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EDITORIAL

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

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ISSN 1638-0981.
Welcome to the first edition of the Bulletin of the Australian and New Zealand College of Anaesthetists.

Anaesthetists, intensivists anaesthesia and intensive care are now legally independent as a College. The Australian and New Zealand College of Anaesthetists is a reality, has the same high academic, scientific and philosophic standards as the Faculty of Anaesthetists, and the same exacting requirements for training, examinations and certification. We must continue to move forward and to carry the standard of the College even higher. We can no longer attribute perceptions of inadequacy or lack of recognition by some of our colleagues and the community to a lack of independence.

This great advance now requires continued efforts on the part of your Council and Committees in all their activities on your behalf and of course by all Fellows. I am assured this will be forthcoming because of the tremendous support that the Board received from the Fellowship during this transition. The Australian and New Zealand College of Anaesthetists will continue to occupy the present offices at Spring Street, Melbourne and I would like to take this opportunity to encourage you to visit your College Headquarters the next time you are in Melbourne, to see the College in action and the facilities which are available, such as the Education Centre, Geoffrey Kaye Museum of Anaesthetic History, Hughes Room, Great Hall and Library. The College staff will be very pleased to meet you.

The forthcoming GSM will be the first year that we have met as a College of Anaesthetists with the College of Surgeons and the first time since 1928 that the College of Surgeons has met in Canberra. Our College Scientific Programme promises to be of a very high standard once again and it would be a great show of strength if the Fellowship of our new College gave this Meeting strong support. Registrations for our College at this stage again and it would be a great show of strength if the Fellowship of our new College gave this Meeting strong support. Registrations for our College at this stage again show a high percentage for this time, but there is always room for more. The social attractions of Canberra for this Meeting are really quite superb. Make a decision now to support the new College and register before the discounted fee expires.

Ethics is one of those subjects which the practitioner facing a busy day in clinical practice may find difficult to fit into context, but nevertheless this is a subject which does concern us all, whether we are anaesthetists or intensive care specialists, full time hospital staff, visiting medical officers academics or private practitioners.

The rapidity of the advances in the practice of medicine has now become so great that the chances are that you will be faced with ethical decisions much more commonly than before. The issue involved in any particular case will require clear thinking on the part of all involved, whether it should be a concern about a colleague who appears to have a chemical dependency, a psychiatric problem, or doubts as to the nature of the therapy (or withdrawal of therapy) being proposed. I am sure I do not need to remind any of you that we as well as the disease are under the microscope of public opinion. It behoves us all to stop from time to time and think about what we are doing.

Ethics also concerns relationships with patients, anaesthetic colleagues, intensive care specialists, surgical colleagues, trainees and other health professionals. These relationships are constantly subjected to severe stress by modern medical practice and the intrusions of other parties. It is important for the common good that such intrusions do not destabilise the ethical relationship which exists in our day to day activities.

The provision of specialist services in many rural areas of Australia and New Zealand has always been a difficulty. In no other specialty is this difficulty as acute as in specialist anaesthetic services. The comparatively recently formed Rural Doctors Association has been proclaiming the need to teach rural practitioners skills in anaesthesia. Our College policy with respect to this matter clearly recognises that there is a need in some areas for general practitioners to administer anaesthesia. Discussion on this matter has now progressed to a stage where a Joint Consultative Committee has been formed between the Australian and New Zealand College of Anaesthetists and the Royal Australian College of General Practitioners. Your College has clearly stated that further progress in this matter is predicated on the training in anaesthesia being part of a programme of training in rural medicine under the auspices of the RACGP and will not be accompanied by a qualification in anaesthesia. I commend the article in this Bulletin on rural specialist practice, particularly to trainees, for your consideration.

I have pleasure in welcoming on behalf of the Council of the Australian and New Zealand College of Anaesthetists, those Fellows already admitted to Fellowship and I urge those who have not yet done so, to complete this formality.

P.D. LIVINGSTONE

PRESIDENT’S MESSAGE

March 1992
ITEMS OF INTEREST FROM THE FEBRUARY 1992 BOARD MEETING

EDUCATION (ANAESTHESIA)

Qualification in Pain Management
The views of a number of Fellows practising in pain management are being sought with the idea of establishing a Post Fellowship qualification in Pain Management. It is envisaged that if such qualification is established, it will be open to Fellows of other Colleges. Shortly Regional Committees will be requested for an input.

Exposure to Specialty Training
There is concern that some trainees are not being exposed to certain important areas of specialty training. Further consideration is to be given to mechanisms to ensure that this problem is rectified.

Trainees Working Week
With the reduction in the working week as a result of Industrial Awards, there is concern regarding the total amount of training experience. The Board has agreed to monitor this matter.

EMST Course Requirement for Fellowship
Because of concerns expressed by the Education Officer of the Training Committee for Hong Kong regarding the difficulty for Hong Kong trainees to complete the EMST Course, which is not available in that region, it was agreed that the Administrative Instructions would be amended such that the requirement would encompass the completion of the EMST Course or the Advanced Trauma Life Support Course.

EXAMINATIONS

Review of the Examinations System
A Workshop will be conducted on Thursday, the 12th March 1992 involving members of the Examinations and Education Committees and other educationalists, as part of the review of the Faculty's Examination systems.

MCQ Bank
This requires supplementing and it was agreed that an advertisement be placed in the Bulletin requesting that Fellows submit suggested multiple choice questions. Pro-forma questions have been included in the advertisement.

REPRESENTATION ON OTHER COMMITTEES

Three Faculty representatives will attend a workshop preceding the RACP Annual Scientific Meeting in May 1992, at which further aspects of the "Continued Demonstration of Qualifications" will be considered.

Dr P. Lowe will attend the Workshop on Electrical Safety mounted by the Advisory Committee on Safety (ACOS) of the International Electrotechnical Commission (IEC).

Drs J.F. Mainland and C.D. Joseph will attend the International Standards Meetings of Technical Committees on Anaesthesia and Respiratory Equipment in Washington. Dr Joseph also attended the Interim Meeting in London.
CONTINUING MEDICAL EDUCATION AND QUALITY ASSURANCE

GSM Canberra
Associate Professor Neville Davis was appointed as the Faculty Board Member in Residence at the Younger Fellows’ Conference.

HELP Modules
On the recommendation of the CME and Quality Assurance Committee, the Faculty will continue to fund the distribution of these modules to Australian Fellows and Part 2 Financial Trainees for 1992.

Incorporation
Following further amendments to comply with requirements of the Australian Securities Commission, the Memorandum and Articles of Association of the Australian and New Zealand College of Anaesthetists were approved.

INTERNAL AFFAIRS

Constitution Review Committee
The Board resolved to establish a Constitution Review Committee as a Standing Committee to review the Constitution of the Australian and New Zealand College of Anaesthetists and consider any suggestions from Fellows.

Archives Committee
Dr Michael Cooper, the Faculty Assistant Historian, was nominated as a Faculty representative to this Committee.

Anaesthesia Representative on AMA Federal Council
The Board supported the recommendation by the ASA of Dr John Richards as AMA Federal Councillor.

DEATHS, HONOURS AND APPOINTMENTS

DEATHS
The Board noted with regret the death of
Dr H.M. Windon, NSW — Fellow 1957.
Dr L. Feldman, WA — Member 1956.

HONOURS
The Board noted the following honours and appointments:
Associate Professor Peter D. Livingstone — elected as a Member of the Malaysian Academy of Medicine.
Professor Teik Oh — elected President of the Hong Kong College of Anaesthesiologists.
Mr John K. Clarebrough OBE — Member of the Order of Australia.
Associate Professor Gordon A. Harrison — Member of the Order of Australia.

APPOINTMENTS
Professor Malcolm McD. Fisher — appointed Professor within the Departments of Anaesthesia and Medicine, University of Sydney.
Professor Duncan W. Blake — appointed Professor and Director of Anaesthesia, University of Melbourne, Royal Melbourne Hospital.
Professor Paul F. White — appointed to the Margaret Milam McDermott Chair in Anesthesiology at the University of Texas Southwestern Medical Center, Dallas, Texas.
Associate Professor Neville J. Davis — appointed Associate Clinical Professor, University of Western Australia.
ADMISSION TO FELLOWSHIP
BY EXAMINATION

The following were admitted to Fellowship:

Endorsed in Anaesthesia
Chan Ling Hong, NSW
Robert David Carpenter, NZ
Roy Chesters, SA
Chua Alfred Wing Yan, NSW
Daniel Francis Joseph Connor, Qld
Peter Dalton Cook, Qld
Michael Paul D’Souza, WA
Andrew Paul Forrest, NZ
Robert Bruce Gillies, NSW
David Bruce Goodie, NSW
Richard John Hiscock, Vic
Michael Johannes Larens Jonker, NSW
Sharon Ui-Lan King, NZ
Leung Chung Cheung, HK
Andrew Michael, SA
Sonya Megen Miller, NSW
Anthony John Mullens, NSW
Desmond Patrick McGlade, Vic
David Hugh McLeod, SA

Fellowship Diploma Endorsed in Intensive Care
John Hamilton Reeves, Vic
Peter William Skippen, Qld
David Yong Williams, Vic

David John Page, NSW
Philip Ralph Palmer, SA
Anastasia Panis, NSW
Gail Christine Pearson, NZ
David Robert Pickford, NSW
Philip Gregory Ragg, Vic
Simon Duncan Reilly, Vic
Carl Brian Scott, NSW
Roslyn Anne Seeney, Qld
Felicity Sinclair, Qld
Malcolm Wayne Stone, Qld
Joanna Rae Sutherland, NSW
Thomas Swee Hock Tan, Vic
Andrew Ferdinand Van Leeuwen, Vic
Robert John Wall, NZ
Wan Yih Lin, NSW
Mark Eric Whitby, WA
Dennis John Alfred Wooller, Qld
John Manning Wynter, NSW
Karl Kang Young, HK
The Advantages of Specialist Rural Practice

Since moving to the country three years ago, I have often wondered why it is so difficult for regional areas to attract more specialist anaesthetists away from capital cities. Again I wonder, as we find ourselves in our town having to advertise overseas due to the lack of interest from Australian Anaesthetists to fill our vacancy. Meanwhile, I hear from my colleagues about the relative oversupply of anaesthetists in the capital cities.

I think there are two main problems. The first is the underestimation of the very real advantages both in lifestyle and work, and the second being the overemphasis of the disadvantages, many of which are easily overcome.

So, what are the advantages? In most towns one walks straight into a reasonable amount of work and income, without having to spend a prolonged period of time building up a practice. The work is usually very varied, and the on call certainly full of surprises!

The medical community welcomes the new arrival warmly, being so relieved to have finally found another specialist. The lifestyle advantages are probably why most of us are “out here”. Gone are the days of traffic jams and long hours commuting home and breathing polluted air. No more frustrations of having to travel around the city doing pre-meds after a busy day in theatre. Those dreams of running a small farm, or just living out of town are easily managed, without adding much to commuting time. Weekends away skiing, bushwalking or at the beach are no longer fraught by long hours of driving, if these pursuits are taken into consideration when choosing your regional area.

