Program Committee to be formed to provide continuity for organisation of the Scientific Program; a senior Surgeon to be appointed to the RACS staff on a one/fifth basis as Co-ordinator of the ASC; and Specialist Surgical CME Committees to be involved as part of the organisation of the ASC.

Hunterian Bicentenary Meeting

The College will be participating in the above meeting in London on September 14th, 1993.

EDUCATION

Surgical Audit

Surgical Audit guidelines were approved and are available on request from the Secretary and a Surgical Audit booklet on how to undertake an audit ("How I Do It") is to be produced and distributed to all Fellows.

PROFESSIONAL AFFAIRS

Recertification

Council resolved to consult widely amongst Fellows before the introduction of mandatory recertification.

The implementation date of the College policy on recertification has been advanced a year to January 1, 1994.

Retirement Age

A policy on retirement age was adopted and is published elsewhere in the *Bulletin*.

FINANCE

Levy on Fellows

Council agreed to levy Fellows to replenish the College funds used for property purchases to ensure that the research and educational activities of the College can continue at least at current levels.

More information on the levy will be provided to Fellows in the near future.

INTERNAL

RACS Organisational and Administrative Structure

Council adopted in principle, a proposal from the Secretary that the organisation and administration of the College be restructured into five divisions being: Pre-Fellowship Education, Post-Fellowship Education, Research, Professional Affairs and Administration and Finance.

COUNCIL OFFICE BEARERS, OFFICERS AND COMMITTEES FOR 1992/93

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

Deputy Chairman (Anaes)	K.D. Cronin	Joint Advisory Committee	President or Vice President
Chairman Final (IC)	A.W. Duncan		
Deputy Chairman (IC)	R.P. Lee	Australian Resuscitation Council	G.A. Harrison I. Rechtman V.I. Callanan
Appointment of GSM Scientific Programme Committee		College Historian and Assistant Historian	
Chairman	R.J. Willis	Historian	M.G. Cooper
Past Scientific Convener	D.I. McCuaig	Assistant Historian	A.J. Newson
President Scientific Convener (SA)	H. Owen		
Future Scientific Convener (Tas)	J. Madden	Geoffrey Kaye Museum of Anaesthetic History	
Computer Sub-Committee		Curator	R.N. Westhorpe
Chairman	M. Martyn	Assistant Curator	C.M. Ball
Treasurer	R.G. Walsh	Representative/Nominees to other outside Organisations	
Registrar	J.M. Sheales	Australian Society of Anaesthetists	
Head Finance Department	R.A. Blain	Executive	President or nominee
Co-opted Member	C.A. Morgan	Joint Liaison Committee	M.J. Hodgson M.J. Davies
Section of Intensive Care Executive		Joint Advisory	
Chairman	R.V. Trubuhovich	National Committee on Day Surgery	D.H. McConnel A.K. Bacon
Secretary	G.M. Clarke		
and two other Members	R.F. Whiting F.H. Hawker	Anaesthetic Co-ordinating Committee for AMA Federal Conference	President Chairman of Executive
Bulletin Editorial Committee		Anaesthetic Industry Liaison Committee	
Editor	J.M. Sheales J.M. Gibbs I. Rechtman		M.J. Hodgson D.H. McConnel R.J. Willis
Victorian Chairs of Anaesthesia Advisory Committee		Joint Consultative Committee in Anaesthesia (JCCA)	
	G.B. Donnan P.A. Lowe I. Rechtman T.C.K. Brown P.J. Keast R. Westhorpe		N.J. Davis R.G. Walsh R.J. Willis
Board Representative to Council		Committee of Presidents of Medical Colleges	President
	Dean Vice Dean	Education Standards Sub Committee	A.B. Baker G.D. Phillips
Representatives on RACS Council Committees		Workforce Committee	
Executive	Dean and Chairman of Executive	Restructuring of the Profession Working Party	A.B. Baker
Censor in Chief	Dean	ANZCA/RACS/RACP Joint Committee	President
Finance	R.G. Walsh	Australasian Board of Cardiovascular Perfusionists	
House Committee	M.J. Davies		A.B. Baker R.G. Walsh
Library	I. Rechtman		
Archives	M.G. Cooper R.N. Westhorpe		
Standards	I. Rechtman		
Physical Facilities	M.J. Davies		
GSM Standing Committee			
Dean	M.J. Hodgson		
GSM Officer	R.J. Willis		
EMST Course	G.D. Phillips		
Road Trauma Advisory Committee	G.D. Phillips		
National Trauma Committee	G.D. Phillips		

