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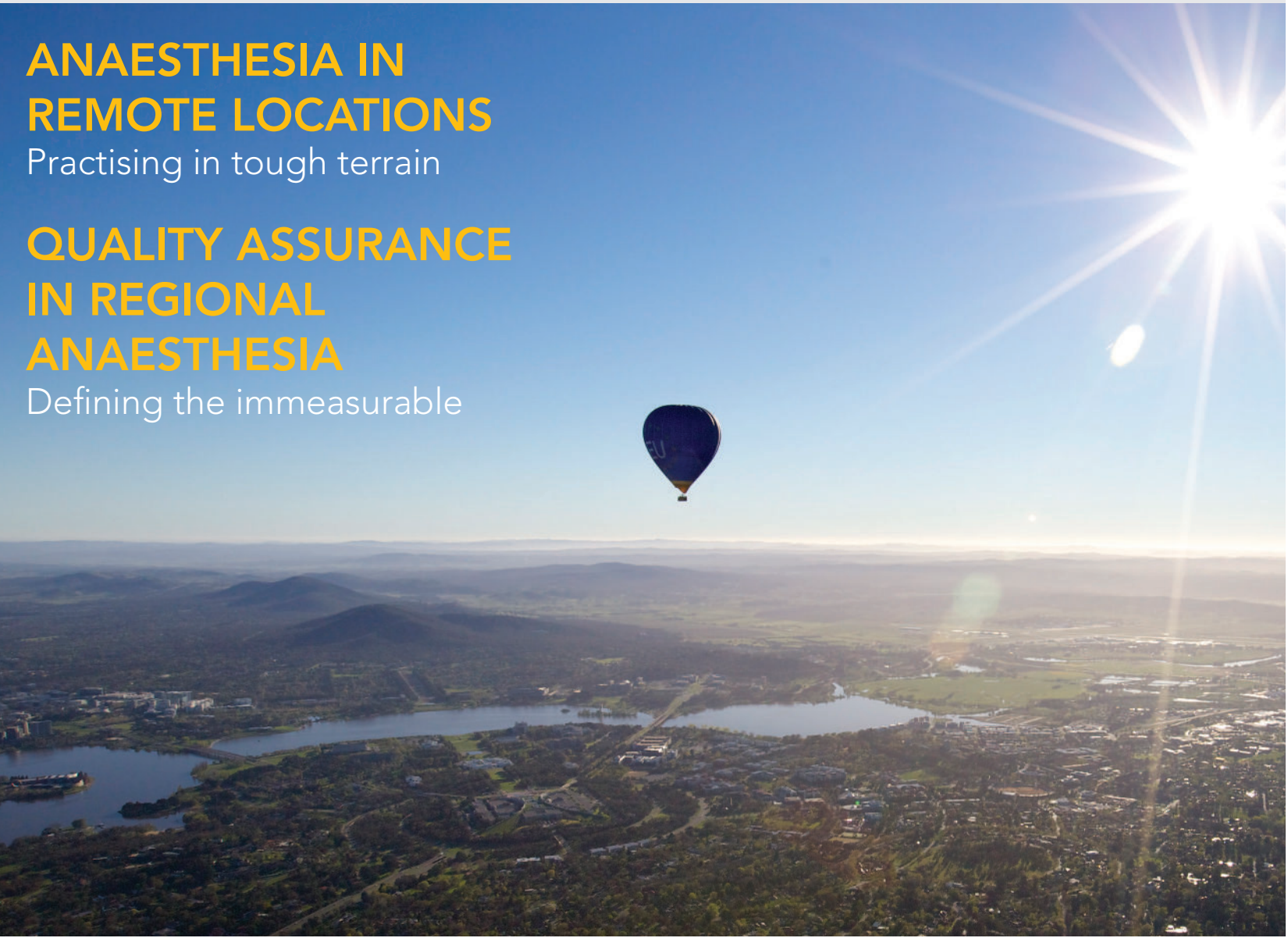
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • DECEMBER 2013

ANAESTHESIA IN REMOTE LOCATIONS
Practising in tough terrain

QUALITY ASSURANCE IN REGIONAL ANAESTHESIA
Defining the immeasurable



NSC WRAP-UP: CANBERRA 2013
Anaesthetists convene and collaborate in the nation's capital

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Letters to *Australian Anaesthetist*:
Letters are welcomed and will be considered for publication on individual merit. The Medical Editor reserves the right to change the style or to shorten any letter and to delete any material that is, in his or her opinion, discourteous or potentially defamatory. Any major revisions required will be referred back to the author for approval. Letters should be no more than 300 words and must contain your full name and address. Please email Adrienne Pilley at editor@asa.org.au to submit your letter or to contribute.

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Canberra from hot-air balloon, courtesy of Prof Keith Ruskin

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ASA
Australian Society of Anaesthetists

REGULARS

FEATURES

22 2013 CANBERRA NSC WRAP-UP

LIFESTYLE

INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The April issue features of *Australian Anaesthetist* will focus on anaesthesia workforce challenges.

If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 17 January 2014.
- Final article is due no later than 14 February 2014.

All articles must be submitted to editor@asa.org.au. Image and manuscript specifications can be provided upon request.

REGULAR

ASA EDITORIAL FROM THE PRESIDENT

DR RICHARD GRUTZNER, ASA PRESIDENT

I would like to welcome members of the ASA to the final edition of *Australian Anaesthetist* for 2013. This publication has undergone significant change this year and we hope that you find the new format engaging, informing and entertaining. In this edition we have a focus on regional anaesthesia in the lead up to the Asian Australasian Congress of Anaesthesiologists and the Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA) meeting to be held in Auckland in February 2014.

There have been significant changes around the world over the last several years in relation to relicensing, recertification and revalidation, particularly in the United Kingdom, the United States and New Zealand. In the United Kingdom changes have been driven in the aftermath of the Bristol cardiac surgical and Harold Shipman enquiries. Strengthening of appraisal and revalidation has occurred and this is seen to enhance trust between doctors and their patients. Despite these changes to a system which largely works there is no way that a guarantee can be made that a future Harold Shipman would be detected. In an editorial of the Royal Society of Medicine, Dr Kamran Abbasi[1] points out that the greatest challenge as we move towards the three Rs of relicensing, recertification and revalidation is to satisfy doctors that the three Rs are indeed reliable, rewarding and required. In this edition of *Australian Anaesthetist*, Vice President Dr Guy Christie-Taylor considers the implications of the changes to the Continuing Professional Development (CPD) standard for anaesthesia as published by the Australian and New Zealand College of Anaesthetists (ANZCA) and what they mean for practising Australian anaesthetists. I urge you to read his article, familiarise yourselves with the new standard and consider how you can put in place a plan to comply with the new standard.

The Medical Board of Australia (MBA) has been talking about the move from CPD to revalidation in terms of starting a conversation. According to the MBA, any such changes as part of revalidation needed to be evidence-based, multifaceted, valid and cost-effective.

I have recently represented the ASA at the American Society of Anesthesiologists meeting in San Francisco

The new CPD standard has been released by ANZCA and approved by the Australian Medical Council as is required by the MBA. There have certainly been changes required by the Medical Council of New Zealand, which are more onerous than those which applied in the past. ANZCA as a bi-national body has created a standard which enables fellows to comply with the requirements of both Australia and New Zealand. The new standard pre-empts the change in requirements of the MBA. Australian anaesthetists are effectively required to comply with the more onerous requirements applicable in New Zealand. By pre-empting the MBA "conversation", the standards imposed on Australian anaesthetists are more onerous than they been up until now. Equally, they may be less onerous than the standards which may have been imposed had we waited for completion of the "conversation". This is speculative and in the absence of a crystal ball we will never know what may have been. What we do know is that Australian anaesthetists are required to comply with much more rigorous standards in order to effectively meet the New Zealand standard. This introduction has been made over a short time frame and commences in January 2014.

I have recently represented the ASA at the American Society of Anesthesiologists meeting in San Francisco. This enormous meeting has become more international in its focus and was an opportunity to meet with international leaders in anaesthesia. The issues we all face are similar and include the rising cost of sophisticated Western medicine and our ability to pay for care for an increasingly older, overweight and obese population. New practice models are evolving in the USA in response to these challenges and include the concept of the perioperative surgical home. Under this paradigm anaesthetists are becoming more involved in pre and postoperative care in addition to the immediate perioperative period. Bundled payments are part of this new model

and create challenges, particularly as this payment includes the management of any complications which may occur and require readmission or reoperation. Other challenges include the proposal that nurse anaesthetists are able to practise independently in the Veterans' Affairs hospitals and the SEDASYS system. SEDASYS is a patient-controlled propofol sedation delivery system which removes the need for the presence of an anesthesiologist. Interestingly, it is a patient-controlled sedation system which has physician override. As we know, the progression from conscious sedation to anaesthesia is unpredictable and may require the intervention of a medical practitioner trained in support of the cardiorespiratory systems. This means that an enthusiastic gastroenterologist, cardiologist, radiologist or procedural physician has the ability to deliver anaesthesia in the absence of a medical practitioner looking exclusively after the patient. Reassuringly, the SEDASYS system would not comply with the ANZCA Professional Standard 09, which sets the standards for practice in this area in Australasia. It is, however, a development Australian anaesthetists should be aware of.

In many developed countries there is now an excess of anaesthetists as governments seem no longer prepared or able to deliver the volume of high-end medical services demanded by their populace

Another issue common to developed countries, and indeed all countries, is anaesthesia workforce. In many developed countries there is now an excess of anaesthetists as governments seem no longer prepared or able to deliver the volume of high-end medical services demanded by their populace. This results in an unmet demand for medical and surgical services as evidenced by both the hidden and formal waiting lists in the Australian health system. It would seem self-evident that patients on waiting lists do not require hospital beds, prostheses, nurses, surgeons or anaesthetists but it has been assumed in much of the workforce planning that an increase in demand for medical services will be matched by an increase in the resources to provide that care. As we have seen over recent years with cutbacks to state health budgets, resources have not and will not necessarily be provided in a quantity to match the demand. This is but one factor in the workforce issue currently faced by most medical practitioners in Australia, including anaesthetists.

The Society is hosting a Workforce Summit in Sydney on 7 December

The anaesthesia workforce remains an issue of core interest to the Society. The problem with the large number of recent graduates and their inability to find employment as full-time staff specialists or Visiting Medical Officers with a significant number of sessions is creating problems for the wider anaesthesia community and for the individuals involved. Despite having achieved ANZCA fellowship, the recent graduates require a period of consolidation prior to being considered fully rounded anaesthetists prepared to deal with the challenges of independent practice. The situation has been exacerbated by the reduced number of work hours, reduced exposure to clinical material and a reduced volume of independent practice as trainees. The ASA continues to engage with ANZCA on this critical issue and awaits the response from the new government on this and other issues. One possible mechanism for resolution to this problem lies with the National Medical Training Advisory Network, an offshoot of Health Workforce Australia (HWA) charged with the coordination of medical training positions throughout Australia. We do note, however, that the CEO of HWA has resigned and a replacement has not yet been reappointed. There are also suggestions that the level of funding of HWA may not be maintained, so we watch this space with interest.

