Australian and New Zealand College of Anaesthetists
and Faculty of Intensive Care

Bulletin

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EDITORIAL

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I would like to congratulate Dr Richard Walsh and his Organising Committee. The 11th World Congress of Anaesthesiologists was a great success. The organisation of the meeting was superb and this certainly was a reflection on the planning which had gone into the meeting.

The CIREBA meeting held at Ullimaroa prior to the World Congress was a very successful meeting. One of the main concerns was the enormous downturn of popularity of anaesthesia as a specialty in the United States. The reasons are multifactorial but there certainly is a lesson to be learned.

In the previous Bulletin, I mentioned that the Australian Medical Workforce Advisory Committee (AMWAC) had identified a shortage of specialist anaesthetists and recommended an increase in the number of training posts. I am pleased to be able to inform you, as a result of the recent increase in training posts, the College has already surpassed the recommendation for the increased number of posts for the first four years of training for 1995/96. As there is a significant shortfall of specialist anaesthetists predicted for the next century, close monitoring of this situation will be undertaken.

There is no doubt that there is a shortage of specialist anaesthetists in rural areas and we certainly have to continue to look at ways to encourage anaesthetists to move to country towns where there are shortages.

Some of you will have seen the publicity involving the implementation of the voluntary euthanasia legislation in the Northern Territory. The College has been asked for advice on drugs and their administration for the purpose of administration. The College responded that it will not advise on how to terminate life. I sought the views of the international Presidents at the CIREBA Meeting and the view was unanimous that voluntary euthanasia is an area in which anaesthetists should not be involved.

Many of you will be aware that One Grand Chain, Dr Gwen Wilson’s book on the History of Anaesthesia in Australia 1846-1934, has recently been published. This book is an excellent historical account and I can certainly recommend it to you.

This is my last message to you as President. I have certainly enjoyed my term on the Council and the time as President. I wish Professor Garry Phillips well in the office when he takes over in June.

I would like to thank the Council, Fellows, Joan Shealess and the College staff for all the help and support they have given me over the past twelve years.

N. J. DAVIS, President

May 1996
Dear Minister,

RE: THE ANAESTHETIC WORKFORCE IN AUSTRALIA 1995-2006
AMWAC REPORT 1996.3

The Anaesthetic Workforce Working Party, as a sub-committee of the Australian Workforce Advisory Committee (AMWAC), presented its report in January 1996. Although this report has not yet been considered by our College Council, I would like to bring several matters to your attention before the findings of this report are made public.

Overall the body of the report strongly supports the efforts of our College in providing a specialist anaesthetic workforce that is meeting the changing needs of the Australian Community. I would particularly draw your attention to page 15 of the report which details the widening role of the anaesthetic workforce. Preoperative assessment, postoperative care, intensive care, acute and chronic pain management, obstetric analgesia, resuscitation, retrieval, management, research, quality assurance and hyperbaric medicine are all referred to as being within the domain of specialist anaesthetic practice in addition to the provision of anaesthesia.

The first two recommendations of the Working Party define a need to increase anaesthetic training positions from 370 in 1995 to 397 by 1997. This has already been achieved with our training numbers for 1996 up to 407, a 10.3% increase.

**NUMBER OF ANZCA ANAESTHETIC TRAINING POSITIONS**

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*Note in the AMWAC Report only 119 quoted for the 1995 NSW figure*

The remaining recommendations of the Working Party require consideration by our College and further dialogue with appropriate bodies.

Our College shares the view of the Working Party that Australians continue to be entitled to the highest standards of qualification, delivery and safety of anaesthetic practice. We look forward to meeting the needs of the Australian community into the 21st century.

Yours sincerely

N. J. DAVIS
President

The above letter was forwarded to all Australian State and Territory Ministers for Health.

Bulletin

May 1996
“ONE GRAND CHAIN” LAUNCHED AT WORLD CONGRESS

Our Emeritus Historian, Dr Gwen Wilson’s most recent book “One Grand Chain – The History of Anaesthesia in Australia, 1846 – 1962,” Volume 1, 1846-1934, was launched in style at the 11th World Congress of Anaesthesiologists in Sydney on April 15.

At the Opening Ceremony in the Darling Harbour Exhibition Centre, crowded by 6000 delegates from most countries in the world, Gwen was linked by satellite to the Ether Dome at the Massachusetts General Hospital in Boston, site of the first demonstration of ether for surgery in 1846. Despite it being 4am in Boston, Dr Bucknam McPeek conversed with Gwen at some length on matters which linked the USA and Australia 150 ago.

The official book launch took place in the History Section of the Congress. Professor Lucien Morris chaired the session, and Associate Professor Neville Davis, President of the College, thanked Dr Wilson for the endless effort she had put in over many years to make the book a reality.

The Wood Library Museum of the History of Anaesthesia, which honoured Gwen Wilson by awarding her their inaugural laureate, has agreed to distribute One Grand Chain in North America.

Photographed at the launch were Dr Wilson, Dr Jeanette Thirlwell-Jones, who edited the book (“the biggest editorial task I have undertaken”) and Professor Garry Phillips, who chaired the Council Committee.

Dr Brian Dwyer, who initiated the then Faculty of Anaesthetists’ project for the history, was present at the Opening Ceremony.

WHICH IS THE SECRET AGENT?

A case report based on an incident in the US has been reproduced to highlight the need for accurate identification as well as measurement of anaesthetic gases.

On a routine list with a new electronic machine and a number of volatile agents somewhat hidden from view, the Anaesthetist noted that the patient was hypotensive. He switched off the volatile agent (X) he had been using and noted the agent monitor measuring the concentrate of Agent X fell to zero. The hypotension persisted and it was only some time later that it was realised that volatile Agent Y was on as well!

The agent monitor was of the type where you have to tell it what agent to measure – and indeed the agent it was measuring was turned off. But because it had not been so instructed, it failed to measure the other agent!

The lessons from this scenario were discussed at the February Council Meeting and it was recommended that a warning be given to Fellows that in order to comply with Policy document P (18), from the 1st January 1998 monitors must be able to identify anaesthetic agents. This may require a modification of your existing monitor and should influence your choice of new monitors.

In addition it is reasonable to suggest that such an incident could not occur if only one vaporiser is on the anaesthetic machine.

MOIRA WESTMORE, Pharmaceutical Officer
CONSENT

Introduction

Stephen Pile records in his ‘Book of Heroic Failures’ details of the least successful safety film.

In 1976, British Aircraft Corporation showed a film on the dangers of not wearing protective goggles to employees at its factory. It was so horrific that 13 employees had to be helped out by workmates and attending nurses.

One scene in the film was so realistic, a welder fell off his chair in fright, and had to have 7 stitches. During the same scene, another worker fainted and had to be carried out. In one full colour close-up of injury to an eye, a group of machinists had to be let out feeling sick and faint.

The BAC Safety Officer said the film was being withdrawn because it was not safe. “We are very keen to get over the point of eye protection, but at this point we have decided not to take any chances. We seem to have at least one person keeling over on every occasion the film is shown.”

The leading High Court case of Rogers v Whittaker also relates to damage to the eye, and there has always been the question of whether, like the safety film, it has gone too far.

In this case, the ‘material risk’ involved the potential development of sympathetic ophthalmia in a patient who had one good eye and one bad eye. The risk was said to be one in fourteen thousand, and the doctor failed to advise of that risk.

The Duty – Rogers v Whittaker

In Rogers v Whittaker, the High Court confirmed the existing obligations of doctors to exercise reasonable care and skill in providing advice and treatment to patients. The standard of care and skill required is that of the ordinary skilled person exercising the particular specialist skills involved. Whilst the law has always recognised that a doctor has a duty to warn a patient of a material risk inherent in any proposed procedure or treatment, the High Court has formulated a higher standard required of doctors.

‘A risk will be considered material if, in the circumstances of the particular case, a reasonable person in the position of the patient, if warned of the risk, would be likely to attach significance to it, or if the medical doctor is, or should reasonably be, aware that the particular patient, if warned of the risk, would be likely to attach significance to it.’

Thus, when considering the need to inform a patient of a particular risk, there will be two separate matters that require consideration:-

1. Would a reasonable person, in the position of the patient, be likely to attach significance to the risk?

2. Is the doctor aware, or should the doctor be reasonably aware, that this particular patient would be likely to attach significance to that risk?

The High Court decision places a high burden on practitioners to ensure that all material risks are considered, and that the particular circumstances of the patient are considered.
Factors to Consider

These can involve a number of factors:-

1. Would the risk influence the decisions of a reasonable person in the position of the patient? The risk might be so slight that no reasonable person would be influenced by it.

2. Obviously, the more drastic the intervention or procedure, the more necessary it is to inform of risks and consequences.

3. The desire for information by the patient necessitates greater disclosure, even if the patient says that they have no desire for information, the doctor might have to carefully evaluate the patient’s real wishes. In Rogers v Whittaker, the patient was particularly inquisitive and anxious about the procedure.

4. In some cases, the temperament and health of the patient might be considered. It may be that disclosing information may be injurious to the physical or mental health of the patient in some cases. The doctor can apply reasonable judgement as to what and how to disclose.

5. The recent case of Kalokerinos v Burnett in the New South Wales Court of Appeal has taken the concept of ‘informed consent’ a step further. Where a doctor referred a patient to a specialist, noting an appointment, and giving details to the patient, the doctor nonetheless was held to be negligent when the patient ultimately did not keep the appointment. The shortcoming for which the doctor was ultimately held responsible, was not explaining adequately to the patient the consequences of not attending the future appointment. The Court accepted the evidence of the patient that, had she been adequately informed, she would have kept the appointment and ultimately avoided the health consequences which subsequently occurred. However, of assistance to doctors generally, was the recognition of the contributory negligence of the patient herself, where 20% of the claim was attributed to the patient’s own negligence.

6. The existence of emergency situations, or lack of opportunity for proper counselling or discussion, can affect the obligations to disclose. Clearly, in an emergency environment, the information that may be disclosed may be minimal or not possible at all.

7. Special issues arise in relation to the obtaining of consent from giving adequate information to children, teenagers and the intellectually disabled.

Causation – Linking Loss to the Negligence

Even where a doctor may not have given adequate information to a patient, the doctor is not automatically liable for the negligence, if it can be shown that the patient would otherwise have had the procedure or agreed to the treatment. In the case of Domeradski v Royal Prince Alfred Hospital, the New South Wales Supreme Court indicated that it would be open for a jury to find that there was a failure to warn the patient of the risk of stroke, and that such a warning should have been given, and also that the jury could determine whether the patient would have changed their mind or decided otherwise, if the information had been given. In such cases, the onus is on the patient to show that they would not have agreed to the procedure or treatment if properly informed. In the case of Rogers v Whittaker, it was accepted that the patient would not have undergone the procedure if adequately informed.

The Problem for the Medical Profession

It is unfortunate that the new regime, as propounded by the High Court, was established in the case of Rogers v Whittaker. The particular and unique features of that case have created a principle that assumes that practitioners operate in a perfect world. The particular condition in Rogers v Whittaker, the unusual features of the procedure, the unique financial and economic circumstances of the patient, and the inquisitiveness of the patient have combined to give us a decision that may be seen as a high watermark.

The decision ignores the fact that practitioners do not operate in a perfect world, and that, in many cases, all of the requirements of proper ‘informed consent’ may be very difficult to achieve.

