AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

A.C.N. 055 042 852

B U L L E T I N

VOLUME 1 NUMBER 4 NOVEMBER 1992

Registered by Australia Post – Publication No. VBQ91 4964

CONTENTS

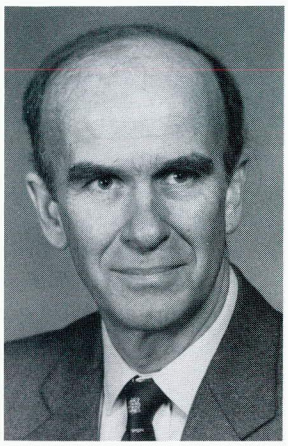
EDITORIAL

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

Printed by Capitol Press Pty Ltd.

ISSN 1038-0981.

PRESIDENT'S MESSAGE



In my last Message I said that the new College needed to determine its direction and consolidate its position. What is our direction? It is towards a truly independent specialty College of Anaesthetists which is hopefully a leader but at least an equal with all other Colleges. This requires dedication, hard work and the highest of ethics, principles and standards. We need to improve our profile within the profession and the community at large. We are part of the medical community but we need to keep working at it.

The College is involved in many Committees dealing with professional and anaesthetic matters.

Currently we are part of the Committee of Presidents of Medical Colleges, the Joint Advisory Committee which comprises representatives of the RACS, RACP, RACOG and RACGP and have only recently agreed to establish Liaison Committees with the RACGP and ACEM.

At every opportunity we must increase our involvement in professional activities. We have also declared our role in South-East Asia and the South Pacific and have determined to improve our relationship with anaesthetic organisations in these countries. We are consolidating our position.

Discussions are occurring with the RACS as to our separation from that College and this is proceeding satisfactorily. The search for College Headquarters continues and a property will not be purchased until Council is sure that it is in the best interests of the College and its Fellows.

The wider role of Anaesthetists is continually being considered. Fellows are being increasingly involved in more post-operative care and pain management and our position in these areas will be secured.

The examination system is under review and continued efforts are being made to improve it. Changes to the Final Examination are likely in the near future.

Continued education of Anaesthetists is vitally important and consideration is being given to utilising modern technology to take CME to Fellows which will assist rural and isolated Anaesthetists. The response rate to the CME questionnaire which was distributed with the subscription notices earlier this year was better than in previous years and indicated a pleasing involvement by Fellows in a wide variety of CME activities.

Academic Anaesthesia and research has been a weak aspect in Australia and New Zealand. Council has determined to establish a Working Party to consider two aspects of Academic Anaesthesia – the shortage of and difficulty in filling Academic Chairs of Anaesthesia in Australia and New Zealand universities and undergraduate teaching of Anaesthesia. It is hoped that some positive initiatives will result.

Research allocation for 1993 amounts to $255,000 including $115,000 for Research Scholarships and Grants, $65,000 for the Inaugural Douglas Joseph Professorship and $75,000 for the Academic Establishment Grant. This allocation, however, only satisfied a small percentage of the requests made of the College.

A Recertification Program based on Continued Maintenance of Standards has been suggested by our Working Party and it is now being widely circulated for comment. This is something which we as professionals must embrace in an appropriate form and something which is being expected of us as part of our professional and public accountability.

The Vice President, the Registrar and myself recently attended the Biennial Meeting of the Conference of International Reciprocating Examining Board of Anaesthesia (CIREBA) in London. This Meeting had representatives from the appropriate specialty organisations in America, Canada, South Africa, Britain, Ireland and Australia, its broad terms of reference being to exchange information on training standards and examination reciprocity matters.

This too-short-a-meeting was extremely worthwhile and showed that the problems we face are the same worldwide and that we are ahead of other countries in several issues and up with most. In conjunction with this Meeting, our sister organisation in Britain celebrated their being granted a Royal Charter and hosted a Symposium on CME and several social functions.

Equity in all College activities has been an important matter to me and some recent decisions have assisted this. In future the Home Evaluation Learning Program modules (HELP) will be sent to Fellows and Trainees in South-East Asia as has occurred for Australian Fellows and Trainees. Uniform subscriptions are to be levied in Australia and New Zealand. The Constitution of Regional Training Committees in South-East Asia are to be brought into line with those applying to similar College Committees and, as previously reported, the cost of the new Headquarters will be spread over the whole Fellowship and also well into the future.

The Australian Society of Anaesthetists held its Annual General Meeting in Adelaide recently and I was fortunate enough to attend. Dr John Hains was elected President and on behalf of the College I congratulate him on his election. I have already written to John conveying our best wishes and offering to help him in any way that we are able.

Finally, it is that time of the year again and on behalf of Margie and myself I would like to wish the Fellowship and staff a Merry Christmas and a Happy New Year.

C M Hodgson

THE ROYAL FLYING DOCTOR SERVICE OF AUSTRALIA

"Meeting the Challenge"

Bernard Cresswell, MB BS, FFARACS, FANZCA, Grad.Dip.Bus.

The objective of The Royal Flying Doctor Service of Australia (RFDS) is to provide health services in remote areas comparable to those provided in urban areas. By efficient use of our resources we are able to effectively meet the challenge of achieving our objective.

In this brief article an outline will be given of the history, the resources, the work and the future of the RFDS.

FACTS AT A GLANCE – 1992

Service Area	**6,300,000 sq km**
Number of patient contacts	**152,894**
Number of patients transported by air	**13,596**
Distance flown	**8,360,912 km**
Number of Bases	**13**
Number of aircraft	**18**
Number of staff	**313**

HISTORY

The RFDS started in 1928 in Cloncurry, Queensland, as a result of an initiative of the hard-working visionary Dr John Flynn. It was initially called The Aerial Medical Service. Flynn talked of providing "a mantle of safety" to those living in the outback. This beginning has grown to seven Sections, each autonomous but each belonging to an Australian Council, a national body. Eighty per cent of the Australian continent is covered by the RFDS.

• *Attending an accident victim on the Eyre Highway, Nullarbor Plain. Nowadays RFDS can usually get a patient to hospital anywhere in Australia within 1½ hours.*

WHAT RESOURCES DO WE HAVE?

There are currently 13 bases. The Queensland Section operates bases at Charleville, Mount Isa and Cairns; the New South Wales Section operates a base at Broken Hill; and the Central Section operates a base at Port Augusta in South Australia and a base at Alice Springs in the Northern Territory.

Western Australia, which comprises one-third of the land mass of Australia is unique in that it encompasses three different Sections of the RFDS: The Eastern Goldfields Section, which operates a base at Kalgoorlie; the Victorian Section which operates a base at Derby, and the Western Australian Section which operates bases at Port Hedland, Meekatharra, Carnarvon and Perth. The Tasmanian Section operates out of Launceston.

Our aircraft fleet consists of fixed-wing aircraft – this being the third largest fleet in the country (excluding the military). Approximately half the fleet is pressurised and turbo-prop., the rest is unpressurised and piston-engined. The RFDS has no rotary-wing aircraft.

There is a staff complement of 300 consisting of pilots (50), engineers, doctors (35), nurses (50), radio operators and administrators. The RFDS is an equal opportunity employer and this is reflected by the employment of female pilots, male nurses, etc.

WHAT DO WE DO?

The RFDS is an integral part of Australia's Health System and aims to provide services where they are not otherwise available, and also to be the interface with specialists and other doctors in towns where our bases are situated. Of our total patient contacts of 150,000, forty per cent are Aboriginal and Torres Strait Islanders.

(1) Radio and Telephone Consultations

The taking of a history and determining a diagnosis on a patient some distance away is still learned by RFDS doctors. Prescribing by "numbers" from our Special Emergency Medical Chests is a way of life for people in remote areas.

• *Broken Hill based medical team attend an emergency in the Corner Country.*

(2) Flying Clinics

The RFDS are the doctors of first contact and primary health care providers over four hundred sites such as small towns, nursing posts, mining sites and aboriginal communities. Other health care providers such as

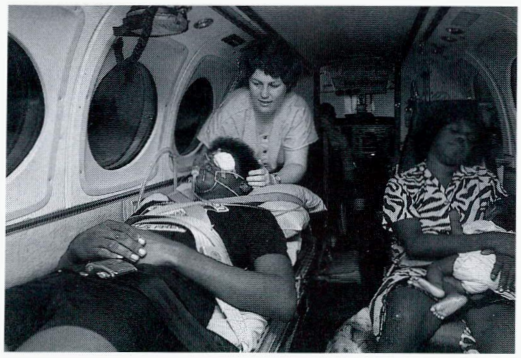
medical and surgical specialists, dentists, child health nurses are also transported to remote sites in RFDS aircraft.

(3) Hospital Services
RFDS doctors have admitting rights to Regional Hospitals and provide inpatient services.

(4) Aerial Transport
Aerial transport may be primary (e.g. from accident site to Regional Hospital) or secondary (inter-hospital transfer). In 1992 the RFDS transported 13,596 patients by air. These impressive figures probably surpass any other civilian organisation in the world. For people in remote areas access to specialist care is dependent on adequate transport systems, either taking the patient to the doctor or the doctor to the patient.

(5) School of the Air
The RFDS high frequency radio network is used to provide primary education to 1250 children at 750 remote locations.

The professional performance of these services over sixty years has resulted in the RFDS acquiring a tremendous reputation such that it has become a national institution similar to Qantas. This has helped significantly in fund-raising.



• *RFDS aircraft have sophisticated medical fitouts.*

WHAT DOES IT COST?

The annual operating budget is about $35 million per year. This currently is funded 45% by State and 45% by Federal Government, the remaining 10% the responsibility of the RFDS and covered by donations, fund-raising, etc.

Capital teams, mainly aircraft, are funded equally between the RFDS and the Federal Government. Each year two or three aircraft need replacing. Currently the cost for a secondhand turbo-prop. aircraft is $1.5-2.5 million.

Services provided by the RFDS are free. This is one of the conditions placed on the RFDS by the Federal Government, the main provider of funds.

Considering the large number of patient contacts, this is a very effective, very efficient organisation. Much professional advice is given to the RFDS through honorary advisory committees in the areas of medicine, aviation, communications and fund-raising. This significantly diminishes administrative costs and highlights the potential cost blow-outs that could occur should governments seek to assimilate RFDS into their services or control.

THE FUTURE

The future of the RFDS offers some opportunities which may be taken but also some problems which have to be addressed.

Opportunities exist for the expansion of services. There is a degree of duplication of aeromedical services in Australia and there is scope for rationalisation of organisations with better co-ordination. The export of aeromedical skills and expertise to developing countries in Asia and Africa is another area that offers opportunity.

Some of the ***problems*** facing the RFDS are similar to those being faced by the Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Surgeons. These include accountability, future funding and the recruitment of staff in remote areas.

A strong commitment to continuing training and education is essential. The RACS EMST Course is particularly appropriate to RFDS doctors and is probably more appropriate to them than to some special area surgical trainees (e.g. ophthalmology, E.N.T.).

Aboriginal health continues to be a challenge, and the RFDS continues to make a major contribution in improving the health of Aboriginal Australians. However, the scope for better co-ordination of services and training of more Aboriginal health workers exists.

SUMMARY

The RFDS continues to meet the challenge of providing health services in remote Australia. Our approach is found in our Mission Statement –

Our Mission is to bring peace of mind to rural Australians by providing the world's best aerial health service.

SECTION OF INTENSIVE CARE

Whither Intensive Care in ANZCA?

Intensive care is now a well established specialty both in the eyes of the medical profession and the general public. In Australia and New Zealand much of the credit for this high profile can be justly accepted by ANZCA.

Currently intensive care is entering a restless stage of its development. Many intensivists, especially those in full time intensive care practice, look for an identity of their own. At the same time they feel both loyalty and debt to the highly respected colleges (ANZCA and RACP) that demanded of them an exacting period of approved training and success in a rigorous examination system.

We all have the right to question the current system. Many Section members have questioned the role of the Section and the influence of intensivists in determining the course of matters relating to intensive care within our College. In fact, Intensivists have had an enormous influence in what is the major role of the College with respect to intensive care. This is the structuring of training requirements, approval of posts suitable for training, designing and conducting the final examination in intensive care, and in developing policy documents related to standards for intensive care. The document Objectives of Training in Intensive Care, though basically prepared by Associate Professor G A Harrison, was contributed to by a wide range of intensivists, both through the Faculty of Anaesthetists and through ANZICS.

Why the feeling then amongst some intensivists that we have not had enough involvement in determining the destiny of intensive care within the College? Possibly the reason is that it can be difficult to identify the extent of involvement when this has not been all channelled through one body, namely, the Section of Intensive Care.

The College is now giving us the golden opportunity to explore the possibility of forming a Faculty of Intensive Care within ANZCA.

This would almost certainly mean autonomy of the Faculty in controlling its own affairs. The venture will only progress if there is certainty that current standards can be maintained or bettered and that we can acquire the resources to achieve this and function effectively.

A working party has been established to examine the issues involved. The first meeting is in November 1992. The Section Executive is fully represented.