The Society is hosting a Workforce Summit in Sydney on 7 December to coincide with the opening of the new head office. This is under the leadership of the Professional Issues Advisory Committee Chair, Dr Jim Bradley, and will include representatives of ANZCA, the AMA and the New Zealand Society of Anaesthetists, as well as ASA members with an interest in this area. Whilst the causes of, and solutions to, the current workforce issues are complex, we hope by encouraging dialogue with members representative of the anaesthesia community to be able to reach some profession-wide consensus. We can then engage with government at the national and state level to generate some solutions to this problematic issue. I will look forward to reporting back to the membership with the outcomes of our deliberations. I trust you enjoy this issue of *Australian Anaesthetist*, and as always feel free to contact myself or your local ASA representative with your feedback.

1. Abassi, K. The three Rs: relicensing, recertification and revalidation. J R Soc Med 2008; 101:387.

FOLLOW THE PRESIDENT ON TWITTER

Keep up with all of Dr Richard Grutzner's activities by following the ASA's presidential account on Twitter.

Follow @ASA_President and @ASA_Australia to get all the latest news and information.

REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

As we approach the Christmas break, I thought it presented a good opportunity to reflect on some of the changes that the ASA has undergone over the past year. In particular, operational changes which have hopefully added value. In doing this, I would like focus on three particular areas: membership, service delivery and office space.

MEMBERSHIP

The ASA is by definition a membership based organisation. As such, all activities need to be undertaken in order to better serve you, the members. The ASA achieved a major milestone in 2011 by surpassing the 3000 (net) membership mark. I am pleased to report that since then overall membership has continued to grow and in July 2013 stood at 3172. The table on the opposite page shows the overall membership growth since 2008.

While a growth in membership has a direct positive impact on revenue, of greater importance is the underlying point that the Society would appear to be meeting the needs of you, the members.

When examining membership I am pleased to report that our most significant category—Ordinary Member—continues to grow. In July 2008 this category had 1571 members, while at the same time this year that number stood at 1879.

Unfortunately, retention of GASACT members during the final years of training remains a problem, and this is the area where the greatest attrition occurs. One initiative put in place to offset this is a specific allocation for trainee-focused events within each state. A recent decision by Council introduced a second initiative to provide each Advanced Trainee with a copy of the recently released *Anaesthetic Crisis Manual*, written by ASA member Dr David Borshoff. Ideally, this manual will be of great assistance for those progressing through their careers and will reinforce the value of the Society.

Importantly, the *Anaesthetic Crisis Manual* is also available to all ASA members at a special member's rate which Dr Borshoff has kindly agreed to. I encourage all members to obtain a copy of this tremendous resource.

SERVICE DELIVERY

The delivery of appropriate and timely services to members is what the Society is about. This takes many forms, and we are constantly looking for ways to either improve service delivery or develop new services.

In highlighting four areas where changes have been implemented I trust that you will see that we are an evolving organisation.

Technology is key to our strategy for service delivery, and this can be seen through a number of initiatives undertaken throughout 2013. The successful roll-out of the iMIS package has allowed the Society to refine and improve its service delivery in a number of areas. Member communication via email updates and the much-improved e-news are two such examples. Additionally, the finance modules in iMIS have allowed for refinements in the banking process, resulting in improved management and reporting of our finances, something that Council have appreciated greatly. A third area of improvement has been in the gradual implementation of eTouches, which is the event registration module of iMIS. This module allows members to directly register for ASA events, ensuring a real-time awareness of event attendees and improved management and customer service. It is hoped that this resource will be more widely implemented over the coming year.

Members will also have noticed the evolution of the ASA publication now known as *Australian Anaesthetist*. The philosophy adopted in this change has been a focus on welcoming contributions from across the membership in order to provide members with an educative and professionally presented publication. The Communications Committee and the Communications staff have worked very hard in bringing this initiative to fruition and the positive response from you, the members, would indicate that it is a most welcome development.

At the same time, the Society is working hard to reinforce its brand through a consistent use of the logo. This does take time, but as we move ahead and the logo is used consistently in all publications and on all promotional material the value will increase.

Through the President and the Secretariat, the ASA has become an active user of Twitter as another means of communication. This area of social media will continue to be explored as we look for a variety of ways to engage with members and the community in order to promote matters of interest and importance within the specialty. In a short period the number of 'followers' has grown to over 700, and rising, reflecting the significance of the medium when looking to engage with members and the community at large.

Policy Services remain central to our operation. The work of the Professional Issues Advisory Committee and the Economics Advisory Committee is critical in the ASA's continued endeavours to promote issues with government and other agencies. It is not surprising that the Policy team have been most active throughout the year, engaging on behalf of the membership with bodies such as:

- Health Workforce Australia,
- Medibank Health Solutions,
- Medical Services Advisory Committee, and
- Treasury.

At the same time, the Policy team receives, on average, 60 queries each month on a variety of issues, including the *Relative Value Guide*, Practice Manager queries, patient questions and workplace matters. While a number of these are handled immediately by staff, well over half are forwarded to either the Economics Advisory Committee or the Professional Issues Advisory Committee for further consideration and advice.

The refurbishment has now been completed and members are welcome to visit the new premises

Our Policy Service remains an active and important area for members and is an integral aspect of the value proposition for being a member of the ASA.

OFFICE SPACE

The need for the Society to consider its space requirements has been occupying Council's mind for an extended period. Following my appointment in April 2012, I joined the already operational Property Advisory Working Group in the search for a more suitable space. The group consisted of four members of the then Executive, Drs Grutzner, Mulcahy, Feeney and Tuch, who, upon his retirement from Council, was replaced by Dr Andrew Miller. On 18 February 2013, the search was successful with the purchase of levels 7 and 8 at 121 Walker Street, North Sydney.

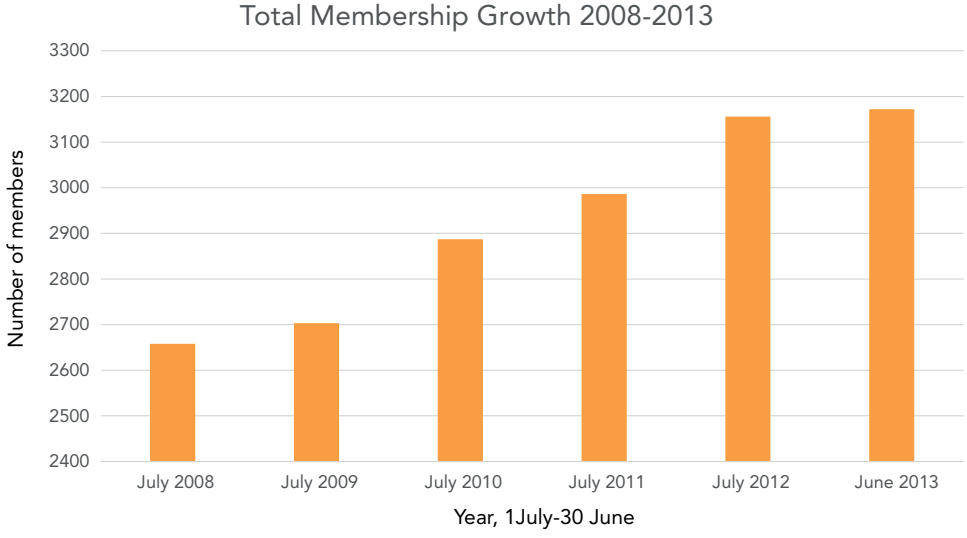
Following the successful purchase and tender for the fit-out, the development phase has been undertaken with great care to ensure a fully functional, modern work environment for the staff with ample room for growth. At the same time, due recognition has been given to the need to retain the important historical aspects of both the Richard Bailey Library and the Harry Daly Museum. This aspect is of particular interest as, at the recent Common Issues Group meeting in Canada, we learnt that the Canadian Society had made a decision to donate its museum pieces to an external museum due to space limitations.

The refurbishment has now been completed and members are welcome to visit the new premises.

While this has been a time-consuming exercise it has also been tremendously exciting as it is hoped that the long-term future of the Society has been secured. I would like to thank all who have been involved.

Before signing off I would like to acknowledge the support given to me by the President Dr Grutzner, the Council, the Committee Chairs and you, the members. It is greatly appreciated. I would also like to say a special thank you to the ASA staff, who are a most committed group of people.

In wishing everyone a safe and happy Christmas, I do look forward with excitement to what 2014 may hold.



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Functions within the OOP are almost limitless for a web service, including built-in features specifically designed for Anaesthetists, Assistants in Surgery, Surgeons, Physicians and others. In addition to all other functions, Anaesthetists are able to enter Procedure Duration or Start and End times, as well as Emergency In hours and ASA Gradings.

Organisation becomes second nature to the OOP users, with the ability to view, add or edit lists. It allows you to search or add patients and referrers/surgeons, verify patients to include Online Eligibility Checking, and gives you the option to select your location and rate. With quick access to generate the Informed Financial Consent (IFC), either Direct CONTROL or the OOP is always ready to generate invoices and facilitate direct billing to Medicare, DVA and other Health Funds.

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LETTERS TO AUSTRALIAN ANAESTHETIST

ISPCOP LINKS TO AUSTRALASIA

I would like to highlight a new resource for the management of morbidly obese patients during anaesthesia and the perioperative period, especially since we have now managed to secure an Australasian presence in the International Society for the Perioperative Care of the Obese Patient (ISPCOP). Inaugurated in 2011, ISPCOP's mission is to promote excellence in clinical management, education and research regarding the care of the morbidly obese patient during the perioperative period.

During the second symposium and business meeting of the Society held in San Francisco, I was appointed to the Board of Directors.

Regular meetings with contributions from leading experts and scientific sessions will be held in New Orleans during the American Society of Anesthesiologists meeting in 2014, in Berlin during the 2015 European Society of Anaesthesiology meeting and at the World Congress of Anaesthesiologists in Hong Kong during 2016. Useful educational resources such as videos, lectures and practice guidelines are available at www.ispcop.org.

The August issue of *International Anesthesiology Clinics* "Obesity" (Vol 51 Iss 3, 2013) has recently been released with authorship largely from office bearers of this society.

Annual membership of ISPCOP is available to anaesthetists from all over the world. This is something I believe should be taken advantage of by members of the ASA.

Dr Adrian Sultana (MD FRCP (Glasg) FANZCA), Double Bay, New South Wales

NSC ONLINE COMMENTS

We've gathered some of the comments from our anonymous online forum for the NSC 2013. Take a look and see what members thought of the event.

"International speakers at the cutting edge of neuroscience were excellent."

"Whilst not as well attended as previous NSCs, it was very friendly and more intimate. I enjoyed the conference and Canberra."

"A well planned conference for participants as well as for family members. There were wide variety of topics from various anaesthetic fields for each and every participant in the form of plenary sessions, small discussion groups and workshops. Extra activities either during the office hours as well as in the evening made family members feel welcome."

"Seemed to me to run on time, the venue [was] well-designed, registration took a minute or less, and [the Congress had] a comprehensive industry representation. I liked the conference bag as a functional addition; plenty of information [in] the program as it progressed."