So what stops people rushing off to become rural practitioners?

There is the worry about “professional isolation”, which in fact is one area which is easily overcome by a bit of organisation. City hospitals are very amenable to helping rural anaesthetists get appointments in their departments, and this can enable the doctor to maintain skills in the subspecialty areas, and contact with colleagues. The difficulties attending the city midweek meetings can be made up by organiseing journal clubs and clinical meetings with other anaesthetists in the area, and it is usually possible for some of the specialists to attend the annual events organised by the College and the Society. I have always found our colleagues in the major city hospitals very willing to help with specific problems on the phone.

Often “social” problems are highlighted as a major block to considering moving to regional areas. Schools in many areas are in fact excellent, and should be investigated before being written off. Cultural isolation is a bit more difficult, as the facilities and events offered are somewhat restricted compared with the capital cities, and require top-ups at weekends, or late night trips to the capital midweek. The final argument against a rural existence is that the anaesthetist, or spouse, is “a city person”, and I have no answer for this.

The easiest way to investigate your suitability for a rural existence is to make a few phone calls, and do a locum (which is very easy to organise).

I can certainly recommend it as a very satisfying way of life and rewarding way to work.

Barbara A. Robertson
FFARACS, FANZCA.
Dear Mrs Sheales

I am writing to express my great disappointment at the minimal time and opportunity afforded to Fellows to become informed and to comment on the Memorandum and Articles of Association of the College of Anaesthetists.

I believe that the formation of a College is one of the most important developments ever in Australian anaesthesia. I am delighted it is being formed and I believe it is long overdue, 40 years overdue, however it is vital that the best possible College be established.

Open, informed, widespread and non-hurried analysis and debate of its structure is necessary. The AMA and the ASA both took years to review their constitutions. The Fellows were given less than three weeks to comment on the proposed College structure.

The only explanation given for such expediency was the legal advice for the Faculty to incorporate urgently so as to overcome financial problems. I would suggest that these financial concerns should have been resolved in some fashion independent of College formation, which is an issue far too important to be rushed.

Topics such as the precise role of the College, an appropriate democratic structure, the presence or absence of New Zealand, and the relationship of the College to the ASA are just a few of the many issues that required thorough debate.

I would like to propose that a College Constitution Review Committee be established so as to thoroughly address the College structure. It should formulate a number of different proposals after widely canvassing the opinions of Fellows. These proposals should be presented to the Fellows who would be then able to vote for those proposals which they consider most appropriate.

Thank you for the opportunity to comment on Dr Deacon’s letter.

I am concerned that Fellows may infer from paragraph four of Dr Deacon’s letter that the Faculty of Anaesthetists has a financial problem. As can be observed from the publication of the Accounts in the July 1991 Bulletin, the Faculty’s finances are in extremely good condition as previously explained to Fellows both in correspondence and at the Meetings I addressed. After many years of believing that the Faculty was in total control of its own funds, the Members of the Board and the Members of the RACS Council were greatly concerned to be advised that Faculty funds were part of the aggregate funds of the Royal Australasian College of Surgeons.

The legal advice given to the Board also stated that the only way to obtain total control of all Faculty funds and activities was to incorporate as a separate legal entity and that this should be done expeditiously.

The Memorandum and Articles of Association of the RACS enables the disbursement of Faculty funds to the Australian and New Zealand College of Anaesthetists and the situation has been handled in accordance with those powers. I believe the Board has acted in a very responsible way to the advice received.

In the section in this Bulletin entitled “Items of Interest from the Board of Faculty Meeting”, you will note that the Board established a Constitution Review Committee to consider proposals for future modification of the Articles of the new College.

Yours sincerely
P.D. Livingstone
President

Yours sincerely
Gregory J. Deacon, FFARACS
HELP Module 7
Blood Disorders

CECANZ received 69 answer sheets, of these 60 of the recipients had completed the intensive care section. The average score for the anaesthetic section was 72% with the 10th and 90th percentiles being 59 and 84 respectively.

Equivalent data for the intensive care section is 67% (42-92).

I would like to draw attention to an error in the module concerning Question 3 on the effects of near drowning.

"In near drowning in salt or fresh water massive haemolysis occurs".

This statement I believe is incorrect.

After consulting various texts the most acceptable version of events in near drowning was from A practical guide to pediatric intensive care (2nd Edition, Eds. Levin, Morris and Moore, Chap 27, pp180-183).

(a) Breath-holding and the swallowing of the immersion fluid occurs first.
(b) Gastric distension leads to regurgitation.
(c) Asphyxia leads to gasping and aspiration of fluid.
(d) Laryngospasm may occur at this point.
(e) Hypoxia leads to unconsciousness with loss of protective reflexes.
(f) Cardiorespiratory arrest.

In THEORY the difference between fresh water and salt water drowning is:

**Fresh water:** haemodilution, increased blood volume, haemolysis, and an increased K+ concentration.

**Salt water:** haemoconcentration, decreased blood volume, and pulmonary oedema.

In PRACTICE:

**Fresh water:** The change in Hb, Hct and electrolytes is not great; a transient increase in blood volume occurs but urine output is increased and hypokalaemia is the norm.

**Salt water:** A change in electrolytes is unusual, but the blood volume can fall significantly depending on the amount of swallowed and inhaled water.

Routine management should address the problems of hypoxia (possibly IPPV with PEEP, or CPAP), maintenance of perfusion and renal output by use of colloids and diuretics, and the control of intracranial pressure if clinically appropriate. Prophylactic antibiotics and steroids have not been proven beneficial.

One colleague (anaesthetist) with a personal experience of treating about 20 fresh water near-drownings could not remember haemolysis as a clinical problem and one of our local intensivists considers it a myth, in his experience he may have seen haemolysis once. It appears that the original research work in this area was performed on dogs and it would seem that it is not clinically relevant.

M.J. Harrison
Medical Director
CECANZ.
ADMISSION TO FELLOWSHIP UNDER ARTICLE 49 (a)