REPRESENTATION ON RACS COUNCIL COMMITTEES

Deputy Chairman of Library Committee	I. Rechtman
Deputy Director of Ceremonies	D.H. McConnel
RACS Foundation Committee	Dean or nominee R.G. Walsh (Treasurer)
Academic Chairs Committee	P.D. Livingstone
Advisory Committee on Aids and Surgery	B.F. Horan
Archives Committee	R. Westhorpe (Curator) M.G. Cooper (Historian)
Computer Committee	M. Martyn R.G. Walsh (Treasurer)
Continuing Medical Education and Recertification (Composition being reconsidered)	
Entrepreneurial Medicine Working Party	J.M. Gibbs
Ethics Committee	P.D. Livingstone
House Committee	M.J. Davies R. Westhorpe J.M. Sheales
Library Committee	I. Rechtman F. Rosenwarne A. Brennan
Political Objectives Sub-Committee	M.J. Hodgson M.J. Davies
National Road Trauma Advisory Council	G.D. Phillips
RACS Trauma Committee	G.D. Phillips

APPOINTMENT OF REGIONAL COMMITTEES

Council ratified the appointment of the Regional Committees as follows:

New South Wales

M.R. Crawford
I.T. Dicks
J. Beckett-Wood
D.B. Gibb
B.F. Horan
M.A. Joseph
P.L. Klineberg
G.E. Knoblanche
E. Loughman
W.J. McMeniman
F.X. Moloney
P.J. Moran

Queensland

V.I. Callanan
M.D. Cobcroft
E.J. McArdle
B.J. McKenzie
P.J. Moran
J.F. Murrary
J.P. O'Callaghan
J.M. Parslow
R.L.S. Pascoe
R.F. Whiting

Victoria

G.H. Beemer
S.C. Chester
G.B. Donnan
M.J. Fajgman
D.I. McCuaig
P. Ragg
P. Roessler
F.A. Rosewarne
A.M. Weeks

South Australia

P.A.S. Germann
J.M. Marshman
P.M. Franklyn
D.P. Tomkins
W.B. Runciman
J.A. Crowhurst
B.L. Duffy
L.T. Seow
A.R. Laver
N.T. Matthews
T.J. Semple
G.D. Phillips
J.D. Richards

Tasmania

J.P. Madden
R.M. Zacks
M. Martyn
A.L. Doughty
M.J. Lorimer

Western Australia

L.J. Coombs
N.M. Gibbs
P.B. Smith
H.M. Speirs
P.J. Maddern
M.D. Westmore

Australian Capital Territory

R.W. Cook
G.J. Flynn
B.T. Kwan
H.J. Lopert
T. Dobbinson

New Zealand

R.S. Henderson
J.H. Havill
M.E. Futter
F.E. Bennett
L.F. Wilson
A.F. Merry
R.V. Trubuhovich
I.A. Ross
C.J. Pottinger
D. Jones

POLICY DOCUMENTS

Review P13(1992)

Review P15(1992)

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

and 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 administered 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.

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

GUIDELINES FOR THE CARE OF PATIENTS RECOVERING FROM ANAESTHESIA RELATED TO DAY SURGERY

The term "Day Surgery" in this document refers to the performance of procedures in hospitals and/or free-standing day surgery units.

GENERAL PRINCIPLES

1. Recovery from anaesthesia should take place under appropriate supervision in an area designated for the purpose.
2. This area should be close to where the anaesthetic was administered.
3. The staff working in this area must be appropriately trained and able to contact supervising medical staff promptly when the need arises.
4. It is desirable that patients have regained consciousness and are in a satisfactory condition before they are transported any distance.
5. If patients have to be transported from the operating suite whilst not fully recovered, then they must be on a suitably designed trolley/bed capable of head down tilt and provided with oxygen, a means of inflating the patient's lungs and suction. They must be accompanied by staff able to deal with problems that may occur during transport.
6. Appropriate discharge instructions must be provided.