"Everything worked like clockwork for me. Congress organisers were very efficient and extremely helpful."

Talking about HCI exhibition: "Amazing new technologies on display. Non-invasive CO, Hb and vein finding using light. It all felt like something from Harry Potter!"

"The plenary speakers were outstanding, as were the social events. The dinner at Parliament House was a truly memorable event."

Talking about Carnival night: "Excellent venue. Great entertainment for the kids so the adults were able to relax! Kids loved the basketball and the ice-cream van. Early kids buffet was also an excellent idea."

"The conference mobile app was par excellence and sets a new standard for all future meetings."

"Outstanding step forward. Especially being able to see the abstracts and get the pre-reading before the meeting!"

HAVE YOUR SAY

We would love to hear your feedback on our magazine and its content. All letters are welcomed and will be considered for publication. The Medical Editor reserves the right to change the style, shorten any letter and delete any material that is, in his or her opinion, discourteous or potentially defamatory. Any major revisions required will be referred back to the author for approval.

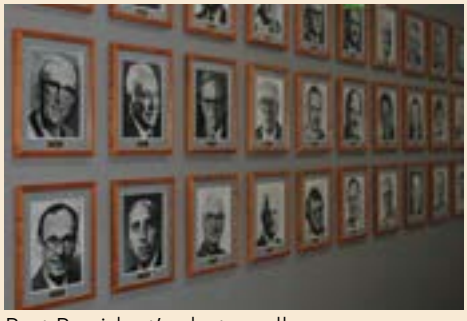
Letters should be no more than 300 words and must contain your full name and address.

Please email us at editor@asa.org.au to submit your letter.

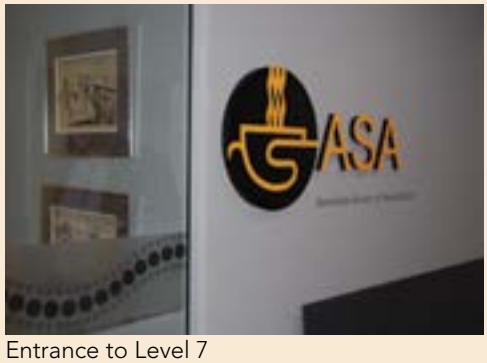
ASA OFFICE MOVE


Looking from CEO's office down to kitchen

Main entrance to 121 Walker Street


Past President's photo wall


President and CEO surveying the Museum



Entrance to Level 7


Staff kitchen with harbour views


President surveying President's office

Feature wall at entrance to Level 8


The finished office


Library under construction


CEO surveying CEO's office


Artwork in lounge

REGULAR

MSAC AND RED TAPE

DR MARK SINCLAIR, CHAIR OF THE ECONOMICS ADVISORY COMMITTEE

The Society fully supports the basic aim of the Medical Services Advisory Committee (MSAC), that is, evidence-based expenditure of public funds. However, the MSAC processes have proven flawed which has resulted in delays and inefficiencies.

The ASA currently has several ongoing applications with MSAC*. Application 1183* has been in place for over two years, which is by no means unusual. The process is slow and inefficient and has revealed problems at a most basic level. The draft Decision Analytic Protocol, the primary document summarising the applicant's position, and posing a number of initial questions to guide the assessment process, for application 1183* aimed at summarising the nature of the application and the evidence required was an extremely flawed document. Written by people with very little knowledge of the clinical nature of the application, or even some of the most basic aspects of anaesthesia care, it resulted in numerous revisions over many months. The ASA was asked to nominate several clinical experts (who were not involved in the application itself) to provide assistance to MSAC and yet their input had not been sought. I can only speculate as to the amount of public resources which were consumed during this time and how this compares to the $2 to $3 million per annum which would be spent, should the application eventually be approved.

These lengthy delays and inefficiencies have a significant effect on the relevance and usefulness of the Medicare Benefits Schedule (MBS) itself. As healthcare interventions evolve and improve based on clinical evidence, the heavy emphasis on economic aspects of MSAC application and the delays and inefficiencies discussed above result in the MBS falling further and further behind, becoming an increasingly irrelevant document in terms of modern health care. There are certainly examples of well-established, evidence-backed procedures which are not represented in either the procedural or anaesthesia sections of the MBS because of the requirement for all such services to be assessed over the course of several years. On the other hand, the previous Federal Government was prepared to spend $350 million of public funds on videoconference consultations with no detailed independent assessment of the benefits to patient outcomes or the cost-effectiveness of the service.

*At time of production the ASA had three MSAC applications under consideration: 'The use of two dimensional ultrasound guidance to aid vascular access and nerve blockade procedures' (application 1183); 'The performance of local anaesthetic nerve blocks to aid postoperative analgesia' (application 1308); and 'Improved funding for complex initial consultations in the practice of pain medicine' (application 1309).

DR STEVE HAMBLETON, PRESIDENT OF THE AUSTRALIAN MEDICAL ASSOCIATION

Australia's health spending in 2009 to 2010 was 9.4% of GDP. Ten years earlier it was 7.9%. It is projected to be 12.4% in 20 years' time. The medical profession is being asked to help control these spiralling costs. Specifically, to help identify the cost-effectiveness of medical services or, as the Department of Health is now describing it, those that are "value for money". This is a reasonable role for the medical profession as a steward of the health system in Australia.

The MSAC is one of the mechanisms being used to look at whether health spending is delivering 'bang for buck' for taxpayers through the Medicare Benefits Schedule (MBS). Formal processes currently being used by the Department of Health, such as Decision Analytic Protocols, don't appear to be the most effective in identifying the real clinical issues that need to be assessed, or collating information to enable good decision-making about the funding of medical services through the MBS.

We now have enough data to be certain that it's not the ageing population or the prevalence of chronic disease that is driving increased health expenditure. It's the volume of treatment provided in each episode of care. We believe it is not unreasonable for governments, with the advice of the medical profession, to have a good look at what can be done to ensure every health dollar is spent wisely. It is important for treating doctors to be involved in this analysis. If funding arrangements can limit choices and effectively limit the doctor to work with what's available, patients' expectations—that everything that can be done will be done—won't be met. They may be dissatisfied with their healthcare experience. They might blame their doctor, not the funding scheme.

As such, the challenge for the medical profession is to accept that we do have a role in the stewardship of the health system, but to make that role workable. Evaluation and change will need to be part of the medical practitioner DNA. In terms of our clinical practice, we are going to have to translate what we know into what we do and do it in a structured way, with much greater scrutiny.

The AMA is already involved in reviews of services on the MBS and a government forum on the sustainability of it. Although the reviews have been challenging, we are keen to work with the government to improve the processes so that assessments can be on point and timely. We're confident that we can achieve arrangements that include the profession's input at the earliest point so that the outcomes are agreed by all and underpinned by good information and analysis.

STATEMENT FROM THE DEPARTMENT OF HEALTH AND AGEING

The Medical Services Advisory Committee (MSAC) advises the Federal Government on the merits of public funding of medical services based on evaluation of the safety, comparative effectiveness and cost-effectiveness of the proposed service. The first two components of this evaluation have clinical focus and it is only when the service demonstrates this clinical benefit that an economic evaluation becomes relevant.

This process is equivalent to the process used by the Pharmaceutical Benefits Advisory Committee to evaluate which pharmaceuticals should be listed on the Pharmaceutical Benefits Scheme. The Health Technology Assessment is used by many governments around the world to ensure that patients have access to medical services and medicines that have proven benefit and are a value for money proposition for government and taxpayers.

In considering an application, the MSAC will assess the safety, efficacy and cost-effectiveness of the proposed service or technology that is sought to be listed on the MBS. Before an application is brought before MSAC it is, usually, considered by its sub-committees—the Protocol Advisory Sub-Committee (PASC), and the Evaluation Sub-Committee (ESC). This process has been put in place to better facilitate applications through the MSAC process to ensure that MSAC applications can be considered for MBS listing by Government in the shortest possible time frame. The Australian Government Department of Health is actively working with stakeholders to identify options for streamlining MSAC considerations.

When MSAC recommends a change, the Department conducts a process of external stakeholder consultation, including with the Australian Medical Association and other professional organisations, to finalise item descriptors and to determine the effects on the sector.

MEDICAL SERVICES ADVISORY COMMITTEE

The publications team at the ASA contacted the Director of the Medical Services Advisory Committee, Jeanette Dunn, for a point of view on MSAC and red tape. Unfortunately, Ms Dunn was unable to provide a point of view before the final content due date of the December issue of *Australian Anaesthetist*.

FEATURE

ANZCA'S NEW CPD STANDARD: TOO FAR OR NOT FAR ENOUGH?

The new Continuing Professional Development (CPD) standard released by the Australian and New Zealand College of Anaesthetists (ANZCA) represents a significant change for Australian anaesthetists. Read on as ASA Vice President Dr Guy Christie-Taylor (MB BCh, FANZCA, FFARACS) considers the implications of the changes to the CPD standard for anaesthesia and what they mean for practising anaesthetists.

ANZCA's new CPD standard: too far or not far enough?

Alternatively, is it a case of 'pretty much the same as before' or 'more rigorous and demanding' and will it 'deliver us from the regulatory environment'? (Vanessa Beavis, College Conversations, September 2013).

So is the new CPD standard 'pretty much the same as before'?

The answer is probably not—in fact the standard is a fundamental and profound change to the nature of CPD for anaesthetists in Australia.

The question is whether it is revalidation, recertification or merely 'beefed up' in anticipation of what requirements the Medical Board of Australia (MBA) might come up with once it has completed its "conversation" concerning revalidation. The MBA has begun the conversation following the implementation of a model of revalidation by the General Medical Council in the UK. In addition, the Medical Council of New Zealand has recently implemented a program of recertification.

It is important to note in relation to revalidation that the Australian Medical Association (AMA) considers that:

- medical indemnity insurers have not called for this type of regulatory activity to mitigate their risks;
- revalidation (without justification) risks putting additional stress on an already stressed workforce and impacts on time spent caring for patients;
- there must be specificity about the intention—to address impairment, incompetence, poor performance or unethical practice;
- it is not clear what standing a document purporting to validate the fitness of an individual to practise would have in the event a patient is harmed; and it is not

clear whether the 'validator' would bear any responsibility in the event a patient is harmed after a medical practitioner has been 'revalidated' (http://bit.ly/1i2ZMRG).

Writing in the AMA (WA) e-newsletter, Dr Steve Wilson wrote the following: "The Medical Board of Australia is working this issue up for input from every medical group including the AMA. The deliberations will be over several years so, don't panic!" (http://bit.ly/1dZECkV).

ANZCA's new CPD standard has been drafted and will be implemented on 1 January 2014—so perhaps there is a need to panic?

ANZCA is the specialist medical college accredited by the Australian Medical Council to set the CPD standard for anaesthesia and pain medicine practice in Australia, and it is also recognised and accredited by the Medical Council of New Zealand to provide a recertification program for specialists registered in the vocational scope of anaesthesia and pain medicine in New Zealand.