If successful in this venture the strength of the new Faculty of Intensive Care will depend upon both the way it is structured and the involvement of its membership.

Clearly a Faculty of Intensive Care would be directing a major part of its energy and resources in matters relating to training, approval of posts and the examination system. However, other important areas such as preparation of standards documents, advising governmental and other bodies on professional and academic matters relating to intensive care, continuing medical education and the fostering of teaching, both bedside and formal, would not be neglected.

The Annual General and Scientific meeting would need to be at least two days in duration and have wide direct involvement and support of members.

Your Section Executive is open to receiving your suggestions.

G M Clarke
Secretary of Intensive Care Executive

REPORT ON CONFIDENTIAL SURVEY OF FELLOWS' CME

Compiled by Dr Mike Martyn — September, 1992

1372 Questionnaires returned.

1. PERSONAL CME DURING 1991	Extensive		Occasional		Never		No Answer	
Anaesthetic journals	723	53%	605	44%	15	1%	29	2%
Anaesthetic texts	165	12%	1058	77%	53	4%	96	7%
(13 indicated no reading of any anaesthetic journals or texts)								
Medical journals	204	15%	991	72%	79	6%	98	7%
Medical texts	81	6%	925	67%	180	13%	186	14%
(50 indicated no reading of any medical journals or texts)								
(2 indicated no reading of any medical or anaesthetic journals or texts)								
CECANZ	223	16%	673	49%	296	22%	180	13%

2. QUALITY ASSURANCE PARTICIPATION DURING 1991

Clinical Audit	748	55%
Morbidity/Mortality	913	67%
AIMS/NZ .	761	55%
Other	404	29%

1125 (65%) indicated that they undertook some form of QA

3. TEACHING ANAESTHESIA/INTENSIVE CARE DURING 1991

Clinical	1069	78%
Tutorials	755	55%
Faculty courses	388	28%
Other	1042	76%

1224 (89%) indicated that they were involved in some form of teaching

4. SCIENTIFIC MEETINGS ATTENDED DURING 1991

MEETINGS LESS THAN ONE DAY

	Number	Average	
Hospital	876	64%	7.9
State	652	48%	2.4
Other	210	15%	2.2

1072 (78%) indicated that they attended at least one of these

MAJOR MEETINGS

	Number	Average	
Hospital	310	23%	1.6
State	640	47%	1.5
National	626	46%	1.4
Overseas	330	24%	1.5

1070 (78%) indicated that they attended at least one of these

1257 (91%) indicated that they attended a scientific meeting

5. NATIONAL MEETINGS IN LAST TWO YEARS

	Number	Average	
Faculty GSM	415	30%	1.2
ASA AGM	437	32%	1.2
NZ CM	125	9%	1.2
ANZICS	139	10%	1.7

665 (48%) attended either GSM or ASA
713 (52%) either GSM, ASA or NZCM
863 (57%) GSM, ASA, NZCM or ANZICS

1993 Research Awards

Professor Laurence E. Mather (NSW) was appointed the **Inaugural Douglas Joseph Professor of Anaesthesia.**

Dr G.L. Ludbrook (SA): *"Relationships between Brain Opioid Concentrations and Analgesia, Cerebral Blood Flow and Metabolism."* ($22,000).

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

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

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

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

Dr J.H. Reeves (Vic): *"Plasmafiltration in Sepsis."* ($10,000 for one year).

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

The **Harry Daly Research Fellowship** was awarded to **Dr Robert Webb.**

The College Annual Academic Chairs Establishment Grant of $75,000 was awarded to the Department of Anaesthesia, University of Melbourne, Royal Melbourne Hospital.

Honours and Appointments

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

Professor G.D. Phillips (SA) – Professor of Anaesthesia and Intensive Care in the Flinders University of South Australia at the Flinders Medical Centre.

Dr Saywan Lim (Malaysia) – President of the World Federation of Societies of Anaesthesiologists.

Dr C. Goodchild (UK) – Professor of Anaesthesia in the Monash University at the Monash Medical Centre.

Dr Hugh J. Clarkson (NZ) – President, New Zealand Society of Anaesthetists.

Dr Cedric H. Hoskins (NZ) – a Vice President of the World Federation of Societies of Anaesthesiologists.

Dr T.C. Kester Brown (Vic) – Vice Chairman of the World Federation of Societies of Anaesthesiologists Executive Committee.

Dr S.J. (Butch) Thomas (USA) – Director of the American Board of Anesthesiology.

GILBERT BROWN PRIZE

At a meeting in November 1961, the Board of the Faculty of Anaesthetists, RACS, instituted a prize to perpetuate the name of Dr Gilbert Brown, who was the first President of the Australian Society of Anaesthetists.

Dr Brown had much influence in the formation of the Faculty of Anaesthetists within the Royal Australasian College of Surgeons and was a Foundation Fellow.

The Prize is awarded to the General Scientific Meeting participant judged to have made the best contribution to the Session devoted to "Recent Local Studies and Developments".

The next Gilbert Brown Prize session will be held at the Annual Scientific Congress in Adelaide from May 9 to 14, 1993.

Eligibility is restricted to Fellows, within eight years of gaining their Fellowship, and Registrars in Training.

Forms of application are available from the Registrar of the College.

Abstracts should be submitted to the Convener of the Scientific Programme by **January 29, 1993** –

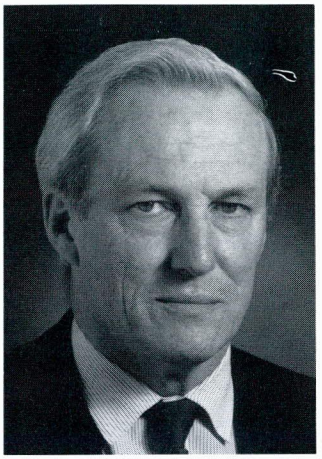
Dr Harry Owen
Australian and New Zealand
College of Anaesthetists
Spring Street
Melbourne Victoria 3000

EXAMINATION PRIZE WINNER

Dr Andrew J. Patrick of Victoria was awarded the Renton Prize for the half year ending December 31, 1992.

NEW APPOINTMENT

Chair of Anaesthesia, Flinders University



Associate Professor Garry Phillips has been appointed to the Chair of Anaesthesia and Intensive Care, Flinders University of South Australia, Flinders Medical Centre.

Garry Phillips is well known to Fellows for his multiple involvements in professional affairs, including Chairman of Examinations, and Chairman of the Education Committee, Intensive Care of the College, and member of the EMST Board.

Other important links are with the Australasian College for Emergency Medicine and the St. John Ambulance Service for South Australia.

The Chair at Flinders achieved an enviable reputation in a short time under the first Professor, Michael Cousins.

Garry Phillips sees as his first three priorities the filling of the position left vacant by Laurie Mather, soon to be advertised, filling of two specialist positions held vacant until the Chair was filled, and major input to the curriculum for the graduate medical course to commence in 1994.

ITEMS OF INTEREST FROM THE SEPTEMBER 1992 COUNCIL MEETING

EXAMINATIONS

Appeals Mechanism

Council is considering an Appeals Mechanism to be established for certain decisions made by Council and its Officers.

EDUCATION – ANAESTHESIA

Temporary Working Visas

Council noted the difficulties being encountered in obtaining visas and temporary registration for overseas doctors seeking training in anaesthesia. Council noted that this responsibility has now become the province of the Immigration Department which is distributed over 26 regional offices. The President will communicate with the Federal Minister for Immigration and Government Authorities in an endeavour to address such difficulties.

Qualification in Pain Management

Council agreed to the establishment of a Working Party to consider a Policy Document on Pain Management Units and the concept of a qualification in Pain Management.

It was also agreed that Dr Terry Little (Vic), Dr John Ditton (NSW), Dr Roger Goucke (WA), and Dr Bruce Rounsefell (SA), be invited to join this Working Party.

INTERNAL AFFAIRS

Admission to FFARACS to the Australian and New Zealand College of Anaesthetists

Fellows will recall that the Australian and New Zealand College of Anaesthetists' Articles of Association provided a time limit of 30 June for the admission of Fellows of the Faculty of Anaesthetists, Royal Australasian College of Surgeons under Article 49(a).

As at that date, there were approximately 100 Fellows of the Faculty who had not been admitted to Fellowship of the new College.

Regulation 6.3.15 was approved by Council to facilitate the admission of such Fellows to the College.

Recertification

A full report of the Working Party on the matter appears in this *Bulletin.* However, the relevant points are:

1. That the Australian and New Zealand College of Anaesthetists establish a Recertification Programme to be entitled "Certification of Maintenance of Standards".
2. That the certification process be voluntary.
3. That the certification process be offered to every Fellow every seven years.
4. That the first component of Recertification be one of credentialling, consisting of provision to the College of:
   (a) A copy of the Fellow's current registration or practising certificate from the relevant Medical Board or Council;

(b) Provision of evidence of current accreditation at an institution of practice.

5. That the second component of Recertification should take the form of provision of evidence of regular involvement in some or all of the following:
   - Attendance at CME meetings (hospital, regional, national, international), including specific workshops or training exercises;
   - Reading of relevant journals;
   - Participation in self-assessment programs;
   - Participation in Quality Assurance activities, including Peer Review;
   - Participation in clinical teaching and clinical research.
6. A third component of Recertification being considered may include measures such as:
   - Evidence of personal participation in clinical audit;
   - Assessment of personal practice by a site visit;
   - Assessment of response to critical situations by participation in simulation exercises;
   - Peer Review based on the use of clinical indicators.
7. That a questionnaire for all Fellows be developed.
8. That the relevant points on Recertification be communicated to Regional Committees, the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists and the Australian and New Zealand Intensive Care Society, for comment.
9. That the resources which would be required to establish a data-bank for Recertification be identified.
10. That the programme of "Certification of Maintenance of Standards" be offered to Fellows from 1994.

The Australian and New Zealand College of Anaesthetists and Royal Australasian College of Surgeons Working Party

The Working Parties established to discuss the implications of the Faculty's separation from the Royal Australasian College of Surgeons will be meeting in the next few weeks.

College Headquarters

Council inspected four properties identified by the Search Sub-Committee, but no decision has been reached.

Historian

Dr Gwen Wilson was appointed Emeritus Historian.

FINANCE

Uniformity of College Subscriptions

Following consideration of uniformity of College subscriptions, Council resolved to abandon the arbitrary payment of New Zealand subscriptions in New Zealand dollar numbers equal to the Australian subscription dollar number.

It was agreed that this resolution will not be implemented until 1994 allowing time for its implications to be discussed with the New Zealand Fellows.

CONTINUING EDUCATION AND QUALITY ASSURANCE

Younger Fellows' Conference – May 1992

Dr Paul Wajon (NSW), addressed the Council and reported on the Younger Fellows' Conference held before the GSM in Canberra and the recommendations made.

Annual Scientific Congress – Adelaide, 1993

Council noted that following the Annual Scientific Congress in Adelaide, the College Foundation Visitors, Professor Pierre Foex will visit Perth and Melbourne, and Professor Michael Roizen will visit New Zealand and Sydney.

Annual Scientific Meeting – Launceston, 1994

Following Council's decision to hold its first independent Scientific Meeting in Launceston in 1994, the following resolutions were passed:

That the Annual Scientific Meeting of the College be known as the ASM.

That a Convention Organiser be appointed who has a contract for 1994 and 1995.

That the Registrar be requested to call for submissions from Convention Organisers and an appointment made as soon as possible.

That the Executive be delegated the responsibility for appointing the Convention Organiser.

That the Annual Scientific Meeting remain a five day meeting for 1994.

That the overall organisation plan be agreed to in principle.

That the ASM Committee as outlined, be established:

- *ASM Officer (Convener)*
- *Protocol Officer*
- *Registrar*
- *President*

Foundation Visitor

Council agreed to invite Dr Jose C.A. Carvalho (Brazil) as a College Foundation Visitor to the 1994 Annual Scientific Meeting.

Special Interest Group – Neurosurgical Anaesthesia

Council resolved to establish a Special Interest Group in Neurosurgical Anaesthesia and called for Fellows to register their interest.

HELP Modules

Council agreed to distribute the HELP Modules to Fellows and Financial Trainees in Australia, Malaysia and Hong Kong.

Council accepted the recommendation of the Continuing Education and Quality Assurance Committee that a box be included on the Fellows' subscription notice indicating whether they wish to continue to receive the HELP Module. Following receipt of such information, distribution of further Modules will only be forwarded to Fellows requesting such distribution.

PROFESSIONAL

Informed Consent – NH & MRC

Council supported the Guidelines on Informed Consent prepared by the NH & MRC Working Party.

Australasian College for Emergency Medicine – NSQAC Registration

Following a review of the submission to NSQAC for recognition as a Principal Speciality by the Australasian College for Emergency Medicine, the Council resolved to support such application.

Drug Administration

A discussion paper on drugs given in error is being prepared by the Pharmaceutical Officer.