These difficulties include:-

(i) Informed consent may require detailed and time consuming discussions with the patient. The Medical Benefits Schedule does not necessarily recognise or reward such endeavour.

(ii) Communication skills of doctors, and indeed patients, vary considerably. Should training courses for doctors now include communications skills? Patients themselves have different abilities or willingness to take in information, or make decisions about their treatment. There will be reactions from fear to aggression, or to meek compliance. This will affect the type of communication involved with the patient.
(iii) Other cultural factors may play a part. Obviously, for patients of an ethnic background, the availability of interpreters becomes an issue. Where a child of the patient acts as an interpreter, there may be differing abilities to adequately communicate the message.

(iv) The circumstances in which practitioners have an opportunity to convey information is never perfect. The ability to have one, two or even three meetings with a patient to discuss the issue is difficult in most cases. In an emergency, it may be impossible. For anaesthetists, radiologists and others with limited contact with a patient, it becomes very difficult. In hospital situations, where hospital administration controls most of the patient contact, the opportunity for the surgeon may be limited.

Standard Consent and Information Sheets

It has been suggested that the use of standard consent forms and information sheets will be sufficient to maintain ‘informed consent’. As has now been noted in a number of journals and guidelines, standard information forms can have some use, but are no substitute for proper information to a patient. Under the requirements of the High Court decision, the information to be given to a patient must be tailor made to the particular patient. It must take into account the particular circumstances of the patient, and the particular requirements of the patient.

Similarly, a simple form signed by a patient is not conclusive proof that valid consent has been obtained. Indeed, in many other legal cases involving guarantees and contracts, the simple signature of the party involved has never been a deterrent to action being taken to contest the guarantee or contract, or to the Courts accepting that the plaintiff should not be bound.

Prepared consent forms and prepared information sheets certainly can have their place and can be used as a prompt or checklist for the discussion that must take place between doctor and patient. They are also useful for the patient to take away after the discussion as a reminder of some of the issues that had been considered. However, they are not, in themselves, adequate to ensure that informed consent has been obtained.

Conclusion

The ramifications for doctors are significant:

1 Since Rogers v Whittaker, doctors must have revised the way they communicate with their patients, particularly explaining the risks of procedures and treatment.

2 Doctors must consider the particular circumstances of each patient, and ensure that, as much as possible, adequate opportunity is given to the pre-treatment discussion.

3 Doctors should keep detailed notes and records of not just the treatment, but the advice and information conveyed to the patient prior to the treatment.

The guidelines issued by the National Health and Medical Research Council provide a good guide to the issues with which doctors should be concerned. They provide a general outline of the type of material that should be discussed with patients.

Obiter

We trust that we will not move in the same way as the American legal system, although there are various signs that we are indeed acquiring some of the worst habits from America. The Americans are also expert in attempting to devise satisfactory consent forms and documentation relating to the informed consent process. I hope we do not get to the stage, as evidenced in the American case of Kammowitz v Department of Mental Health (Wayne County), where the following consent form was used.

“Since conventional treatment efforts over a period of several years have not enabled me to control my outbursts of rage and anti-social behaviour, I submit an application to be a subject in a research project which may offer me a form of effective therapy. The therapy is based upon the idea that episodes of anti-social rage and sexuality might be triggered by a disturbance in certain portions of my brain. I understand that in order to be certain that a significant brain disturbance exists, which might relate to my anti-social behaviour, an initial operation will have to be performed.

This procedure consists of placing fine wires into my brain, which will record the electrical activity from those structures which play a part in anger and sexuality. These electrical waves can then be studied to determine the presence of an abnormality.

In addition, electrical stimulation with weak currents passed through these wires will be done in order to find out if one or several points in the brain can trigger my episodes of violence or unlawful sexuality. In other words,
this stimulation may cause me to want to commit an aggressive or sexual act. I understand that the investigators will destroy this part of my brain. I agree that it should be surgically removed, if the doctors determine that it can be done so, without risk of side effects. Should the electrical activity from the parts of my brain into which the wires have been placed reveal that there is no significant abnormality, the wires will simply be withdrawn.

I realise that any operation on the brain carries a number of risks which may be slight, but could be potentially serious. These risks include infection, bleeding, temporary or permanent weakness or paralysis of one or more of my arms or legs, difficulty with speech and thinking, as well as the ability to feel touch, pain and temperature. Under extraordinary circumstances, it is also possible that I might not survive the operation.

Fully aware of the risks detailed in the paragraph above, I authorise the physicians of La Fayette Clinic and Providence Hospital to perform the procedures outlined above.”

Address to the Annual Scientific Congress of the Royal Australasian College of Surgeons, 7 May, 1996 – Melbourne
The written section was held in all capital cities of Australia, Auckland, Christchurch, Dunedin, Hong Kong, Kuala Lumpur and Wellington.

The viva section was held at College Headquarters in Melbourne and Prince of Wales Hospital in Hong Kong.

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EXAMINATION PRIZE WINNERS

The Renton Prize for the period 30 June, 1996 was awarded to Dr Anthony Neville Coorey of Queensland.

The Cecil Gray Prize for the May 1996 Examination was awarded to Dr Cyrus Edibam of Western Australia.
## Final Fellowship Examination

### April/May 1996

The written section was held in all capital cities in Australia, Auckland, Hong Kong, Kuala Lumpur, Singapore and Wellington.

The Viva Examination in anaesthesia and medicine was held at the College Headquarters and the Alfred Hospital, Melbourne.

### Successful Candidates

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### World Federation of Societies of Anaesthesiologists

#### Local Appointees

At its recent meeting in Sydney the following appointments were made:

- **Dr T C (Kester) Brown** Chairman – Executive Committee
- **Dr Hayden Perndt** Chairman - Education Committee
- **Professor W R (Bill) Runciman** Chairman – Safety and Quality of Practice

The following Fellows were appointed to various Committees:

- **Dr Richard Walsh** Finance
- **Dr John Richards** Statutes and Bylaws
- **Dr Rod Westhorpe** Equipment & Technology
- **Dr Bob Webb** Paediatrics
- **Dr Rob Eyres** Pain
- **Prof Michael Cousins** Resuscitation
- **Prof Tony Gin** Obstetric
AVALANCHE

We sat at the top of the Ramp on the NW ridge of Mt. Aspiring (Otago's highest at 3029m) at 5pm on November 6th to eat our sandwiches and consider our descent. We had had a good but slow ascent of the SW ridge - the north-westerly storms had deposited and sculpted a variable amount of powder snow on top of an invariably present firm layer 5-10cm thick.

The usual descent from this point would be down the Ramp, a descending traverse down a sloping snow shelf above a line of cliffs and a route that has claimed several lives after simple slips. Despite having descending the Ramp three times before I felt uneasy and briefly considered an alternative descent route to a different hut, however the lure of our sleeping bags at French Ridge Hut and a beer the next day won the argument. I felt strongly that we should descend unrope for safety reasons - the snow was never going to be secure enough to take anchors and without them a rope turns one falling climber into two. I was encouraged by the first 20m of descent as there was a firm surface layer which gave secure foot and axe holds. David had just started his descent when the snow quality under my feet abruptly changed to unconsolidated windblown powder and I called up to him that 'it seems dangerous here'. Within seconds there was a low-pitched 'wumpf!' and I was on the move along the greater part of the slope. I could feel an icy stationary layer scraping against my axe tips and tried to brake on it, jettisoning my hammer to get the most effective brake with the axe, but with the moving weight of snow and rapidly increasing speed I realised my efforts were increasingly futile. I began to cartwheel and my final thoughts were firstly, in a surprisingly matter of fact way, the realisation that I was to die, and secondly and more emotionally, that I was leaving Janice and Abbey, my wife and baby, behind, alone. A bright flash of light in both eyes heralded unconsciousness.

I awoke clear headed and pain-free. It took me little time to realise I was on the Bonar Glacier amongst avalanche debris with my head facing down the 20degree slope and both legs buried. A small patch of snow was coloured red from the cut under my nose. The sun was still high and I realised I had been unconscious for barely a few minutes. The sound of falling ice drew attention to the 300ft cliffs over which I had been swept. My first piece of good fortune was starkly obvious - I was alive. I tried to pull my legs clear but they wouldn't come. My axe was still on my wrist and I chopped my legs free with ease to discover my feet were in a far from anatomical position - I clearly had fractured both legs below the knee. The pain on attempted movement confirmed this. Taking each leg at a time I gripped my plastic boot and gingerly swung them around so that I could sit up with my legs down the slope. I sat and considered my position.

I was out of sight of the top of the Ramp where I felt David still was. I tried a few yells but the southerly breeze carried them away with no effect. A brief attempt at crawling made me realise I could not emulate Jo Simpson's amazing crawl to safety with a broken leg (Touching the Void), I was unlikely to even be able to clear the avalanche debris. My only option was to stay put and await rescue, whenever that would be. I found my knife in my pack and cut off my crampons and loosened my bootlaces. The forecast had rumoured a cold front was approaching and my position was exposed. Some mist was rolling on to the lower Bonar. I took my axe and started digging in.

Some 40 minutes later I heard a single engined plane at some altitude. I took my orange backpack liner and began waving it violently. The plane flew back and forth across the west face some four times, at successively lower altitude but each time I felt he was flying directly over me and would be unable to see me. The last pass, however was perhaps 500ft. above the glacier. This was no ordinary tourist flight - they must have seen something.

The silence was deafening once the plane had flown off. I realised a rescue would take a while to organise but as the time ticked away and the mist continued to roll up the glacier my euphoria ebbed away - a night on the glacier seemed likely, possibly longer if bad weather set in. I continued to dig...
in, succeeding in hollowing out a 6ft long 3ft deep trench which I lined with a rope and my empty backpack. I put on all my layers and eased my legs into my gore-tex bivi bag - the single most difficult task yet. I wriggled into my trench and roofed it with the back-pack liner attached with ice-screws, then relaxed for 20 minutes.

When I sat up again I was aware how cold I was becoming despite the sun still being up and having all my best clothing on. If the cold front came through I wouldn’t be in good shape by morning and I realised I needed some more luck to survive. I found my camera and at arms length snapped a couple of self portraits with the biggest smile I could muster - I wanted my family to know that I had been in good spirits. However, as the evening light began to fade luck was to come in the form of a Hughes 500 helicopter which appeared abruptly over a rise, reminiscent of MASH. My relief on seeing the familiar faces of some of the local guides was echoed in their relief - the had not expected me to be alive after a total descent of a thousand feet or more with around a third of that being free-fall.

The Hughes 500 is not known for its cavernous interior and it was necessary for me to sit upright crossways behind the pilot. An attempt to straighten my legs in the valley was aborted because of intense pain and my climbing partner, an orthopaedic registrar, assessed that a rapid transfer to base hospital was necessary as circulation was markedly impaired. A small dose of morphine was sufficient to render me pain free for the rest of the journey, provided I didn’t move. On arrival at the Dunedin Heli-pad a TV crew was determined to get the closest halogen illuminated footage they could, a most unwelcome intrusion.

Having worked in Dunedin Hospital for three years I knew most staff members and it seemed most of them were waiting for me in the Casualty Department. The surgical registrar efficiently took me through the familiar trauma assessment protocol and reprimanded me for sitting up to remove my expensive jacket rather than letting it succumb to the scissors. The orthopaedic Professor was clearly concerned about my ischaemic feet and when it became clear I could not tolerate manipulation awake I was rapidly rendered unconscious.