ANZCA is able to set standards for training but the question remains as to whether it can mandate a unitary standard for the workforce in two distinct countries

The standard is therefore designed to accommodate the requirements of two distinct jurisdictions and the needs of practitioners in two sovereign states. In addition, the standard has to consider the workforce issues, financial resources, public expectations, human resources and geographical differences between these two countries. The question is whether such a standard can reconcile these or whether some allowance might be needed to take account of these. ANZCA is able to set standards for training but the question remains as to whether it can mandate a unitary standard for the workforce in two distinct countries, particularly when the requirements of the statutory bodies in those two countries are different. The requirements for recertification and revalidation in Australia have not been fully articulated by the MBA.

The definition of CPD used by ANZCA has a well-defined component of maintenance of skills and standards, and it places practice evaluation as its first principle, followed by self-directed learning. This emphasis is in keeping with the MBA registration standard, which states:

CPD must include a range of activities to meet individual learning needs including practice-based reflective elements, such as clinical audit, peer-review or performance appraisal, as well as participation in activities to enhance knowledge such as courses, conferences and online learning (http://bit.ly/17rgk3J).

The new standard now requires the attainment of 180 points per triennium (previously 120), and 100 of these will have to be obtained through Practice Evaluation activities. This is the equivalent of obtaining 100 of the 'old' Category 3 points, which have always been a bit harder to achieve.

At least 40 of these points per triennium must be obtained by undertaking a minimum of two of the following activities: patient experience survey, multi-source feedback, peer review of practice, or clinical audit of own practice or significant input into a group audit of practice.

The remaining 60 points or 30 hours can be obtained from a variety of activities, including reviewing a peer, reviewing patient care processes, morbidity and mortality meetings, incident monitoring, case conferencing, hospital accreditation, medico-legal reports/expert witness, root cause analysis and a team training scenario within your own work environment.

There has been a reduction in the types of activities that earn points, and some activities have had their points allocation reduced from 3 to 2 (e.g. reflection notes of own experience, self-assessment tests or programs, simulation and skill courses, and workshops on practical skills and procedures).

The emphasis is therefore on how you are performing. These suggested activities, whilst appearing benign, might be quite confronting to many members who have had little experience of such activities since completing training (or even during their training) and will certainly require considerable resources and time. While completion of many of these activities is feasible when working in a public or academic practice, the feasibility of a busy private practitioner or a more isolated practitioner meeting these requirements remains to be elucidated.

These suggested activities, whilst appearing benign, might be quite confronting to many members who have had little experience of such activities since completing training

Will they make a difference to the majority of members and will practice be enhanced and public safety and outcome improved?

A very large medico-legal study, conducted in Australia, was recently published in *BMJ Quality and Safety*. The research, conducted at the University of Melbourne, found that just 3% of Australian doctors account for half of all formal patient complaints against doctors made to health service ombudsmen.

The number of previous complaints a doctor had experienced was a strong predictor for the risk of recurrence. Doctors named in a third complaint had a 57% chance of being named in another one within two years (http://bit.ly/1ch3N06).

Prior to adding to the compliance burden for the 97%, it would seem reasonable to ensure that the mechanisms to deal with known and recalcitrant 'offenders' are functioning adequately and resources are guaranteed to ensure that the processes are expeditious. The mechanisms to deal with any underperformance that may be uncovered by the processes within the new standard need to be clearly defined and the roles and responsibilities of the reviewed, the reviewer, ANZCA, the employer and

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the MBA need to be articulated. Up until now, the only mechanism available to deal with the poorly performing practitioner is reporting to the Australian Health Practitioner Regulation Agency. Whether other mechanisms are proposed remains to be seen.

Anaesthetists will require additional materials, resources and explanation to understand precisely what the requirements are and, more importantly, what consequences might emerge from any of the listed activities in the new Category 1 (Practice Evaluation).

The ASA is committed to assisting its membership to deal with these changes

The attainment of the necessary knowledge and skills credits requires 80 credits or 80 hours of activity. Emphasis is placed on short courses, workshops, problem-based learning discussions and courses towards formal qualification. The implications of this emphasis together with the more rigorous practice evaluation will potentially influence member choice of conference attendance and selection of educational activity. Much of the activity can be obtained locally. This includes teaching, workplace-based assessment of trainees, examining, research and publication. Again, for those members whose practice does not involve access to these activities and who need to obtain the points, a conference with an emphasis on workshops and problem-based learning discussions will clearly have greater appeal than one with a more didactic lecture-based approach.

The new Emergency Responses component requires completion of two activities. Anaphylaxis and haemorrhage can be completed via e-learning. The Australian and New Zealand Anaesthetic Allergy Group's *Anaphylaxis Management Guidelines* are a good example of the type of resource that will presumably be utilised (http://bit.ly/1eFvBQE). Additionally, the *Critical Bleeding Massive Transfusion* guidelines from the National Health and Medical Research Council might form part of the e-learning for major haemorrhage (http://bit.ly/1gEkcBh). ANZCA will need to ensure that the activities utilised are of the highest standard and reflect current consensus and practice relevant to Australia.

Undertaking activities to remain current in 'can't intubate, can't oxygenate' and cardiac arrest will require active participation in an education activity endorsed by ANZCA. Making such activities available to Fellows and members is important; however, ensuring the uniform standard and quality of these activities is imperative in setting and maintaining standards. ANZCA must ensure that such activities are monitored and quality controlled, as well as guard against the proliferation of 'educational offerings' by non-endorsed providers.

Members must clearly understand the difference between the CPD standard and a CPD program.

The ASA might offer a CPD program with an IT interface that provides easy recording and management of the activities undertaken by a member; however, in order for this to be acceptable to the MBA and to comply, it has to meet the standard set by ANZCA.

The ASA is not in a position to offer an alternative standard with a different emphasis or content.

The new standard raises the spectre for revalidation and recertification of Australian anaesthetists, and ANZCA has taken the initiative by setting the standard, rather than have it imposed externally

The ASA has endeavoured to create for its members the best possible CPD recording system, which will now require significant modification and alteration to allow members to use it to record and manage their activities determined under the new standard. Should the MBA complete its "conversation" and decide to impose alternative requirements upon the profession, then a revision of the tool will be needed and further additional costs will be incurred.

ANZCA's new standard is a significant alteration from its predecessor, with a much greater emphasis on practice evaluation, and it will require members to undertake a range of activities that might be unfamiliar and confronting. In addition, the new standard has highlighted the 'fragility' of any IT tool utilised to assist members. The cost of modifying and updating such systems must be acknowledged by any agency proposing changes and the benefit must outweigh the cost.

The new standard raises the spectre for revalidation and recertification of Australian anaesthetists, and ANZCA has taken the initiative by setting the standard, rather than have it imposed externally. Whilst this is laudable and probably the most reasonable course of action, it does, however, add considerably to the 'burden' of an already overburdened anaesthetic profession struggling with a considerable compliance load and workforce issues.

The recent beyondblue survey produced some alarming results concerning the mental state of the medical profession, particularly in respect to depression, suicidal ideation and substance abuse (http://bit.ly/1bwwnKM).

Former Australian Medical Association president and beyondblue adviser Dr Mukesh Haikerwal says the red tape burden faced by doctors needs to be reduced to lighten their load and doctors need to be taught other ways of dealing with stress than "hitting the bottle" (http://bit.ly/1gEkhVK).

The CPD standard has been promulgated by ANZCA in anticipation of future moves towards revalidation by the MBA. This process has occurred within a very short time frame, with no additional resourcing by any government agency, with many details yet to be finalised and no CPD tool as yet.

The ASA is not in a position to offer an alternative standard with a different emphasis or content

The ASA is committed to assisting its membership to deal with these changes.

The ASA would welcome your feedback and enquiries and will continue to lobby ANZCA and relevant government agencies to clarify the requirements and seek the additional resources to assist members with compliance.

FEATURE

NATIONAL SCIENTIFIC CONGRESS WRAP-UP: CANBERRA 2013

The 72nd ASA National Scientific Congress (NSC) was held from 26 to 29 September in our capital city, Canberra. The theme of the meeting was 'Anaesthesia—Art and Science' with the intention of asking anaesthetists to consider how to improve patient outcomes through the combination of both these facets in an ever-increasing world of 'evidence-based medicine'.

The Congress was held in the heart of Canberra at the National Convention Centre, only a few strides from Canberra shops and, more importantly, the annual Floriade. Attendees were inundated with the aroma of millions of blooms out for one of Australia's biggest celebrations of spring. The iconic Canberra event showcased more than one million flowers in Canberra's Commonwealth Park and, whilst a little windy, this only added to the effect as the cherry blossoms were out and spreading their petals with every gust.

This year's event boasted a record number of international speakers from the UK, USA, New Zealand, France, Sweden, the Solomon Islands and Fiji. International invited speakers included Prof Mike Grocott from the University of Southampton, Prof Colin Mackenzie from Maryland, Prof Martin Smith from London and Prof Anthony Quail, the Australian invited speaker. With an impressive international and local line-up, the delegates found themselves spoilt for choice.

After a few swift registration drinks on Wednesday night, the President's Cocktail Party was held at the National Portrait Gallery. Invited attendees were given the opportunity to wander through the gallery at their leisure before the cocktail party began. During the evening, Prof David Gibb was awarded the President's Medal for his services to the Society, primarily with the History of Anaesthesia Library, Museum and Archives Committee and the Retired Anaesthetists Group.

The Congress was opened on the Thursday morning by the President, Dr Richard Gruztner. This was followed by the Kester Brown Lecture, which was presented by Prof Julio Licinio, who is originally from Brazil but now based in South Australia. His presentation on depression and obesity was well received by those in attendance. Following this session were presentations from ANZCA

President Dr Genevieve Golding, Prof George Mashour from the University of Michigan and Prof Mike Grocott.

This year's event boasted a record number of international speakers from the UK, USA, New Zealand, France, Sweden, the Solomon Islands and Fiji

Thursday afternoon saw the opening of the exhibition hall, brimming with over 50 companies filling 60 booths (one of our largest trade rooms to date). A number of concurrent sessions ran in the afternoon, including sessions on trauma, economic updates, data and muscle relaxants. The afternoon sessions were followed with the Health Care Industry welcome drinks, which gave delegates and sponsors a chance to relax and enjoy a drink.

The Friday plenary session was opened by Dr Rob Carpenter, President of the New Zealand Society of Anaesthetists. This was followed by Prof Tony Quail, who gave an intriguing insight into asthma syndromes in anaesthesia and the integration of control systems regulating bronchial blood-flow and calibre. Prof Martin Smith also spoke on new approaches to multimodal monitoring in brain injury. The morning sessions included the Gilbert Troup poster prize session, followed in the afternoon by the Smiths Medical/ASA poster session. Dr Dale Currigan won the Gilbert Troupe with his insightful report on 'Vasopressor responses in human pulmonary and radial arteries', and Dr Mark Colson won the Smiths Medical/ASA award for his presentation on 'Cardiopulmonary exercise testing predicts 5 year survival after major surgery'.