24th February, 1992

HONORARY FELLOWS
John Kevin Clarebrough, Vic
Gustav Julius Fraenkel, SA

FELLOWS
Chris Milward Adey, Vic
Abdul Aleem, SA
Michael David Allam, ACT
Thomas Howard Allen, SA
Maurice Amir, Vic
Genevieve Anderson, SA
John James Andrew Anderson, WA
Christopher Matthew Anstey, Qld
John Basil Archdeacon, Qld
Anthony John Archer, SA
Philip John Armstrong, Vic
Peter Mitchell Ashton, Vic
Elizabeth Margaret Ashwood, NSW
Ilze AugustsKalns, SA
Paul Gabriel Azzopardi, SA
Andrew Kenneth Bacon, Vic
Ronald Winston Bailey, NSW
David Bruce Baines, NSW
Tony Anatole Bajurnow, Vic
Jane Elizabeth Baker, NSW
Vivian George Balmer, NSW
Ian Gregory Balson, Vic
Keith William Barker, WA
David Kevin Barrie, SA
Benedict John Barry, NSW
John Hugh Bartram, Vic
Elizabeth Jane Bashford, Qld
David Arthur Beale, Vic
Robert Ellis Beavis, Vic
Christopher John Beem, Qld
Geoffrey Howard Beemer, Vic
Heather Marie Belcher, Vic
Graham Thomas Bell, Qld
Anthony John Benny, SA
Helen Lesley Bidstrup, ACT
Walter Wyndham Biggs, Qld
Roderick John Binsted, NSW
Gilliam Frances Bishop, NSW
John Aspinall Blaxland, Tas
Kathleen May Bock, NSW
Andrew Boman, NSW
Alan Gerrard Bond, Qld
Michael John Bookallil, NSW
Jacob Boon, Vic
Miroslaw Borodzicz, Qld
David Ralph Bowie, NZ
Michael Hebert Boykett, Vic
Rhonda Katherine Boyle, Qld
Grant Richard Brace, Vic
Simon Thomas Bradfield, Vic
Alan David Bradshaw, Vic
Christopher Patrick Bradshaw, Qld
Emile Brands, Qld
John Nigel Francis Breakery, WA
Francis Xavier Breheney, WA
Helen Jilanne Bridgman, NSW
Juris Herbert Briedis, Vic
David Alfred Brooks, NSW
Evan Christopher Brown, SA
Thomas Christopher Kenneth Brown, Vic
Peter Brownridge, SA
Alison Elizabeth Bruce, Qld
Graham John Bruce, NSW
Peter Kaye Bryan, Vic
Lindsay John Bryant, NSW
Terence Buckman, NSW
Jonathon Neil Buckmaster, WA
Robertson Wesley Burgess, NSW
Desmond Kevin Burke, Vic
Anthony John Burn, Vic
Sheena Lesley Burnell, NSW
Anthony Richard Burrell, NSW
Bruce James Burrow, Qld
David John McGregor Butcher, NSW
Brendan Richard Butler, Vic
Kevin John Byers, NSW
Philip Leonard Byth, NSW
Lynnette Cade, Vic
Victor Ian Callanan, Qld
Alan Graham Cameron, Vic
Peter Donald Cameron, WA
Reginald John Cammack, NSW
David Carne, Tas
Michael William Carr, NSW
Gregory Roy Carruthers, NSW
Noel Morris Cass, Vic
Daryl Richard Catt, NT
Terence Vern Cerche, Vic
Chi Keung Chan, H K
Maria Siu So Chan, Vic
Michael Ching Yin Chan, NSW
Wai Kam Chan, H K
Marianne J. Chapman, SA
Ui Jin Cheah, NSW
Charles Chong Wah Chen, NSW
Anne Christine Chenoweth, Vic
Stephen Charles Chester, Vic
Kai Shuen Cheung, H K
Vijay Chibber, NZ
Lai Keung Alice Chow, Vic
Sui-Ping Alice Chow, H K
Paul Joseph Christie, ACT
Maria Veronica Cinicotta, Vic
Iain Scott Clark, NSW
Ralph Reginald Clark, Vic
Rodney James Clark, NSW
Frederick Brian Norton Clarke, NSW
Michael Richard John Claxton, Tas
Michael John Cleary, Qld
Bruce Stewart Clifton, NSW
Anne Patricia Coady, NSW
Lee Ann Coaldrake, Qld
Theresa Marie Cockbill, Vic
Geoffrey Douglas Cole, NSW
Jim Coleman, Qld
Russell Evan Heath Comber, NZ
Richard Hugh Shepherd Connon, Vic
Daniel Francis Joseph Connor, Qld
Jerome Howard Benedict Coombs, NSW
Leigh John Coombs, WA
David James Cooper, Vic
Diana Theresa Cooper, NSW
Michael Gerard Cooper, NSW
John Copland, Vic
David Albert Corbett, Vic
Nicholas John Coroneos, NSW
Timothy Gerard Costello, Vic
Henri Rene Paul Coutanceau, Vic
James Ian Cowling, NSW
Margaret Helen Cowling, SA
Patricia Coyle, Ethiopia
Teresa Rita Crandim, Qld
David Pilkington Crankshaw, Vic
Peter Joseph Cranswick, Vic
Brian Keith Crawshaw, NSW
Nickel Crombie, NSW
Keith David Cronin, Vic
David Keith Crooke, NSW
John Anthony Crowhurst, SA
David Wilray John Cullingford, WA
Philip Howard Vaughan Cumpton, ACT
Anne Marie Cunningham, Qld
David Neil Cunningham, SA
Trevor Talbot Currie, Vic
Geoffrey Ronald Cutfield, NSW
Prudence Mary Dale, Vic
Geoffrey James Dalgarno, NSW
Brian William Daniels, SA
Linda Margaret Dann, WA
George Madgwick Davidson, NSW
David Edwards Davies, WA
Alan Charles Davis, NSW
Angela Rose Dawson, Vic
Kevin Frances Dawson, Vic
Peter John Dawson, Vic
Robert John Dawson, Vic
Ian Jeffrey De Jersey, NSW
Arabel Alice Dickson, NZ
James Jeffrey Dickson, NSW
Nerida Margaret Dilworth, WA
Desmond Patrick Dineen, SA
John Norman Ditton, NSW
Thomas Cecil Dixon, SA
Christopher Peter Dodds, NSW
Anna Irena Doktor, Vic
Charles Marcel Domaine, Vic
Francois Georges Domaine, Vic
Graeme Alexander Donaldson, Qld
Garry Bryan Donnan, Vic
Michael Patrick Doolan, Qld
Ian David Douglas, NSW
James Michael Dowling, NSW
Geoffrey Michael Dowling, Vic
Leone Agnes Doyle, Qld
Aldo Victor Dreosti, SA
Sally Elizabeth Drew, SA
Michael Paul D’Souza, WA
Herbert John Dudley, Qld
Peter Julian Duff, Qld
Ian Bruce Dugan, NSW
Graeme John Duke, Vic
Bernard Leslie Dunn, Vic
Stephen Arthur Edlin, WA
Ian Fleming Edmiston, NSW
Barry David Egan, SA
Dexter Joseph De Silva
Ekanayake, NSW
Sivachautchadevi Ekanayake, NSW
Anne Christine Elliott, NZ
Sankararaa Epari, Tas
Frederick Grant Eruini-Bennett, NSW
Ian Edward Hepburn Evans, NSW
Ian Alexander Everett, SA
David George Fenwick, SA
John Fenwick, WA
Jonathan Kenneth Fernandes, Vic
Lawrence John Ferrari, Qld
Robin John Field, SA
William Trethewon Fifoot, Qld
Graham Chudleigh Fisk, NSW
Gerald James Livingstone
Flynn, ACT
Alistair Millar Forbes, WA
Peter John Forgan, SA
Wesley Howe Fowler, NSW
Winifred Lambert Fowles, Qld
Paul Howard Francis, Vic
Peter Mark Franklin, SA
Simon James Cowan Fraser, Tas
Peter Gibb Freeman, Vic
Shirley Roy Gaifnis, WA
Vera Gallagher, NSW
Leslie Henry Galler, NZ
Robert Lawrence Alan Galley, Qld
Kerry Michael Garske, Qld
Stephen Paul Gatt, NSW
Peter Alexander Scott Germann, SA
Mark Kenneth Gibbs, Qld
Peter Robert Jerome Gibson, NSW
Harbans Singh Gill, SA
Ching Woo Goh, NT
Eric Oswald Goonetilleke, Vic
Patricia Hester Goonetilleke, Vic
Geoffrey Stewart Gordon, Qld
Roger Henry Wingate Graham, NSW
Iving Green, Vic
Rodney Michael Green, NSW
Lais Valerie Grewar, WA
William Alexander Grey, Vic
Margaret Elizabeth Griggs, Vic
William Middleton Griggs, SA
David William Gronow, NSW
Ananda Sarath Gunatunga, Vic
Bruce Warren Gunner, NSW
Penelope Joan Hall, Vic
Patricia Bernadette Halliwell, Vic
Hamid Bin Hamzah, WA
Russell Kay Hancock, NSW
John Reid Hankey, WA
Peter Wallace Harbison, NT
Robert McKay Hare, Vic
John Frederick Harriott, WA
Alexander George McDonald
Harris, NSW
Leila Harris, Vic
Christopher Gaisford Harrison, NZ
Gordon Alfred Harrison, NSW
John Edward Harrison, Vic
John Grant Harrison, Vic
John William Gildas Hughes, SA
Victor Mooglun Leung
Harrison, NSW
Robert Mercer Hart, NSW
Philip David Hatch, NSW
Anthea Helen Hatfield, Vic
Geoffrey James Haughton, Vic
Anna Karolina Havlin, Vic
Paul John Heenan, Vic
Roger Kent Henderson, Vic
Ian Bruce Hendy, NSW
Ai-Lee Heng, NSW
Lorraine Clare Hibbard, NSW
Keith Graham Hickling, NZ
John Arthur Hickman, WA
Brian Hill, NSW
Kenneth Mark Hillman, NSW
Ruth Margaret Hippisley, NSW
Richard John Hiscock, Vic
Alick Frederick Truscott
Hobbes, NSW
Michael Hodges, NZ
Edward Terence Hodgson, SA
Robert Alan Hodgson, NSW
William Ralph Hodgson, NSW
Francis Peter Hofmann, Vic
Ross Beresford Holland, NSW
Andrew William Holt, SA
Paul Holz, NSW
John William Hood, NSW
Brian Francis Horan, NSW
Phillipa Jane Hore, Vic
Michael Noel Hosking, NZ
Wayne Lawrence Houghton, NSW
Gordon Houseman, Vic
Gregory Alan Hughes, Vic
Patrick James Hughes, Vic
Stafford Michael Hughes, NSW
Timothy Louis Hunt, SA
Basil Rockliff Hutchinson, NZ
Mary Clarenza Irvine, Vic
Gary Max Jackson, Vic
Theresa Clair Jacques, NSW
Owen Francis James, NSW
Peter Allan James, NSW
David Andrew Jarvis, SA
George Michael Jerogin, ACT
Colin James Jessup, NSW
Christopher Mark Johnson, WA
Robert Douglas Morrison
Jones, II K
Christopher David Jones, Qld
Winston Khi-Min Jong, S’pore
Brian Thomas Jordan, Vic
Christopher Dalton Joseph, Vic
Peter Andrew Jowitt, Vic
Po Lin (Pauline) Kam, NSW
Siri Rama Karthigesu, NZ
Nicholas Kevin Keely, WA
Bernadette Maureen Kelly, Vic
Bernard John Kelly, NSW
Lawrence John Ferrari, Qld
Robin John Field, SA
William Trethewon Fifoot, Qld
Graham Chudleigh Fisk, NSW
Gerald James Livingstone
Flynn, ACT
Alistair Millar Forbes, WA
Michael Kister, Vic
Neil Gordon Kiloh, NSW
Elaine Lillian Klouwer, Qld
Robert John Knight, Vic
Gregory Ernest Knoblanche, NSW
Marjorie Helen Kolawole, ACT
David Komesaroff, Vic
Martin Kiang Tin Koo, SA
Wilga Frances Kottek, Vic
Christine Elaine Kozaera, Qld
John Francis Kraegen, NSW
Bernard Tai Shin Kwan, ACT
Thomas Francis Lambert, Vic
Archibald Stewart McCallum
Lamont, Tas
Kay Yvonne Lane, Qld
Mark Langley, Vic
Peter Lardy, Vic
John Campbell Lawrence, NSW
Walter Samuel Lederman, Vic
Richard Priestly Lee, NSW
Tsun Woon Lee, H K
Shaun Philip Leighton, NSW
Graham John Letham, NSW
Zoltan Lett, H K
Michael Wayne Douglas
Levitt, NSW
Kenneth Joseph Lewis, Qld
Henry Liberman, NSW
Yong Teck Lim, NZ
David Alexander Lindsay, Vic
Sydney James Lines, Qld
Christopher David Ling, NSW
Bruce Gregory Lister, Qld
Terence Francis Little, Vic
Roslyn Lloyd-Williams, NSW
Joh-Wah Ronald Lo, H K
Donald Alan Logan, Qld
Michael Keith Logan, NSW
Joseph George Lomaz, NSW
Geoffrey Joseph Long, NSW
Edmund Dominic Loong, NSW
Heather Jacqueline Lopert, ACT
Terence Edward Loughman, Vic
Christopher John Lourey, Vic
Peter Anderson Lowe, Vic
James Arthur Lowson, Vic
Barbara Kenna Luey, NSW
Vera Lukursky, Qld
David Derek Lum, NSW
John Neville Lunn, UK
Maxwell Thomas Lyon, NSW
Kean Boon Mac, Vic
Patricia Mackay, Vic
Allan Douglas Forbes
Mackillop, NSW
Mark Lionel Maclean, Vic
Alan Joseph Mahoney, Qld
Barbara Joan Main, Vic
John Francis Mainland, Vic
Jennifer Gay Major, ACT
Peter Simmons Malcolm, NSW
Stephen John Mambczuk, NSW
Robert Ross Manning, NZ
Barrie Noel Margetts, Vic
Joseph Alfred Marich, Vic
John Maxwell Howard Marshman, SA
John Richard Marum, Vic
Neil Thomas Matthews, SA
Sudhakar Vishnu Mayadeo, NZ
Eliza Joan Maycock, WA
Peter Graham Bruce Mayne, NSW
Lindsay John McBride, NSW
John Bernard McCarthy, Qld
John Ronald McCarty, NSW
David James McCleave, SA
Alison Elizabeth McCready, Vic
Stephen Peter McCreedy, Qld
David Ian McCuaig, Vic
Helen Mary McDonald, NSW
Ian Hamilton McDonald, Vic
Ian Raban McDonald, Qld
Patricia Rae McDonald, NZ
Anthony John McDonough, NSW
George Richard John McEwin, SA
Stephen Ralph McKay, NSW
Donald Bruce McKenzie, WA
Robert Malcolm McLean, NSW
Peter Denis McLoughlin, WA
Ian Ross McPhee, NSW
Kevin Lorne Merrett, Vic
David Norman Meyers, Qld
Andrew Michael, SA
Andrew John Middleton, Vic
Lloyd James Miller, NSW
Michael Townsend Miller, NZ
Warren Henry Russell Millist, NSW
Wilfrid Christie Mills, NZ
Alistair Joseph Moffitt, WA
Ruth Molphy, Qld
Alexandra Deborah Moore, Vic
John Leigh Moran, SA
Patrick John Moran, SA
David Gordon More, NSW
Craig Arthur Morgan, Vic
Evan Brian Morgan, Vic
Rhys Raymond Morgan, Qld
Thomas John Morgan, Qld
Helen Rose Morley, SA
Peter John Glasgow Morris, Qld
Richard Walter Morris, NSW
Anthony John Mullens, NSW
Blair John Munford, NSW
Graham Harold Murray, NSW
John Robert Murray, Qld
Graeme Campbell Murrell, Vic
Stephen William Myers, NSW
Paul Stewart Myles, Vic
Sankarakurup Gopinathan Nair, NZ
Craig Nancarrow, SA
Graeme Noel Newcombe, SA
Peter Emery Newland, SA
Herbert Claus Newman, Vic
Ann Elizabeth Newton, Qld
Pauline Margaret Nicholson, SA
Colin Eric Boyd Norgate, NSW
Hubert Desmond O'Brien, NSW
Anthony John O'Connell, NSW
Miceal Seamuse O'Fathartaigh, SA
Teik Ewe Oh, H K
Andrea Margaret O'Regan, H K
John Francis Oswald, Vic
Harry Owen, SA
Alfred Owies, Vic
Harry Frank Oxer, WA
Peter William Padbury, Vic
Michael James Paech, WA
David John Page, NSW
David John Pallot, Vic
John Philip Pardy, NSW
Graham Reginald Parker, NSW
Hannah Margaret Parker, Vic
Sally Jane Parnis, SA
Jennifer Margaret Parslow, Qld
Ranald Lochiel Stewart Patsoe, Qld
Margaret Matilda Patterson, Tas
William John Pattison, SA
John David Paull, Vic
David Max Pemberton, NZ
Peter William Peres, Tas
Milorad Petrovic, Qld
Brian Pezzutti, NSW
Albert Pfeifer, NSW
Ian Ronald Philipott, NSW
Silvia Plesmann, Vic
Brian James Pollard, NSW
John Leslie Poole, NSW
Renald John Portelli, Vic
Michael John Power, Qld
Sheila Mary Power, NSW
Cedric Prys-Roberts, UK
Peter David Pullen, NSW
Mark Kenneth Radnor, Vic
Ronald Dunbar Rae, Tas
Alan Rainbird, SA
Paul Malcolm Rainsford, Vic