Policy Documents

Following review, Council approved the following Policy Documents for promulgation:

E4 *"Duties of Regional Education Officers"*
E5 *"Supervisors of Training in Anaesthesia and Intensive Care"*
E11 *"Formal Project"*
P7 *"The Pre-Anaesthetic Consultation".*

Because of the concern about Policy Document *T2: "Protocol for Checking an Anaesthetic Machine Before Use"* it is to be reviewed.

These documents are published in this *Bulletin.*

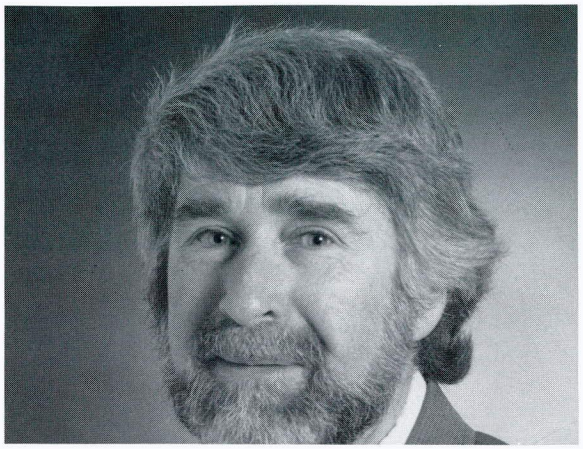
INAUGURAL DOUGLAS JOSEPH PROFESSOR OF ANAESTHESIA – PROFESSOR LAURENCE MATHER

Professor Laurence Mather has been appointed the Inaugural Douglas Joseph Professor of Anaesthesia for a research project into "Consequences of Using Mixtures of Left and Right handed Stereoisomers for Anaesthesia and in the Management of Pain".

The Douglas Joseph Professorship is the prestigious Research Award of this College, which was established by the Board of Faculty following a bequest to the Faculty of Anaesthetists from the late Professor Joseph to commemorate a Fellowship or grant-in-aid for research into human anaesthesia.

The late Douglas Joseph was a former Dean of the Faculty of Anaesthetists, Royal Australasian College of Surgeons and the first encumbent of the Nuffield Chair of Anaesthetics in the University of Sydney. Professor Joseph was appointed to this position in May 1963, an appointment he held until his retirement in 1989.

Professor Mather is the Founding Professor of Anaesthesia and Analgesia (Research) in the University of Sydney at the Royal North Shore Hospital. He is a Science graduate who progressed to a PhD whilst employed in the Department of Pharmacology at the University of Sydney.



Subsequently he worked in the Department of Anesthesiology and Pharmaceutical Sciences at the University of Washington School of Medicine leaving as Associate Professor to become the first lecturer in Anaesthesia at the Flinders University School of Medicine.

Professor Mather is a prolific researcher and writer and has an international reputation. He was elected to Fellowship of the Faculty of Anaesthetists, Royal Australasian College of Surgeons in 1983 and Fellowship of the Australian and New Zealand College of Anaesthetists in 1992.

Autologous Blood Transfusion in Elective Surgery
RACS POLICY STATEMENT

Autologous blood donation and transfusion is the preferred method of blood replacement in elective surgery.

This principle should not alter standard practices of blood ordering and transfusion, and should complement techniques for conservation and minimisation of blood loss and usage.

If patients are undergoing surgery where blood **would not** normally be ordered, there is no requirement for the surgeon to offer the facility for pre-operation donation of autologous blood. If, however, a specific request is made for this service by the patient, it should then be offered.

The availability of autologous blood **does not** circumvent all the contra-indictions to blood transfusion.

Not all patients will be suitable for autologous blood donation.

Exclusions might be, for example, anaemia, unstable angina, poor general health, infection or inadequate time before surgery.

Fitness for donation should be assessed by the Surgeon and the Blood Transfusion Service or Department where the donation is made.

Prior to donation, a consent form containing the following information should be used:

- Patient's suitability for donation
- Hazards of autologous blood use
- Unused autologous blood will be discarded
- Homologous blood may be necessary in addition to donated autologous blood.

Autologous blood should be handled and used according to the policies laid down by the Australian and New Zealand College of Anaesthetists.

RECERTIFICATION

The College Council earlier this year formed a Working Party to consider the question of recertification in Anaesthesia and Intensive Care. After examining the views of Fellows expressed at Regional Meetings and the GSM in Canberra, correspondence following the article in the November 1991 *Bulletin,* and the approaches taken by other Colleges, the Working Party has made a series of recommendations to Council.

The substance of these recommendations is that the College should establish a recertification program which will be developed after further consultation with Fellows, Regional Committees and Special Societies.

The concept put forward by the Working Party and on which we seek further views, is as follows:

1. That the program should be entitled 'Certification of Maintenance of Standards'. The aim of the program is to assist all Fellows to maintain their standards of patient care.

   Our training and examinations process is a demanding one, resulting in award of Fellowship. Any recertification program should not threaten Fellowship, but rather state that the College considers that Fellows are taking appropriate steps, at regular intervals, to demonstrate that they are maintaining certain standards of clinical practice. The process would therefore be voluntary.

   There are good reasons for taking this approach. The College aims to be supportive of its Fellows. It provides a program but recognises that any **requirement** for recertification should be a matter for the individual practitioner. The interval between recertifications is controversial, but is usually stated as five-ten years. The Working Party suggests seven years, commencing in 1994.

   There needs to be a balance between having an interval beyond which there is no credibility, and below which the work and cost involved is unreasonable. The issue of a certificate would be the visible sign of a process of continuing maintenance of professional and clinical standards.

2. The recommendations of the Working Party on the proposed components of the program are as follows:

   a. That the first component of Certification be one of credentialling, consisting of provision to the College of:

      - a copy of the Fellow's current registration or practising certificate from the relevant Medical Board or Council;
      - evidence of current accreditation at an institution of practice.

   b. That the second component of Certification should take the form of provision of evidence of regular involvement in some or all of the following:

      - attendance at CME meetings (hospital, regional, national, international), including specific workshops or training exercises;
      - reading of relevant journals;
      - participation in self-assessment programs;
      - participation in Quality Assurance activities, including Peer Review;
      - participation in clinical teaching and clinical research.

   c. That the third component of Certification being considered may include:

      - evidence of personal participation in clinical audit;
      - assessment of personal practice by a site visit;
      - assessment of response to critical situations by participation in simulation exercises;
      - Peer Review based on the use of clinical indicators.

Component (c) has not yet been considered in detail and is the area where there needs to be a lot more discussion. Outcome is seen as the most relevant evidence of maintenance of standards, but how should it be measured?

It has been argued that the College does not do this in its Final Examination, but it does monitor very carefully the knowledge, performance and competence of our trainees during training, and requires achievement of a certain standard of practice. The College must investigate ways of measuring the standard of practice maintained over the years following completion of training, and in a practical, relevant, reasonable and achievable way.

The Working Party does not believe an examination is appropriate and this is supported by the Committee of Presidents of Medical Colleges, but if Fellows felt strongly that it should exist, then it could be included

as one component. The Working Party takes the view that the components of the process should be able to be tailored to each Fellow's practice profile.

In summary, Council has decided to proceed with a process of recertification, the details of which have yet to be finalised. Before this happens, the views of all Fellows, Regional Committees, the Australian Society of Anaesthetists, the New Zealand Society of Anaesthetists, and the Australian and New Zealand Intensive Care Society are being sought. In addition, the responses to the next CME survey will be taken into account.

This is a very important issue – it is essential that we get it right.

Please let the College know of your views – via your Regional Committee or directly to the Working Party at the College.

G.D. Phillips, R.G. Walsh,
J.M. Gibbs, F.H. Hawker
Recertification Working Party

ELECTION TO FELLOWSHIP

UNDER REGULATION 6.3.1.(c)

P.G.C. Houlton, Qld
G. Dobb, WA
R.A. Sharp, Vic
K. McLeod, Qld.

UNDER REGULATION 6.3.1.(e)

J.D. Villiers, Vic.

DIPLOMA OF FELLOWSHIP ENDORSED IN INTENSIVE CARE

A.R. Burrell, NSW

THE EXPERT WITNESS

In the past few years, medical practitioners in New Zealand have become increasingly accountable in law and to their peers for their professional actions. Significant factors in this process have included:

(a) The coming of the Accident Compensation Commission with the associated removal of the right for an aggrieved party to sue those considered to have caused them harm as a result of "medical misadventure".

(b) The loss of trust in respect of the actions of doctors. The effects of enquiry by Judge Sylvia Cartwright into the events at National Women's Hospital are still being felt.

Anaesthetists in New Zealand have not been immune from these events. A corollary has been that their colleagues have been drawn into the processes of legal enquiry as expert witnesses. The processes by which tribunals and courts determine the weight to be given to evidence are often adversarial and are very different to those to which we are accustomed as medical practitioners when debating or discussing clinical issues. Some senior anaesthetists found themselves in a very alien environment and considered that their performance left much to be desired.

The New Zealand Regional Committee has therefore held two workshops on matters related to the presentation of expert testimony. They were structured to allow anaesthetists and lawyers to meet and work together on 'simulated cases' after hearing from some experienced lawyers. The substance of some of the presentations may be of interest to a wider group of Fellows.

The Right Honourable Mr Justice Hardie Boys is a Member of the Court of Appeal in New Zealand. He gave a clear and succinct overview of the place of the expert witness in legal proceedings. He was followed by Mr R.P. Wolff, a barrister, who concentrated on practical issues related to the preparation and presentation of expert testimony.

The workshop attracted some 40 participants. Feedback suggested that the great majority felt the exercise to have added significantly to their knowledge.

J.M. GIBBS

THE ROLE OF THE EXPERT WITNESS

The Rt. Hon. Mr Justice Hardie Boys

While a seminar like this may be a recent phenomenon, the expert witness is by no means so. The law has long been ready, sometimes reluctantly, sometimes condescendingly, and sometimes gratefully, to acknowledge that it needs the assistance by way of explanation and opinion of those skilled in other disciplines in order that it can adequately exercise its own. Today, when each of us knows or should know more and more about less and less, this need is greater than ever, and so a seminar such as this, may be seen as a sign of the times and will, I am sure, be of great value to both doctors and lawyers. A measure of the importance of the expert witness is that the Law Commission has recently published a discussion paper on the topic, and proposed some reforms to the law. These, if accepted, may to some extent modify one or two of the points I want to make this morning.

There was a day prior to Accident Compensation when doctors, and particularly orthopaedic specialists, were the experts most frequently called upon. These witnesses were such a small and well defined group that they could almost have formed their own Royal College. Of course other experts were needed too — neurosurgeons and plastic surgeons, indeed, all those who helped patch up the victims of accident. By and large I expect these people are still frequently used at ACC hearings, but they are rarely seen in the Courts, although there seems to be a measure of hope, among the lawyers if not the doctors, that that may change, and I gather it is this hope, or fear, that is one of the factors that prompted the holding of this seminar.

The criminal law on the other hand was primarily the domain of the pathologist, some of whom in their heyday had an almost oracular status: willing, even if not always able, to venture opinions, not only on the immediate cause of death, but as to the likely way in which the very incident came about. Some of these were very impressive men, as accustomed to the courtroom as to the mortuary, and exercising in the former the same kind of authority that doubtless they exercised in the latter, and perhaps with the same results. Whether they always advanced the cause of justice may be open to debate. But now they have gone, in the same way that the great advocates, the orators, the theatrical performers, have gone, due I suspect to the fact that juries are now better educated, less impressionable, and a bit more cynical.

In civil cases the expert nowadays is more likely to be an engineer, an accountant or a valuer. In crime the pathologist is still essential, but so is the scientist, the ballistic expert, and the fingerprint expert, although he will doubtless lose ground to the specialist in DNA testing. Today, however, is really the heyday of the

psychologist and the psychiatrist. They have had a great run in the Family Court, in custody cases, although restrictions on legal aid may bring about some reduction in their business. They are also important in criminal cases where there is a defence of insanity or automatism, and in child abuse cases where they are able to give evidence about symptoms within carefully defined limits. Let it not be thought that I underestimate the value of the anaesthetist too. It is just that your expert role is more specialised than that of these others. Where it is needed, it is equally as important.

With all this interplay, even dependence, it is easy to overlook that the expert's role is a limited one. To understand that, it is necessary to understand a little about the judicial process. Its purpose of course, is to do justice according to law; in other words, not according to individual or sectional concepts. To do that, it must necessarily establish the truth as best it can. Even if there be such a thing as absolute truth, in our daily affairs truth is a rather elusive thing, often a matter of individual perception. Yet it must be found, so far as it can be. Every system of justice there is, I suppose, recognises the limitation, by requiring no more than that the truth be established to the satisfaction of a tribunal: in ours, either a Judge, qualified by training and experience to attempt to perceive it, or by a jury or twelve ordinary people qualified by nothing except their collective experience and common sense. The means by which this is done is by the examination of witnesses, generally to say what they have seen and heard. There are restrictions on what they may say, even about these matters, devised rather pragmatically over the centuries, as much to keep cases within reasonable bounds as anything else, but they need not concern us today.