Gala dinner at Parliament House

The social function on the Friday night was held at the Australian Institute of Sport, themed as Carnival Night. Adults and children alike were entertained by jugglers, entertainers, stilt walkers, snakes, lizards and hula-hoopers. It was a delight to be able to try out all of the sporting equipment, including basketball hoop-shooting, rowing, rock climbing and virtual cycling and skiing. The highlight of the evening for the children would have been the Mr Whippy van, although this was also a lowlight for many parents who didn't want to stand in the queue.

AFL Grand Final day kicked off with plenary sessions by Prof Colin Mackenzie, talking about myths, reality and the future for haemoglobin-based O_2 carriers; Prof Mashour, speaking on 'Interfaces of sleep and anaesthesia'; followed by the Pioneer Lecture from Prof Tony McMichael AO on 'The effects of climate change on health'. The morning schedule included sessions on exercise, obstetrics and welfare of anaesthetists. GASACT also commenced their session stream with tips for passing the primary exam, followed by the GASACT poster presentations. The afternoon began with the Annual General Meeting of the Society followed by the AFL Grand Final in the exhibition area. There weren't many left who couldn't be found congregating in the exhibition hall to cheer Hawthorn in victory over Fremantle on the big screen.

This year's black tie Gala Dinner was held in the capital's number one building, Parliament House. Following pre-dinner drinks and canapés, the attendees were piped into the Grand Hall by a bagpiper to wine and dine in the impressive surrounds. The evening saw people enjoy the tunes from the Stilettos and Atomic, with many people hitting the dance floor to show off their moves.

Sunday morning breakfast was filled with tender feet and croaky voices from all that AFL cheering and Gala Dinner dancing but enthusiasm for the congress was not lost. There were no plenary sessions on the final day but many attendees still made their way to the regional anaesthesia, Overseas Development and Education Committee, pain and day surgery Special Interest Group sessions. A very entertaining Hypothetical led by Convenor Dr Mark Skacel and organising committee member Dr Vida Viliunas closed the Congress.

This year's black tie Gala Dinner was held in the capital's number one building, Parliament House.

Another year and another NSC wrapped up, the ASA would like to say a special thanks to Convenor Dr Mark Skacel, Scientific Convenor Dr Paul Burt and their team, who put on an excellent scientific and social program that kept the delegates entertained and engaged throughout the four days. We would also like to thank everyone who came to the meeting and hope you're all perusing the shops for your snazzy new swimsuit to attend next year's NSC to be held on the Gold Coast.

FEATURE

NSC SCIENTIFIC CONVENOR'S REPORT

As Scientific Convenor for the 72nd National Scientific Congress of the Australian Society of Anaesthetists, Dr Paul Burt (MBBS, FRACS) was presented with a grand challenge which he rose to spectacularly. Picking through a plethora of options, he selected speakers for each topic, encouraged them to speak at the NSC and organised an excellent program for our Canberra attendees. His efforts are greatly appreciated by the ASA and NSC attendees. Dr Burt has also kindly written a Scientific Convenor's Report for this issue to sum up his experience.

The theme of this conference was 'Anaesthesia—Art and Science'. Planning began in 2010, with Dr David Duke as Scientific Convenor, but due to burgeoning family commitments he had to withdraw, and I took over in May 2011.

By this time, the principal ASA invited speakers, Profs Mike Grocott from Southampton, Martin Smith from London and Colin Mackenzie from Baltimore had already agreed to come.

David Duke had thought to invite a speaker with an interest in consciousness and, pursuing this idea, healthcare products producer Covidien was approached to see if they would consider providing an educational grant to facilitate the attendance of Prof George Mashour from Ann Arbor, US Presidential Scholar of 2011. Covidien agreed and Prof Mashour, whose name was put forward by a noted ANU philosopher with an interest in consciousness, Prof David Chalmers, was free to come.

It was decided to try to engage local talent if possible, especially for the Kester Brown Lecture and the Pioneer Lecture

We were fortunate to also interest several other international speakers in attending through the provision of educational grants by Edwards Lifesciences (who assisted with Prof Benoit Vallet's expenses) and Nihon Kohden (who did likewise for Prof Gilles Dhonneur), as well as through the assistance provided by the ASA to Prof Per-Olof

Grände from Sweden, Prof Keith Ruskin from Yale, Dr Guillermo Martinez from the UK and Dr Gordan Mijovski from Slovenia.

The Australasian visitor was Prof Tony Quail from Newcastle, who delivered a series of very interesting lectures on cardiorespiratory physiology. All major invited or sponsored speakers gave at least three lectures. Interestingly, a number of medical companies were very quick to refuse any financial assistance when approached.

SCIENTIFIC PROGRAM

The program was arranged such that almost all lecture sessions were of 90 minutes in duration—most plenary sessions consisting of two 45-minute lectures and most parallel sessions of three 30-minute lectures.

It was decided to try to engage local talent if possible, especially for the Kester Brown Lecture and the Pioneer Lecture. Both of these were given by two professors who were, at the time they committed to give their lectures, employed at the Australian National University.

The ASA also proved helpful in providing funding for the travel expenses of non-anaesthetists delivering lectures

The Kester Brown Lecture was given by Prof Julio Licinio, former Director of the John Curtin School of Medical Research, on the topic 'Depression and obesity—modern diseases'.

Prof Tony McMichael AO of the National Centre for Epidemiology and Population Health delivered the Pioneer Lecture on 'The effects of climate change on health'.

Parallel sessions were run as far as possible on a variety of sub-themes, including brain injury management, cardiac physiology, respiratory physiology, registrar education, muscle relaxant properties, the limitations of evidence-based medicine, exercise physiology and medical informatics.

All Special Interest Group (SIG) Chairs were contacted and asked if they were prepared to organise a session dedicated to issues of concern to their own SIG. Interestingly, only about half the SIG Chairs were in a position to prepare a session. One of the reasons for the lack of engagement of certain SIGs was the scheduling of annual SIG meetings close to the timing of the NSC.

Parallel sessions were run as far as possible on a variety of sub-themes, including brain injury management, cardiac physiology, respiratory physiology, registrar education, muscle relaxant properties, the limitations of evidence-based medicine, exercise physiology and medical informatics

I found this kind of timing conflict quite a handicap in preparing the program and would advise future Convenors to contact SIG Chairs as early as possible to see if they can obtain a commitment to become involved. Those SIGs that did participate did so very diligently.

The ASA also proved helpful in providing funding for the travel expenses of non-anaesthetists delivering lectures. These non-anaesthetists provided a degree of variety to the program.

AUDIOVISUAL SERVICES

All speakers seemed quite satisfied with the contractors, and my own impression was that they were very engaged, professional and committed.

WORKSHOPS, SMALL GROUP DISCUSSIONS AND POSTERS

Drs John Ellingham, Girish Palnitkar, Don Lu and Linda Weber had separate authority over these areas.

ACKNOWLEDGEMENTS

All the members of the local organising committee provided useful suggestions and feedback over the course of the planning phase. I am also grateful to Dr Piers Robertson and Dr David Elliott of the ASA for the benefits of their experience, and to the constructive suggestions for prospective speakers made by Prof Thomas Brussel.

I would also like to acknowledge the assistance of Robert Campbell and Katie Fitzgerald of the ASA, as well as the perseverance of Annabel Holliss of the professional conference organiser firm Sapmea.

WEDNESDAY


Registration for the NSC


President's Cocktail Party


President's Cocktail Party

THURSDAY


Prof Ross Holland opening the NSC


President Dr Richard Grutzner's opening address

Convenor, Dr Mark Skacel

Kester Brown Lecture, delivered by Prof Julio Licinio


Muscle Relaxant Quirks lecture delivered by Dr G Palnitkar


Dr Jeanette Thirlwell speaking about the History of Anaesthesia SIG


ACT invited speaker, Prof Keith Ruskin


Trade stands at the exhibition


Neuromuscular blockade workshop

FRIDAY

NZSA President, Dr Rob Carpenter

ASA invited speaker, Prof Tony Quail

ASA invited speaker, Prof Martin Smith

ACT invited speaker, Prof Per-Olof Grände

ASA invited speaker, Prof Mike Grocott

GASACT trainees

Carnival Night at the Australian Institute of Sport

Carnival Night at the Australian Institute of Sport

Testing the sporting equipment

Carnival-themed ballroom

Hula-hoopers entertaining the guests

Lining up for the Mr Whippy van

SATURDAY


ASA invited speaker, Prof Colin Mackenzie


ACT invited speaker, Prof George Mashour


Prof Tony McMichael AO delivering the Pioneer Lecture


Dr Neville Gibbs speaking at the AGM


ACECC AGM


AFL Grand Final screening


AFL Grand Final screening


Gala Dinner at Parliament House


Gala guests being piped into the Grand Hall


Dining in the Grand Hall


Gala Dinner table settings


Dr Piers Robertson awarding Covidien

President Dr Richard Grutzner addressing Gala guests

2013 NSC organising committee

Atomic performing for guests

Dancing at the Gala Dinner

ASA and NZSA CEOs Mark Carmichael and Renu Borst

Conga line in the Grand Hall

The Stilettos encouraging guests to hit the dancefloor

Prof Mike Grocott, Dr Mark Skacel and Dr Nick Gemmell-Smith

Drs Guy Christie-Taylor, Richard Grutzner and Simon Macklin

SUNDAY

Hypothetical Q and A session

Hypothetical panel

ODEC AGM

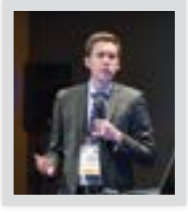
2013 AWARDS, PRIZES, RESEARCH GRANTS AND HONOURS

WINNERS ANNOUNCED

ASA PHD SUPPORT GRANT

Dr Alwin Chuan

Postgraduate training and teaching methodologies in regional anaesthesia



GILBERT TROUP ASA PRIZE

Dr Dale Currigan

Vasopressor responses in human pulmonary and radial arteries: an in vitro study

SMITHS MEDICAL/ASA BEST POSTER PRIZE

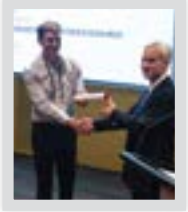
Dr Mark Colson

Exercise testing predicts survival after major surgery

SMITHS MEDICAL/ASA BEST POSTER PRIZE

Dr Paul Stewart

Residual neuromuscular blockade and critical respiratory events



AIC BEST PAPER AWARD

Cliff Grant with GL Ludbrook, EJ O'Loughlin and TB Corcoran

An analysis of computer-assisted pre-screening prior to elective surgery

JACKSON-REES RESEARCH GRANT

A/Prof Nolan McDonnell

A study of the transfer of gabapentin and pregabalin into breast milk

JEANNE COLLISON PRIZE

Dr John Loadsman

Factors influencing plasma ropivacaine levels associated with regional nerve blocks for postoperative analgesia

SMITHS MEDICAL/ASA BEST POSTER PRIZE

A/Prof Philip Peyton and Dr Christine Wu

Nitrous oxide induced PONV is related to duration of exposure

(C. Wu accepting on behalf of P. Peyton)

SMITHS MEDICAL/GASACT BEST POSTER PRIZE

Dr Gregory Bulman

"Still waiting in pain": a review of referral quality and the use of the pro forma

PRESIDENT'S MEDAL

Prof David Gibb

FEATURE

QUALITY ASSURANCE IN REGIONAL ANAESTHESIA

Quality can be described as the degree or grade of excellence of a trait or characteristic of a system. There is no single definition of quality and it is essentially non-measurable, writes Drs Anjalee Brahmbhatt (FRCA, FANZCA) and Michael J. Barrington (FANZCA, PhD). In this article, they discuss the importance of quality assurance and ongoing improvement in anaesthesia.