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Andrew David Russell, Qld
Jeffrey Kenneth Rowlands, Vic
Walter John Russell, SA
William Ben Runciman, SA
Charles Sara, NSW
Geoffrey Robert Schroder, Vic
Grahame Ross Savage, Qld
Glenda Elizabeth Rudkin, SA
David Ryan, NSW
Malcolm Robert Scarr, Qld
Douglas Leonard Rigg, NSW
John Malcolm Riseborough, Vic
Francis William Roberts, Tas
Andrew Peter Robertson, Vic
Barbara Ann Robertson, Vic
Ray Dudley Robinson, Qld
Martin Douglas Robson, WA
Heinz Honna Rodins, Qld
Peter Roessler, Vic
Ronald Alexander Andrew Rollison, Qld
Andrew William Ross, Vic
Joseph David Ross, NSW
Jeffrey Kenneth Rowlands, Vic
Elliot Rubinstein, Vic
Glenda Elizabeth Rudkin, SA
William Ben Runciman, SA
Andrew David Russell, Qld
Walter John Russell, SA
Leonard Vincent Russo, Vic
David Ryan, NSW
Martin Stephen Sandler, Qld
Charles Sara, NSW
Grahame Ross Savage, Qld
Stephen John Scammell, SA
Malcolm Robert Scarr, Qld
Alfred Gerald Schebesta, NSW
Geoffrey Robert Schroder, Vic
David Edward Blackshaw Schuster, NSW
Robert Morris Schweitzer, Vic
Stanley Alexander Schweitzer, Vic
Graham Harvey Searle, NSW
Patrick Joseph See, Qld
Derrick Graham Selby, SA
Murray Selig, SA
John Anthony Sendall, NZ
Lea Thin Seow, SA
Michael John Seyfort, Vic
Susan Shadforth, Qld
Bryan Edmund Sharkey, NSW
Bruce Donald Sharpe, NSW
Yahya Mah’d Saleh Shehabi, NSW
Martin Henry Sher, Qld
Norman Robert Sherwood, Qld
John Serope Shrapnel, Qld
Brendan Sydney Silbert, Vic
Edward Grant Simmons, SA
Ian James Simpson, NSW
Felicity Sinclair, Qld
Peter William Skippen, Qld
Stuart Charles Skyrme-Jones, Vic
Paul Quirinus Smelee, NZ
Brian Alan Smith, WA
Lloyd Lawton Smith, Vic
Malcolm Richardson Smith, NSW
Ross Francis Smith, NSW
Derek Frank Snelling, NZ
Neil Soni, UK
Betty Brenda Spinks, Vic
Denise Berthe Germaine Sporr, NSW
Alexander Waddell Squire, NZ
John Hamilton Stace, SA
John Richard Stamell, NSW
David Alexander Stanton, Qld
Ian David Stephens, Qld
Neil Thomas Stokes, NSW
Keith Arthur Streatfeild, Ethiopia
Neil Eastwood Street, NSW
Mark John Sullivan, Vic
Sinnathamy Sundaraj, NSW
Anthony David Sutherland, Vic
Donald Ballantyne Sweeney, SA
Robert James Sweeney, SA
David John Swift, WA
Geoffrey Harold Symonds, NSW
Nigel Lawrence Penn Symons, NSW
Douglas Geoffrey Tabrett, NSW
Ronald Justin Henry Tapson, Tas
Kersi Jalejer Taraporewalla, Qld
John Edward Taske, Qld
Murray Grant Taverner, Vic
George Tay, S’pore
Jeffrey Ernest Taylor, NSW
John Henry Taylor, Tas
William Henry Taylor, Vic
David Harold Temperley, NSW
David Ah Chew Teo, NSW
Raymond Cheng Soon Teo, S’pore
Heng Khung Tey, NSW
Kenneth See Hoong Thean, WA
Robert Ernest Thiel, Qld
Jeanette Rae Thirlwell, NSW
Peter Dean Thomas, SA
Peter Gerald Thomson, NSW
Robert Gregory Thorne, Vic
Elizabeth Anne Thorp, Vic
Michael George Tingay, SA
Diana Nowlan Tolhurst, Vic
David Peter Tomkins, SA
Peep Nurmi Toom, Vic
Roger Edward Trall, NSW
Gregory James Trevaskis, SA
Michael Du Coudray Troson, Vic
Ching Woo Lillian Tsou, S’pore
Siu Lun Tsui, H K
Michael Melvyn Tuch, Qld
John Marcus Tully, Qld
Grant Andrew Turner, WA
Malcolm Ernest Turner, NZ
Robert Terence Turner, Vic
Marcus Leslie Unwin, Qld
Johan Hendrik Van Der Walt, SA
Cornelius Van Der Weyden, NSW
Robyn Anne Vaughan, NSW
Helen Margaret Vokack-Brodsky, Vic
John Bennett Vonwiller, NSW
Rita Magdalene Voselis, Vic
Thomas James Vivian Voss, NSW
Ian Archibald Waldie, Vic
Andrew Garry Walpole, Vic
Jonathon Hugh Warren, NZ
Christopher John Watson, WA
Alastair William James Watt, NSW
Rupert Anthony Weaver, Vic
Anthony Maxwell Weeks, Vic
Frederick Herman Wegener, NSW
Gerald Brian Westmore, Vic
Stephen Osborn Weston, NSW
David Keith Milroy Whish, NSW
Robert Frederick Whiting, Qld
Frank Hugh Whittin, Vic
Margaret Carolyn Ridgway Wiese, SA
David Yong Williams, Vic
Jennifer Williams, Vic
John Egerton Williams, SA
Judith Anne Williams, NSW
Kenneth Allen Williams, WA
Kenneth James Williams, Qld
Rhonda Williams, NSW
John Aubrey Henry Williamson, SA
William Williamson, NSW
Michael Christian Willow Willis, Qld
Richard John Willis, SA
Charles Michael Wilson, Vic
Roland John Wilson, NZ
Janice Helen Windsor, NSW
Daniel Kinwei Wong, NSW
Robert Manching Wong, WA
Julia Claire Wood, Vic
Stephen Leigh Wood, NSW
Ian James Woodforth, NSW
Arthur Frederick Woods, Vic
David Frank Woolner, NZ
Robert Harold Woog, NSW
Graeme Stanford Worsley, NSW
Stephen Roger Noel Wride, Vic
Jan Wrobel, SA
David John Wylie, Qld
Edward Joseph Yarad, NSW
2nd March, 1992

HONORARY FELLOWS
Mary Taylor Burnell, SA
Thomas Cecil Gray, UK
Anthony Jephcott, NZ
Michael Douglas Allen Vickers, UK

FELLOWS
Weragoda Arachchige Abeypala, H K
Anthony Peter Adams, UK
Raymond Stephen Ahearn, UK
Alexander Ross Alcock, NSW
Jean Marie Allison, H K
Hugh James Anderson, Vic
Thomas Young Anderson, Tas
David Drummond Archibald, NZ
Alain Aronowicz, Vic
Stephen Dhevaseyan Aseervatham, NSW
Alexander Joseph Babarczy, Vic
Roderick Graham Bain, NSW
Paul Andrew Baker, NZ
Christine Mary Ball, Vic
Geoffrey Arthur Barker, Canada
Paul Thomas Barnard, NSW
Alan Marshall Barr, UK
Stephen McGregor Barratt, NSW
Chairmaine Grace Barrett, Qld
Andrew Clive Bashford, SA
Ranu Basu, NSW
Peter Grattan Beahan, WA
Jennifer Mary Beasley, UK
Michael George Beaudoin, NSW
Jennifer Beckett-Wood, NSW
Michael Francis Beem, Qld
David Shan-Nih Beilby, Vic
Forbes Eadie Bennett, NZ
Norris Barry Bennett, NSW
Gwynne James Bentley, Qld
Sydney Mervyn Berger, UK
Thomas John Berrigan, WA
Andrew David Bersten, SA
Debralie Alison Mary Bettenay, Vic
Ashleigh Alick Bishop, Qld
Duncan Walter Blake, Vic
Alan John Board, Qld
Robert Albert Boas, NZ
Brent Patrick Boon, NZ
Dennis Boon Von Ochssee, NZ