It is unlikely that any two people, even if they were eye-witnesses, will have seen or heard *exactly* the same thing, and so what they say must be tested by questioning, the tribunal reaching its conclusion on an assessment of the final result. In inquisitorial systems such as those on the Continent, this questioning is done by or on behalf of the tribunal itself. In the common law system it is done by advocates, indeed, the whole process is an adversarial one, a contest between parties, each calling witnesses and arguing to support its case, testing and trying to demolish the witnesses and arguments on the other side. Undoubtedly it is not a perfect system; although it is debatable whether any other is better. But is is the method we have and it is the system to which the expert witness must adapt himself, just as we who entrust ourselves to doctors must adapt ourselves to the ways in which they go about their work. The expert witness may comfort himself with the reflection that though the law may be an ass, it has been described as a dignified and ruminating animal, and when two contending litigants are trying to make it move in opposite directions, it is interesting to see to what extent one's own prods are effective.

As I said, the purpose of witnesses is generally to speak of facts: to describe what they saw and heard. It is not for the witness to express opinions upon those facts, to draw inferences or conclusions from them. That is the function of the tribunal. Be it Judge or jury, the assumption is that his or their general knowledge and experience will enable them to draw the necessary conclusions from the evidence of the witnesses of fact. But obviously there are many, indeed more and more, matters outside the knowledge and experience of the ordinary person, so that in those matters it would be wrong to allow a Judge or a jury to come to an opinion or a conclusion unaided.

Here, then, is the role of the expert witness. He is there to assist the tribunal, from the facts established by the evidence, to reach its conclusion as to where the truth lies. He does this by explanation of medical, scientific, technical principles and applications, and by proferring his opinion, something which the lay witness cannot do. The Court itself has the power to call expert evidence, but it is rarely exercised. Consistently with the adversarial process, the Court relies on the parties to do so. Thus the expert is almost always called by one side or the other. That fact however, does not affect his true role, to assist the Court.

This being the expert's role, certain things follow. First, the subject matter on which expert evidence may be given must be a sufficiently recognised branch of knowledge for it to be able to be said that explanations or opinions about it can assist the Court come to the truth. Thus no matter how accomplished or recognised in his or her particular vocation, a soothsayer or palmist would not be able to give expert evidence, except perhaps about their occupation itself. Next, to give expert evidence, the witness must qualify himself as an expert. In other words, he must give evidence of qualifications and/or experience in the particular field which enable him to speak expertly about it. Some professional witnesses find this embarrassing. They need not. It is an essential prerequisite. I personally think it better for the witness to overcome modesty and give his qualifications himself rather than merely give a blushing acknowledgement to a list read out by counsel. Having given his qualifications, he must keep his evidence within the confines of the field in which he is qualified. The requirement is quite stringent. Specialist qualifications in say anaesthetics do not of themselves enable a witness to proffer an opinion on say paediatrics.

Then the field must be one in which the tribunal is unlikely to be able to arrive at a correct conclusion without expert assistance; it must be one outside the ordinary experience of the average person; and the expert's evidence must be confined to that field. The use of expert evidence in cases of child sexual abuse provides a good example. Section 23G of the Evidence Act enables a registered psychiatric specialist or registered psychologist with experience in the professional

treatment of sexually abused children, to give evidence about certain specific matters, legislatively recognised as being proper for specialist evidence, namely the intellectual attainment, mental capacity and emotional maturity of the complainant; the general developmental level of children of the same age group; and whether any evidence about the complainant's behaviour is from the expert's professional experience or from his or her knowledge of the professional literature, consistent or inconsistent with the behaviour of sexually abused children of the same group. The Court of Appeal has held that these limitations may be extended as the sphere of accepted knowledge, as distinct from hypothesis or speculation or experiment, enlarges. Until then, the evidence may not go beyond these limits. For example, what may not be done, at least at the present time, is give an opinion as to whether the child is telling the truth, for that is a judgment that is thought to be within the experience of the ordinary person, and indeed is one of the essential functions of the Judge or jury.

This prohibition is in fact an example of a wider one, namely that even an expert cannot give an opinion on the ultimate issue of fact that has to be determined by the tribunal: for that would be to usurp the tribunal's function. There are exceptions, although they are hard to define – whether or not an accused person is insane is the most notable. But that is the general rule, although more and more it is being relaxed. The prohibition is particularly relevant, and is likely to remain, in the area of negligence. A witness cannot be asked whether he considers there was negligence. His role is to set the standard of reasonable care and competence, to say what a competent practitioner would reasonably do in the particular circumstances. The final decision, whether the practitioner in fact fell short of the standard, is for the Court. I might add, for this is often overlooked, he should not say what he himself would do. His personal standard may be higher – or lower – than that of the reasonably competent practitioner, and it is the latter that is the legal standard.

Next, the expert must be honest. He must be true to his own expertise, and not become an advocate. That may seem a surprising thing to say, but surprisingly, it is easier said than done. The danger for any witness, and it can befall an expert too, is to become an advocate of the party calling him, to forget that his role, whoever calls him, is to assist the Court. That experts, in the past in any event, have fallen into this trap is a reason for some of the mistrust that has been displayed by even eminent scholars such as Phipson, the renowned writer on evidence, and Taylor, who wrote the textbook on medical jurisprudence. The former said:

> *The testimony of experts is often considered to be of slight value, since they are proverbially, though perhaps unwittingly, biased in favour of the side which calls them, as well as over-ready to regard harmless facts as confirmation of preconceived theories.*

And then the latter:

> *These (expert) witnesses are usually required to speak, not of facts, but to opinions; and when this is the case, is is often quite surprising to see with what facility, and to what an extent, their views can be made to correspond with the wishes or the interests of the parties who call them.*

The expert must therefore not be afraid to give an opinion contrary to the interests of the party calling him. Opposing counsel may well try to trap him here, to challenge him in a way that pushes him to commit himself to an untenable proposition, or to refuse to make a very proper concession. Once he does that his value to his own side could be destroyed. This necessity to be honest, you will appreciate, is particularly important when one is called, as sometimes one is, to give evidence in a matter affecting another professional colleague. There is a natural reluctance to accept the assignment at all. But the interest of justice demand that one should; and that having done so one is totally honest in one's opinions. Surely it is better for a profession frankly to acknowledge shortcomings than to build a protective wall around them.

The next point is that the expert must be humble. Lest that might seem offensive, let me acknowledge at once that we all need to be humble, even though we may suspect that others have more reason than ourselves. What I mean is that the expert must remember that it is not he who is deciding the case. The Court indeed is entitled to disregard his evidence. Why sometimes it must, is illustrated in this quotation from T.E. Lawrence:

> *So I distrusted experts who were often intelligences confined within high walls, knowing, indeed, every paving stone of their prison courts, while I might know from what quarry the stones were hewn and what wages the mason earned.*

At times the Court will have to decide between the conflicting views of experts. To do that intelligently, it will consider not only their respective qualifications, but the reasons they give for their conclusions, and it is entitled to set them against all the other evidence in the case. Thus there are instances where the Court of Appeal has refused to set aside the jury's rejection of an insanity plea when the defence experts' evidence of insanity was not challenged by contrary expert evidence, but was challenged on the basis of the evidence of what the accused was proved to have said and done at the time of the offence. I must reassure you however, that the process is not entirely irrational: if the evidence is such that no reasonable jury could come to the verdict, it will be set aside.

I would like to make a couple of other comments before I say something specifically to the lawyers. The first is that a professional expert will obviously be expected to speak not only from his own practical or clinical

experience, but also from his knowledge of the literature. He should not however, step into the witness box armed with a pile of textbooks. It is he, not an unseen author, who is giving the evidence. In his evidence in chief, he should give his own opinions. It is only in cross-examination that textbooks need be referred to. Then the proper procedure is for counsel to ask whether the witness knows the book. If not, he can't be asked about it. If he does, then he should be shown the relevant passage, and only after he has familiarised himself with it and with its context should it be read, and he be asked his opinion on it. Then he is able to say that he prefers another view, to be found in such and such a work, which will conveniently be open and ready to be handed to him by counsel on his side and from which he can then read.

Finally, there is the question of notes. Traditionally, witnesses have been expected to speak from memory – an absurd expectation. They could refer to notes only if they were made at the time, and only to refresh their memory. Experts are given much more latitude, but still they should not read a prepared script unless that has already been agreed to. Anyway, it's not always a very persuasive way of giving evidence, at least before a jury. In civil cases, however, tried before a Judge alone, the practice is encouraged of briefs of evidence being prepared and exchanged before trial. This is a civilised and sensible procedure provided the brief is the witness's and not the lawyer's. It can happen that the enthusiastic lawyer will prepare the brief as he wants it to be rather than as the witness intends and that can lead to some embarrassment in cross-examination. In preparing and giving evidence, try to avoid too much technicality. To the extent that it needs to be there, explain it in layman's terms as you go along. Do your best to avoid having to be asked what you mean.

Much of what I have said will I hope be of use to the lawyers as well as to the doctors. Before I finish I would like to say one or two things particularly to the lawyers. The secret of success with expert witnesses is to be prepared yourself. A good lawyer will seek to know all he can about the subject on which he is to call his expert, especially if there is to be a contest. He must be able to challenge the opposing expert on his own ground. He must, however temporarily, become an expert himself.

One point often overlooked is that the facts upon which the expert's opinion is based must be proved by admissible evidence. A medical witness must often reach his conclusions in part on the basisof what the patient has told him. But the conclusion will be worthless unless what the patient told him is independently and properly proved. It cannot be proved from the mouth of the expert.

Then please be courteous and considerate. Gone are the days when judges expect witnesses to wait about to suit their own convenience. There should never be any resistance to the expert's evidence being interposed at a suitable stage. Arrange for your witness to be there when the Court resumes after a break. Tell the Judge in advance, and then the witness can give his evidence without having to wait.

And please be honest too. I'll illustrate that innocuously with a famous story about a scientific witness and a barrister, the latter later of very great eminence – in England. The witness, a motor engineer, gave damning evidence. At its conclusion the barrister rose to cross-examine him. His first question had nothing whatever to do with the case or the topic which the witness had been discussing. It was: *What is the co-efficient of expansion of brass?* It was brilliantly successful; the scientist didn't know the answer off the top of his head and the jury was easily persuaded he didn't know anything much. The barrister wouldn't get away with it today. Indeed he was lucky to get away with it then, because he didn't know the answer himself.

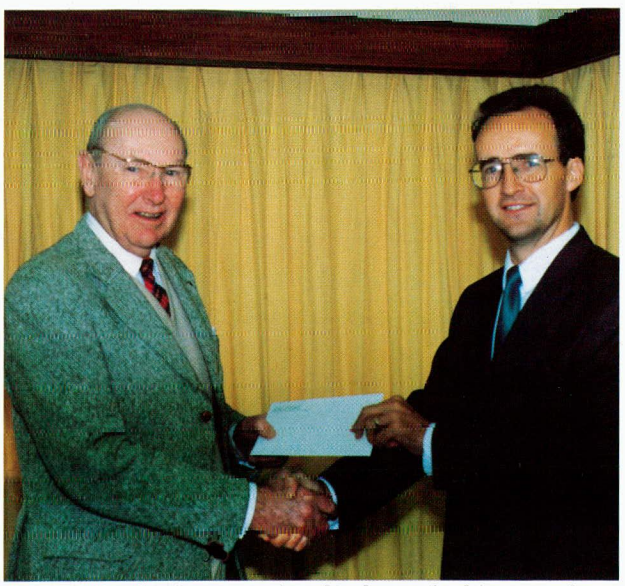
To put us all on what is now called a level playing field, let me conclude by reading you something that appeared in a recent issue of the *New Zealand Law Journal:*

> *Traditional justice is based on the concepts of right and wrong; modern justice, on mental health and illness. Faced with two women both of whom claimed to be the mother of the same child, Solomon talked to them, listened to them, and awarded the child to the woman who, he inferred from the information he obtained, was the real mother. A modern American Judge would proceed quite differently. Faced with two such women, he would conclude that one of them must be deluded. Then, he would order both to be examined by psychiatrists, who would duly discover that one of the women is a fanatic, insisting that she wants the whole child or nothing, whereas the other is reasonable, willing to compromise and accept half a child. Accordingly, the psychiatrist would declare the real mother to be suffering from schizophrenia, and recommend awarding the child to the imposter — a recommendation the Judge, respectful of the findings of medical experts, would rubber-stamp.*

To be fair, I should say that this was written by a psychiatrist.