Further details about the rescue subsequently came to light. The Aspiring Air pilot, Andy Woods was returning from Milford Sound with tourists on board. He would normally have flown past Aspiring on the way to Milford, but on this occasion had been late for the Milford boat rendezvous and was ‘doing the mountain’ on his return - much to our good fortune. As a mountaineer himself he had spotted the avalanche debris from a height and knowing there were climbers on the mountain had gone to investigate, seeing first David at the top of the Ramp waving violently, then the celebrated ‘HELP’ sign stamped by David in the snow, then me amongst the debris. I probably owe the salvage of my right foot and possibly my life to the astute observations made by Andy from altitude.

Much of my idle time over the past few months has been spent thinking the trip through and how the accident could have been avoided. The most often heard and least helpful option is to avoid the high mountains and indulge in a safer sport. When I think of the options I realistically might have taken that day the one that comes back over and over again was my first thought on looking down the Ramp - I don’t like the look of that. Avalanche risk wasn’t my major reason for that thought, it was just an uneasy feeling and I will remember to take more heed of such feelings in the future.

I am indeed fortunate that I may get another chance to venture above the bush line. Although I clearly took the major force on my legs my shattered fibreglass helmet is testimony to its shock absorbing properties and I have to speculate on the shock absorbing properties of the unconsolidated powder snow that must have impacted on the glacier simultaneously with me. Most of all my life was saved by the combination of cumulative good fortune and the astute observation and efficient actions of others.

(modified from an article in the Otago Section newsletter of the New Zealand Alpine Club)

WAYNE WRATHALL
(Anaesthetic Registrar, Dunedin Hospital, New Zealand)
MAINTENANCE OF STANDARDS

As of 30th April 1996, 1249 Fellows were registered in the Maintenance of Standards Programme. Of these, 292 had supplied their Annual Return for 1995. As can be seen from the table, the most commonly used activities were:

1.3 Quality Assurance – participation in morbidity and mortality meetings.

2.1 Attendance at accredited CME meetings.

2.4 Practice related CME (journal reading etc).

3.1 Teaching of health professionals.

The least commonly used activities were under category 4 (other activities), although a number of Fellows did take up options under this heading. A number of participants claimed well in excess of the 5 year maximum allowance of 500 points. While this is undoubtedly possible, particularly during extended overseas leave, the 5 year maximum remains 500 points, and an annual return is requested each year.

Although the number of annual returns is small to date, it is clear from the table that the 'average' return documents enough points to achieve the minimum number required in Categories 1 & 2, and the minimum number to achieve 500 points over 5 years.

In order to enable a more detailed analysis, all Fellows enrolled who have not submitted their 1995 Annual Return are requested to do so. Those Fellows who have not yet registered with the College for the Maintenance of Standards Programme are urged to do so.

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MAINTENANCE OF STANDARDS RETURNS 1995
Category 1 Quality Assurance Activities
Category 2 Continuing Medical Education
Category 3 Teaching & Research
Category 4 Special Projects

GARRY D. PHILLIPS
MOS Officer
DEATHS

Council noted with regret the death of:
Dr Gwenda M Lewis - N.Z., FFARACS 1967, FANZCA 1992
Prof. Ross Hawker, Qld, FRACS, Primary Examiner 1966-1978

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<td>Jonathan Carlos DE LIMA, NSW</td>
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<td>Geoffrey Peter FRAWLEY, Vic</td>
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<td>Kwee Peng NG, Malaysia</td>
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<td>Andrew Paul NUSSEY, Qld</td>
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<td>Mark Stewart OLIVER, New Zealand</td>
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<td>Warren Ronald SAUNDERS, Vic</td>
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<td>Julian Yeou Yu WANG, New Zealand</td>
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<td>Sally Jane WHARTON, NSW</td>
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## Supervisors of Anaesthesia Training

### New South Wales

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<tr>
<td>Albury Base Hospital</td>
<td>Dr W. Fowler</td>
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<td>Auburn Hospital</td>
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<td>Bankstown Hospital</td>
<td>Dr M. Palmer</td>
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<td>Blacktown Hospital</td>
<td>Dr J. Scroope</td>
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<td>Canterbury Hospital</td>
<td>Dr D. Ekanayake</td>
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<td>Concord Repatriation Hospital</td>
<td>Dr K. Singer</td>
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<td>Dubbo Base Hospital</td>
<td>Dr D. Schuster</td>
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<td>Gosford Hospital</td>
<td>Dr W. Lewis</td>
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<td>Hornsby Ku-Ring-Gai Hospital</td>
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<tr>
<td>John Hunter Hospital</td>
<td>Dr K. Streatfield</td>
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<td>Liverpool Hospital</td>
<td>Dr P. Martin</td>
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<td>Manly Hospital</td>
<td>Dr S. Inglis</td>
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<td>Mona Vale Hospital</td>
<td>Dr L. Gadd</td>
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<td>Dr P. Day</td>
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<td>Westmead Hospital</td>
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<td>Woden Valley Hospital</td>
<td>Dr N. Gemmell-Smith</td>
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### Victoria

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<td>Alfred Hospital</td>
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<td>Austin and Repatriation Medical Centre (Austin Campus)</td>
<td>Dr P. McCall</td>
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<tr>
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<td>Dr D. Tremewen</td>
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<td>Ballarat Base Hospital</td>
<td>Dr B. Christie</td>
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<td>Bendigo and District Base Hospital</td>
<td>Dr S. Perrin</td>
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<td>Box Hill Hospital</td>
<td>Dr T. Lambert</td>
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<td>Dr M. Sandford</td>
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Preston and Northcote Community Hospital  
Royal Melbourne Hospital  
Royal Victorian Eye & Ear Hospital  
St Vincent's Hospital  
Wangaratta Base Hospital  
Western Hospital  
Women's and Children's Healthcare Network (Royal Childrens' Campus)  
Women's and Children's Healthcare Network (Royal Womens' Campus)  

Dr J.H. Briedis  
Dr F. Rosewarne  
Dr A. Strunin  
Dr A. Stewart  
Dr M. Radnor  
Dr E.M. Ashwood  
Dr S. Robinson  
Dr A. Hill  

QUEENSLAND  
Cairns Base Hospital  
Gold Coast Hospital  
Greenslopes Private Hospital  
Ipswich Hospital  
Mater Misericordiae General Hospital  
Nambour General Hospital  
Prince Charles Hospital  
Princess Alexandra Hospital  
Redcliffe Hospital  
Royal Brisbane Hospital  
Royal Children's Hospital  
Royal Women's Hospital  
Toowoomba Base Hospital  
Townsville General Hospital  

Dr G. Clarke  
Dr J. Thatcher  
Dr M. Carroll  
Dr S. Brunke  
Dr A. Newton  
Dr C. Anstey  
Dr J. Avery  
Dr B. McKenzie  
Dr H. Muller  
Dr L. Patterson  
Dr C. Beem  
Dr R.K. Boyle  
Dr A. Thorne  
Dr G. Gordon  

SOUTH AUSTRALIA  
Alice Springs Hospital  
Flinders Medical Centre  
Lyell McEwin Health Service  
Modbury Hospital  
Repatriation General Hospital  
Royal Adelaide Hospital  
Royal Darwin Hospital  
The Queen Elizabeth Hospital  
Women's and Children's Hospital (Children's Campus)  
Women's and Children's Hospital (Queen Victoria Campus)  

Dr D.R. Catt  
Dr D. McLeod  
Dr A. Michael  
Dr R.J. Singleton  
Dr J. Cantor  
Dr C.K. Lai  
Dr C-W. Goh  
Dr G.M. Miller  
Dr M.J. Gabriel  
Dr S. Simmons  

WESTERN AUSTRALIA  
Fremantle Hospital  
Hollywood Private Hospital  
King Edward Memorial Hospital for Women  
Princess Margaret Hospital for Children  
Royal Perth Hospital  
Sir Charles Gairdner Hospital  

Dr G. Coppinger  
Dr J. Storey  
Dr T. Pavy  
Dr M. D'Souza  
Dr J. Akers  
Dr P. Platt  

May 1996  
Bulletin
TASMANIA
Launceston General Hospital
Royal Hobart Hospital
Dr P. Ogden
Dr M. Lorimer

NEW ZEALAND
Auckland Hospital
Christchurch Hospital
Dunedin Hospital
Green Lane/National Women’s Hospitals
Healthcare Hawkes Bay Napier
Hutt Hospital
Memorial Hospital
Middlemore Hospital
North Shore Hospital
Palmerston North Hospital
Southland Hospital
Taranaki Base Hospital
Tauranga Hospital
Timaru Hospital
Waikato Hospital
Wellington Hospital
Whangarei Area Hospital
Dr N. Robertson
Dr P. Smeede
Dr M. Zacharias
Dr R. Hall
Dr F.E. Bennett
Dr P. Yee
Dr F.E. Bennett
Dr T. Mark
Dr V. Hoggard
Dr A. McKenzie
Dr R. Wall
Dr R. Lloyd
Dr R. McLeod
Dr A. Robert
Dr J. Currie
Dr C. Pottinger
Dr S. Gathercole

SINGAPORE
Alexandra Hospital
National University Hospital
Singapore General Hospital
Tan Tock Seng Hospital
Toa Payoh Hospital
Dr Lim Kim Seong
Dr Chen Fun Gee
Dr L. Nair
Dr Lim Siew Hoon
Dr Koay Choo Kok

MALAYSIA
General Hospital
University Hospital
Dr K. Misiran
Professor A.E. Delilkan

HONG KONG
Caritas Medical Centre
Kwong Wah Hospital
Pamela Youde Nethersole Eastern Hospital
Prince of Wales Hospital
Princess Margaret Hospital
Queen Elizabeth Hospital
Queen Mary Hospital
The Grantham Hospital
United Christian Hospital
Dr J.C.Z. Lui
Dr K.O. Sun
Dr S.M.K. Omiyong
Professor C.S.T. Aun
Dr F.M. Lai
Dr E.T.K. Au
Dr A.M. O'Regan
Dr A.W. Aitken
Dr A. Kwan

Bulletin
May 1996
WORLD CONGRESS

Dr Richard Bailey with Dr Gwen Wilson following the launch of One Grand Chain.

Helen Cody and Helen Morris assisted visitors at the College Booth during the Congress.

Dr Noel Cass and Dr David McConnel joined the Jazz Group during the luncheon breaks at the Congress.

Dr Peter Roessler presenting Assoc. Prof. Garry Graham with his Certificate of Recognition, following completion of his term on the Panel of Examiners.

Court of Primary Examiners: Associate Professor Garry Graham, Drs Richard Morris, Ted McArule, Matthew Crawford, Malcolm Futter, Professor Tony Gin, Drs Peter Roessler (Chairman), Gillian Bishop with administrative staff Karen Monette and Cherie Wilkinson.

May 1996
CIREBA MEETING

Members of the CIREBA Meeting held at the College Headquarters just prior to the World Congress.