Gary Bennett Branch, NSW
Judith Mary Branch, NSW
Henry Michael Bray, Vic
Penelope Anne Briscoe, SA
Maurice John Brookes, NSW
Malcolm John Brown, Vic
John Martin Rutherford Bruner, USA
Thomas Anthony Buckley, H K
Alan Geoffrey Burton, Vic
James Walter Butler, Qld
Christopher Gordon Cain, NSW
Andrew Frank Cameron, NZ
Robert James Cameron, NZ
Duncan Islay Campbell, NSW
Matthew Marshall Campbell, NZ
Stephen Abraham Carvin, SA
Terrance Peter Cassidy, NSW
David Laidley Cay, NSW
Joseph Zbigniew Ceglarski, Qld
David Michael Chamley, NZ
Chiu-Suck Chan, H K
Raymond Arthur Chapman, Vic
Roy Chester, SA
Joanna Cheung, NSW
Wing-Lun Blase Cheung, H K
Alfred Wing Yan Chua, NSW
Kin Kwok Albert Chung, H K
Geoffrey Malcolm Clarke, WA
Hugh James Clarkson, NZ
James Ivor Clayton, NZ
Henry Sweetman Cohen, WA
Ian Clifford Colbert, Qld
Kathleen Isabel Cole, WA
Clive Bourne Collier, NSW
Veryan Jean Collyer, Qld
Robert William Cowie, Vic
John Boyd Craig, WA
Matthew Ronald Crawford, NSW
Stephen Arthur Crocker, WA
Marilyn Currie, NSW
Helen Elizabeth Currow, NSW
Graham Lindsay Dale, WA
Gregory Bernard Dargan, NSW
Murray Llewellyn David, Qld
Francis Michael Davis, NZ

Richard Woodley Davis, SA
Gregory John Deacon, NSW
Peter Richard Degotardi, NSW
Kerry Ronald Delaney, ACT
William Lawrence Dennis, Vic.
Ralph Mervyn Harry de Plater, Qld
Geoffrey Campbell Elmslie Dixon, Vic

John Frederic Donnelly, NSW
Arthur Lachlan Doughty, Tas
Alan William Duncan, WA
Iain Norman Duncan, Vic
Mary Elizabeth Dwyer, Vic
Haydn Dyer, WA
Henry Paul Dyer, Qld
Paul Michael Dyer, Qld
Ross Henderson Dysart, NZ
David Lyndsay Earle, NSW
Garry Robert Eastaugh, Vic
Robert Alison Edmeades, Qld
Robert James Edwards, Qld
Robert Eichel, NSW
Elie Robert Emmanuel, UK
Christopher John Evans, NZ
John Stuart Martin Evans, NZ
Thomas Ian Evans, Vic
Suzanne Gai Everingham, Qld
Patrick Thomas Farrell, NSW
Rosemary Agatha Faull, NZ
Eoin David Feisenfeld, NZ
Hillary Kathleen Jocelyn Fisher, Qld
Malcolm McDougall Fisher, NSW
Carolyn Anne Fitzgerald, NSW
Julia Ann Fleming, Vic
Bruce Spafford Owen Fox, Vic
Thomas Aird Fraser, NSW
Cressy William Free, NZ
Helen Margaret Frith, NZ
Meredith Joan Gabriel, SA
Lawrence Tasman Gadd, NSW
Arumugai Ganendran, Qld
Peter Gartrell, SA
Phillip Barry Gaukroger, SA
Rowan David Gebert, Vic
Geoffrey James Gee, WA
Neville Mark Gibbs, WA
Sydney Dennis Giddy, Vic
David Arthur Gilbert, NSW
Edgar Robert Nisbitt Gillies, Vic
AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS

Beverley Joan Peers, Vic
Aaron Ronny Pelosi, SA
Geoffrey Lewis Perkins, Qld
Simon Bruce Perrin, Vic
James Latham Peters, Vic
Stevenson Philip Petito, SA
Joseph Edmund Petoe, NZ
Dermot Michael O’Malley
Phelan, Ireland
David Robert Pickford, NSW
Frank David Plight, NZ
Graham Miles Heazlewood
Piper, NSW
Peter Rostron Platt, WA
Newton Potter, NSW
William James Power, Qld
Ian Noel Pryde, NSW
Colin Hutson Pryor, SA
Gregory John Purcell, NSW
Anthony David Purser, SA
Peter John Quach, ACT
Philip Gregory Ragg, Vic
Robert John May, Vic
Michael Andrew Raynes, NZ
Merilyn Anne Rees, Vic
Vivian Ealden Rees, SA
William Sheldon Rehfish, Vic
Simon Duncan Reilly, Vic
William Michael Reilly, NSW
Reinhart Rippert, Vic
John Gordon Roberts, SA
Michael Thomas Scott Roberts, NZ
Jill Margaret Robertson, Vic
Mark Langdon Robertson, NZ
Stewart Maitland Robinson, NZ
Isobel Anne Ross, NZ
Bruce Allan Rudge, NZ
Albert Saady, NSW
Radha Krishna Sabapathy, Malaysia
David John Sage, NZ
David Andrew Sainsbury, SA
Iain MacAulay Salkfield, Qld
Stephen David Same, WA
Gordon John Hart Sanders, NSW
William Peter Saul, NSW
Peter Julian Sayers, Tas
Nigel William Schodel, Qld
Robert Steve Schumacher, NSW
George Steven Sellton, Vic
Donald Geoffrey Serle, Vic
Virginia Setright, NSW
Alan John Sexton, NSW
Thomas Francis Shakespeare, NSW
Graham James Sharpe, NZ
Robert James Shield, Qld
Timothy Gordon Short, H K
Robert James Sinnett, Vic
Navaratnam S/O Arumugam
Sivaneshwaran, NSW
Maxwell Thomas Sloss, WA
Gregory Alan Smith, Qld
Ian Stuart Smith, Vic
Philip Graham Smith, WA
Hing-Yu So, H K
Janene Louise Solomos, Qld
Christopher John Sparks, Sol Isl
Hugh Timothy Spencer, NZ
John Vincent Stapleton, SA
Alan Warren Stern, NSW
Allan Geoffrey Stevenson, Vic
Erika Stielow, UK
Malcolm Wayne Stone, Qld
Graeme Roland Storey, NSW
Hong Zee Su, Singapore
Richard Lake Clayden Sutcliffe, Vic
Jasper Matthew Charles
Swann, NSW
Christine Rebecca Sweeney, Vic
Susanne Mary Szekely, UK
Wai Ling Tam, H K
It Tan, Malaysia
Lewis John Targett, Vic
Cheong Seong Tay, NSW
Rodney Vincent Taylor, Vic
Sandra Margaret Taylor, NSW
Helen Jeanette Telford, NSW
Choe Yelow Aloysius Teo, Singapore
Seong Hee Tham, H K
John Patrick Sandeman
Thomson, Qld
Richard James Graham Thomson, NZ
Thomas Thomson, Tas
James Tibballs, Vic
Brett Anthony Todhunter, NSW
Tham Chye Toh, Qld
John Howard Tomlinson, UK
Phillip Simon Tong, NSW
Wai-Nung Tong, H K
Simon Charles Bruce Towler, WA
Brian Richard Trainer, WA
David Ross Tremewen, Vic
Beatrix Christina Treuren, NZ
Shing Lam Tse, H K
William Brightwell Tucker, Qld
Seamus Anthony Tupply, NSW
Michael Arthur Turner, UK
David Byam Ulyatt, NZ
Shantha Kumaran Vallipuram, Vic
Andrew Ferdinand Van Leeuwen, Vic
Paramapalam Vikneswari, K L
Veronica Yuk-Chun Wai, H K
John Geoffrey Walker, NZ
Alan Macdonald Wallace, Vic
William Thomas Raeburn Ward, NZ
Kerry Narelle Warner, NSW
Robin Farquhar Waspe, Qld
Ronald Greaves Waterhouse, SA
John Hedley Waters, Vic
Margaret Ann Watson, Vic
Robert Kendall Webb, SA
John William Nicholas Weekes, WA
Moira Denise Westmore, WA
Mark Eric Whitty, WA
Anthony Roy White, Vic
Robert Faulkner White, Qld
Michael Bernard Whitehead, Vic
Nalin Rohitha Wijeyesekera, NZ
Gwenifer Catherine May
Wilson, NSW
Leona Fay Wilson, NZ
Peter Robert Wilson, USA
Ronald David Windeyer, WA
Alex Wai-Lik Wong, H K
Boon Hin Wong, Malaysia
Sally Choon Mee Wong, Singapore
Tet Nyuke Anne Wong, Malaysia
David Griffin Woods, SA
Lindsay Ian Grant Worthley, SA
Robert Arthur Nunneley Wright, Qld
Ching Ying Amy Wu, H K
David Wu, NSW
William Geoffrey Wurth, NSW
Karl Kang Young, Qld
Richard Michael Zacks, Tas
John Lokman Zubevich, Vic

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INAUGURAL COUNCIL

Back Row: (Left to Right) Mrs Joan Sheales (Registrar), Drs S.T. Bath, R.G. Walsh, Professor A.B. Baker, Dr D.H. McConnel, Professor J.M. Gibbs, Dr I. Rechtman.

Front Row: Associate Professor G.D. Phillips, Dr M.J. Davis, Associate Professor P.D. Livingstone (President), Dr M.J. Hodgson (Vice President), Associate Professor N.J. Davis.

Absent: Mr R.L. Atkinson and Mr J. McK Watts.

Ms Kyjie Maddern (Product Planner), ICI Hospital Products Pty Ltd, presenting Mr R.K.W. (Bob) Bennett, Chairman of the Victorian Chairs of Anaesthesia Appeal with a donation of $30,000.
FOR THE RECORD

SOMETHING ABOUT THE 1928
‘GSM’ IN CANBERRA

The 1992 Canberra GSM will be the first annual meeting of ANZCA as a College. There is thus some parallel with 1928 — when the then “College of Surgeons of Australasia” chose Canberra as the venue for its inaugural Annual Meeting — the first ‘RACS GSM’.

About 90 Fellows met in the Albert Hall from Saturday 31 March to Tuesday 3 April. Most of them probably stayed in the Hotel Canberra next door — now splendidly restored as the Hyatt Hotel Canberra.

However, Sir George Syme, the first President, was right when he predicted that “for some time at least the Annual Meeting would not be repeated at Canberra” — observing that such meetings needed facilities found “only in largely populated cities”. (The population of Canberra at the time was about 1% of what it is today).

Syme saw the first meeting as a special case, however — where they had to “emphasize [the] ultra-federal character of the College”. Canberra was seen as symbolic of this.

It was also important for this “ultra-federal” image that they had a good attendance from throughout Australasia. The Secretary virtually directed Fellows “to allow nothing to stand in the way of their attendance”, and secured at least a 35% compliance from the 260 Fellows. About 25 to 30 came from each of Sydney and Melbourne, and there were another 25 from the rest of Australia, plus about 10 from New Zealand.

Both of the originators of the idea of the College — Barnett and Devine — were there — along with about 16 of the other Founders. There were eight future Presidents — plus the incumbent. Two of the three female Fellows were there — Lillian Violet Cooper and Constance Elizabeth D’Arcy. At least nine members of the Surgical Association of Melbourne — shortly to be wound up in favour of the new College — were present.

The “ultra-federal” aspiration also inspired the proposal that the future headquarters building should be in Canberra. There was a fear of “jealousy... if the College were permanently centred in the capital of one State”.