Quality assurance can be defined as ensuring clinical care is consistently practised and delivered to the highest standards. Quality assurance and improvement can be achieved through monitoring and reporting the quality of care. The use of guidelines and continual educational and professional development are important.

MONITORING QUALITY AND SAFETY IN REGIONAL ANAESTHESIA

Monitoring and reporting on the quality and safety of regional anaesthesia is important for informed patient consent and clinical decision-making. Postoperative nerve injury is a frequently quoted reason for not employing regional anaesthesia. This complication is often presumed to be a risk unique to regional anaesthesia; however, postoperative nerve injury may have diverse aetiologies.

Monitoring the quality and safety of regional anaesthesia is also important because clinical practice is continually evolving. Nevertheless, new techniques do not automatically equate with improved quality and safety. All new technologies, devices and drugs that patients are exposed to should be assessed for safety and effectiveness.

Monitoring the quality and safety of regional anaesthesia is also important because clinical practice is continually evolving

Registries and similar multicentre studies provide the foundation for many quality improvement processes. Cook reported that the incidences of paraplegia or death were 1.8 and 0.7 per 100,000 respectively following neuraxial blockade[1]. Orebaugh reported an incidence of nerve injury following 9069 peripheral nerve blockades of 0.09% at six months[2]. Sites determined

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the incidence of postoperative neurological symptoms following 12,668 peripheral nerve blockades at six months to be 0.09%[3]. In a large cohort study, the use of peripheral nerve blockade for knee arthroplasty was not associated with an increased risk of postoperative nerve injury[4].

TECHNOLOGY AND EQUIPMENT

New technologies including ultrasound guidance have significantly advanced our clinical practice, improving the safety and efficacy of peripheral nerve blocks. The chief utility of ultrasound-guided peripheral nerve blockade is the ability to image nerves, nerve plexuses, needles and injectate and to avoid structures such as blood vessels. However, a range of clinical and professional behaviours are associated with the quality and success of regional anaesthesia.

GUIDELINES FOR SAFE CONDUCT OF REGIONAL ANAESTHESIA

The Australian and New Zealand College of Anaesthetists has developed professional documents relevant to regional anaesthesia, including guidelines for the management of major regional anaesthesia, patient consent, facilities, equipment, assistance, infection control and sedation. Minimal standards of monitoring are deemed necessary during performance of a regional anaesthetic technique. Skilled assistance should be present at all times.

Other organisations have recommended that a lead anaesthetist or director of regional anaesthesia be appointed in each department to provide support and supervision in regional anaesthesia. Guidelines for the management of local anaesthetic systemic toxicity have been produced by the American Society of Regional Anesthesia and Pain Medicine and the Association of Anaesthetists of Great Britain and Ireland.

PROCEDURE-SPECIFIC PROTOCOLS, CHECKLISTS AND TEAMWORK

Checklists, teamwork and procedure-specific protocols all have a role in the delivery of safe regional anaesthesia. Numerous protocols have been developed in an effort to standardise care and effectively manage patients in the perioperative period. Hebl et al reviewed patients undergoing hip or knee surgery and suggested that a total joint regional anaesthesia protocol may improve outcomes such as reduced hospital length-of-stay[5].

Checklists, teamwork and procedure-specific protocols all have a role in the delivery of safe regional anaesthesia

Checklists in surgical and anaesthetic practice were endorsed following the 2008 publication of the World Health Organization *Surgical Safety Checklist*. It was believed that perioperative morbidity and mortality would be reduced by routinely checking common safety issues and improving team communication. The effectiveness of surgical safety checklists has been subject to further evaluation[6]. Teamwork is increasingly recognised as being important for high-quality clinical care, and one example is its use in the prevention of wrong-site peripheral nerve blockade. A patient safety initiative titled 'Stop before you block' has been developed in an attempt to reduce the incidence of wrong-site nerve block. Recurring causes of 'wrong-site' blocks include distraction in the anaesthetic room, a time delay between performing the checklist and peripheral nerve blockade, and blankets covering the marked limb.

TRAINING AND EDUCATION

Educating and training anaesthetists to the highest standards and their subsequent development are integral to assuring quality. The safe practice of regional anaesthesia requires both knowledge and practical skills, and correctly identifying all anatomical structures in the procedural field is an important prerequisite. Teaching in the clinical environment can be ad-hoc, with service delivery predominating. Various teaching methods have been employed, including the use of video teaching, part-task trainers and cadavers. We would also endorse, following appropriate patient consent, that trainees obtain proficiency in sonography and recognising sonoanatomical landmarks independent of performing peripheral nerve blockade. High-fidelity simulation has been shown to be effective for training novices in managing emergencies, including severe local anaesthetic systemic toxicity.

FUTURE DIRECTIONS

Training and education forms the foundation for future quality of care in regional anaesthesia. The use of specific educational strategies, rather than relying on volume of exposure, is essential. Systematic monitoring and reporting of outcomes are critical to describe and define our evolving practices. Outcomes should include the broad range of metrics and outcomes that define quality. Evaluation of new technologies and equipment will remain important. We should recognise that anaesthetists are our greatest quality improvement resource because of their potential to collectively capture quality data close to the point of care from large patient cohorts.

Systematic monitoring and reporting of outcomes are critical to describe and define our evolving practices

The science of safety did not originate in health care, and there is likely value in collaborating with quality and safety experts outside of the healthcare industry.

CONCLUSION

Existing large-scale and nationwide studies indicate that the incidence of serious adverse events attributable to regional anaesthesia is infrequent or rare. However, ongoing evaluation of the quality of our care is important; hence, quality assurance and improvement are critical processes in which all anaesthetists should be actively involved. The initial training of anaesthetists, assessment of the final product and subsequent continual professional development remain important for delivering high-quality care. Guidelines, checklists, teamwork and attitudes to safety in routine clinical practice are all important components of the modern quality paradigm.

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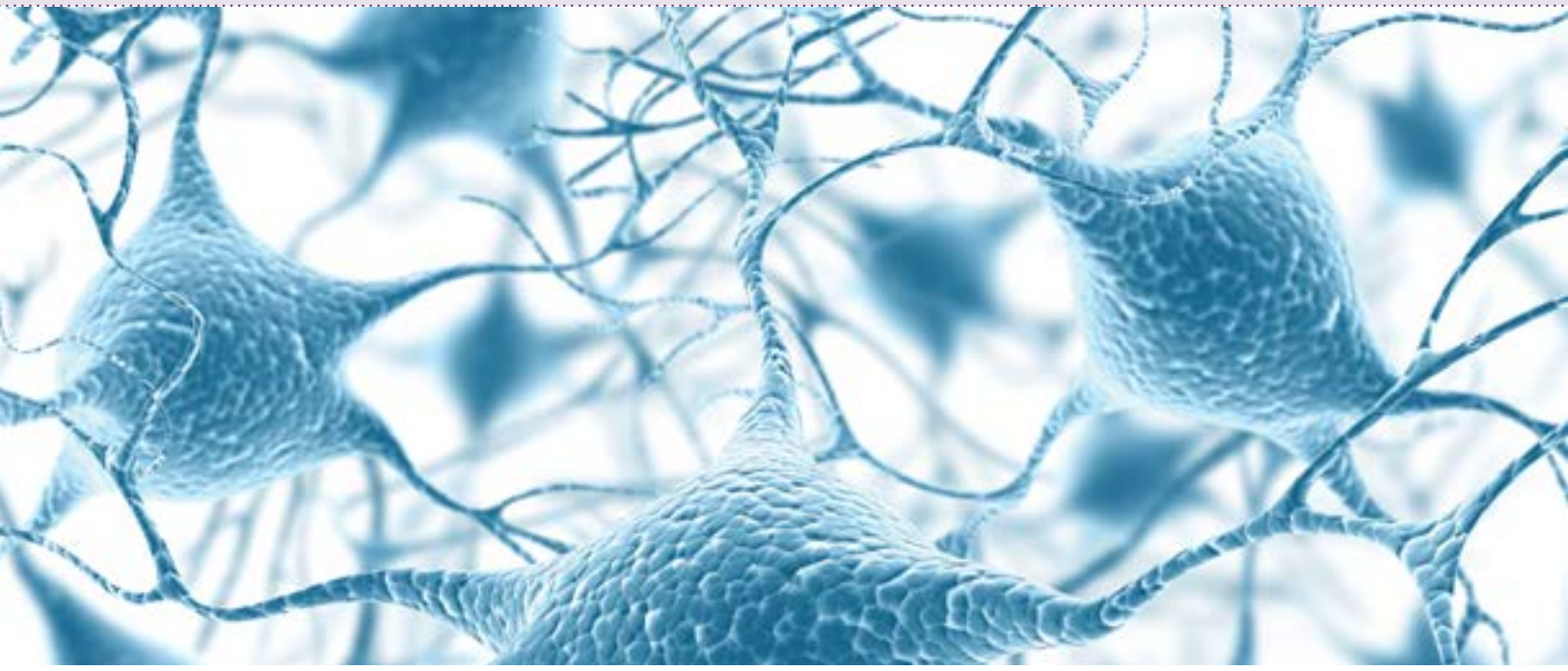
FEATURE



NERVES AND THEIR CONNECTIVE TISSUE LAYER

Whilst the issue of where to place local anaesthetic has been extensively discussed in the literature, there is still considerable uncertainty which is further compounded by confusing terminology. Where exactly should you inject the local anaesthetic? Drs Neil MacLennan (MBChB, FANZCA) and Chris Nixon (MBChB, FRCA, FANZCA) clarify an evolving area of clinical practice.

For the anaesthetist performing an ultrasound-guided regional anaesthetic procedure, the issue of where to place the local anaesthetic (LA) should now be crystal clear. After all, the gross anatomy of peripheral nerves has been thoroughly documented and we have the knowledge obtained by over a decade of ultrasound imaging to add to our understanding of the appearance of nerves and their surrounding soft tissues. However, it turns out that this issue is clouded by some confusing terminology and uncertainty about the safety of injecting LA very close to nerves.

PERIPHERAL NERVE ANATOMY

The basic structure of a peripheral nerve starts with the individual nerve fibre, which is surrounded by an inner fascial layer called the endoneurium. Groups of nerve fibres are collected into bundles called fascicles, which are surrounded by a tough fibrous sheath called the perineurium. Fascicles are then clustered together by the external covering of the nerve—the epineurium. All peripheral nerves have an epineurium whether they are an individual nerve or part of a plexus. Peripheral nerves begin as spinal nerves and here their external layer starts as a continuation of the dural nerve sleeve and subsequently blends into the epineurium[1]. It is clear there are also extraneural connective tissue layers which provide mobility and protection to the nerve. The extraneural layers are of particular importance in both the popliteal sciatic nerve and brachial plexus. Their anatomy and clinical relevance will be discussed further below.