Professor David Morrell, Chairman, CASA, Drs David McKnight, Chairman of Anesthesia, RCSPC, Carlos McDowell, Chairman Education Committee, FARCSI, Laurie Saidman, Member ABA, John Cooper, Dean FARCSI, Professor Garry Phillips, President Elect ANZCA, Associate Professor Neville Davis, President ANZCA, Dr Clive Daniel, Secretary CASA, Dr Geoff Clarke, Dean FICANZCA, Professor Cedric Prys-Roberts, President RCA, Mrs Joan Sheales, Registrar ANZCA, Dr Bill Owens, President ABA and Professor Leo Strunin, Vice President RCA.

May 1996
REGIONAL COMMITTEES
ANNUAL REPORT 1995-1996

Office Bearers:
Chairman
Dr Tony Weeks
Deputy Chairman
Dr Steve Chester
Honorary Secretary
Dr David McCuaig
Honorary Treasurer
Dr Rowan Molnar
Education Officer (Anaesthesia)
Dr Mark Fajgman
Assistant Education Officer (Anaesthesia)
Dr Peter Roessler
Education Officer (Intensive Care)
Dr Graeme Duke
Safety Officer
Dr Chris Joseph
CME Officer
Dr Philip Ragg
Formal Project Officer
Dr Garry Donnan
Paramedical Personnel
Dr Mark Buckland
Assistant CME Officer
Dr Peter McCall
Councillors:
Dr Ian Rechtman
Dr Rod Westhorpe

VICTORIA
1. Activities
The past year seems to have passed very quickly. Certainly the efforts of so
many anaesthetists directed towards the success of the World Congress of
Anaesthesiologists has brought many of us into contact with Fellows from
other States. This can only be good for our specialty and for the College. The
VRC has been active on many fronts as evidenced by the following reports
which have been prepared by members of the Committee. I am most grateful
for the tireless support and commitment shown by all VRC Members and
particularly thankful to Mrs Veronica Quetglas for the many reminders which
have been necessary for me to complete the necessary tasks as Chairman.

The Victorian Health and Community Services Standard on Infection Control,
Infection Control Guidelines for Anaesthesia have now been released and
circulated to anaesthetists. I am most thankful to Dr Pat Mackay and Dr Rod
Westhorpe for their involvement and patience with this task. I believe that the
guidelines are appropriately guarded in their response to cross infections that
have occurred interstate.

2. Consultative Council on Anaesthetic Mortality and Morbidity
During 1995 the Council met on 10 occasions and to date has reviewed 118
cases with approximately 12 further cases to be completed.

The 1989-1992 report is in the final stages of preparation and, following
passage of the appropriate legislation, the Council is again free to publish
regular bulletins so as to provide an update on current problems. One such
bulletin was published in August 1995 and circulated by the Regional
Committee. It is expected that the next bulletin will be circulated in May, 1996.

The Council is in the process of introducing a sophisticated computerised data
base system which will enable the Council to provide reports much more
expeditiously and provide selected data for national mortality studies as well
as respond to requests from individual anaesthetists. Anaesthetists should be
reassured that extreme care has been taken to maintain security of the
computerised data from which all identifying information about patient,
anaesthetist and hospital has been removed. In addition any deductions
arising from the data can only be interpreted by the Council and circulated
with the full approval of Council.

Collection of information on perioperative mortality is very much dependent on
the voluntary reports from anaesthetists and intensive care specialists and on
the records from the Department of Coronial Services, with the information
from anaesthetists by far the most valuable contribution. With its focus now
directed at quality assurance and outcomes the ACHS has introduced a
requirement for anaesthetic departments to report relevant perioperative
mortality to the appropriate State Mortality Committee. To this end the
Victorian Council is forwarding first report forms to all public and private
hospitals in the State.

While the Council must review all cases of mortality, it is of the opinion that
there is more benefit to the anaesthetic community of ‘in depth’ studies of
major morbidity which usually provides the material for the information
bulletins. In extrapolating from the Quality Assurance Records of three public hospitals over three months, it is assessed that there may be a total of about 850 such incidents per year in Victoria and clearly the Council has not the resources to study all such cases although aggregation of the raw data would be useful. However consideration of major morbidity continues to be an important function of the Council for providing information to all anaesthetists, many of whom work in relative isolation. In requesting that anaesthetists continue to provide such reports the Council wishes to reaffirm that total confidentiality is maintained and that only the Chairman has access to any identifying material.

3. **Paramedical Personnel**

The Regional Committee continues to support the pilot course for the Associate Diploma in Health (anaesthesia and operation theatre technicians). The students enrolled in this course are entering the anaesthetic practice portion of the course and will be undertaking clinical rotations in the middle of this year. Both the educators and students involved are very pleased with the progress and quality of the course.

It is planned to run a second course commencing in the latter half of this year. Members of the anaesthesia community are still actively involved in education of MICA paramedical trainees and perioperative and intensive care nursing courses.

4. **Continuing Education**

Continuing Medical Education continues to assume an important role for the Victorian Regional Committee. Several quality speakers presented papers and visited hospitals during 1995/96.

The Combined ANZCA/ASA Meeting in August 1995 on “Risks to the Anaesthetist” was again one of the most successful on record. Guest speakers included Associate Professor Bill Arnold III, M.D. from Charlottesville, Virginia, USA and Ms Fiona Tito, Government Advisor on Health Issues, both whom congratulated the Australian and New Zealand College of Anaesthetists for its commitment to maintenance of standards and peer review.

Topics covered in 1995/96 include:

- **April 1995**
  - *Common Paediatric Problems – Opinions from around the World.* Dr Olli Meretoja, Dr Krister Nilsson, Dr Carlos Riquelme

- **May 1995**
  - *Evaluation of New IV Hypnotic Agents.* Dr John Sear

- **July 1995**
  - *Rocuronium - An Overview.* Dr Rajinder Mirakhur

- **September 1995**
  - *Low Flow Anaesthesia.* Dr Jan Baum

- **February 1996**
  - *Mivacurium - A Review.* Dr Geoff Beemer

Most of these topics have been videotaped and are available for borrowing from the ANZCA Library.

This year’s Combined ANZCA/ASA CME topic is “Issues In Obstetric Anaesthesia” to be held on Saturday 3rd August at the Regent Hotel.
5. Education

Registrars' Scientific Meeting
The Registrars' Scientific Meeting was held last July. There were 20 papers presented covering topics ranging from hospital practice audits to assessments of "new" drugs, equipment and techniques. The Prize donated by Anaequip (Vic.) Pty Ltd was awarded to Dr Phil McDonald (A Timed Re-Expansion Inspiratory Maneouvre (TRIM) is better than increasing FIO2 for treating Oxygen Desaturation in Lambs During General Anaesthesia) from Adelaide. Although well advertised, the attendance of this meeting by Fellows was poor.

Places at the Part I and Part II Courses were yet again keenly sought. The standard of these courses remains extremely high and all the Fellows who continue to teach at these courses, take trial exams and do the organising are to be congratulated and thanked.

The College's Education Committee is considering introducing training in (a) Medical Ethics and (b) Communication Skills, for trainees.

Primary Fulltime Course
This course is still very popular attracting trainees from both Australia and New Zealand. The next Primary Course will be held from Monday 20th May to Friday 31st May 1996.

Part II Fulltime Course
The Part II Course Organiser, Dr Garry Donnan, is very grateful for the contributions from so many Victorian Fellows.

The next Part II Course will be held from Monday 8th - Friday 12th July. This is the last Part II Course for 1996.

6. Formal Projects
During 1995/1996, twenty (20) projects were submitted for assessment. A large proportion of these were presented at the 1995 Annual Registrars' Scientific Meeting. The projects are generally of high standard.

Formal Projects approved were:

- Painless Epidural Haematoma. Dr A. Nicholson
- Brain Protection During Neurosurgery: Update from the Anaesthetist's Perspective. Dr M. Solly
- Propofol and Hepatic Blood Flow. Dr D. Daly
- Avoidance of Cardiopulmonary Bypass During Bilateral Sequential Lung Transplantation Using Inhaled Nitric Oxide. Dr H. Venema
- How Much Dantrolene?
- A Case of Fulminant Malignant Hyperthermia. Dr A. Cain
- PC vs PCEA in Abdominal Vascular Surgery. Dr G. Stainsby
- Anaesthesia for the Elderly. Dr A. Jeffreys
- A Double-blind, Randomised Trial of Smoking Cessation Following Audio tape Suggestion During Anaesthesia. Dr Y. Layher
- Evaluation of the time course of action of Rocuronium Bromide. Dr C. Tippett
- Mivacurium Infusion for Craniotomy. Dr C. Goh
- The Efficacy of Adding a Continuous Intravenous Morphine Infusion to Patient Controlled Analgesia (PCA) in Abdominal Surgery. Dr J. Libreri
Victoria (continued)

A Case Report of Masseter Muscle Rigidity.
Dr Ng Kwee Peng

Incidence of Phrenic Nerve Block and Hypercarbia in Premedicated Patients Undergoing Carotid Endarterectomy Under Cervical Plexus Block.
Dr G. Emery

History of Cocaine.
Dr C. Bolton

The relation of Helicobacter Pylori Infection to acute Stress Ulceration.
Dr M. Robertson

A Comparison Between Sevoflurane and Halothane.
Dr A. Richards

Postoperative Epidural Infusion Audit.
Dr W. Saunders

Postoperative Nausea & Vomiting in Day Surgery.
Dr G. Burgin

Does Choice of Induction Agent Affect Outcome?
Dr A. Bennett

The Role of High Frequency Jet Ventilation in Anaesthesia Today.
Dr M. Hurley

7. **RACS Road Trauma Committee**

   Representation is maintained to provide advice on matters relevant to the VRC. Recent emphasis has been on driving performance in the elderly.

8. **Treasurer’s Finance Report**

   The two VRC accounts, ANZCA - Victorian Regional Committee and ANZCA & ASA (Vic) CME Fund, have been audited by Mr Ross Blain.

   A new account ANZCA - VRC Courses has been created so that income and expenditure relating to the Victorian Courses can be separately identified.

   An additional new Kodak Ektapro 5000 slide projector has been purchased for the Douglas Joseph Meeting Room for use with courses and CME meetings.

   Cost: $1780

   Two new dictator/transcriber machines (Sony and Philips), for different size cassettes, have been purchased for VRC business.

   Overall Cost: $1210

   These items of equipment have been purchased with VRC funds generated from courses and meetings but will be available for use by all groups at the College.

9. **Victorian Medical Postgraduate Foundation Inc.**

   The traditional activities continue. The VMPF Journal “Access” continues to be available for reference in the College Library, the latest issue is April 1996 Volume 21 No 2. The Quality Assurance Network of the VMPF continues to expand with the guidance of the Chairman, Dr Moss Cass.

   The latest VMPF publication is titled “Imaging Guidelines - Second Edition”.

10. **Social**

    In May 1995 a dinner was held at 'Ulimaroa' to farewell Dr Michael Davies as President. The Committee expressed their appreciation for his contribution over the years to the Regional Committee.

    A dinner was held in October 1995 to welcome Professor Neville Davis as the new President. This was a good opportunity for Professor Davis and Mrs Trish Davis to meet members of the Regional Committee and their partners and for the Committee to wish Professor Davis well for his term as President.

May 1996
11. Library
The Librarian, Miss Shanti Nadaraja has advised that the College Library is open 9am - 5pm Monday to Friday, however it will remain open later every Wednesday until 8pm.