● *Prof Patrick Boulter (President, Royal College of Surgeons of Edinburgh), Prof Raj Nambiar (Master, Academy of Medicine Singapore), Mr Yeo Chow Tang (Minister for Health, Singapore), Dr Michael Hodgson (President, ANZCA), Mr John Hanrahan (President, RACS), and Dr Eugene A. Hildreth (Immediate Past President, American College of Physicians) at the Opening Ceremony Reception fo the 26th Singapore-Malaysian Congress of Medicine.*

● *Prof Alastair Spence (President, RCA) accepting a Huon Pine Bowl presented by the President on behalf of the College to commemorate the granting of the Royal Charter to the Royal College of Anaesthetists.*



● *Dr John Craig presenting the cheque for his annual award to Dr Dermott Murphy.*

● *ABOVE:*
Some of the 450 registrants at the Day Care Anaesthesia Australasian meeting "Current Issues in Day Care Anaesthesia" held at the College on August 1, 1992.

● *LEFT:*
Presentation of the Cecil Gray Prize to Dr John Storey (WA), by Associate Professor Neville Davis.

EXPERT WITNESS

On July 18, 1992, my address to the College was made without notes. I have been asked to provide a paper so that participants could review the material that I addressed. What follows is a reconstruction and may not entirely reflect the talk given on the day.

An expert has attaching to him a particular status which gives him a very special position. Unlike any other witness he is entitled to give evidence of opinion. It is this ability to give an opinion which marks the difference between an expert and an ordinary witness. It is this distinction that also gives rise to the rules and responsibilities which govern the giving of expert evidence.

In order to be an expert witness it is necessary to possess specialised knowledge which is outside of the ordinary realms of knowledge of mankind. This can be acquired by a course of study or by some special experience. Counsel leading an expert witness must go through the course of establishing that the witness is an expert before allowing the witness to give an opinion to the Court.

It is of primary importance to both Counsel and to the witness that the witness must know all the facts of the case. There is a responsibility on Counsel to inform the witness of all known facts and there similarly is a responsibility for the witness to inform himself of the facts and to ensure that counsel understands the significance of the factual matters within his area of expertise. Counsel and expert witness are a team working together on that aspect of the case in which the expert evidence has special knowledge. Both need to clearly understand the significance of what the other is saying.

I gave some examples of the importance of the witness knowing all the facts. I trust that my memory of the events that made up the examples has not dimmed my failings or amplified my successes. If that has happened I trust that I will be forgiven. One example comes from a case where I was Prosecuting Counsel, prosecuting a man who had been charged with setting fire to his house in order to recover the insurance on it. In the house at the time of the fire there was a particular brand of heater which had been the subject of Consumers Institute investigations because it had a reputation for being unreliable and in certain circumstances likely to catch fire.

The Defence called an expert from the Consumers Institute who had carried out tests on this particular brand of heater. He gave evidence to the effect that if steps were carried out in the laboratory to simulate the failure of the inbuilt safety features in the device, and if the heater was left running, the heater would spontaneously burst into flame after four or five minutes.

This evidence was accompanied by very spectacular photographs taken for the purpose of a Consumers Institute article.

Cross examination proceeded along the line of confirming that to produce this fire in the laboratory it was necessary to have the heater switched on. In addition the safety mechanism needed to be overridden to simulate a failure in its operation. It was necessary for both these conditions to exist before the heater was in danger of catching fire. In order for current to run down the heater it needed to be plugged in and switched on at the wall and at the machine itself.

The witness was then asked:

Q: ***If the evidence in this is that the heater was switched off at the machine would your test suggest that it is an unlikely source of the fire?***

A: ***It is an unlikely source of the fire.***

Witness was then asked some further questions which established that he had not inspected the heater himself, though he knew another expert had inspected the heater, he was unfamiliar with the results of that inspection. He did not know that the other expert had recorded that the heater knob was in the "off" position when found after the fire. The cross examination finished thus:

Q: ***If the heater is "off" it would be safer to exclude the heater as a source of the fire?***

A: ***If the heater is turned off you are right.***

This example illustrates the need for the witness to have all the facts.

To ensure that the examples were not all one way and to illustrate the importance of the witness doing his full amount of research and informing Counsel I gave an example of another arson case in which I was briefed for the Defence where an expert biochemist with European degrees to a Doctoral level, who specialised in pyrolysis and arson investigation, had been briefed by the Defence to consider a house fire.

The Crown case was that the fire had been started by the two accused who had set a delayed ignition device involving diesel fuel as the principle incendiary substance. The delayed ignition device allowed them to be some 20 minutes drive away at a social function at the time the fire was proved to have started.

A neighbour had heard during the course of the evening what she thought to be a prowler and a noise which may have been a breaking window. That combination of factual features suggested that some prowler may have thrown a Molotov cocktail through the window – a Molotov cocktail of course being a petrol incendiary device.

The relevant Crown gas chromatograph was inspected and the Defence expert indicated that the pattern of the graph did not represent the pattern that was characteristic of diesel. The diesel pattern was described as "hedgehog shaped", but the present pattern was more elongated and comb shaped. The Defence witness concluded that the Crown biochemist had misinterpreted the graph or done something wrong in his investigations. He concluded that there must therefore be a reasonable doubt as to whether or not the samples taken from the floor of the fire at its alleged seat contained diesel. If the accelerant was not diesel then there must be a reasonable doubt that a delayed ignition device was used.

The Crown witness (a very capable and respected forensic scientist) was cross examined minutely about each and every mistake that could have been made in the analysis of the samples. During the cross examination, the Defence scientist tugged at my gown to advise me "he is right, I am wrong". A short adjournment was sought (it's moments like these you need Minties!). It was then the Defence discovered that its expert had assumed that the X and Y coordinates of the graph were those that were most commonly used. In particular, the Y coordinate, that related to time, revealed that the machine was running at a specific speed. The evidence had revealed that the speed was not the conventional speed and thus the 'hedgehog' had become somewhat flattened. The Defence case too was rather flattened and all attempts to resuscitate it failed. The accused was convicted.

I now have a practice of ensuring that the expert explains to me even the most basic of propositions so that this sort of catastrophe does not reoccur. It is imperative that both expert and Counsel are sure that each understands the entire evidence.

This again illustrates the importance of checking all the facts and ensuring that they are properly understood by all parties.

From these examples it can be seen that Counsel can only assist the witness and vice versa in circumstances where there is thorough preparation.

When making a decision about calling a particular witness, the first question that Counsel needs to ask himself is whether in fact that witness is an expert, i.e. has there been special study or experience, and secondly, is the evidence of opinion. If the highly qualified witness is only presenting observed facts then perhaps opinion is not necessary although it may be that qualification is necessary to carry out those particular observations. The fact that the witness is an expert has a very valuable strengthening effect to his evidence in the eyes of a jury.

A brief of evidence if not jointly prepared by Counsel and the witness must be fully understood by Counsel. Questions to the witness must be open ended so that it is the expert and not Counsel who is giving evidence. It is important that technical terms are explained so that the Tribunal or jury understand them. Diagrams or physical models may help explain technical matters and assist with the conveying of the expert's viewpoint.

Ethical responsibilities are another area of major importance for the expert witness. The witness must maintain his own ethical standards and not align himself with any proposition that he does not believe he can sustain. In reinforcing this statement, the Right Hon. Peter Mahon gave the following example at a seminar held in Auckland in May, 1985. I quote from the paper he delivered:

"What are the ethical responsibilities of the expert when he enters the judicial arena?

Above all things, the expert must maintain the integrity of the profession in which is he qualified. He must not align himself with a proposition which he himself does not really believe to be maintainable. Unless he takes this precaution, then his omission will almost certainly be uncovered during the course of cross examination and he has betrayed not only his own integrity, but the allegiance which he owes to his own profession.

I recall a case long ago when I was appearing for the Crown on an indictment for dangerous driving causing death. The accused was alleged to have driven at a dangerous speed across a pedestrian crossing and to have killed an elderly man who was at that time crossing the road. The indictment was most strongly defended. Eye-witness accounts were challenged, and emphasis was placed upon an apparent unknown defect of the vehicle which the accused had been driving, and so on. But, on the morning of the fourth day of the hearing before a jury, Counsel for the Defence produced a surprise witness. He was a medical practitioner. He had testified in hundreds of cases in the Civil Courts involving claims for personal injury. He had, I regret to say, achieved a local reputation as a doctor who was not unwilling to tailor his opinion to the explicit requirements of the case in respect of which he was being called. Upon this occasion he excelled himself.

The doctor said that he had read carefully the pathologist's report produced at the Inquest, had noted a considerable degree of coronary occlusion, and he had also been instructed that when the body of the dead man was taken to the nearest hospital, it was observed that there had been no bleeding from the multiple wounds sustained by the deceased. Basing himself upon these circumstances, he advances with positive assurance his theory that whilst the victim was walking across the pedestrian crossing, he had dropped dead from natural causes and had fallen in the path of the defendant's car. If this were so, or to put it precisely, if this were a reasonable possibility, then the

accused could not be convicted of dangerous driving causing death.

I felt it my duty as Counsel for the Crown to attack this proposition with some degree of hostility. I began by asking the doctor whether in the course of his distinguished university career he had studied the laws of physics. When he answered in the affirmative, I asked whether this had persuaded him to the conclusion that the sanctity of the oath in the witness box was controlled by the principles of relativity.

Having been rebuked from the Bench for this unseemly question, I proceeded along more orthodox lines, but I obtained leave to introduce by way of rebuttal the morgue attendant who had recieved the body of the victim at the mortuary. He said that when the body was received it was covered with blood and that the victim had bled profusely over the short period between impact and death, and that in the course of his duty had washed the corpse clean on the mortuary slab.

I asked the morgue attendant whether he had received from anyone associated with the Defence an enquiry along the lines just described. He said that he had, and that his answer had been the same as just given in the witness box.

The jury, incensed by this heroic piece of medical evidence given by the doctor, lost no time in returning a verdict of guilty, and it only remains to say that the doctor's professional colleagues in the city where he lived saw fit to make known to him their distress that he should have applied his medical skills in this way.

Such extreme examples are rare, but they have occurred from time to time. In the end, the integrity of a professional opinion is based on the integrity of the profession of the expert who gives that opinion.

Mr Mahon then went on to deal with the expert as advocate and said that a witness must beware that he is not partisan as this can rebound severely on the witness. It is not only because of this rebound possibility that independence is important. An expert should regard himself as independent of the parties, providing his expertise for the benefit of the Court. For the Counsel preparing an expert though, it is probably true to say that the ideal expert witness is one who appears unpartisan, but is nonetheless a good advocate for the cause.

I then suggested for the legal participants a method of leading expert witnesses that was particularly effective and derived from Mr David M Malone, a senior litigation partner in the Washington DC office Rivkin Radler Dunne & Bayh. This suggests that the witness be introduced along the lines of name, business and business address. Then before the witness is qualified he is asked the tickler question:

"Have you come to Court today Doctor Jones prepared to state your expert opinion as pathologist in the cause of Harold Good's lung disease?"

To this particular question the witness has been trained to answer "yes, I have", but to say no more, and this is an effective attention builder for the jury because the jury immediately understands why he is there. It is then that the witness is asked,

"Doctor, before you give us your opinion could you please tell us of your qualifications that enable you to do so".

The witness is then taken through his broad general qualifications and then his particular qualifications to the specific question before the Court, so establishing himself as an expert. Sometimes it is necessary to formally tender the witnesses in expert opinion. It must always be recalled that the witnesses cannot give answers to the ultimate questions that the Court must decide. Once the opinion is given, the witness is taken through the basis for that opinion, the reasons and any assumptions made. It may be necessary to anticipate areas of cross examination by leading that evidence in anticipation of other or opposing views during subsequent evidence.

In order to anticipate cross examination it is essential to have an idea of the likely area of attack therefore some comment was also made concerning the cross examination of experts. I do not repeat those remarks here because they are rather better expressed in James W McElhaney's article in the American Bar Journal of March 1989 in an article entitled "Expert Witnesses — 9 Ways to Cross Examine an Expert". Reference to this article is recommended to all budding cross examiners of expert witnesses.

It is my view that for an effective cross examination of an expert be careful to ensure that you get such help from them that you can where it assists your case. Avoid attacking the expert unless it is absolutely unavoidable because the cross examiner is likely to get lost in the witnesses' expertise, or the complexity of the subject matter. Rather than attack the witness in the area of his expertise a safer method is to attack the margins of the expertise and to attack the assumptions that every witness is forced to make.

It is for this reason that both Counsel and expert need to ensure that the expert has good source material and is involved in the case as soon as practical, so first hand evidence is not lost.

The expert's obligation to the Court and his responsibility to his profession dictate that he is given every assistance to discover all the available material and can properly form a professional view that is less susceptible to attack.