FASCIAL LAYERS OF THE BRACHIAL PLEXUS

Several recent studies of the brachial plexus have used a different approach to the above terminology. Bigeleisen et al[2]

examined the anatomy of nerves of the brachial plexus, aiming to measure their neural content as the nerves moved from proximal to distal. However, the terminology used in this study is at odds with the description of nerve anatomy above as the term epineurium is used to describe the external connective tissue layer of the entire brachial plexus, implying that LA placed inside this layer results in an intraneural injection. A second study by the same group[3] describes the nerve stimulation thresholds for intraneural and extraneural supraclavicular blocks. Again, the term epineurium was used to describe the compartment containing all the nerves of the brachial plexus. Not surprisingly they demonstrated a lower current was required for a motor response for an 'intraneural' needle position compared to an 'extraneural' one.

The nerve anatomy diagram (Figure 1) suggests that the epineurium is the external layer of an individual nerve rather than the covering layer of the entire plexus.

An alternate interpretation of the anatomy is provided by Franco et al[4] in his study of the brachial plexus sheath in human cadavers. In all specimens, he was able to identify "a macroscopic envelope of fibrous tissue" surrounding the brachial plexus. It is several millimetres thick, contains nerves and vessels, and runs from the neck to the upper arm where it blends with the deep fascia.

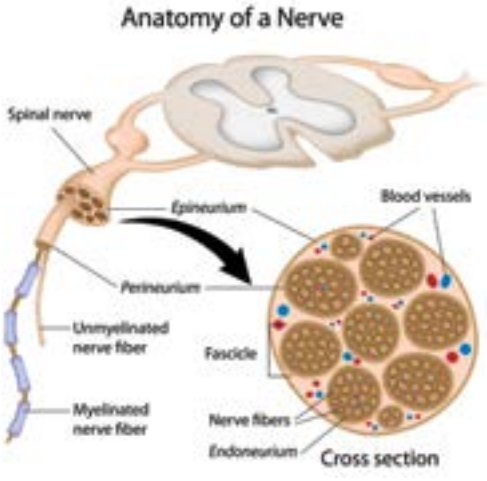


Figure 1. Anatomy of a peripheral nerve.

This suggests that the outer layer referred to by Bigeleisen et al can be more simply viewed as an extraneural connective tissue layer or sheath of the brachial plexus. All the nerves within have their own epineurial covering. Injections within this space are intrasheath but remain extraneural. Franco added to his earlier descriptions of the brachial plexus fascia in a recent editorial on the subject[1]. Here he clarifies that the epineurium is the external layer of the nerve regardless of whether the nerve is a root, trunk, division, cord or branch. He also defines an intraneural injection as being one in which the epineurium is breached.

FASCIAL LAYERS OF THE SCIATIC NERVE

There is a similar level of confusion in the lower limb when considering the sciatic nerve. When performing a popliteal sciatic nerve block, if the LA is injected close to and between the tibial nerve and common peroneal nerve, both nerves appear to be surrounded by an outer fascial layer. This layer has been referred to as a sub-epineural sheath[5], a complex fascial layer[6] and common paraneural sheath[7]. The study by Tran[5] in particular suggests that injection beneath this layer should be considered an intraneural injection.

Several recent papers have clarified the terminology. Referring again to Franco's editorial[1], we can see that the common peroneal and tibial nerve are separate nerves as they do not mix their fibres and each have their own investing epineurium. Just as in the brachial plexus, there is an additional extraneural investing layer of fascia containing both nerves that run from the origin of the sciatic nerve and down into the popliteal fossa. This has recently been referred to as the paraneural sheath[8,9]. Clinically, it can be thought of in a similar way to the brachial plexus sheath.

Finally, just when it was all becoming clear, there is in fact one further fascial plane to be described! In a recent study using high-definition ultrasound in patients undergoing foot surgery, Karmakar et al[9] were able to identify another layer of fascia outside the paraneurium. This is called the epimysium.

This epimyseal layer is a well-defined intermuscular space filled with adipose tissue and vessels. Injections of LA beneath this layer are into the subepimyseal perineural compartment. LA injected here or beneath the paraneural sheath are both considered extraneural.

WHERE TO INJECT THE LOCAL ANAESTHETIC?

Having now sorted out the terminology, it should be reasonably straightforward to decide where to put the LA. However, perhaps not surprisingly, the best place for the LA is still a topic of some debate. There are three possible techniques: 1) intraneural injection, 2) intra-sheath or sub-paraneural injection, 3) peri-plexus or sub-epimyseal injection.

Intraneural injection

Deliberate intraneural (sub-epineural) injection has been described and advocated by Bigeleisen and his group. Their technique is to inject LA directly into the nerve by breaching the epineurium whilst still remaining outside of the fascicles containing the nerve bundles (an intraneural extrafascicular injection)[10]. They argue that intraneural injections have been performed accidently for years using nerve stimulation techniques, usually without complications. Details of the technique include avoiding very proximal nerves (e.g. interscalene brachial plexus) which have very little non-nerve tissue, using a blunt short bevel needle and injecting very small volumes of LA. It is fair to say that deliberate intraneural injection is not widely accepted and most authorities believe it should be avoided[11].

FEATURE

Intra-plexus (sub-paraneural) injection

Sub-paraneural LA placement now seems to be the preferred technique for popliteal sciatic nerve blocks[5-9]. The evidence suggests sub-paraneural injections result in improved block quality for all block parameters. Interestingly, in a recent editorial, Abdallah and Chan[12] offered a more conservative interpretation of the literature and advised caution with paraneural injections, arguing that current ultrasound technology still limits our ability to discriminate between the different layers of connective tissue.

Turning to the brachial plexus, the options are to place the LA inside or outside the sheath. For intra-sheath blocks, these can either be perivascular or perineural. The perivascular technique is slightly more conservative, with LA being deposited within the sheath but not aiming to target individual nerves within the sheath. In the axilla this means LA being injected deep to the axillary artery. For the infraclavicular perivascular block, LA is placed beneath the axillary artery without attempting to target the three cords separately. From an empirical perspective it seems reasonable to expect improved block quality with closer LA application. However, several studies have shown equivalent outcomes when comparing an intra-plexus perineural to an intra-plexus perivascular technique[13,14].

Peri-plexus (sub-epimyseal) injection

Finally the peri-plexus technique involves placing LA close to the plexus without aiming to get LA completely surrounding the epineurium. For an interscalene block this means LA outside of the sheath[15]. Overall there still seems to be a slightly more conservative approach to LA placement for brachial plexus blocks compared to popliteal sciatic blocks.

CONCLUSION

When choosing between sub-paraneural (intra-plexus) and peri-plexus techniques, several factors should be considered.

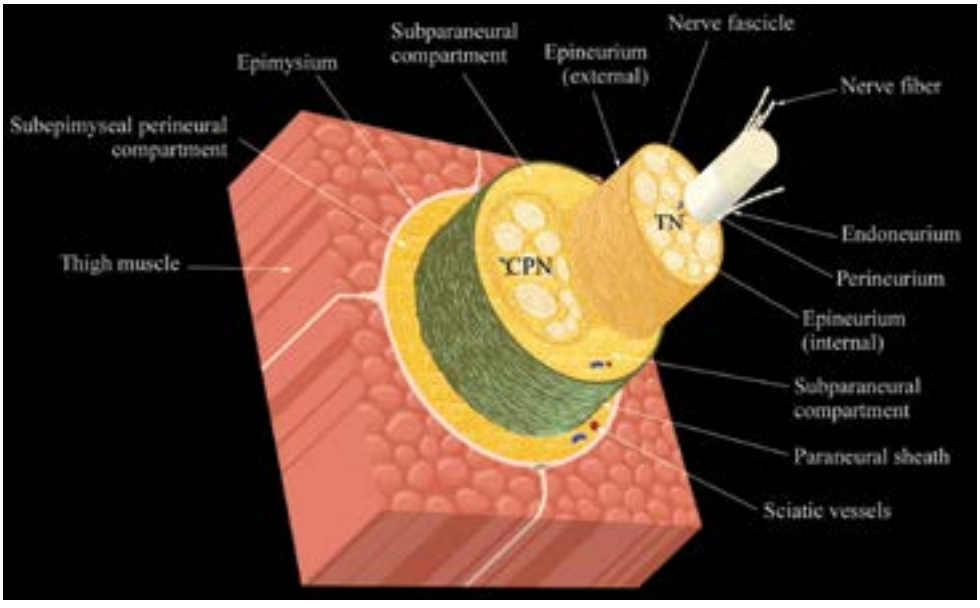


Figure 2. Functional anatomy of the sciatic nerve, paraneural sheath, and the fascial compartments that surround the sciatic nerve, before its bifurcation at the popliteal fossa. Copyright 2009 American Society of Regional Anesthesia and Pain Medicine. Used with permission. All rights reserved.

If surgery is to be performed under the block alone (especially where general anaesthesia is best avoided), we favour a sub-paraneural or intra-plexus technique. Caveats include having an experienced operator performing the procedure and excellent ultrasound image quality. If the block is for postoperative analgesia only (surgery to be performed under general anaesthesia), the operator is inexperienced, or ultrasound imaging is challenging, it may be wiser to stick with a peri-plexus technique. As this is an area of active research, it is likely that further studies will become available to help guide our decision-making.

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FEATURE

REGIONAL ANAESTHESIA IN REMOTE LOCATIONS

The benefits of regional anaesthesia have been well documented. Dr David M. Scott (BMed [Newc], GradCertClinUS, FANZCA) explains that when regional anaesthesia is used as the sole technique it offers a protected airway, less respiratory and cardiovascular depression (with the exception of vasodilatation associated with neuraxial blockade) and a generally smooth and pain-free recovery. When regional anaesthesia is combined with general anaesthesia, it offers a smooth perioperative course and superior outcomes when compared to general anaesthesia alone[1].

These advantages also apply equally in remote locations. For patients with painful injuries who require medical evacuation to higher levels of care, continuous regional anaesthesia techniques provide unique opportunities for analgesia and comfort over what are often rough roads and bumpy transfers.

OPPORTUNITIES IN REMOTE LOCATIONS

The opportunity for regional anaesthesia in remote locations is really determined by the caseload, the availability of technology to perform it and the availability of appropriate resuscitation equipment.

Low-tech options

Spinal anaesthesia is really limited by availability of needles and appropriate drugs. It is a very useful technique for procedures on the lower body, and obstetric and gynaecological conditions.

Epidural blockade can be a very useful tool for anaesthesia and for analgesia when transporting patients with a wide range of injuries from chest to lower limb[2]. However, if choosing this technique one must ensure that there is a chain of care for the patient that will assure appropriate management of the analgesia and of any complications that may occur. Caution should be exercised for neuraxial blocks considering the potential for infection. The experience in Banda Aceh after the Boxing Day Tsunami in 2004 was that many of the injured had seriously infected wounds and sepsis was common. For this reason spinal anaesthesia was not commonly employed.