12. Rural Activities
From the College perspective, Specialist Rural Anaesthesia in Victoria has made progress in the last two years.

A new accredited position has been created at Wangaratta as part of the Monash rotation. This rotation now has its third registrar, and it seems to be a success – the first registrar still returns to Wangaratta to play in the local soccer team. Since one of the objectives of creating rural rotations is to expose trainees to the rural anaesthetic environment with the hope that they will return, this sign is a most positive one.

Of similar importance is the recognition of this post for funding by the Department of Health and Community Services, which was not easy to achieve. However, the Department has now not only funded this position, but has funds available to finance at least two other rural rotations should hospitals and their anaesthetists wish to organise College accreditation and the appropriate rotation with a major metropolitan scheme. I have hopes that these positions will be organised and filled within the next 18 months.

CME has always been a major difficulty for rural anaesthetists, and the Victorian Regional Committee approved the videotaping and distribution to rural hospitals of most of the College CME Meetings. I hope that this not only fills some of the CME gap but makes the more remote members of our College feel that they are remembered and involved in College activities.

Tony Weeks, Chairman
Regional Committee:
Chairman
Dr. Peter Moran
Vice-Chairman
Dr Ted McArdle
Honorary Secretary
Dr Ranald Pascoe
Regional Education Officer (Anaesthesia)
Dr Jenny Parslow
Continuing Education Officer
Dr John Murray
Other Members
Dr Rob Whiting
Dr Jim Bradley
Dr Di Khursandi
Dr Bart McKenzie
Councillor
Dr David McConnel
Faculty Education Officer
Dr T. John Morgan

QUEENSLAND
EDUCATION
A very successful seven day pre-exam Primary Refresher Course was held in May last year. This course was attended by 24 candidates. The examination success rate and the educational benefits justified a repeat course planned for May 1995.

The highlight of the Continuing Education for the year was the Annual Scientific Meeting held in Townsville. The Committee would like to publicly express its thanks to Dr Vic Callanan, Ms Doreen Callanan and all their able assistants from Townsville for ensuring a highly successful Annual Scientific Meeting. The record number of registrants and the quality of the scientific programme was clear evidence of the continuing growth of our College as well as the influence of our past-President in encouraging the growth of Australasian based quality research in anaesthesia.

A very successful weekend Continuing Education Meeting organised by Dr Jennifer Parslow was held at Redcliffe in November. The meeting covered a variety of topics including malignant hyperthermia with Dr Michael Denborough as the interstate guest lecturer. Associate Professor Joe Brimacombe as the guest local speaker gave an entertaining lecture on the laryngeal mask.

The Regional Committee would like to express its thanks and appreciation to Dr Jim Bradley for organising the Pharmacology long Course lecture series for a period of 10 years.

Ipswich General Hospital, Logan Hospital, the Greenslopes Private Hospital and the Royal Children’s Hospital were all inspected during the 1995/96 year. An inspection of Caboolture Hospital is proposed for the end of May.

Following the recent inspection of Royal Children’s Hospital in Queensland, the Regional Committee has sent a letter to the State Health Department emphasising the need for an increase in the number of paediatric training positions, so that appropriate training experience can be provided for registrars in this specialty area as required by the College.

There are now 71 training positions within the first four years of training in Queensland. This number includes both anaesthesia and intensive care approved positions.

The increased need for anaesthetists is due to many factors including
- the changing age distribution of specialists in anaesthesia (an increasing number will retire in the next 5 - 6 years),
- the increased demand for expertise of anaesthetists in chronic pain, palliative care, acute pain and intensive care,
- the significant percentage of female specialists with associated decreased level in workload, (21% of the 35-44 age group are female, 14% of the 45-59 age group are female, 52% of anaesthetists who work part time are female),
- the need for all overseas trained doctors to successfully complete the College’s final examination plus the completion of a residential year in a post approved by Council, as a minimum requirement prior to receiving College support for specialist recognition in Anaesthesia, as from 1 January 1996.
TEACHING HOSPITALS
Improved working conditions for both Full Time and Visiting Specialists has helped make hospital positions more attractive. There has been a pleasing increase in the number of interstate and overseas applicants for Teaching Hospital Specialist positions.

Professor Douglas Jones has worked hard to expand his academic department at Royal Brisbane Hospital. An application has been made to the University Senate for autonomy of the Department of Anaesthesiology and Intensive Care which is currently within the Department of Surgery. Autonomy is an important step forward in the development of Academic Anaesthesia in Queensland.

RECOGNITION OF SERVICE
Thanks are expressed to Dr John Murray and Dr Bart McKenzie who will retire from the Queensland Regional Committee this year having served in a variety of positions over the last 12 years.

REGIONAL REPRESENTATIVES ON EXTERNAL COMMITTEES ARE AS FOLLOWS:

Dr Peter Moran
Editorial Committee Representative “Australasian Anaesthesia”
Advisory Panel to Health Rights Commission
Committee Queensland Medical Colleges
Medical Workforce Specialist Working Party
Health Department Theatre Utilisation Steering Committee
Postgraduate Diploma in Anaesthetic Nursing, Queensland University of Technology

Dr Ranald Pascoe
AMAQ Casemix Representative

Dr Jim O'Callaghan
Perioperative Mortality Committee

Dr John Murray
Post-Graduate Medical Education Committee Representative

Dr Bart McKenzie
RACS Road Trauma Committee
Medical Workforce Specialist Working Party
Queensland Ambulance Medical Advisory Committee

Dr Rob Whiting
State Health Department’s Committee (Statewide Management Systems for Elective Surgery)

OTHER FELLOWS SERVING COMMITTEES:

Dr Frances Ware
Physiology long Course Lecture Series Co-ordinator

Dr Bill Miles
Pharmacology Long Course Lecture Series Co-ordinator
Queensland continued)

Dr Rhonda Boyle
Practise Viva Sessions Co-ordinator

Dr Alison Holloway and Dr Julia Byatte
Anaesthetic Technician Training Committee

Dr Eric Hewett
Maternal and Perinatal Mortality Committee
Doctors’ Health Advisory Service

Dr Paul Mead
Australian Resuscitation Council

Dr Col Busby
Red Cross Blood Transfusion Service

Dr Peter Moran, Chairman
SOUTH AUSTRALIA

MEETINGS

The Annual General Meeting of the South Australian Regional Committee was held on Saturday, 23rd September 1995 at the Ramada Grand Hotel, Glenelg.

Continuing Education Meetings - The South Australian Regional Committee thanks the Combined CME Committee for organising the following meetings throughout 1995/early 1996:

1. 17th May 1995 - at Calvary Hospital - Presentation by Dr John Sear, Clinical Reader in Anaesthesia, Nuffield Department of Anaesthetics, University of Oxford, UK - "Anaesthesia for Hypertensive Patients"

2. 7th June 1995 - at Calvary Hospital - "Infection Issues - Who Really is at Risk?". Speakers were Professor Ross Kalucy and Dr Michael Jones.

3. 5th July 1995 - at Calvary Hospital - "Obstetric Anaesthesia - Is Your Awake Patient Aware?". Speakers were Drs John Crowhurst and Scott Simmons and a representative from MDASA.

4. 9th August 1995 - Dinner meeting at The Sir Donald Bradman Room, Adelaide Oval. "Issues in Pain Management'. Speakers were Professor Terry Murphy, and Drs David Cherry, Phillip Gaukroger and Michael Buist.

5. 23rd-24th September 1995 - Weekend conference at the Ramada Grand Hotel - "Trauma, Emergencies and Other Odd Situations in Anaesthesia". Visiting speakers were: Dr A MacKillop, Chair of the Department of Critical Care, John Flynn Hospital, Gold Coast, Queensland. Professor A McFarlane, Professor of Community Medicine and Rehabilitation Psychiatry, The University of Adelaide, South Australia. Professor S Sutherland, Foundation Director and Associate Professor, The Australian Venom Research Unit, Department of Pharmacology, The University of Melbourne, Victoria. Dr A J Slater, Consultant Intensivist, Paediatric Intensive Care Unit, Women’s and Children's Hospital, South Australia. Local speakers also participated, with workshops involved in the programme.

6. 17th October 1995 - at Calvary Hospital - Presentation by Dr Joachim (Nick) Gravenstein, Graduate Research Professor, Department of Anesthesiology, University of Florida College of Medicine, Gainesville, Florida, USA. "Gas Monitoring".

7. 1st November 1995 - at Calvary Hospital - Presentation by Mr Leigh Jamieson, Managing Director, Bench Mark Mutual Hospital Group. “Musings about Managed Care”.

8. 6th December 1995 - at Calvary Hospital - Registrars’ Scientific Presentations - Drs P MacAleer, R Russell, G Koo, Dr Barker and J Perks participated.

9. 14th February 1996 - at Calvary Hospital - Presentation by Mr Michael Flood, “The Role of the Therapeutic Goods Administration”.

Burnell-Jose Visiting Professorship - 26th March 1995 until 7th April 1995. The Burnell-Jose Visiting Professor for 1995 was Professor M.F.M. James from the University of Cape Town, South Africa.
MATTERS OF CONCERN TO SOUTH AUSTRALIAN FELLOWS

1. Workforce Issue
Following a letter from the President of the College requesting Regional Committees to identify areas which could accommodate increases in training positions by 15-20% in 1995, the Regional Committee initially referred this matter to the Directors of Anaesthesia meeting which identified a possible ten extra accredited positions, which would have increased the number of trainees from 46 to 56 in the South Australian region.

There was then considerable debate at the Regional Committee as to whether the workforce issues prevalent in the eastern states were as relevant to South Australia whose training numbers have been relatively high by comparison with other States.

A near absence of VMO positions in public hospitals in anaesthesia being cited as an example of the different workforce issues in South Australia compared with the other states.

Concerns were expressed that further training positions would dilute the caseload/experience available to, and thus the quality of training, for current trainees.

The opinion of the Directors of Anaesthesia meeting was again sought and after further discussion it was felt that an increase in the number of accredited training positions in the South Australian Rotation would not be appropriate at the current time.

2. National Anaesthesia Day
National Anaesthesia Day 1995 raised considerable discussion with concerns over problems with prior communication of the event at a local level.

General concerns over the duplication of Public Relations exercises of ASA and ANZCA were expressed.

The Council Representative emphasised the Council's intention for a coordinated approach between the College and the ASA.

3. Administrative Assistant - SA Office
Mrs Sue Harrison was appointed to the position of Administrative Assistant, SA Regional Office, in November 1995.

CORRESPONDENCE AND MAJOR DISCUSSIONS
1. Draft Polity Document: Paediatric Anaesthesia in Non Paediatric Hospitals
5. Consent to Medical Treatment and Palliative Care Act.
6. Registrar Supervision/Training – Modbury Hospital
   – The Queen Elizabeth Hospital
7. Medical Ethics and Training in Anaesthesia.
8. ANZCA/ASA - Replication of roles vs. Fundamental differences.
(South Australia continued)

Regional Training Committee:
- Chairman, Regional Education Officer: Dr Peter Woodhouse
- Coordinator of Training: Dr Neil Maycock
- Organiser - CME: Dr Meredith Gabriel
- Course Organiser - Primary: Dr Anthony Pearce
- Course Organiser - Final Fellowship: Dr Christopher Acott
- Chairman: Dr Tony Laver

Regional Committee:
- Chairman: Dr Simon Fraser
- Secretary: Dr Michael Lorimer
- Treasurer: Dr Ruth Matters
- Regional Education Officer: Dr John Blaxland
- CME Officer: Dr Simon Irner

Dr Margaret Walker

Co-opted Council Member
Dr Mike Martyn

Co-opted Faculty of Intensive Care Member
Dr Dr George Merridew

TASMANIA

Continuing Medical Education
A one day meeting was held at Salamanca Inn in Hobart of 22nd July. Invited speakers were Michael Gorton and Bill Turner.