R.P. WOLFF, BA, LL.B, F.Arb NZ

ADMISSION TO FELLOWSHIP UNDER ARTICLE 49(a)

25TH MAY, 1992

FELLOWS

Warwick Vincent Agnew, WA
Peter Graeme Brown, Qld
Roger Alan Capps, SA
Kenneth John Carlile, Vic
Steven Louie Cerutti, Qld
Helen Kam Wan (Lucy) Chan, M'sia
Mun Kui Chin, S'pore
Peter Denholm Crone, NZ
David Gray Fegent, NSW
Colin Ashley Fletcher, WA
Colin Paul Gordon, NZ
Gail Denise Grunberg, USA
Anthony James Gyngell, Vic
Margaret Jane Haylen, NSW
Paul Tyrrell Hines, NSW
Roberta Hines, USA
John Lockwood Holmes, NSW
Ruth Anne Sandford Jackson, Qld
Stephen Bryce Kinnear, SA
Jill L'Armand, USA
Kok Ho Lim, S'pore
Frederik Johan Lips, NSW
Margaret Ellen Lythgo, Vic
Marie Joy McKell, NSW
Trevor Ashton Mitchell, NSW
Susila Nair, M'sia
Gregory Francis O'Sullivan, NSW
Ronald William Quinn, Qld
Bruce Gordon Ryley, S'Arabia
Peter Tait Sheridan, NSW
John Pattison de Hautrey Spoor, WA
Andrew Benjamin Stewart, Vic
Colin Richard Tredrea, USA
Paul Raymond Waizer, NSW
Harold John White, NSW
Chiu Shui Dominic Woo, HK
Jan Marian Wuth, Qld
Keat Him David Yeo, M'sia
Sol David Yezerski, NSW

5TH JUNE, 1992

FELLOWS

Eileen Tak-Kwan Au, HK
Paul Anthony Birrell, NSW
John William Burkhart, NSW
Richard Frederick Hume Catchlove, Canada
Martin David Culwick, Qld
Mary Louise Done, Vic
Margaret Therese Goodrick, NSW
Hedley Anthony Hosking, Vic
Kok Chye Lim, M'sia
Timothy John McCarthy, Vic
Malcolm Wesley McSorley, Qld
Paul Thomas Moran, NSW
Phillip Rubinstein, Vic
Linton Joseph Sharp, WA
Janet Stirling Smith, NSW
Philip Anthony Stephens, NSW
Arien Hendrik Douwe van de Meene, Qld
Julie Anne Walker, Vic
John Charles Warden, NSW
Dennis John Alfred Wooller, Qld

ADMISSION TO FELLOWSHIP UNDER ARTICLES 12(c) AND 23

20TH SEPTEMBER, 1992

HONORARY FELLOW

John Edward Riding, UK

FELLOWS

Peter John Adams, Qld
John Colin Dunn Callander, WA
Murray Leonard Farrant, NZ
Faridah Jalil Safwan, M'sia
Philip Latham Jobson, NSW
Leslie Francis Kamaker, NSW
Jonah Barry Katz, Vic
Susan Margaret Mortimer Kelly, NSW
Chik Hing Lam, Canada
Stephen Wilson Low, NZ
William George McLellan, Qld
Reta Mary McLeod, NZ
Christine Helen Moffatt, SA
Livia Suzanne Nagy, NSW
John Allan Norrie, NSW
Kenneth Oldroyd, NSW
Brian Daniel O'Shea, NSW
Stuart George Paige, Qld
Hamid Abdul Rahman, M'sia
Richard Ranger, Vic
Alan Patrick Nigel Rankin, NZ
Ramachandra Reddy, Ind
Bruno John Ricci, WA
Martin Peter Rowley, NSW
Arnachalam Sappany, M'sia
Adrian Soroszczuk Selwyn, NSW
Marie Margaret Simpson, NZ
Richard Alexander Steele, NSW
Wai Ting Tai, HK
Heng Tong (Albert) Tan, M'sia
Shuk Ying (Susan) Toh, S'pore
Anthony McCrae Trewartha, SA
Sivasakthi Velayuthapillai, M'sia
Yih Lin Wan, NSW
Warwick James Wilson, NSW

ANAESTHESIA & PAIN MANAGEMENT RESEARCH CENTRE

University of Sydney at Royal North Shore Hospital

UPDATE ON DEVELOPMENT OF THE NEW CHAIR

1992 – A Hard but Most Successful New Year
The establishment of a strong Centre for anaesthesia research and a Pain Management and Research Centre has been an exceedingly difficult task in the current economic climate. However, under the circumstances, the Appeal for funds has been extraordinarily successful, with support coming from a very broad cross-section of the community, including patients, the general public, "medical" and non-medical companies, foundations and the government.

We are extremely grateful for all of this support which has made it possible to make the following progress:

A superb **large animal facility** has been completed and this contains appropriate holding facilities, a fully equipped operating theatre and appropriate facilities for holding instrumented animals; **new offices, tutorial rooms,** administrative/secretarial area, a Library/Conference room and a new clinical anaesthesia research laboratory, all of them immediately adjacent to the Main Operating Theatres, have been completed; a purpose designed **Pain Management and Research Centre** has reached the stage of final architectural planning and space allocation within the main hospital building where it will contain facilities for outpatient consulting, minor and major treatment areas, including a fully equipped operating theatre, a large teaching area and appropriate office space for a range of staff, including accommodation for acute pain service personnel; **basic research laboratories** have also passed the stage of final architectural planning and space allocation on the floor immediately above the main offices of the Department where 300 square metres of laboratory space will accommodate staff with projects already underway in the fields of anaesthesia pharmacology and physiology, pain neurophysiology, pharmacology of spinally mediated analgesia and chemical pharmacology of drugs used in anaesthesia and pain management.

Support of the new Chair by the College
The award of the 1991 Australian and New Zealand College of Anaesthetists Academic Chair Establishment Grant was an enormous boost to the development of this new academic department. It was decided to utilise the $75,000 provided by the grant to assist with the development of the clinical anaesthesia research laboratory and this was officially opened by the President of the College, Dr Michael Hodgson, on Friday, November 6, 1992, where a demonstration of the project in progress was given by the department's first PhD candidate, Dr Stephen Barratt, MB, BS, FANZCA, who is the recipient of a College of Anaesthetists Scholarship for 1993.

The anaesthesia related research of the new department was also greatly helped by the award of the Douglas Joseph Professorship to Professor Laurie Mather. These funds will be utilised to recruit a Research Fellow who will have an opportunity to work on an exciting project in the field of anaesthesia pharmacology.

Highlights of the Appeal for funds to support the Chair

1. Glaxo Australia Pty Ltd have funded a Fellowship at the level of $60,000 a year for five years to support anaesthesia and pain management research and to assist in the development of postgraduate teaching in pain management.
2. The Medical Benefits Fund of Australia have provided seed funding of $100,000 and a further $50,000 a year for two years to assist in the development of the Pain Management and Research Centre.
3. Abbott Australia has added to their original contribution of $210,000 over 15 years (Laurie Mather's Chair of Anaesthesia and Analgesia Research) by supporting our Appeal Launch Dinner and by additionally providing $50,000 over five years to help with development of facilities.
4. Syntex Australia Pty Ltd have provided a Senior Research Fellowship at a level of $40,000 per annum for three years to support an individual with a high level of experience in clinical bioassay relevant to anaesthesia and pain management research.
5. The Adolph Basser Trust have endowed the Department Library at a level of $50,000 to support the purchase of texts and journals.

In addition to the very substantial donations noted above, we are extremely grateful for the large number of individuals and organisations that have helped us. Prominent among these donations have been members of our specialty within the Department and within New South Wales. We would also like to note the donation of time, expertise and materials to produce the very high

quality Appeal brochure, which has proved invaluable in obtaining support from major companies, foundations and other bodies. This generous donation from George Patterson Advertising Pty Ltd permitted the development of a high standard document which would have been well outside the modest budget set for Appeal costs. We would again like to note the vital assistance provided by the "Line of Credit" from the College which enabled us to engage a professional fund-raiser during the early stages of development of the Appeal.

A summary of contributions to the Appeal to date is provided below:

Support for facilities and equipment

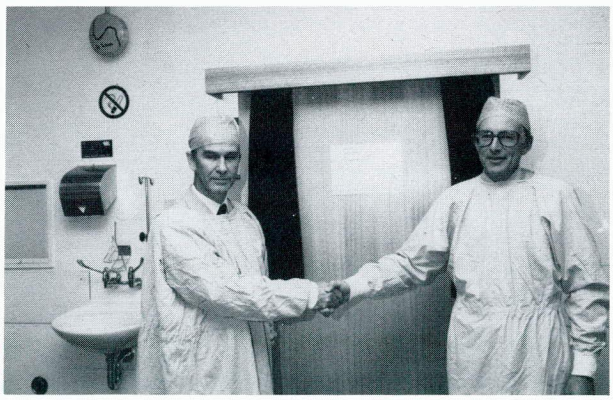
Hospital/Government	
Seeding funds and budget allocations from Royal North Shore Hospital and the NSW Government	300,000
Corporate and Other:	
Medical Benefits Fund of Australia Ltd	200,000
Professional Staff of the Department of Anaesthesia and Pain Management, and NSW members of the profession	75,900
Australian and New Zealand College of Anaesthetists Establishment Grant	75,000
Abbott Australasia Pty Ltd	50,000
The Adolph Basser Trust	50,000
Anonymous Charitable Trust	50,000
The Raymond E Purves Foundation	35,000
Floral & Services Committee, RNSH	35,000
Clive & Vera Ramaciotti Foundations	31,870
Mailing by RNSH Fund-Raising Office	31,857
National Australia Bank Ltd	30,000
Commonwealth Industrial Gases Ltd	30,000
Janssen Cilag Pty Ltd	25,000
AMP Society	20,000
Syntex Pharmaceutical International P/L	16,000
Astra Pharmaceuticals P/L	10,000
The Boots Company (Aust) P/L	10,000
Macquarie Bank Ltd	10,000
ICI Australia Ltd	10,000

Baxter Perpetual Charitable Trust
Various donations of patients and other community members
Pharmacia Australia P/L
Medtronic Australasia P/L
Ronald Geoffrey Arnott Foundation
Association of NSW Workers Compensation Self-Insurers
Permanent Trustee Foundation

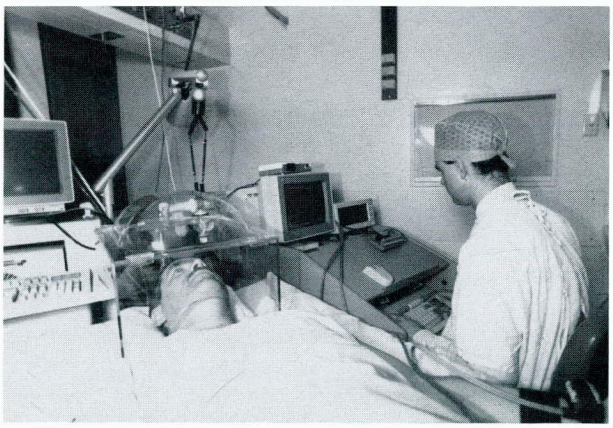
Support for teaching and research

In addition, the following grants have been committed to support teaching and research in anaesthesia and pain management:

Glaxo Australia P/L	300,000/5 yrs
Abbott Australasia P/L	210,000/15 yrs
Syntex Australia P/L	120,000/3 yrs
Clive & Vera Ramaciotti Found.	32,000
Graseby Group (UK)	25,000/2 yrs
Astra Pharmaceuticals P/L	25,000



● *The President, Dr Michael Hodgson opened the laboratory in the presence of the Chairman of the Area Health Board, Professor Tom Reeve, Senior Hospital and University staff, the Chairman of the Appeal Board, Mr Richard Turner and Professor Michael Cousins.*



● *Pictured at the opening of the Research Laboratory, Dr Stephen Barratt, College Research recipient, carrying out postoperative metabolic studies using computerised equipment to measure oxygen consumption.*

REGISTRAR'S REPORT ON THE SEVENTH CIREBA MEETING

Back Row, Left: Professor David Glass (Assistant Secretary/Treasurer, ABA); Professor Richard Clarke (Dean FARCSI); Dr David McKnight (Chairman, Specialty Committee in Anaesthesia RCPSC); Dr Carl Hug (President, ABA); Dr Michael Davies (Vice President, ANZCA); Mr Stanley Alan (Secretary, RCA); Dr Jean Lumley (Vice President, RCA).
Front Row, Left: Professor David Hatch (Vice President, RCA); Mrs Joan Sheales (Registrar, ANZCA); Professor Anthony Cunningham (Hon. Secretary FARCSI); Professor Alastair Spence (President, RCA); Professor David Morell (Chairman, FACMSA); Dr Michael Hodgson (President, ANZCA).

The biennial Meeting of the Conference of International Reciprocating Examining Boards of Anaesthesia was hosted by the Royal College of Anaesthetists in October. The Meeting was held at the time of the celebration of the granting of the Royal Charter to the College of Anaesthetists. This Meeting was attended by representatives of the Royal College of Anaesthetists, American Board of Anesthesiology, Australian and New Zealand College of Anaesthetists, Faculty of Anaesthetists, Royal College of Surgeons in Ireland, Royal College of Physicians and Surgeons of Canada and the Faculty of Anaesthetists, The College of Medicine of South Africa. This College was represented by the President, Vice President and myself.