Fellows at the meeting were able to inspect the proposed site (close to where the Academy of Science now stands), and to debate the proposal. The tale will be told — in a future article — of how the idea got its strongest advocacy, and its death-blow, during those four days. Suffice it to observe, here, that “ultra-federalism” was probably defeated by a recognition that a ‘city’ considered inadequate to host future GSMs was going to be even more unsatisfactory as the seat of College government.

Canberra was probably the right place, however, to organise some pomp and ceremony, and draw the existence of the College to attention. The Governor-General, Lord Stonehaven, told the Fellows they were “laying one more stone in that great national edifice... entitled ‘progress’”, and recommended the local fishing.
The Governor of Queensland, Sir John Goodwin, FRCS, FACS, attended to receive the first Honorary Fellowship, and also to accept Syme’s prior written invitation to “make a few remarks about the College” — prefacing them with a claim “that he had not the least expected to be called upon to speak...”!

W.F. Victor Bonney, FRCS, — “one of the great masters of gynaecological surgery” — was also present, and received the second Honorary Fellowship. He said this honour “set the crown of happiness on his journey to New Zealand and Australia”, and that he accepted it as a tribute not only to himself but to the RCSE, to British surgery, and to British ideals. He also mentioned that he “had had the honour of marrying a Tasmanian”, and had been told “that he had the makings of a good New Zealander”.

The scientific discussions at the meeting were devoted to “the plastic surgery of the human body”. There was a section of papers with discussion; a section of case reports; and a cholecystographic display. H.S. Newland talked about whole thickness skin grafts; S.H. Harris described a prostatectomy techniques, and was sceptically questioned by R. Gordon Craig; R.C. Begg described a urethectomy technique and was tactfully told of a better way by Hamilton Russell — but defended his as having its place and point; F.A. Maguire was commended by Victor Bonney for his paper on the repair of the pelvic floor in the female, illustrated by excellent sections, dissections and casts; A.N. McArthur gave a series of cinematograph demonstrations; N.D. Royale described an original method of tendon transplantation; A. Newton read a report on plastic operations on the pancreas; and there were many other presentations.

Issues debated at the business meeting included the following:
— whether Fellows should call themselves ‘Mr’ or ‘Dr’;
— the need to improve hospitals and hospital methods;
— means of providing medical services for the poor;
— provision of post-graduate surgical training.

The ‘Mr’/’Dr’ question was to be resolved later in the affirmative. The weight of opinion at this meeting, however, was against it. One speaker called it an “English localism”; another raised the problem of “lady Members”; a third argued that “if we all declare ourselves “MISTER” there will be a lot more “MISTERS” and they won’t be the College of Surgeons...”

Regarding hospitals, there was a call to have “one surgeon and one assistant surgeon for every twenty-five surgical beds” — at least in hospitals of 100 or more beds — and “a central hospital board... in each State and Dominion” in order “to prevent the multiplication of unnecessary hospitals and to correlate and co-ordinate the hospitals of various grades...”

Regarding medical services for the poor, the meeting agreed that “the community hospital system under which all classes of patients are received — non-paying, intermediate and paying — is the ideal to be aimed at and should replace the present unsatisfactory system of small private hospitals.”

Regarding the question of post-graduate surgical training, Sir George Syme mentioned BMA “antagonism” “directed against one of the essential principles of the College... ‘that the practice of surgery demands adequate and special training’”, and H.B. Devine called for a “return to the apprenticeship system”. Resolutions were carried calling for “a chair of surgery and a professor of surgery at each medical school”; hospital/university co-operation in providing surgical training; “endowments and scholarships”; “uniformity of senior surgical degrees”; and “facilities for medical research... in all teaching hospitals.”

For more information — see the Archivist’s booth at the 1992 GSM!

Colin Smith
ANZCA Archivist

Sources
College Archive, Series 7, Council Minutes, Vol 1.
College Archive, Series 25, items 11, 41, 42.
College Archive, SB29/1-5; SB92/...; SB103/14/4.
AN ANAESTHETIC ADDENDUM
SIR GEORGE SYME AND
INTRA-TRACHEAL INSUFFLATION

Dr Gwenifer Wilson — the Honorary Historian of ANZCA — has recently discovered that Sir George Syme — the first "PRACS", and the leader of that meeting in Canberra in 1928 — was responsible for an important innovation in anaesthesia in Australia.

The first mention of intra-tracheal insufflation is in a paper by J. H. Jopson in "Annals of Surgery" May 1911. Sir George Syme quoted from this when he explained the method at a clinical meeting of the Victorian Branch of the BMA on 16 August 1911 (using a demonstration apparatus rigged up in 15 minutes before the meeting!).

It seems that Syme had been travelling in America at the time of the first trials of the technique earlier that year, and had already used it twice during July 1911. He was, it seems, not only a technically outstanding surgeon, but had the ability to construct an apparatus seen only briefly — if at all.

Again, his immediate recognition of the value of the new technique for thoracic surgery, indicates not only his understanding of the problems connected with anaesthesia for surgery in this area, but that he was prepared, when confronted with something new — to "give it a go".

His trials could, however, have ended in disaster. He had argued strenuously at many meetings for chloroform anaesthesia — defending it against a school that wished to see it abolished. Thus, he having caused his anaesthetist to use chloroform instead of following the American practice of using ether. However, his mistake was almost immediately evident, and corrected in time. He was admirably frank about this — ensuring that others learned from his experience.

The full story will appear in Dr Wilson's forthcoming book, "One Grand Chain", which will describe how many Australians and New Zealanders were links in a chain of progress in techniques. See the section "New Techniques 1911-1929" (Chapter 5).

This chapter will also refer to the first-ever Section of Anaesthetics at an Australasian Congress — in 1929 — part of which was devoted to developments in Syme's technique.

Reproduced herewith is a copy of the diagram that appeared with the report in the AMJ.

Footnotes
(2) Australian Medical Journal, 2 September, 1911, page 72.
HIGHLIGHTS OF RACS COUNCIL MEETING 20 AND 21 FEBRUARY, 1992

**AWARDS, ELECTIONS AND HONOURS**

**Australia Day Awards**
Professor A.G.R. Sheil, AO
Mr H.C. Barry, AM
Emeritus Professor R.C. Bennett, AM
Mr J.K. Clarebrough, AM, OBE
Mr T. Hamilton, AM
Mr D.M. Southwood, AM
Mr J.M. Grant, AM, OBE
Mr P. Byrne, AM (Military)
Mr T.G. Pickering, OAM
Mr I.M. Rosen, OAM
Mrs Diana May Ramsay, AO, and
Mr James Stewart Ramsay, AO
(Ramsay Fellowship)

**New Year's Honours**
Mr Ian Civil (NZ), MBE
Sir Patrick Moore, (NZ), Knight Bachelor

**Honorary Fellowship, College of Medicine of South Africa**
J.C. Hanrahan (Faculty of Surgery)
B. McC O’Brien (Faculty of Plastic and Reconstructive Surgery)

**Honorary Fellowship, Royal College of Surgeons of England**
J.C. Hanrahan

**Other**
Mr Bernard McC O’Brien AC, CMG — received Victorian of the Year Award.

**New Zealand Censor's Committee**
Council appointed a New Zealand Censor's Committee, comprising representatives from the various Specialty Training Committees in New Zealand, to help the New Zealand Censor in matters such as hospital inspections and eligibility to present for the Part 2 Examination.

**Training**
It was resolved to ask each Surgical Board to define its optimum period of training experience and that the combined Basic and Advanced Training period should be a minimum of six years.

Each Surgical Board was also asked to develop a mechanism for reducing the gap between Basic and Advanced Training, preferably to remove the gap altogether.

**Urology Training and Examination**
The duration of Advanced Surgical Training in Urology was extended from four to five years, incorporating a first year of approved General Surgery followed by four years exclusively in Urology and it was agreed that the Part 2 Examination in Urology could be undertaken in the fourth of these five years of training.

**Effect of Industrial Awards for Junior Medical Officers upon Training Programs**
Council established a Subcommittee to consider any likely adverse effects upon training programs due to industrial awards for Junior Medical Officers.
Part 2

The consultative process for appointments by Council of members of the Court of Examiners, which exists for Australian members of the Court, has been extended to New Zealand.

Council resolved to hold the annual election of Chairman of the Court of Examiners in February at the same time as Office Bearers of the College are elected. The person elected would hold the position of Chairman Elect until taking office in the following June.

Proposed RACS/RACP/Singapore and Malaysia Academies Meeting

Council approved in principle holding a joint meeting of RACS/RACP/Singapore and Malaysia Academies of Medicine, perhaps in 1994 or 1995.

This is to be further investigated with the Academies involved.

ANZ Journal of Surgery

Council approved the College participating in the South East Asian Scientific Editors Association and the attendance of the Journal Editor at the periodic Workshops of the Association.

Cambridge Conference Workshop

Council resolved to invite the Chairman of the Court of Examiners to attend the 1992 Cambridge Conference Workshop on the theme “Improving the Assessment of Clinical Competence”.

Continuing Medical Education

Council approved the printing of the proceedings of the Surgical Audit Seminar scheduled for March 7, 1992 and distribution of the proceedings to all Fellows.

Seeding grants or floats are to be provided for CME activities from the CME budget.

A workshop for Rural Surgeons is to be held in Darwin in the second half of 1992.

A logo to be used on letterhead and other printed material for Continuing Medical Education was approved.

Library

The position of Honorary Curator of the Cowlisshaw Collection was created with the possibility of the Curator lecturing on the contents of the collection.

Certification of Surgical Services in Hospitals

Council resolved as follows:

That the RACS requirement for the Certification of Surgical Services in Hospitals be promulgated to all Hospitals where surgery is carried out;

That standards not be defined in detail but be represented by a comprehensive questionnaire as an Aide Memoir of what features should be looked for;

That surgical standards be monitored in three situations:

a) Hospitals with training posts. RACS will inspect concurrently.

b) Hospitals inspected by the ACHS — if a surgical problem is flagged RACS will investigate.

c) Hospitals not being inspected by ACHS and not training Hospitals — RACS representative responsible for instituting standards — RACS to inspect if a problem is encountered.
d) The RACS do not issue a certificate of accreditation.

(For information of Fellows refer page 33 for RACS requirements).

**FRACS as The Only Registerable Surgical Diploma in Australasia**

Council resolved that the RACS recognise the FRACS as the only diploma for the practice of Surgery in Australasia.

In passing this resolution Council noted the procedures that were to be implemented for the assessment of the qualifications and training of overseas trained specialists, which produced opportunities for those who are not recognised for registration to undertake training and the RACS Part 2 Examination and thereby gain admission to Fellowship. Currently registered non Fellows would not be affected.

**Relocation of Surgeons Following Closure of Public Hospitals**

Council expressed the view that a reaffirmation of its policy on multiple teaching hospital appointments would assist in alleviating the problem of the displacement of Surgeons following the closure of Public Hospitals.

**Laparoscopic Cholecystectomy**

Council noted that a State Health Department had issued guidelines on the maintenance of skills in Percutaneous Laparoscopic Cholecystectomy.