A combined ANZCA/ASA meeting was held at Cradle Mountain Lodge on the weekend 28/29 October 1995. Invited speakers were Dorothy ffoulkes – Crabbe, Joe Brimacombe, and Brian Duffy.

Training
Two Candidates presented for the Primary examination, and passed.

A post for a Tasmanian trainee has been established at The Western General Hospital in Melbourne. The Statewide training programme is now functioning.

Other Issues
- Planning is underway for a meeting in Launceston in June 1997 to commemorate the first Australian anaesthetic.
- Anaesthetic manpower in rural regions of Tasmania remains suboptimal.

Michael Lorimer, Secretary
Dr Bernard Dunn (above) presented “Dust Off” by Bruce Fletcher depicting the medical evacuation of wounded soldiers from the field in Vietnam.

WA Section of the ASA presented the College with a bound set of Flowering Plants of the Eastern Goldfields of Western Australia.

Dr John Cooper, Dean of the Faculty of Anaesthetists, RCSI presented a Waterford Crystal Carriage Clock.
Regional Committee:
Chairman
Dr. Neville Gibbs
Deputy Chairman
Dr Leigh Coombs
Secretary
Dr Geoff Mullins
Regional Education Officer
Dr Grant Turner
Treasurer
Dr Hugh Speirs
Continuing Education Officer (Anaesthesia)
Dr Leigh Coombs
Faculty Education Officer
Dr Steve Edlin
Councillors
Dr Neville Davis
Dr. Moira Westmore
Other Members
Dr Terry McAuliffe
Dr Phil Smith
Dr Mike Hellings
Dr Robert Godkin
Special Interest Representatives
Acute Pain: Dr Grant Turner
Rural Anaesthesia: Dr Graham Dale
Cardiac, Vascular & Perfusion: Dr Ken Williams
Neuroanaesthesia: Dr Wally Thompson
Research: Dr Neville Gibbs
Medical Education: Dr Robert Godkin
Day Care Anaesthesia: Dr Brent Donovan

WESTERN AUSTRALIA
Continuing Education
During the year CME meetings were organised with the following speakers:
July 1995 Dr John Russell
August 1995 Dr Michael Harrison
August 1995 Professor Michael James
January 1996 Dr Gavin Kenny

Country visits
During the year there were two ANZCA organised meetings to rural areas; Bunbury (May) and Broome (September). Speakers included Dr L. Coombs, Dr P. Smith, Dr. M. D'Souza, Dr C. Orlkowski, Dr M. Hamilton, Jocelyn Namby and June Gorrinage. Each meeting consisted of one full day directed at GP Anaesthetists, a half day for Assistants to Anaesthetists, and a half day directed at nurses on Acute Pain Management. Sponsorship was received from Roche, Hoescht, Abbott, Ohmeda, Health Department of Western Australia and the West Australian Centre for Remote and Rural Medicine.

Regional Education
The Part 1 and Part 2 Tutorial programmes were organised by Dr R. Wong and Dr W. Weightman respectively. All trainees continue to have adequate subspecialty exposure. High success rates were achieved in both Part 1 and Part 2 Examinations. The Cecil Gray Prize for May 1995 was awarded to Dr Hilton Swan.

Nerida Dilworth Prize
This ANZCA/ASA(WA) Regional Committee sponsored prize for the best registrar presentation at an ASA or ANZCA meeting was won by Dr George Chalkiadis.

The Dr John Boyd Craig Research Award was awarded to Dr Stephanie Davies.

1996 CSM (ANZCA, Faculty of Intensive Care, ASA)
This will be held at the Hyatt Hotel Perth, 26th-30th October 1996. The convenor is Dr Leigh Coombs. The Younger Fellows Conference will be convened by Dr Dennis Hayward and will precede the CSM. It will be held in the Monastery at New Norcia.

Other Matters
Rural Anaesthesia Practice
In addition to organising continuing education for Rural GP Anaesthetists, the Committee continues to have representation on the Western Australia Statewide Anaesthetic Reference Group.

ANZCA/ASA Combined activities
All ANZCA CME activities in WA from 1st January 1996 have been combined with the ASA. From January 1997, there will be a formal Combined ANZCA/ASA CME Committee. The ANZCA and ASA Regional Committee continue to meet together at least three times a year.

Geoff Mullins, Secretary
Office Bearers:

Chairman
Dr. Ed Loughman
Vice-Chairman
Dr Matthew Crawford
Honorary Secretary
Dr Michele Joseph
Other Members
Dr Jenny Beckett-Wood
Assoc. Prof David Gibb
Dr Michael Jones
Dr Ross Kerridge
Assoc. Prof Peter Klineberg
Dr Bill McMeniman
Dr Frank Moloney
Dr Tony, Quail
Dr Chris Sparks
Co-opted Member
Dr Brian Horan
Ex-Officio
Dr Richard Walsh
Prof Michael Cousins

Education Officer:
Assoc. Prof Peter Klineberg

Supervisors of Training
Part I Course – Dr Peter Kam
Part II Course – Dr Michael Bookallil

Education Sub-Committee
Dr Gillian Bishop
Dr Michael Bookallil
Assoc. Prof Peter Klineberg

Continuing Education Committee
Dr Matthew Crawford
Dr Geraldine Goulding
Dr Peter Isert
Dr Michele Joseph
Assoc. Prof Peter Klineberg

Intensive Care Representative
Dr Gillian Bishop

NEW SOUTH WALES

As in previous years, the Committee’s activities through the year have included hospital inspections for the accreditation of training posts, advice to Hospital Appointments’ Committees about applicants’ qualifications; and participation in the ongoing review of College Policy Documents. This year the Committee also contributed to the taskforce established to oversee the Department of Health’s Surgical Waiting List Reduction Programme in New South Wales. A consequence of this activity has been the further development in day of surgery admission processes, which attempt to reduce unnecessary inpatient time.

The Committee has also considered how paediatric anaesthesia should be provided outside specialised Children’s Hospitals. This has been part of the Department of Health’s review of its Guidelines for the hospitalisation of children, and is particularly relevant to rural anaesthesia practice.

Two General Meetings of Fellows were held this year, in May and November. At the first meeting, the President, Dr Michael Davies described the development of the Maintenance of Standards Programme and spoke of the College’s efforts to address a maldistribution of the anaesthesia workforce. To assist in these efforts, the Regional Committee has been active through the year assisting with the establishment of rural rotations for several of the training programmes based in Sydney.

Continuing Medical Education

A successful series of meetings was held this year in both rural and metropolitan centres. The Anatomical Workshop continued to attract strong support; a weekend meeting at Leura, in the Blue Mountains heard about Recent Developments in Anaesthesia Drugs and Techniques; Emergency Anaesthesia and Retrieval Issues were considered at the weekend meeting in Orange two months later; and finally the Management of Neurotrauma Patient was discussed in November in Sydney. The joint College ASA Committee overseeing continuing education has introduced an audio tape record of meeting highlights to complement the abstract booklet of meeting proceedings. The tape of the Neurotrauma meeting is available to N.S.W. Fellows and N.S.W. A.S.A. members without charge, and to others for $10, on request to the Committee’s office in Sydney. The first meeting of the N.S.W.A.C.E. will be in July, 1996, as the World Congress was held in Sydney.

Ed Loughman, Chairman
Regional Committee

Chairman
Dr Jack Havill

Deputy Chairman
Dr Alan Merry

Honorary Secretary/Education Officer (Anaesthesia)
Dr Malcolm Futter

Honorary Treasurer
Dr Sharon King

Other members
Dr Forbes Bennett
(Also Faculty Education Officer)

Dr David Jones
Dr Chris Pottinger
Dr Isobel Ross
Dr Hugh Spencer
Dr Leona Wilson

Ex-Officio
Professor John Gibbs
Dr Steuart Henderson
Dr Sandy Garden
(Medical Director, CECANZ)
Dr Ron Trubuhovich
(Faculty of Intensive Care)
Dr Rob Burrell
Younger Fellows' Representative

NEW ZEALAND

New Zealand is in the middle of rapid change in the structure and administration of the health service. Accompanying this, major pieces of legislation have been introduced, affecting discipline, registration, recertification and competency programmes and quality assurance endeavours. Members of the New Zealand Committee had been exceptionally busy in making submission and trying to influence the changes. In addition, the Committee is at the forefront in trying to change legislation relating to criminal manslaughter.

In all these activities, it has become very obvious that the NZ Committee had particular problems related to the fact that we are a separate nation from Australia. This involves constant interaction with Government agencies, legislation and regulation which are peculiar to New Zealand.

Committee

Sharon King has now become Honorary Treasurer from 1996. Our thanks go to Isobel Ross for a sterling effort.

Rob Burrell is our New Younger Fellows representative.

All members of the Committee have been exceptionally busy in College affairs and we acknowledge their excellent efforts.

We were pleased to have Neville Davis, Garry Phillips and Joan Sheales at our recent meetings.

Activities over the last twelve months have included:

1. Medical Practitioners Act

This has passed all its readings in the House now and is expected to become law in July 1996. The Act will have major effects on specialist practice in New Zealand. For instance, it makes recertification compulsory for vocational registration.

Several meetings in conjunction with the Medical Council have been held on these issues and they are proving very difficult.

(a) The two main forms of registration are:

(i) General – where practice had to be supervised. What supervision means, how close it should be, who is responsible legally should things go wrong and who is going to pay the supervisor are all unsolved questions.

(ii) Vocational – this means that specialist registration as we know it will disappear. The area is a minefield of problems. Many practitioners practise in a number of fields e.g. anaesthesia, intensive care and pain management. Do we have a vocational group for each small group (“splitting”) or do we simply have very large vocational groups which encompass all the smaller subspecialties (“lumping”). For example, the physicians cover a large group of subspecialties. “Lumping” avoids too much restriction of practice and “splitting” will make it extraordinarily awkward to administer even though it may meet the objectives of the Act in delivery of care only by those qualified in the particular area.

Consideration of procedures for registration of overseas specialists has consumed a lot of Committee time. All the Colleges are struggling with this and attempts are being made to bring the procedures closer. Our College had stated that equivalent training to the FANZCA training is required and overseas specialists now have to sit the Final FANZCA examination. The College merely recommends to the Medical Council of New Zealand what they want.
consider the standards to be. The new Medical Council has to work through these issues and it is going to be a very difficult process. It is quite within their rights to ignore the College recommendations.

2. **CEPOD**

This is an English body which stands for Confidential Enquiry into Perioperative Deaths. In conjunction with the Surgeons and possibly the Obstetricians we are meeting with the Ministry of Health to set up a body to replace the now defunct Anaesthetic Mortality Assessment Committee. The Quality Assurance provisions in the new Medical Practitioners Act coming into force in July 1996 means that reports are not entirely safe from judicial subpoena, but these issues are being looked at closely. They may be workable and we are certainly committed to getting the process going again this time with the wider participation of Surgeons.