I believe the following matters will be of interest to Fellows:

IN-SERVICE ASSESSMENTS

The American Board of Anesthesiology has two basic methods of assessment:

1. *An In-Training Examination which is conducted each year is a level of achievement test at various stages rather than a Pass/Fail exam. This exam consists of 350 questions, 270-290 of which questions are to be considered questions of fact.*
2. *Each Training Program must have a Clinical Competence Committee comprising Members of Faculty*

including the Chairman of the Department and the Program Director to formally evaluate every resident's program biannually. This assessment is discussed with the candidate and signed by the parties verifying that the trainee has read the assessment and forwarded to the ABA.

In the event that there is an unsatisfactory report on any essential component, this results in an overall unsatisfactory report and that six months period of training will not be recognised. Such report requires the Program Director's comment. However, in the event that the resident remains in that program and achieves a satisfactory report for the following six months, retrospective recognition can be granted for that 12 months training.

The Canadian College requires a Final In-Service and Training Evaluation Report (FITER) to be completed prior to a candidate's acceptance for examination which is usually taken following completion of training.

The South African Faculty utilises a tick sheet mechanism which is completed quarterly.

EXAMINATIONS AND TRAINING

The Irish Faculty and the English College, as does our own College, require completion of a 12 months residential requirement for Fellowship. The Canadian College will recognise a training program which has been totally completed in approved or reciprocal posts outside Canada. However, in order to practise as a specialist in that country, a practitioner must pass the College exam for certification.

The format of the American Board of Anesthesiology exam has been modified and requires "additional" topics to be addressed in short cases rather than during the vivas. This change has been well received by both Examiners and Candidates.

Following a three year training program to be eligible to apply for the American Board of Anesthesiology exam, the candidate must hold a State Licence and nominate three referees who are required to submit a reference. The Board always requests a report from the Program Director and a Certificate of Good Standing before the candidate is accepted for examination.

The Royal College of Anaesthetists has adopted two orals – one structured, the other unstructured. That College is committed to change to an OSCA examination in June 1994 with a minimum of twelve stations.

CERTIFICATION IN PAIN MANAGEMENT

The American Board of Anesthesiology has established a time-limited qualification in Pain Management because of concern expressed at other Boards contemplating such an "add on" certification which would preclude Anesthesiologists' involvement with practice in pain management. The pre-requisite for such certification which is only available to Diplomates of the American Board of Anesthesiology, are twelve months formal training in acute, chronic and oncology pain management and a successful MCQ examination.

A grandfather provision exists for Diplomates who document two years full time in pain management or four years at 50% or more involvement. The American Board of Anesthesiology will consider other cases on individual merit.

To date, the American Board of Anesthesiology is the only Board to be granted approval of special requirements for certification in pain management by the American Committee for Graduate Medical Education (ACGME). The first examination will be conducted in late 1993. To date there have been in excess of 400 enquiries with thirty-five exam applications received.

In the UK, a working party of the Committee of Presidents has been established to explore the initiative of pain being recognised as a sub-specialty. It is considered that acute pain is within the interests of anaesthetists but pain management is in a minority interest.

RECERTIFICATION

The American Board of Anesthesiology has introduced a Certificate of Continued Demonstration of Qualification (CCDQ) which is a voluntary program available to Diplomates who hold an unrestricted medical licence and produce peer evaluation from Colleagues (if in private practice) or letters of reference from the Medical Director of their Hospital. The exam consists of 100 general anaesthesia questions and 100 sub-specialty questions – all A type questions with four possible answers with a fifth slot "I choose not to answer this question". Candidates must score 150 questions.

As some American States require a general medical examination for licence renewal, it is believed the American Board of Anesthesiology CCDQ will satisfy this requirement.

The CCDQ Examination may be taken as often as the Diplomate chooses. In the event that a candidate is unsuccessful in the examination or credentialling process, no such advice will be given to anyone other than the candidate, and the records destroyed.

The Canadian College has set up a pilot study on Maintenance of Competence (MOCOMP) and offered it to ten groups in each specialty covering 4000 Fellows in all, with an outstanding response. The study responses will be considered by the April 1994 Council Meeting when a decision will be made as to whether such program

should be offered to all Fellows. If such program is adopted, it will be a voluntary program. The Canadian College believes it certifies to a high standard and such program will demonstrate the continuance of such standards on an outcome basis.

CONTINUING MEDICAL EDUCATION

Twenty-two of the 52 States of the USA require CME points for licence renewal. There is a formal Court of Grantors (the State, the ABA and the AMA) that award these points.

There are three categories: Lectures; Teaching; Journal reading and self study examinations for which points are awarded.

ACCREDITATION IN CRITICAL CARE

There are now five sub-specialties in South Africa registered with the General Medical Council providing a career in intensive care: anaesthesia, surgery, paediatrics, general surgery and medicine.

The American Board of Anesthesiology has an "add on" certificate in critical care which is offered to Diplomates who have completed twelve months of training obtained in a critical care medicine program accredited by the Residency Review Committee for Anaesthesia.

The Royal College of Anaesthetists is investigating the establishment of a Diploma in Intensive Care as a multi-disciplinary Diploma.

TRAINEE WORKING HOURS

In the United Kingdom, the Colleges have agreed that a reduction to 83 hours per week for junior doctors will permit adequate training.

JOAN SHEALES

HIGHLIGHTS OF RACS COUNCIL MEETING HELD ON OCTOBER 22-23, 1992

PRESIDENT'S REPORT

Subscription Levy
The response to the subscription levy had been very good. Approximately 30% of Fellows had paid the levy with 70% of those who had paid, paying the full amount.

Questions had been raised by some and these had been answered by the President, Honorary Treasurer or College Secretary.

Neurosurgical Chair in South Australia
The first payment of the $150,000 promised by the College to the Inaugural Chair of Neurosurgery in Adelaide had now been made. The President had attended the announcement of the Chair. Council had some years ago resolved to support Chairs in new surgical disciplines.

Project Guangzhou
Numerous Surgeons had expressed interest in working in Guangzhou under the aegis of the above project and the first would probably travel to Guangzhou in February-March, 1993.

AWARDS, ELECTIONS AND HONOURS

Louis Barnett Medal
Professor John Ham was awarded the Louis Barnett Medal for outstanding contributions to education, training and advancement in Surgery.

Certificates of Appreciation
Certificates of Appreciation were awarded to Mr H G Lander and Mr C H Rennie for their contributions to road trauma and the Road Trauma Trust and to Mary Ellen Sgro for her outstanding contributions to the College through her assistance to the Chairman and the Board in Paediatric Surgery.

Prince Henry's Hospital Medal
To commemorate the association between Plastic and Reconstructive Surgeons of the College and Prince Henry's Hospital a Medal was approved to be awarded for distinguished contributions to Plastic Surgery in a broader sense including original contributions to the literature and to scientific meetings, academic achievement including research, undergraduate and post-graduate teaching, intellectual leadership and the encouragement of others for the overall advancement of the highest levels of Plastic Surgery.

Ramsay Fellowship
Ramsay Fellowships for rural surgeons were awarded to W K Hunter of Moree and J Swinnen of Greymouth, New Zealand.

Rowan Nicks Scholarship
The 1993/94 Scholarship was awarded to Dr Harjit Singh of Malaysia.

CENSOR-IN-CHIEF

Assessment of Surgical Standards in Hospitals
Council agreed to amend the RACS document on assessment of surgical standards in hospitals to include the Hospital Medical Director on Hospital Credentials Committees.

SCIENTIFIC MEETINGS

Annual Scientific Congress
Associate Professor John Masterton was appointed Chairman of the ASC Scientific Program Committee and E Durham Smith to the part-time position of Co-ordinator of the ASC.

K J Wickham Pty Ltd was reappointed ASC Meeting Organiser for the period 1995-1997, subject to receipt of an acceptable submission from Mr Wickham.

Proposed RACS/RACP/Singapore/Malaysia Academies Meeting
A joint meeting involving the above bodies will be held in 1995, probably in South-East Queensland.

Proposed RACS/ACS Joint Meeting
The American College of Surgeons had shown interest in a joint meeting with the RACS and it was agreed that the President should discuss such a meeting further with the American College of Surgeons suggesting it be held in conjunction with the Annual Scientific Congress in Brisbane in 1997.

PROFESSIONAL AFFAIRS

Recertification
Council resolved that recertification of Fellows should be mandatory.

Surgical Audit is part of recertification and a manual "How I Do It" on Surgical Audit was approved and will be printed and sent to all Fellows of the RACS with the March 1993 edition of the *Bulletin.*

Quality Assurance - Clinical Indicators
Council adopted a policy on quality assurance and the following statement in the area of clinical indicators.

1. The Royal Australasian College of Surgeons, in conjunction with the Australian Council on Healthcare Standards, will develop the formulation and interpretation of validated surgical clinical indicators in the hospital accreditation process.
2. The College endorses the use of hospital-wide validated medical clinical indicators by the Australian Council on Healthcare Standards in the hospital accreditation process. A problem flagged by quality of care measures should be investigated by an appropriate clinical team.

Autologous Blood Transfusion
A policy on autologous blood transfusion was adopted and is published elsewhere in the *Bulletin.*

New Technology
A New Technology Advisory Committee was established to collect information on new technology available and in-development to advise appropriate College groups which will then evaluate and develop guidelines for education, training and utilisation.

Retirement Age
Council has amended the College Policy on Retirement Age by defining more closely the conditions under which it would be normally expected that surgeons over 65 years of age would not seek or accept employment. The emphasis in this regard is on surgeons seeking or accepting employment in a full clinical capacity in a public hospital.

The policy now reads as follows:

"The College agrees that obligatory retirement by an employing authority solely on the basis of a specified advanced age may be seen as discriminatory. At the same time it is equally discriminatory to restrict the opportunities of younger employees for career advancement by the unrestricted retention of older employees.

1. The Royal Australasian College of Surgeons believes that the sole factor which should determine whether or not a surgeon with appropriate qualifications continues to practise is that of continuing competence and maintenance of skills.
2. The College believes that surgeons and employing authorities should pay due regard to the profession's requirements for appropriate career structures and opportunities and also manpower requirements.

Except in unusual circumstances, such considerations make it inappropriate for a surgeon beyond the age of 65 years to continue employment in a full clinical capacity in a public hospital."

INTERNAL

Australian and New Zealand College of Anaesthetists

In view of the formation of ANZCA, Council resolved to dissolve the Faculty of Anaesthetists, RACS, by removing all reference to the Faculty from the Articles of Association of the RACS.

Discussions will continue on other matters relating to the incorporation of the ANZCA.

Appeals

An Appeals Committee and an appeals process were approved by Council to hear appeals from any person adversely affected by a decision of a Complaints Committee – Regional of the College or any Board or Committee of the College with responsibility for training, accreditation, examination or related matters.

CHANGES IN REGULATIONS

2.9.1 Membership of the Committee shall include the Continuing Education and Quality Assurance Officer, who shall be a Council Member and Chairman, the ASM Officer, a representative of the Australian Society of Anaesthetists, a representative of the New Zealand Society of Anaesthetists, a Member of the Executive of the Section of Intensive Care, a representative of the Australian and New Zealand Intensive Care Society and such other members as the Council may appoint.

2.14 ASM scientific Program Committee
Membership shall include the ASM Officer who shall be the Chairman, the Continuing Education and Quality Assurance Officer, the immediate past, the present and the next ASM Regional Scientific Program Conveners.

6.3.15 Council may elect to Fellowship of the College without examination, any person who, as at 30 June, 1992, was a Member or Fellow of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in good standing and who had, as at that date, fully paid all membership fees then due and payable by the Fellow.

(a) Any person seeking election to Fellowship pursuant to this Regulation may be required by the Council to prepare and submit an application form (in such form as may be approved by the Council) and may be required to pay such admission fee, membership fee or other fees as the Council may from time to time determine.

(b) Council will be entitled to enquire as to the qualifications, registrations and other professional qualifications of any person seeking election pursuant to this Regulation and such person shall provide all such information immediately upon request.

(c) The decision by Council to elect any person to Fellowship pursuant to this Regulation shall be entirely at the discretion of Council (without the need to give any reasons therefore).

(d) Applications for election to Fellowship pursuant to Regulation 6.3.15 may be considered at any meeting of the Council.

15.7.1 The Council will approve for training in Anaesthesia:

15.7.1.1

Anaesthetic posts in Australia, New Zealand or areas in which the College examines provided they are held for a continuous period of at least three months.

This applies to all posts commencing on or after January 1, 1979.

(a) Provisional Fellowship Year Posts provided they have the prior approval of the Council.

(b) Posts recognised by the Council as part of an approved training program.

(c) For trainees who commenced training in posts outside those in Australia, New Zealand or areas in which the College examines before July 1, 1993 a training program including 12 months in an approved post in Australia or New Zealand.

For trainees who commence training in posts outside those in Australia or New Zealand on or after July 1, 1993 a training program including 12 months in an approved post in Australia or New Zealand.

This 12 month period of required training may occur within the first four years of approved vocational training or in the Provisional Fellowship Year.

15.7.1.2

Anaesthetic posts held outside Australia, New Zealand or areas in which the College examines provided they are held for the continuous period of at least three months.