Council reaffirmed its view that this area is the province of the College and Health Departments and Hospitals should not be involved.

**Rural Surgery**

A College policy on the training of Rural GP’s in Surgery was approved.

**Endoscopy Training**

The title of the Conjoint Committee for the Recognition of Endoscopy Training was altered to Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy.

Council approved the following statement on “Endoscopy and Surgeons”.

1. This College endorses the recommendation of the Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy with regard to training in Gastrointestinal Endoscopy and supports the role of this Committee to advise on adequate standards in Gastrointestinal Endoscopy.

2. This College considers that the FRACS is the only certification required for a surgeon to be accorded the clinical privileges of the discipline in which that Diploma has been awarded and no separate certification should be required for the performance of individual procedures. Upper Gastrointestinal Endoscopy and Colonoscopy are considered to be integral parts of General Surgery.

3. Any surgeon with an FRACS in General Surgery who has had training in, and currently performs, Gastrointestinal Endoscopy and/or Colonoscopy should therefore be accorded the appropriate clinical privileges in those hospitals in which he or she works, subject to the approval of the Hospital Credentials Committee.

4. Individual practitioners should not be required to apply to the Conjoint Committee for assessment.

5. In disciplines other than General Surgery eg: Cardiothoracic, Otolaryngology, Orthopaedic and Urology, it is accepted that an FRACS in those disciplines is the only certification necessary for privileges in Endoscopy procedures of those disciplines.
MISSING FELLOWS

I have been unable to invite the following Fellows to join the Australian and New Zealand College of Anaesthetists.

- DR R.F. CATCHLOVE, FFAARC
- DR H.M. MARSH, FFAARC
- DR J.E. CHAN, FFAARC
- DR M.C. POOPATHY, FFAARC
- DR ELSA ENRIGHT, FFAARC
- DR A.S. SANDHU, FFAARC
- DR N.D. GEMMELL-SMITH, FFAARC
- DR TAN CHIAN YONG, FFAARC
- DR J.Z. HICKMAN, FFAARC
- DR D. THANGATHURAI, FFAARC
- DR JILL L'ARMAND, FFAARC
- DR L.A. YATES, FFAARC
- DR J.G. LUCAS, FFAARC

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

Joan Sheales
Registrar

Bulletin
March 1992
Sedation for dental procedures includes the administration by any route or technique of all forms of drugs which result in depression of the central nervous system. The objective of these techniques is to produce a degree of sedation whereby rational verbal communication to and from the patient is continuously possible, so that uncomfortable diagnostic and minor surgical procedures may be facilitated. The drugs and techniques used should provide a margin of safety which is wide enough to render unintended loss of consciousness unlikely.

Thus it is important to understand the variability of effects which may occur with sedative drugs, however administered, and that over-sedation or airway obstruction may occur at any time. To ensure that standards of patient care are satisfactory, equipment and staffing of the area in which the patient is being managed should satisfy the requirements as laid down in this Policy Document.

2. GENERAL PRINCIPLES

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

2.1.1 A concise medical history and relevant examination such as might be available from the patient’s General Practitioner, and must include blood pressure measurement.

2.1.2 Informed consent for the procedure and sedation.

2.1.3 Appropriate written instructions for preparation for the procedure, the recovery period, and discharge of the patient.

2.2 If the patient has any serious medical condition or danger of airway compromise then an anaesthetist should be present to monitor the patient during the procedure.

2.3 The practitioner administering these drugs requires sufficient basic knowledge to be able to:

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

2.3.2 Detect and manage appropriately any complications arising from these actions.

2.3.3 Anticipate and manage appropriately the modification of these actions by any concurrent therapeutic regime or disease process which may be present.
2.4 A written record of the dosages of drugs and the timing of their administration must be kept as a part of the patient’s records. Such entries should be made as near the time of administration of the drugs as possible. This record should also note the readings from the monitored variables, and should contain other information as indicated in the Faculty Policy Document P6 “Minimum Requirements for the Anaesthetic Record”.

2.5 Pulse oximetry, when available, will assist in monitoring every sedated patient.

2.6 Techniques which compensate for excessive anxiety and/or for inadequate local analgesia by means of heavy sedation must not be used unless an anaesthetist is also present.

3. STAFFING
There must be an assistant present during the procedure appropriately trained in resuscitative measures who shall monitor the level of consciousness and cardio-respiratory function of the patient. The need for a second assistant will depend on the complexity of the procedure.

3.1 Provided that rational, verbal communication to and from the patient is continuously possible during the diagnostic, minor surgical or dental procedure, the operator may provide the sedation and be responsible for care of the patient.

3.2 If at any time such rational, verbal communication is lost, then the operator must cease the procedure and devote his/her entire attention to monitoring and treating the patient until such time as the patient recovers consciousness or another practitioner becomes available to monitor the patient and take responsibility for any further sedation, analgesia or resuscitation.

3.3 If loss of consciousness or loss of rational, verbal communication is sought as part of the technique, then an anaesthetist must be present to care for the patient.

4. TRAINING
Dental practitioners who administer sedation must be able to demonstrate an appropriate level of training.

4.1 All dental practitioners should be capable of administering the correct oral medications for such conscious sedation.

4.2 Practitioners wishing to administer relative analgesia must attend a special course and demonstrate competence in the technique and such associated resuscitative measures which may be required.

4.3 Practitioners wishing to administer intravenous drugs for sedation must attend a further special course and demonstrate competence in these techniques and their associated resuscitative measures which must include management of artificial ventilation and external cardiac massage.

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

5.1 A chair which can be tilted readily to the horizontal position.

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

5.3 Equipment suitable for the measurement of a patient’s blood pressure.

5.4 Adequate suction and room lighting.

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

5.6 A means of inflating the lungs with oxygen (e.g. a range of pharyngeal airways and self-inflating bag suitable for artificial ventilation).

5.7 Appropriate drugs for cardiopulmonary resuscitation (see Appendix) and a range of intravenous equipment.

5.8 A pulse oximeter must be used to monitor the patient when intravenous sedation techniques are used.

6. SPECIALISED EQUIPMENT FOR NITROUS OXIDE SEDATION
A machine which may be a completely portable device with attached oxygen/nitrous oxide cylinders or be able to be connected to piped gases must be available which is capable of delivering nitrous oxide sedation in accordance with the following requirements:

6.1 A continuous gas flow.

6.2 A minimum flow of two and a half (2.5) litres of oxygen per minute at any time that nitrous oxide is delivered, or in machines so calibrated of 30% oxygen in the gas mixture.
6.3 A maximum flow of 7-10 litres of nitrous oxide per minute.
6.4 Easily read flow meters.
6.5 A fail safe device — in the event of oxygen failure the nitrous oxide cuts off immediately and the air inlet valve opens and the patient breathes air.
6.6 A non-return valve to prevent rebreathing and a three litre bag which acts as a reservoir.
6.7 Wide tubing of approximately 2cm internal diameter leading up to the nasal harness.
6.8 A light-weight nose piece incorporating an air dilution valve and a low tension expiratory valve.
6.9 Emergency oxygen button (oxygen flush).
6.10 Installation and maintenance of piped gases must be carried out by a registered professional using appropriately coded copper piping or reinforced nylon tubing for connection to the nitrous oxide sedation machine.
6.11 Servicing of equipment and piped gases by an appropriate organisation must be carried out on a regular basis, and at least annually.
6.12 For anything other than occasional use, a commercially supplied scavenging device must be used as an adjunct to nitrous oxide sedation. The accepted non-toxic level of circulating nitrous oxide is set at 25-50 parts per million. One half hour session of nitrous oxide sedation in a poorly ventilated area would produce a level well in excess of 100 parts per million for several hours.

7. SPECIALISED EQUIPMENT FOR INTRAVENOUS SEDATION
7.1 Patients undergoing intravenous sedation must be monitored continuously with pulse oximetry. This equipment must alarm when easily set limitations are exceeded. Digital readings of saturation must be easily visible from two metres. Alteration in pitch as the oxygen saturation changes is desirable.
7.2 Intravenous equipment must be available which will keep access to a vein patent throughout the procedure.
7.3 Suitable reversal agents must be available depending upon the drug used.

8. DISCHARGE
8.1 The patient should be discharged only after an appropriate period of recovery and observation in the procedure room or in an adjacent area which is adequately equipped and staffed.
8.2 Discharge of the patient should be authorized by the practitioner who administered the drugs, or another appropriately qualified practitioner. Where oral or other intravenous agents have been used, the patient should be discharged into the care of a responsible adult to whom written instructions should be given.
8.3 Adequate facilities should be available in the Recovery Area for managing patients who have become unconscious, who have lost rational verbal contact, or who have suffered some medical mishap. These facilities should be similar to those listed under 5 above.
8.4 Should the need arise the patient must be transferred to appropriate medical care.

9. ASSOCIATED POLICIES
A number of Policy Documents from the Australian and New Zealand College of Anaesthetists and the Faculty of Anaesthetists RACS should be noted where appropriate in conjunction with this Policy Document on Sedation for Dental Procedures. These Documents include the following:

T5 Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries
P4 Guidelines for the Care of Patients Recovering From Anaesthesia
P5 A Statement of Principles for the Care of Patients who are given Drugs Specifically to produce Coma
P7 The Pre-Anaesthetic Consultation
P9 The Use of Sedation for Diagnostic and Minor Surgical Procedures
P15 Guidelines for the Care of Patients Recovering from Anaesthesia Related to Day Surgery
P18 Monitoring During Anaesthesia
P19 Monitored Care by an Anaesthetist

APPENDIX
Emergency drugs should include at least the following:
adrenaline
atropine
dextrose 50%
lignocaine

February 1992

Bulletin March 1992
INTRODUCTION
Safe transport of the critically ill requires accurate assessment and stabilisation of the patient before transport. There should be appropriate planning of transport and optimum utilisation of communications. Safe transport requires the deployment of appropriately trained staff with essential equipment, and effective liaison between referring, transporting and receiving staff.

An important principle is that transport of the critically ill patient should be aimed at achieving improved patient care. Management during transport should equal or better management at the point of referral.

1. ADMINISTRATIVE GUIDELINES
Administrative guidelines should cover all aspects of transport of the critically ill. These may include guidelines for such matters as insurance, budgeting and personnel.

1.1 Initiation and Response
Medical transport services using road ambulance, fixed and rotary wing aircraft must be coordinated for prompt, rapid, efficient and safe transport of critically ill patients on a 24 hour basis.

Initiation of patient transport should be simple, with clear guidelines and communication channels.

In all situations requiring transport of the critically ill, rapid response of the transport system and minimal delays are paramount. In emergency interhospital transports, despatch of the medical transport team to the referring hospital should not be delayed pending the identification of a receiving hospital.

1.2 Coordination and Communication
Coordination of transport services for the critically ill should be centralised to ensure optimum utilisation of resources. Designated individuals need to be available immediately for consultation and planning.