3. **Medical Manslaughter**

The Regional Committee lent its full support to the campaign to have a law change. Our members on the Medical Law Reform Group have been Alan Merry and Leona Wilson. An enormous number of hours have been spent by these two as they “led the charge” in initially setting up the Medical Law Reform Group, continuing with a major submission on the Medical Practitioners Bill and pursuing repeated contacts with politicians, official bodies and the media. This is still ongoing.

The culmination of their efforts has been the commissioned report by Sir Duncan McMullin which suggests strongly that a law change is needed along the lines which we have been advocating.

Much work still has to be done, but continuing contact with other political party leaders has suggested that they will support the amendment to the Crimes Act. This lobbying will need to continue in the light of an uncertain political framework.

We owe a great debt of gratitude to Alan and Leona and other members of the MLRG. We have also been well supported by NZ anaesthetists in general and our parent ANZCA Council.

4. **Clinical Training Agency**

An attempt has been made to unbundle clinical training costs for postgraduate training. It has been an abysmal effort but is forming the “base money” for contracting with providers who will run the training programmes. A Northern Consortium of CHEs and University has been set up to try to capture these funds and we understand a similar approach is being tried in the South Island. The Council of Medical Colleges sees great danger in the above and are very opposed to the Universities moving into an area where they have traditionally contributed virtually nothing. Other Colleges are moving to direct contracting with the CTA to run their programmes and it is possible that we will have to do the same if we wish to retain control of our registrar appointments and their training. Contracts with the CTA are ongoing.

5. **Council of Medical Colleges**

This is the New Zealand equivalent of the Australian body which is attended by the College Presidents. The Chairmen of the NZ parts of Colleges attend this Committee and it is becoming an increasingly important forum. The Council is frequently asked for advice by political and health body sources. It meets 3-4 times per year and is wrestling in particular with specialist registration procedures.
6. **Health and Safety**

We are making submissions on a Health Ministry document foreshadowing an updating Act on Health and Safety. This involves regulations to maintain standards in areas such as homes for the elderly. Unfortunately there seems to be a perception that we can regulate by law for clinical standards e.g. anaesthesia and when a preoperative visit should be made! Thus it is important we point out some of the stupidities inherent in the process. Our thrust will be that cognisance should be taken of regularly reviewed standards guidelines from such bodies as Colleges.

7. **CECANZ**

*(Continuing Education Committee of Anaesthetists in New Zealand)*

CECANZ is now on a firm footing with a formal constitution outlining the agreement between the NZSA and the College. This has been excellent progress (though somewhat belated). It is intended that CME in New Zealand be self funding. Thus we are looking at methods of increasing income to support CECANZ. The HELP modules for instance are now to be paid for by the College with some assistance from a sponsor. Profits from CANZ and Single Theme Meetings will also be directed to CECANZ and the extent of the profits will need to be adjusted with CECANZ funding in mind.

Our thanks go to Sandy Garden who has been doing an excellent job as CECANZ Director

8. **Combined Newsletter**

New Zealand Anaesthetists have been in receipt of three local anaesthesia newsletters: NZSA, ANZCA and Anaesthesia Aotearoa. Agreement has been reached to amalgamate the publications and the first edition of “NZ Anaesthesia and Perioperative Care” is about to be published.

9. **Faculty of Intensive Care**

We have many areas of common concern with the NZ Regional Committee of the Faculty and are keeping a very close liaison with them. In particular many of the national issues of legislation etc. can be addressed as a group.

10. **Code of Rights for Consumers and Disability Services**

A detailed submission by the Regional Committee was made in September 1995. The regulations will receive the power of law in July 1996. We have also had excellent meetings with the Commissioner. Some major problems exist in the legislation but generally it formalises a standard way in which patients can address problems and be dealt with fairly and expeditiously. In fact, the passing of this sort of legislation will hopefully facilitate change in our draconian manslaughter legislation.

11. **Primary Courses**

Two courses will now be held each year in New Zealand; Christchurch (earlier part of year) and Waikato (latter part of year). Auckland continues to run the Part II Course.

12. **Continuing Medical Education and Conferences**

**Single Theme Meeting** 17-19 March 1995, Whangarei

**Teleconferences**

26/2/95 “Substance Abuse by Anaesthetists”

26/9/95 “The Acute Pain Service”
New Zealand (continued)

Special Interest Group Meetings
Day Care Anaesthesia, 15/7/95
"Controversial Issues in Day Care Anaesthesia"
CVP, 18-20/8/95, Wanaka, "Issues in Thoracic Anaesthesia"
ARGONZ Meeting, 14/11/95, Palmerston North
ISRA Meeting, Auckland, 9-11 April 1996

These are coordinated by CECANZ under the Directorship of Sandy Garden.

Jack H. Havill, Chairman

AUSTRALIAN CAPITAL TERRITORY

There are currently thirty Fellows listed in the ACT Region.

Three candidates presented for the Primary Examination and all were successful. At that time there was only one recognised post in the Region but this has now increased to two rotating registrar positions.

CONTINUING MEDICAL EDUCATION

Visiting Lecturers included Dr Paul Older (CPX Testing) and Dr Sue Kelly (Pre-anaesthetic Assessment).

September Meeting

There were approximately 80 registrants for this Meeting with excellent presentations and discussion.

A good session on Public Relations was convened with the Presidents of both the College and ASA contributing considerably to the discussion.

With regard to Public Relations, suggestions are being sought for an interactive educational display, intended for children, relating to anaesthesia.

Ray Cook, Chairman
HONORARY TREASURER’S REPORT

The Annual Financial Statements of the College for the year ended 31 January 1996 are presented in their formal and required manner. All Fellows and Trainees are requested to examine these Statements, which were prepared by the Auditors and accepted by the College Council. As the Statements are found by many to be difficult to fully understand, I offer the following interpretation of the salient features, along with a diagrammatic summary.

Revenue and Expenditure Statement
This Statement summaries the total revenue and expenditure of the various Accounts and Funds operated by the College. Both revenue and expenditure increased significantly for many reasons, and these are detailed further in the Statements. The operating surplus was just over $1.4 million, with $526,000 derived from Subscriptions and $140,000 from the Trainees Fund. Less than half the surplus was therefore raised from Fellows and Trainees. It is also important to note that the overall surplus does not reflect the actual gain to College cash reserves, which the Council has been attempting to significantly increase for future activities.

Balance Sheet as at 31 January 1996
The Balance Sheet reflects the overall monetary value of the College as at 31 January 1996. The net assets are determined by the College total assets minus its liabilities, the latter mainly being subscriptions and trainees' fees held in advance until the following financial year. Net assets are shown in the Equity section of the Balance Sheet as held by the three funds of the College – the Project Fund, the Trainees’ Fund and the Foundation Fund (ANZCA Foundation). The Subscription Account is not a fund but represents the use of income from Fellows' subscriptions during the year, at the end of which any surplus is transferred to the Project Fund.

Accounts and Funds

Subscription Account
This Account shows distribution of funds received as subscriptions for the daily running of the College on behalf of Fellows. Any surplus at the end of the year is transferred to the Project Fund to add to College cash reserves. Revenue increased by 15% over the previous year (it was 19% last year) while expenditure marginally increased as many potential activities were put on hold. As with previous years, 10% of income was allocated each to the Foundation Fund and to the Project Fund. The Trainees’ Fund contributed $801,376 to administration of the College; this amount is likely to increase significantly in future years.

The effective surplus of the Subscription Account was $525,990 and accounts for the significant improvement in cash reserves of the College. It also enabled the College Council to maintain the annual subscription for 1997 at the same level as for 1996. I believe, however, that future years will see substantially increased expenditure from the Subscription Account as the costs of recent initiatives (such as Maintenance of Standards, Pain Management Certification, Library services expansion) and other new projects for Fellows are impacted.

Project Fund
This fund represents the Fellows’ share in the net assets of the College. Revenue is mainly from interest on investments, a “development” allocation from subscriptions, and the surplus from the Subscription Account. The interest shown as allocated from subscriptions in advance is actually transferred to the ANZCA Foundation for research purposes.

Foundation Fund
This fund represents the financial activities of the ANZCA Foundation, the balance of which has now reached $2.7 million. While general donations to the Foundation were disappointingly low, revenue was boosted by an unexpected but welcome surplus on the 1995 Annual Scientific Meeting. Regional Continuing Education income and expenses both significantly increased over the previous year, mainly due to improved financial reporting methods. The expenditure on research varies considerably from year to year due to variations in timings of payments for such purposes, although the $304,704 is noted as the largest ever annual payment. The Foundation Fund continues to be a great and growing asset for Australian and New Zealand anaesthetists.
and intensive care, being extensively used for both research and continuing education purposes.

**Trainees' Fund**

This fund provides for the College training and examinations system, aiming to run with a minimal but safe financial surplus. Revenue remained fairly static but total expenditure increased by 7% to nearly $1.04 million, which includes administration costs ($801,376). The latter item is expected to undergo major increases in the coming year. The College Council is determined to ensure that training of anaesthetists and intensivists in Australia and New Zealand remains amongst the best in the world and like all things, the costs of achieving this will not be inconsiderable. The overall surplus from the Trainees' Fund ($140,058) decreased by 17% compared with last year but resulted in a balance of the Fund of $472,124, not dissimilar to that held prior to the purchase of the College Headquarters. I regard this figure in current terms to be appropriate for future development of the College training and examination systems.

**Conclusion**

I am pleased to report, once again, that the College finances are in a healthy state, reflected by continued growth which will serve our professions in many ways. The overall financial surplus from College activities (and those of immediate past years) was anticipated in order to restore cash reserves of the College, which were severely depleted when the College was initially formed and purchased its official headquarters. Unlike other medical Colleges, ANZCA has not imposed special levies or fees in this time of establishment, increasing responsibilities and current developments.

Fellows' subscriptions and Trainees' fees are always unwelcome and the College Council is acutely aware of this fact. The annual increase in subscriptions has been falling over the past four years, to the extent that the 1997 subscription remains the same as that for 1996. Administration costs of the College have deliberately been contained over the past few years. However, as the roles of the College continue to expand on behalf of Australian and New Zealand anaesthesia and intensive care, I predict these and other expenses will increase significantly in the immediate future.

In managing the College finances, I particularly thank the College Accountant, Ms Vivienne Lillis, the College Registrar, Mrs Joan Sheales, and all other staff of the College both in Melbourne and in each Region. I also note with thanks the important role undertaken by Fellows who are Honorary Treasurers of each Regional Committee of the College, an often recognised but important function. I also thank my fellow Councillors who have been extremely diligent in ensuring that the best financial outcome for the College and therefore its Fellows is achieved. Finally, and on a totally different subject, I take this opportunity to thank all Fellows and the College generally for their support in my organisation of the recent World Congress of Anaesthesiologists.

I welcome any queries and comments from Fellows and Trainees regarding this Report and accompanying Financial Statements. I request that such inquiries be in writing.