Candidates in their own interest should seek from the Assessor prior approval of such posts.

A period of at least 12 months must be spent in an approved post in Australia or New Zealand.

(a) In the Provisional Fellowship Year (Regulation 15.4.1.4) all training posts in Great Britain and Ireland acceptable for Higher Specialist Training.

Such other posts outside Australia, New Zealand or areas in which the College examines as may be deemed acceptable after individual assessment.

(b) In the first four years of training (Regulations 15.4.1.1, 15.4.1.2 and 15.4.1.3), all training posts in Great Britain and Ireland of Registrar status or above accepted by the English College or Irish Faculty.

Regulation 15.7.1.2 will be implemented from January 1, 1986.

POLICY DOCUMENTS

Review E4(1992)

DUTIES OF REGIONAL EDUCATION OFFICERS IN ANAESTHESIA AND INTENSIVE CARE

1. Regional Education Officers occupy an important position in the College's educational network. They have responsibilities to provide liaison between trainees, Supervisors of Training, their Regional Committee and the central administration of the College. Specific duties include:

   1.1 Maintaining a list of approved hospitals in each region. Notifying the Regional Committee and the College Council of any changes in senior Anaesthesia or Intensive Care staffing which have the potential to affect the training programmes.

   1.2 Obtaining a list, (on Form R1 or R2) from Supervisors of Training with:

   1.2.1 The names of all trainees in College approved posts.

   1.2.2 The numbers of occupied service posts which are not approved by the College for training purposes.

   These lists should be forwarded to the College within two months of the commencement of the hospital employment year in each region.

   1.3 Obtaining notification from Supervisors of Training of any changes in the list referred to in 1.2.1 caused by trainees joining or leaving a rotational training scheme during the hospital employment year. It is particularly important that the dates of such changes are noted to allow independent verification of training by the Assessor.

2. Informing the College of changes in personnel occupying the following positions in each approved hospital:

   2.1 Chief Executive Officer or equivalent.

   2.2 Chief Medical Officer or equivalent.

   2.3 Director of Anaesthesia and deputy.

   2.4 Director of Intensive Care and deputy.

   2.5 Supervisors of Training in Anaesthesia and in Intensive Care (see College Policy Document E5 "Supervisors of Training in Anaesthesia and Intensive Care").

   2.6 Departmental Quality Assurance Co-ordinator.

3. Assisting Supervisors of Training with monitoring of staffing and trainee supervision in each approved hospital. When considered necessary by Council or the Regional Committee, a survey of staffing and workload (using Form HA-2) should be conducted. Results should be forwarded — with any relevant recommendations — to the Hospital Accreditation Group of the College.

4. Understanding of College Regulations related to training and examinations.

5. Maintaining a calendar of dates relevant to College examinations.

6. Maintaining contact with Supervisors of Training with advice as appropriate on matters related to training and examinations. At least one meeting each year of Supervisors in each region is recommended.

7. Ensuring that courses for Primary and Final Examinations are held on a regional basis.

8. Keeping College Education Officers informed of regional activities and problems. Providing a report to the relevant Education Committees by 1st July each year.

9. Attending or nominating a representative to attend the annual meeting of Regional Education Officers with College Education Officers held during the ASM.

10. Monitoring and advising on systems for assessment of trainee performance in approved hospitals.

11. Providing advice as appropriate to trainees and prospective trainees.

12. **REGIONAL EDUCATION SUB-COMMITTEE**

   12.1 This sub-committee will be elected from members of the Regional Committee and will include the Regional Education Officer (Anaesthesia) and the Regional Education Officer (Intensive Care) one of whom will ordinarily chair the sub-committee.

   12.2 The sub-committee will assist the Education Officers with all matters related to educational activities in the region and will report to the Regional Committee.

September 1992

Review E5(1992)

SUPERVISORS OF TRAINING IN ANAESTHESIA AND INTENSIVE CARE

Supervisors of Training are the College's representatives on training in its approved hospitals. They have an important role and must have a broad understanding and experience in College affairs. They provide liaison between trainees and Hospital authorities (in respect of matters related to training) as well as with Regional Education Officers and the central administration of the College.

1. APPOINTMENT AND TENURE

1.1 The Supervisor of Training in Anaesthesia or Intensive Care shall be recommended by the Hospital Administration on the advice of the relevant Department. The appointment shall be ratified by the College Council.

1.2 The Supervisor shall not be the Director of the Department or administratively responsible for its functioning unless the circumstances are exceptional.

1.3 The appointee shall hold the Diploma of FANZCA or an equivalent qualification acceptable to the College Council and should not be a candidate for any College examination.

1.4 The Hospital Administration shall be responsible for notifying the Registrar of the College of the recommendation for appointment.

1.5 The College Council, at its discretion and after consultation with the relevant Regional Education Officer, may not approve of the Supervisor recommended by a Hospital. In that case, the Registrar shall notify the Hospital and request the recommendation of a different Supervisor.

1.6 The appointment of a Supervisor of Training shall be for an initial term of five years with a review by the Regional Committee after two years. Supervisors will be eligible for reappointment by the Council after advice from the Regional Committee.

2. DUTIES OF SUPERVISORS

2.1 **Within the Hospital**

2.1.1 To be familiar with the College's Regulations on Training, Examination and Registration of Trainees.

2.1.2 Providing a list (on Forms R1 and R2) to the Regional Education Officer with:

2.1.2.1 The names of all trainees in College approved posts.

2.1.2.2 The numbers of occupied service posts which are not approved by the College for training purposes.

These lists are to be forwarded to the Regional Education Officer within two months of the start of the hospital employment year. Forms R1 and R2 will be provided by the Regional Education Officer.

2.1.3 Notifying the Regional Education Officer of any changes to the list referred to in 2.1.2.1 created by trainees joining or leaving the rotational training scheme during the hospital employment year. It is particularly important that the date of such changes is noted to allow independent verification of training by the Assessor.

2.1.4 To notify the Regional Education Officer of any senior staffing changes likely to impact on training programmes. To provide information when requested for a Hospital Data Sheet or for a Trainee Workload Survey.

2.1.5 To advise potential and current trainees on their training, registration requirements, fee payments and examination preparation.

2.1.6 To monitor supervision, experience and fair allocation of duties for trainees and to facilitate such changes as may be necessary.

2.1.7 To liaise with the Director of the Department in respect of trainee duties, supervision, rest and study time and release for approved courses.

2.1.8 To complete and despatch promptly trainees' training certificates to the College with particular emphasis on the accuracy of the dates of specific training experiences or specialty attachments.

2.2 **Outside the Hospital**

2.2.1 To establish and maintain liaison with the Regional Education Officer and with other Supervisors of Training.

2.2.2 To refer any difficulties in respect of training programmes or trainees to the Regional Education Officer.

2.2.3 To be aware of appropriate training courses and to see that trainees receive this information.

2.2.4 To maintain a calendar of examination dates, and dates of closure for entries.

2.2.5 To attend, when possible, any regional meetings of the Supervisors of Training.

September 1992

Review E11(1992)

FORMAL PROJECT

Guidelines for Completion of a Formal Project to be a Requirement for the Award of the Diploma of FANZCA Endorsed in Anaesthesia

1. INTRODUCTION

In order to further the educational aspects of the Objectives of Training, all trainees in anaesthesia of the Australian and New Zealand College of Anaesthetists, who commence training on or after the 1st July 1988, will be required to submit evidence of satisfactory completion of a formal project which has been carried out during the period of approved vocational training, before the Diploma of FANZCA endorsed in anaesthesia will be awarded. This project is not a prerequisite for presenting for either the Primary or the Final Examinations and may be undertaken at any time.

Submissions should be made in the first instance to the Regional Committee.

2. PROJECT

Suitable activities may include:

2.1 presentation of a paper at a scientific meeting approved by a Regional Committee (at which abstracts are subject to review and selection)

2.2 acceptance of a scientific paper for publication in a journal which referees all manuscripts

2.3 a dissertation on a case study or series of cases, or other interesting clinical or research topic, including a critical review of the literature

2.4 a period of not less than 3 months full-time research in a programme approved by the Assessor.

Other projects, degrees or diplomas given approval by the Assessor prior to 31st December 1992.

3. ASSESSMENT OF PROJECTS

Regional Committees and, in South East Asia, Training Committees, will be responsible for certifying to the Assessor that each trainee has complied with the above requirements. Each Committee will nominate a member to be responsible for this, and will develop local mechanisms (which may include referral to people with special expertise outside the Regional Committee) for assessment and certification of projects within the following guidelines.

That the project:

3.1 has been conducted in major part by the trainee

3.2 has been submitted to the appropriate Committee for certification

3.3 has complied with the Objectives of Training in Anaesthesia and/or Intensive Care

3.4 falls into one of the categories in Section 2 above.

3.5 is of a satisfactory standard.

4. CERTIFICATION

Upon compliance with the above, the Committee nominee will certify to the Assessor that the trainee has complied with the relevant regulation.

A copy of the project must be submitted to the College at the same time as Register of Training "Form J".

September 1992

Review P7(1992)

THE PRE-ANAESTHETIC CONSULTATION

1. INTRODUCTION

Consultation by an Anaesthetist is essential for the medical assessment of a patient prior to anaesthesia for surgery or other procedure. The main purpose of the consultation is to ensure that the patient is in the optimal state for anaesthesia and surgery but will also include other aspects of anaesthetic management listed under the recommendations. The skills and judgment required for the pre-anaesthetic consultation are different from and additional to those involved in the administration of the anaesthetic.

Fellows of the Australian and New Zealand College of Anaesthetists are trained to perform such assessments.

2. GENERAL PRINCIPLES

2.1 The pre-anaesthetic consultation should wherever possible be performed by the anaesthetist who is to administer the anaesthetic. When this is not possible, there must be an adequate mechanism for the findings of the consultation to be conveyed to the anaesthetist performing the anaesthetic.

2.2 The consultation should take place at an appropriate time before anaesthesia and surgery, to allow for adequate consideration of the many factors involved.

2.3 The particular features of management of anaesthesia for Day Surgery make it imperative that the principle contained in 2.2 be observed, just as it should be for inpatient management.

2.4 Notwithstanding the Principles above, it is acknowledged that early consultation is not always possible, (e.g. emergency surgery).

In such circumstances however the medical assessment of the patient by the anaesthetist prior to the commencement of anaesthesia and surgery is still a necessary and separate part of the overall management of the patient.

3. RECOMMENDATIONS

The pre-anaesthetic consultation should include:

3.1 Identification of patient.

3.2 Confirmation with the patient (or guardian, if present, in the case of children or the intellectually impaired) of the nature of the procedure and their consent for anaesthesia.

3.3 A concise medical history and clinical examination of the patient. This assessment should include a review of any current medication, the results of any relevant investigations and arrangement of any further therapeutic or investigatory measures which are considered necessary.

3.4 Consultation with colleagues in other disciplines where appropriate.

3.5 A general discussion with the patient (or guardian, if present, in the case of children or the intellectually impaired) of those details of the anaesthetic management which are of significance to the patient. This discussion may also be helpful in reassuring the patient.

3.6 The ordering of pre-medication if considered necessary.

3.7 A written summary which becomes part of the medical record of the patient.

September 1992

POLICY DOCUMENTS

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

E1 (1991)	Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Anaesthesia
E2 (1990)	Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Intensive Care
E3 (1989)	The Supervision of Trainees in Anaesthesia
E4 (1992)	Duties of Regional Education Officers
E5 (1992)	Supervisors of Training in Anaesthesia and Intensive Care
E6 (1990)	The Duties of an Anaesthetist
E7 (1989)	Secretarial Services to Departments of Anaesthesia and/or Intensive Care
E8 (1991)	The Duties of an Intensive Care Specialist in Hospital with Approved Training Posts
E9 (1987)	Clinical Review
E10 (1990)	The Supervision of Vocational Trainees in Intensive Care
E11 (1992)	Formal Project
E13 (1991)	Guidelines for the Provisional Fellowship Year
EX1 (1991)	Guidelines for Examiners with Respect to Candidates Suffering Illness (or Accident) at the Time of Examination
T1 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites
T2 (1990)	Protocol for Checking an Anaesthetic Machine Before Use
T3 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Units
T4 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice for Electro-Convulsive Therapy (ECT)
T5 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries
T6 (1989)	Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites
P1 (1991)	Essential Training for General Practitioners Proposing to Administer Anaesthetics
P2 (1991)	Privileges in Anaesthesia Faculty Policy
P3 (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 (1992)	The Pre-Anaesthetic Consultation
P8 (1989)	Minimum Assistance Required for the Safe Conduct of Anaesthesia
P9 (1991)	Sedation for Diagnostic and Minor Surgical Procedures
P10 (1991)	Minimum Standards for Intensive Care Units
P11 (1991)	Management of Cardiopulmonary Bypass
P12 (1991)	Statement on Smoking
P13 (1992)	Protocol for The Use of Autologous Blood
P14 (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

September 1992