OPERATING SUITE RECOVERY ROOMS

1. DESIGN FEATURES

- 1.1 The area should be part of the operating suite

but access should be available to medical staff who are not in operating suite clothing, so that they may continue to supervise the patient's care.

- 1.2 The number of bed/trolley spaces must be sufficient for expected peak loads and there should be at least two spaces per operating room.
- 1.3 The space allocated per bed/trolley must allow adequate access for observation and clinical assessment of the patient. There must be easy access to the head.
- 1.4 Space also must be provided for a nursing station, storage of clean linen, equipment and drugs, and a utility room.
- 1.5 Each bed space must be provided with:
 - 1.5.1 an oxygen outlet
 - 1.5.2 a suction outlet (to A.S. 2120)
 - 1.5.3 two general power outlets
 - 1.5.4 adequate lighting (A.S. 1765)
 - 1.5.5 appropriate facilities for mounting and/or storing the necessary equipment, and for the patient's chart.
- 1.6 There must be appropriate facilities for scrubbing up for procedures.
- 1.7 There should be a wall clock with a sweep second hand clearly visible from each bed space.
- 1.8 Communication facilities should include:
 - 1.8.1 an emergency call system
 - 1.8.2 a telephone.
- 1.9 Climate control to operating room standards is desirable.

2. EQUIPMENT AND DRUGS

- 2.1 Each bed space should be provided with:
 - 2.1.1 oxygen flowmeter and nipple
 - 2.1.2 suction equipment including a receiver, tubing, rigid hand piece and a range of suction catheters
 - 2.1.3 a sphygmomanometer
 - 2.1.4 a stethoscope.
- 2.2 Within the recovery room there must be:
 - 2.2.1 a range of devices for the administration of oxygen to spontaneously breathing patients
 - 2.2.2 a means of inflating the lungs with oxygen in a ratio of one per two beds, but with a minimum of two
 - 2.2.3 intubation equipment
 - 2.2.4 emergency drugs
 - 2.2.5 a range of I.V. equipment and fluids
 - 2.2.6 drugs for pain control
 - 2.2.7 a range of syringes and needles
 - 2.2.8 pulse oximetry.
- 2.3 There should be easy access to:
 - 2.3.1 an electrocardiogram
 - 2.3.2 a defibrillator
 - 2.3.3 a warming cupboard
 - 2.3.4 a refrigerator for drugs
 - 2.3.5 a procedure light
 - 2.3.6 a range of appropriate drugs
 - 2.3.7 a basic surgical tray
 - 2.3.8 diagnostic services.
- 2.4 The recovery trolley/bed must:
 - 2.4.1 have a firm base and mattress
 - 2.4.2 tilt from either end both head up and head down at least 15°
 - 2.4.3 be easy to manoeuvre
 - 2.4.4 have efficient and accessible brakes
 - 2.4.5 provide for sitting the patient up
 - 2.4.6 have side rails which must be able to be dropped below the base or be easily removed
 - 2.4.7 have an I.V. pole.

3. STAFFING

- 3.1 Nursing staff trained in recovery room care must be present at all times.
- 3.2 An appropriately trained nurse should be in charge.
- 3.3 Nurses not experienced in recovery room care should be supervised.
- 3.4 The ratio of nursing staff trained in recovery room care to patients needs to be flexible so as to provide no fewer than one nurse to three patients, and one to each patient who has not recovered protective reflexes.

4. MANAGEMENT AND SUPERVISION

- 4.1 Written protocols for safe management should be established. The Director of Anaesthetics or Anaesthetist-in-Charge should be responsible for the medical aspects of these policies.