Reliable communication must be available at all times between the transport team and the referring and receiving hospitals.

1.3 Responsibility
The chain of responsibility must be clear throughout the transfer. Responsibility for patient care aspects of transport must be vested in an appropriately qualified medical practitioner.

1.4 Documentation
The clinical record should briefly summarise the patient’s clinical status before, during and after transport, relevant medical conditions, environmental factors and therapy given.

1.5 Review and Quality Assurance
Organisations involved in medical transport should have an effective medical advisory committee which can review performance and make recommendations for appropriate clinical management of patients.

There should be a process to regularly review records made during transport, to assess the level of care provided.

There should be a process to investigate delays in transport and any specific incidents.

A means of patient follow-up after transport should be available as feedback to the clinical staff involved and to assist in evaluating the performance of the organisation overall.

There should be opportunities for peer review within the organisation.

2. CATEGORIES OF TRANSPORT
Transport of critically ill patients is necessary in three sets of circumstances, namely, prehospital transport, interhospital transport and intrahospital transport.

2.1 Prehospital Transport refers to:
Transport of a critically ill patient from an accident or illness location to hospital.

2.2 Interhospital Transport may be:
2.2.1 Emergency Interhospital Transport:
For acutely life-threatening illnesses due to either lack of diagnostic facilities or lack of staff or facilities for safe and effective therapy in the referring hospital.

2.2.2 Semi-elective Interhospital Transport:
For transport of the critically ill patient with major organ failure, requiring organ support, to a tertiary referral centre.
2.3 Intrahospital Transport may be required for diagnostic or therapeutic reasons.

3. STAFFING
Personnel engaging in transport of critically ill patients should be selected for the transport role, be trained in the various aspects of patient transport and be regularly involved in this activity. Ability to communicate effectively, and to function as part of a team is essential.

3.1 Prehospital Transport
Staff will usually be Ambulance Service personnel. Crews with specialised advanced life support skills should be deployed appropriately. In some circumstances, medical officers and/or nurses may be deployed to provide prehospital treatment and transport.

3.2 Interhospital Transport
Interhospital transport of critically ill patients requiring major organ support must be performed and supervised by experienced medical practitioners. Experienced ambulance personnel, or nurses or technical staff should accompany, assist and advise the medical practitioner. On extended journeys, sufficient staff should be carried to allow maintenance of high standards of patient care.

Where it would be immediately lifesaving, the transport of expert medical assistance to the referring hospital should be considered.

Specifically trained personnel are required for neonatal and infant transport.

3.3 Intrahospital Transport
Appropriately trained medical and nursing or technical staff should accompany critically ill patients requiring intrahospital transport.

4. TRANSPORT
Mode of transport used will depend partly on clinical requirements and partly on vehicle availability and conditions.

4.1 Choice of transport vehicle will be influenced by:
- nature of illness
- urgency of intervention
- location of patient
- distances involved
- road transport times and road conditions
- weather conditions for airborne transport
- aircraft landing facilities
- range and speed of vehicle

4.2 Transport Vehicle Requirements
Vehicles should be appropriate to the task in terms of design and equipment. Particular requirements relate to:
- safety
- adequate space, with room for an attendant at the head and side
- adequate energy and gases for life support systems
- easy access for embarkation and disembarkation
- adequate lighting and internal climate control
- restrained stretcher and equipment
- acceptable noise and vibration levels
- adequate speed and response times
- good communication systems, both internal and external
- pressurisation to sea level when clinically indicated
- auditory patient monitoring alarms routed through attendants' headsets where noise is unavoidable, in addition to usual alarms
- appropriate seating and restraints for staff

In general, medical fittings to aircraft, and bulky items carried need to have approval of the aviation authorities.

4.3 Airborne transport creates special problems, including:
- reduced oxygen partial pressure
- impaired gravity drip of fluids
- expansion of air filled cavities
- limb swelling beneath plaster casts
- worsening of air embolism or decompression sickness
- danger from agitated patients
- space, lighting and facilities for interventions
- noise
- reduced temperature
- reduced humidity
- acceleration and deceleration
- turbulence
- vibration
- interference with monitoring devices

With all modes of transport, stabilisation of vital signs, provision of a secure airway and IV access, securing of all catheters and provision of appropriate monitoring before departure is fundamental to safe transport.

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5. **EQUIPMENT**

Equipment should be adequate in amount for each transport, taking into account duration of transport and the patient’s condition. In choosing equipment, attention must be given to size, weight, battery life and durability, as well as to suitability for operation under conditions of transport. Equipment should be adequately restrained, and continuously available to the operator.

5.1 **Respiratory Support Equipment**
- Airways
- Oxygen, masks, nebuliser
- Self inflating hand ventilating assembly with PEEP valve available
- Suction equipment of appropriate standard
- Portable ventilator with disconnect and high pressure alarm
- Intubation set
- Cricothyroidotomy set
- Pleural drainage equipment

5.2 **Circulatory Support Equipment**
- Monitor/defibrillator/external pacer
- Pulse oximeter
- Aneroid sphygmomanometer (not mercury containing)
- Vascular cannulae, peripheral and central
- IV fluids and pressure set
- Infusion pumps
- Arterial cannulae
- Arterial monitoring device
- Syringes, needles
- Pacemaker equipment
- MAST

5.3 **Other Equipment**
- Nasogastric tube and bag
- Urinary catheter and bag
- Nasal decongestant spray
- Instruments, sutures, dressings, antiseptic lotions, gloves
- Thermal insulation and temperature monitor
- Splints

5.4 **Pharmacological Agents**
Pharmacological agents necessary to manage:
- Cardiac arrest
- Hypotension
- Hypertension
- Cardiac dysrhythmia
- Pulmonary oedema
- Anaphylaxis
- Bronchospasm
- Hypoglycaemia
- Hyperglycaemia
- Raised Intracranial Pressure
- Uterine atony
- Adrenal dysfunction
- Narcotic depression
- Convulsions
- Agitation
- Pain
- Emesis
- Electrolyte abnormalities

and to provide sedation and neuromuscular paralysis.

6. **MONITORING**

Monitoring of certain fundamental variables should be carried out.

Some or all of these basic recommendations will need to be exceeded routinely depending on the physical status of the patient. Occasionally some of the recommended methods of monitoring may be impractical or inappropriate.

The described monitoring methods may fail to detect unfavourable clinical developments and their use does not guarantee any specific patient outcome.

6.1 **Personnel**
Clinical monitoring is the basis of intensive patient care during transport. This should be supplemented by appropriate devices.

6.2 **Patient Monitoring**

6.2.1 **Circulation**
The circulation must be monitored at frequent and clinically appropriate intervals by detection of the arterial pulse and measurement of the arterial blood pressure.

6.2.2 **Respiration**
Respiratory function should be assessed at frequent and clinically appropriate intervals.

6.2.3 **Oxygenation**
The patient’s oxygenation should be assessed at frequent and clinically appropriate intervals by observation, and by pulse oximetry as appropriate.

6.3 **Equipment**

6.3.1 **Oxygen supply failure alarm**
An automatically activated device to monitor oxygen supply pressure and to warn of low pressure should be fitted to the oxygen supply.

6.3.2 **Pulse Oximeter**
A pulse oximeter should be available for every critically ill patient during transport.
6.3.3 Alarms for Breathing System Disconnection or Ventilator Failure
When an automatic ventilator is in use, a device capable of warning promptly of a breathing system disconnection or ventilator failure should be in continuous operation.

6.3.4 Alarms for Breathing System High Pressure
When an automatic ventilator is in use, a device capable of warning promptly of high pressure in the breathing system should be in continuous operation.

6.3.5 Electrocardiograph
Equipment to monitor and continually display the electrocardiograph must be available for every critically ill patient during transport.

6.3.6 Other Equipment
When clinically indicated, equipment to measure other physiological variables, such as a capnograph should be available.

February, 1992

POTENTIAL MUTAGENICITY OF PAPAVERETUM

In vitro studies of noscapine, a component of Papaveretum, have shown it to have mutagenic properties.

Though no link to clinical use has been established, the UK Committee on Safety of Medicines has seen fit to warn against its use in women of child bearing potential.

Morphine does not contain noscapine and neither do other analgesic preparations.

STEWART T. BATH
Pharmaceutical Officer

POLICY DOCUMENTS

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

E1 (1991) Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Anaesthesia
E2 (1990) Guidelines for Hospitals Seeking Faculty Approval of Training Posts in Intensive Care
E3 (1989) The Supervision of Trainees in Anaesthesia
E4 (1987) Duties of Regional Education Officers
E6 (1990) The Duties of an Anaesthetist
E7 (1989) Secretarial Services to Departments of Anaesthesia and/or Intensive Care
E8 (1991) The Duties of an Intensive Care Specialist in Hospitals with Approved Training Posts
E10 (1990) The Supervision of Vocational Trainees in Intensive Care
E11 (1989) Formal Project
E13 (1991) Guidelines for the Provisional Fellowship Year
EX1 (1991) Guidelines for Examiners with Respect to Candidates Suffering Illness (or Accident) at the Time of Examination

T1 (1989) Recommended Minimum Facilities for Safe Anaesthetic Practice in Operating Suites
T3 (1989) Recommended Minimum Facilities for Safe Anaesthetic Practice in Organ Imaging Units
T5 (1989) Recommended Minimum Facilities for Safe Anaesthetic Practice in Dental Surgeries
T6 (1989) Recommended Minimum Facilities for Safe Anaesthetic Practice in Delivery Suites
P1 (1991) Essential Training for General Practitioners Proposing to Administer Anaesthetics
P2 (1991) Privileges in Anaesthesia Faculty Policy
P3 (1987) Major Regional Anaesthesia
P4 (1989) Guidelines for the Care of Patients Recovering from Anaesthesia
P5 (1991) Statement on Principles for the Care of Patients who are given Drugs Specifically to produce Coma
P6 (1990) Minimum Requirements for the Anaesthetic Record
P7 (1989) The Pre-Anaesthetic Consultation
P8 (1989) Minimum Assistance Required for the Safe Conduct of Anaesthesia
P9 (1991) The Use of Sedation for Diagnostic and Minor Surgical Procedures
P10 (1991) Minimum Standards for Intensive Care Units
P11 (1991) Management of Cardio-Pulmonary Bypass During Cardiac or Major Cardio-Vascular Surgery
P12 (1991) Statement on Smoking
P15 (1987) Guidelines for the Care of Patients Recovering from Anaesthesia Related to Day Surgery
P16 (1988) Continuous Intravenous Analgesic Infusions
P17 (1987) Endoscopy of the Airways
P18 (1990) Monitoring During Anaesthesia
P19 (1990) Monitored Care by an Anaesthetist
P20 (1990) Responsibilities of Anaesthetists in the Post-Operative Period
P21 (1992) Sedation for Dental Procedures
P22 (1990) Statement on Patients' Rights and Responsibilities
P23 (1992) Minimum Standards for Transport of the Critically Ill

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