RICHARD G. WALSH
Honorary Treasurer

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Bulletin

May 1996
Depending on the position one holds in a teaching hospital there are varying commitments to clinical practice, teaching, research and administration. In Australia and New Zealand the majority of specialists have prided themselves on their standard of clinical practice. Others have excelled as teachers, but relatively few have had a major commitment to research. Administration usually rested with a central hospital authority together with involvement by the Head of Department, his or her deputy, and those involved in organising teaching programs. Today the whole balance is changing.

The current push is to have clinicians more involved in management. I see this as a good thing, as long as we distinguish the subtle differences between 'management' and 'administration'. The former encompassing planning and decision making, whilst the latter involves more of the operational issues and is much more time consuming. Excessive involvement in administration impinges upon time for clinical practice, teaching and research.

Clinicians must be involved in top management in this present climate of economic restraint if we are to prevent a fall in clinical standards, and less funding for teaching and research. Many colleagues have refused to become involved citing the situation of many years ago where there were extremely few managers and administrators. This is certainly true, but from my recollections hospitals were then extremely inefficient. Patients frequently spent days in hospital, waiting to see consultants; others were admitted for investigations which could have safely been done on an outpatient basis. Things had to change and they have.

Hospital stays are shorter, more patients are admitted on the same day as surgery and everywhere people seem to be making spending cuts. Unfortunately all of this plus shorter working hours for junior staff have meant teaching and research may suffer.

Well what is the message? It is simply that with or without us change will continue. I think it is better if more of us get involved and share the load thereby lessening the impact on any one individual's time. With the inevitable changes in shorter hours or work for trainees and various other imposed economics, we must plan how our teaching and research can be adapted to fit into the new scheme of things. It may well be that medical students will have to move around to more peripheral hospitals for their general medical and surgical experience and specialist trainees will have to accept that more of their teaching and research project time is to be undertaken when they are not on clinical duty.

To most questions there are answers. If we want to find the right answers then I suggest clinicians share the load and become more involved in management.

GEOFFREY M. CLARKE

May 1996
SUPERVISORS OF INTENSIVE CARE TRAINING FOR THE
FACULTY OF INTENSIVE CARE

New South Wales
CareFlight Pty Ltd
CareFlight Repatriation Hospital
Gosford Hospital
John Hunter Hospital
Liverpool Hospital
Nepean Hospital
New Children's Hospital
The Prince of Wales/
Prince Henry Hospitals
Royal North Shore Hospital
Royal Prince Alfred Hospital
St George Hospital
St Vincent's Hospital
Westmead Hospital

Dr B. Hanrahan
Dr Y.V. Tran
Dr A.J. McDonogh
Dr P. Saul
Dr G. Bishop
Dr A. McLean
Dr A.J.O'Connel
Dr G. Hill
Dr R. Raper
Dr R. Traill
Dr R. Morris
Dr R.P. Lee
Dr J. Gallagher

South Australia
Women's and Children's Hospital
Ashford Hospital
Flinders Medical Centre
Queen Elizabeth Hospital
Royal Adelaide Hospital
Wakefield Hospital

Dr S. Keeley (Acting)
Dr A. Bersten
Dr A.D. Bersten
Dr J.L. Moran
Dr J. Myburgh
Dr D. Clayton

Victoria
Alfred Hospital
Austin and Repatriation
Medical Centre
Box Hill Hospital
Epworth Hospital
Geelong Hospital
Monash Medical Centre
Royal Children's Hospital
Royal Melbourne Hospital
St Vincent's Hospital
Western Hospital

Dr D. J. Cooper
Dr G. Hart
Dr P.J. Cranswick
Dr D. Ernest
Dr C. Corke
A/Professor W.G. Parkin
Dr J. Tibballs
Professor J.F. Cade
Dr J. Santamaria
Dr P. Older

Queensland
Gold Coast Hospital
Greenslopes Repatriation
Hospital
Mater Misercordiae Children's
Hospital
Princess Alexandra Hospital
Prince Charles Hospital
Royal Brisbane Hospital
Royal Children's Hospital
Townsville General Hospital

Dr J. Renton
Dr R.F. Whitting
Dr B.F. Lister
Dr J. Cockings
Dr J. McCarthy
Dr J. Morgan
Dr J. McNieney
A/Professor V.I. Callanan

Western Australia
Princess Margaret Hospital
Royal Perth Hospital
Sir Charles Gairdner Hospital

Dr A.W. Duncan
Dr S. Edlin
Dr P.V. van Heerden

Tasmania
Launceston General Hospital
Royal Hobart Hospital

Dr R. Parkes
Dr A. Bell

New Zealand
Auckland Hospital
Christchurch Hospital
Dunedin Hospital
Middlemore Hospital
Palmerston North Hospital
Starship Children's Hospital
Waikato Hospital
Wellington Hospital

Dr L. Galler
Dr G. Downward
Dr M. Ramsay
Dr P.D. Crone
Dr P. Hicks
Dr B. Anderson
Dr N. Banres
Dr R.A. Dinsdale

Hong Kong
Prince of Wales Hospital
Queen Elizabeth Hospital

Dr C.S.T. Aun
Dr Cheng Fan

April 1996
FIFTEEN YEAR SURVEY OF FELLOWS OF THE FACULTY OF INTENSIVE CARE (BY EXAMINATION)

The first Final examination in Intensive Care for Fellowship of the Faculty of Anaesthetists, RACS was held in 1979. In 1985, Professor Don Harrison the first Chairman of the Final Examination Committee in Intensive Care and Dr Phil Byth, one of the early Fellows by examination, began a unique longitudinal study of Fellows who had successfully completed the examination/training scheme in Intensive Care. The objectives of the study were:

i) to obtain feedback of the Fellows' perceptions of the appropriateness of the training and examination to their vocational needs and

ii) to validate the hypothesis that the Fellows would remain in practice in Intensive Care long term. This assumption had been questioned by some authors in North America and Europe.

A number of important issues on the content of training and subsequent professional practice were revealed by the responses to the first questionnaire and modifications were made to the training scheme especially in the area of internal medicine.

The second survey was conducted in 1991. The number of Fellows had by then grown from 24 to 70. With the larger number of respondents, it was possible to discern better the pattern of practice of the Fellows and the utility of the training and examination. The results suggested that Fellows remain predominantly in Intensive Care Medicine but many maintained some commitment to anaesthetics, perfusion or other disciplines. Compared to 1985, a wider range of issues related to training and subsequent practice was revealed including training in research, practice in private hospitals, rotations in training, courses and professional roles.

The third survey is about to begin! The potential number of responders is now 128. We are hoping that Intensive Care Medicine in Australasia has now reached “steady state” and this survey will reveal the nature and the importance of the contribution of the Fellows to the practice of Intensive Care. Data will be collected under three headings, Demographics, Professional Roles, Training and Examinations. The format of the questionnaire will enable Fellows to express their strength of feeling or indifference to many importance issues.

The response of the Fellows to the previous two surveys was terrific. 94% responded to the first and 83% to the second. If we can obtain the same enthusiastic response to the upcoming study we believe that we can encourage any potential change to the training and examination system based on valid assessment of the present and future Fellows' needs. We encourage all Fellows of the Faculty of Intensive Care (by Examination) to participate. This is a great opportunity to let us know what you think of your training and examination and suggest change where it is necessary. It also gives us the opportunity to demonstrate to the rest of the world whether the format and content of the Faculty's training and examination is felt to be worthwhile by those who have come through them.

G.A. (DON) HARRISON


May 1996
FACULTY OF INTENSIVE CARE
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

EXAMINATION CANDIDATES SUFFERING FROM ILLNESS, ACCIDENT OR DISABILITY

1. INTRODUCTION

1.1 Candidates should not be disadvantaged unnecessarily as a result of events outside their control. Nevertheless, in seeking to redress any disadvantage, no action should be taken which could be construed to be unfair to other candidates.

1.2 Some guidelines can be formulated for the procedures to be followed in some cases of illness or disability in relation to the examinations. However, it is impossible to foresee every eventuality.

1.3 Where a problem arises which is not covered in the Administrative Instructions, instructions to examiners, or these guidelines, advice should be sought from the Censor or Dean.

2. ACUTE ILLNESS OCCURRING AT THE TIME OF EXAMINATION

2.1 Sudden illness which precludes a candidates from attending all or part of an examination, may provide grounds for remission of the examination entry fee.

2.2 Application for this consideration must be made by the candidate and supported by a medical certificate. Such a medical certificate may be provided by a member of the Court of Examiners, but not by the candidate.

2.3 In the event that examiners become aware that a candidate is illness, they should:

2.3.1 Determine whether, in their opinion, the illness is incapacitating.

2.3.2 Advise the candidate to withdraw if appropriate.

2.3.3 Notify the Dean in writing of this action.

2.4 Further action is at the discretion of the Board, on the advice of the Chairman of the Fellowship Examination Committee.

3. ACUTE ILLNESS, ACCIDENT OR DISABILITY WHICH IMMOBILISES, BUT DOES NOT INCAPACITATE THE CANDIDATE

3.1 It is possible that a candidate may be precluded from attending the venue for the written examination, by an illness, accident or disability which does not otherwise affect his or her participation.

3.2 Under these circumstances, the Chairman of the Court of Examiners and the Chairman of the Fellowship Examination Committee should consider the possibility that the WRITTEN examination could be taken at some other appropriate place at the same time as other candidates in the region. An appropriate invigilator should be appointed for that purpose.

3.3 No such concession is possible for the oral examination, so that if action under 3.2 is contemplated, it must be dependent on the likelihood that the candidate will be fit to attend the vivas.

4. CHRONIC ILLNESS OR DISABILITY

Candidates with a chronic illness or disability will not normally be granted any concession with respect to any part of an examination. If a candidate believes that extraordinary consideration should be given to particular circumstances, a fully documented application should be submitted to the Chairman of the Fellowship Examination Committee at least four (4) calendar months prior to the advertised closing date. Further action is at the discretion of the Board, on advice from the Chairman of the Fellowship Examination Committee.

5. OTHER CONCESSIONS

5.1 Candidates who have been presented from completing an examination by illness, accident or disability will NOT be exempted from any part of a future examination.
5.2 A candidate precluded from completing an examination by illness, accident or disability, will remain eligible for awards of prizes at a future examination.

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

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

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

Promulgated: 1996
Date of current document: February 1996

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FELLOWSHIP EXAMINATION IN INTENSIVE CARE
APRIL/MAY 1996

The written section was held in Adelaide, Brisbane, Sydney and Hong Kong.
The Viva Examination in intensive care was held at The St. George Hospital, Sydney.

The names of the successful candidates are as follows:

- P.T. CLARK, NSW
- M.E. FINNIS, SA
- A. FLABOURIS, SA
- P.A. MacDONALD, NSW
- O.A. MONTEIRO, NSW
- E.R. STACHOWSKI, NSW
- B.E. TRYTKO, NSW
- H.Y. YAP, HK

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POLICY DOCUMENTS INDEX

- IC-7 (1994) Secretarial Services to Intensive Care Units Bulletin Aug 94, pg 57
- IC-12 (1996) Examination Candidates Suffering from Illness, Accident or Disability Bulletin Mar 96, pg xx

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<td>P24 (1992)</td>
<td>Sedation for Endoscopy</td>
<td>May 92</td>
<td>45</td>
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<tr>
<td>P27 (1994)</td>
<td>Standards of Practice for Major Extracorporeal Perfusion</td>
<td>Nov 94</td>
<td>46</td>
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