- 4.2 A written routine for checking the equipment and drugs must be established.
- 4.3 Observations should be recorded at appropriate intervals and should include at least state of consciousness, colour, respiration, pulse, blood pressure and oxygen saturation of the blood.
- 4.4 All patients should remain until they are considered safe to discharge from the recovery room.
- 4.5 The anaesthetist is responsible for:
 - 4.5.1 supervising the recovery period and authorising the patient's discharge
 - 4.5.2 accompanying the patient to the recovery room and adequately handing over to the nursing staff
 - 4.5.3 providing written and verbal instructions to the recovery room staff
 - 4.5.4 specifying the type of apparatus and flow rate to be used in oxygen therapy
 - 4.5.5 remaining in the vicinity until the patient is safe to leave in the care of the nursing staff or delegating this responsibility to another anaesthetist.
- 4.6 The surgeon is responsible for:
 - 4.6.1 authorising the discharge of a patient from the recovery room when it depends on a surgical decision
 - 4.6.2 being available to consult with the anaesthetist should the need arise in the recovery period
 - 4.6.3 providing any specific postoperative instructions regarding the surgery.

5. RECOVERY AREA

An area must be provided with comfortable reclining seating for patients to recover satisfactorily prior to discharge home. This area must be adequately supervised by nursing staff and should also have ready access to resuscitation equipment, including oxygen and suction equipment. Patients must not leave this area unaccompanied.

6. DISCHARGE OF THE PATIENT FROM THE DAY SURGERY LIST

- 6.1 The patient should be discharged only after an appropriate period of recovery and observation in the recovery room.
- 6.2 Discharge of the patient should be authorised by the anaesthetist after vital signs are stable, the patient is alert, orientated and co-ordinated.
- 6.3 Written and verbal instructions must be given to an adult, responsible for the care of the patient; and to the patient. These instructions must include the name and telephone number of a medical practitioner to be contacted should complications develop, and warnings about transport, decision-making, prohibition of alcohol, and possible postoperative effects of the anaesthetic.
- 6.4 The discharge area should have easy access to vehicles, wheelchairs and ambulances to minimise walking for the postoperative patient and to facilitate transfer of the patient to hospital if required.
- 6.5 Suitable inpatient hospital transfer arrangements must be available if the need arises.

June 1992

FELLOWS' DATA BASE

Dr Philip Neil King
 Dr Muttu Coomaraswamy Poopathy
 Dr Semesa Gucake Seruvatu
 Dr Stuart MacGregor Shepherd
 Dr Yi Chueng Sit
 Dr Chian Yong Tan

I would appreciate receiving any information relating to the address of any of these Fellows.

JOAN SHEALES
 Registrar

EXAMINATION
PRIZE WINNERS

The Renton Prize for the April, 1992 Primary Examination was awarded to

Dr Brian Spain, Western Australia

The Cecil Gray Prize for the May 1992 Final Examination was awarded to

Dr D.C. McEwan, Queensland

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

POLICY DOCUMENTS

E = educational. P = professional. T = technical. EX = examinations.

E1 (1991)	Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Anaesthesia
E2 (1990)	Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Intensive Care
E3 (1989)	The Supervision of Trainees in Anaesthesia
E4 (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 Hospital 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)	Sedation for Diagnostic and Minor Surgical Procedures
P10 (1991)	Minimum Standards for Intensive Care Units
P11 (1991)	Management of Cardiopulmonary Bypass
P12 (1991)	Statement on Smoking
P13 (1992)	Protocol for The Use of Autologous Blood
P14 (1987)	Guidelines for the Conduct of Epidural Analgesia in Obstetrics
P15 (1992)	Guidelines for the Care of Patients Recovering from Anaesthesia Related to Day Surgery
P16 (1988)	Continuous Intravenous Analgesic Infusions
P17 (1992)	Endoscopy of the Airways
P18 (1990)	Monitoring During Anaesthesia
P19 (1990)	Monitored Care by an Anaesthetist
P20 (1990)	Responsibilities of Anaesthetists in the Post-Operative Period
P21 (1992)	Sedation for Dental Procedures
P22 (1990)	Statement on Patients' Rights and Responsibilities
P23 (1992)	Minimum Standards for Transport of the Critically Ill
P24 (1992)	Sedation for Endoscopy

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