Experience from the conflicts in the Middle East revealed that epidural analgesia can be very useful in the early

management of pain in wounded soldiers, particularly in their early, often repeated, surgery and their medical repatriation to higher levels of care[3,4].

Patients receiving high-quality analgesia from these continuous blocks have been shown to have ... fewer problems with post-traumatic stress disorder

There are many techniques for peripheral neural blockade which are relatively safe and reliable and require nothing more than an understanding of the usual anatomy and a needle, syringe and local anaesthetic to achieve a clinically useful result. These blocks include blocks around the face (mental, infraorbital, supraorbital and supratrochlear nerves), peribulbar, trans-arterial axilliary, wrist, digital, infrainguinal fascia iliaca and ankle. All of these blocks can be performed with a relatively high success rate using minimal technology and equipment. It should be recognised that the results will not be as reliable as ultrasound and/or nerve-stimulator guided techniques, but with judicious dosing of anaesthetic agents many can be repeated if the first attempt is unsuccessful. These blocks are generally not conducive to continuous techniques, but can be most useful as a bridge to higher levels of care where more sophisticated techniques may be employed.

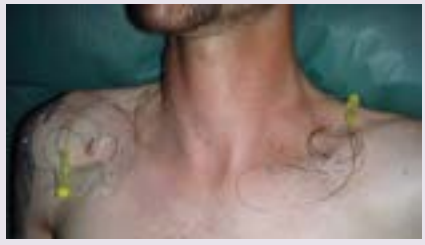
Higher-tech options

With the introduction of highly portable point-of-care ultrasound devices, relatively sophisticated continuous regional anaesthesia techniques can be employed in remote and austere environments. During my time as a deployed anaesthetist in Tarin Kowt, Oruzgan Province, Afghanistan, I was able to provide continuous peripheral regional anaesthesia for wounded Australian and coalition soldiers, which allowed them to be painlessly repatriated back to Australia or Europe[5]. These patients all arrived home comfortable, requiring minimal opiate analgesia. Other coalition medical teams duplicate this experience and the US army has extensive experience in both management and follow-up of these wounded men. Patients receiving high-quality analgesia from these continuous blocks have been shown to have significantly reduced analgesia requirements and fewer problems with post-traumatic stress disorder[6].

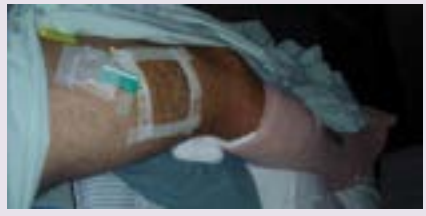
The use of specialised needles in this situation is not crucial as most nerves can be blocked continuously using an epidural kit. The needle is large and easy to visualise and the catheter is quite suitable for peripheral nerves, as well as for use in trunk blocks like continuous transversus abdominus plane blocks and rectus sheath catheters. These blocks can be performed pre or postoperatively on trauma patients. When working in less-than-ideal conditions with regard to sterility, peripheral nerve blockades probably pose less risk of serious infection when compared to epidural analgesia. The quality of analgesia has been reported as comparable to epidural block.

INSTITUTING REGIONAL ANAESTHESIA AND ANALGESIA IN REMOTE ENVIRONMENTS

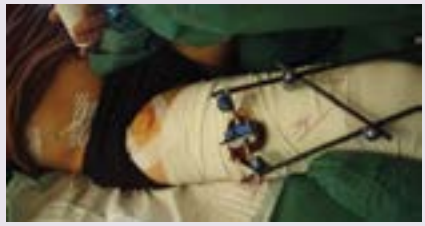
As has been described, if one has access to portable ultrasound and epidural kits there is a wide range of opportunities to provide excellent analgesia for our patients. Both peripheral and trunk blocks can be easily and quickly performed if the operator is suitably trained. The opportunity just needs to be identified. Many patients are not receiving the benefit of these blocks because they have not been considered beforehand. In modern anaesthesia practice I believe that instead of considering balanced anaesthesia as hypnosis, amnesia and analgesia, we should add a fourth fundamental of regional anaesthesia. There are many injuries and surgeries that are amenable to supplementation with local anaesthesia techniques, which can be quickly and easily applied if ultrasound is available and the operator is trained.



Bilateral infraclavicular brachial plexus catheters for bilateral hand injury due to grenade explosion (including traumatic amputation). Transported to Paris pain-free and in good spirits.



Sciatic nerve catheter for gunshot wound (thigh). Transported to Australia over three days, including two dressing changes. Now returned to active duty.



Femoral nerve catheter for fractured shaft femur. Transported to Holland pain-free for internal fixation. Returned to active duty.

FEATURE

Simple dosing regimes of intermittent boluses of low-concentration local anaesthetic agents can be instituted on an as-needed basis and are safe and effective. Careful dressing and use of tunnelling of catheters can reduce displacement; and replacement or removal when the patient arrives at a higher level of care has been shown to be safe and carries a low infection risk.

Many patients are not receiving the benefit of these blocks because they have not been considered beforehand

Once trained, retrieval physicians can use these techniques to reduce analgesia requirements and make transport more comfortable for trauma patients. It may be that these patients also experience less post-traumatic stress disorder from this intervention, although this requires investigation.

CONCLUSION

Regional anaesthesia offers significant advantages over general anaesthesia in the remote and austere environment. With minimal equipment and technology there is a range of options that can allow surgical procedures without a general anaesthetic, as well as opportunities to provide excellent analgesia while avoiding opiates.

With the addition of portable ultrasound, the options expand to include almost all possibilities for anaesthesia and analgesia. With ultrasound and training, these blocks are safe, easily performed and reliable. They provide a clear benefit to risk advantage and avoid systemic drugs. Their introduction should not be difficult and is worthwhile considering in almost all patients with peripheral trauma and most patients undergoing surgical procedures.

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FEATURE

ON THE ROAD TO MANDALAY

The recent Primary Trauma Care (PTC) Instructor Master Class in Myanmar (Burma) came close to being a remake of that classic Bob Hope, Bing Crosby and Dorothy Lamour film, *Road to Singapore*, as its instructors worked their way to Mandalay writes Dr Haydn Perndt (MBBS, FANZCA, FFARCS).

The Instructor Master Class 'starred' Bob Hope (aka Dr James Kong, a surgeon from Hong Kong) with Bing Crosby (Dr Tsun Woon Lee, an anaesthetist also from Hong Kong) and Dorothy Lamour (Dr Georgina Phillips, a Melbourne emergency physician currently working in Yangon). Dr Yu Fat Chow (another anaesthetist from Hong Kong) and Dr Haydn Perndt (an anaesthetist from Hobart) played supporting roles.

The 'Road Movies' were 1940s and 1950s Hollywood at its best. Light, entertaining and deceptively well crafted, these films amused a generation of theatregoers. Filled with song and humour, they needed minimal narrative. Not so the PTC story, which started in 1997 in Suva, Fiji, with a course co-authored by Tasmanian anaesthetist Associate Professor Marcus Skinner and Dr Douglas Wilkinson, an anaesthetist/intensivist from Oxford. PTC is now in over 60 countries and has been translated into 14 languages.

Like any good film franchise, the PTC roadshow spread quickly across cultures and language. The commonality of the burden of trauma care was recognised by surgeon, emergency physician, intensivist and anaesthetist alike. Here was a practical and systematic approach to improve the management of trauma that had been specifically designed for the low resource countries where 90% of the mortality and morbidity occurs.

The British ran courses in Africa and South America while the Australian activities were in the Pacific and South East Asia. The PTC course was agnostic of medical specialty, attracting instructors and participants from Early Management of Severe Trauma, Advanced Trauma Life Support, surgical, anaesthetic and emergency backgrounds. The courses have now spread to the Middle East and Central Asia.

Bob Hope (James Kong) and Bing Crosby (TW Lee) have been 'on the road to Mandalay' since 2007. James Kong had visited after Cyclone Nargis and with Royal Australasian College of Surgeons funding started what is arguably one of the most interesting PTC start-ups. A charismatic, softly spoken local general practitioner, Dr Vijay Kumar has been a very quiet achiever, leading the courses from success to success. Senior orthopaedic surgeons

and Yangon University professors helped move the political obstacles. Any new health initiative in low or middle income countries must perforce take resources from other pre-existing health care priorities. The success of a new program is often more political than medical.

Like all the 'Road Movies' the Yangon Instructor Master Class had a story within a story. On this particular week of teaching, Bob Hope (James) was planning to train new PTC instructors, coach old instructors and mentor the nascent PTC leaders in the complex politics of developing PTC in Myanmar, all at the same time! Meanwhile, Dorothy Lamour (Georgina) was double-dealing elsewhere, designing and teaching a completely new training program for Myanmar's first Emergency Physicians from the ground up.

This was a plot that was bound to have complications. Between Dorothy's teaching sessions in the Emergency Department at the Yangon General Hospital and Bob's executive team building games in the lecture hall of the Myanmar Medical Association, Bing (TW Lee) decided to run a Change Management workshop. TW Lee has been a senior bureaucrat in the Hong Kong Health Department, so is well placed to teach on the subject. The irony of this in Myanmar, a country experiencing change at such an incredible pace since the easing of political sanctions, was not lost on any of the 'Road' cast.

Was there a happy ending in Mandalay? How do the Road Movies usually end? With a song and dance, of course. So, fittingly, this world-first PTC Instructor Master Class cut to the credits with the airway, cervical spine, breathing, circulation, disability and exposure refrain ringing in our ears. A tightly choreographed Primary Survey was the encore before all returned home through the rainy and steamy Myanmar night.

'Road Movie' aficionados will know that the hugely popular *On the Road to Singapore* was released in 1940. It was the first of the very successful 'On the Road' series.

For more information, go to http://bit.ly/1bpM5JI.

FEATURE

SAN FRANCISCO BOOK LAUNCH CELEBRATION

It is always a joy to celebrate the achievements of members of the ASA, and after six years of dedicated hard work we are pleased to report on the launch of *The Wondrous Story of Anesthesia*. Co-editor, Dr Rod Westhorpe (MB, BS, FRCA, FANZCA) attended the launch in San Francisco this October along with several other members.

The launch took place at a special event during the American Society of Anesthesiologists' recent meeting.

The Wondrous Story of Anesthesia is the culmination of six years' work by the three co-editors, Prof Edmond (Ted) Eger (MD), Prof Lawrence (Larry) Saidman (MD) and Rod. As well as writing several of the 67 chapters themselves, the editors engaged over 100 authors from around the world to create a comprehensive history of the specialty.

Several Australians are among the contributors to the book. In addition to Rod, Prof Michael Cousins, Dr Neville Gibbs, Prof Bill Runciman and Dr Jeanette Thirlwell have all co-authored chapters.

While the book embraces the story of anaesthesia from ancient times to the present, the focus is on the last 70 years, the period where the specialty "has emerged from empiricism and developed into a science-based practice". The 950-page book captures the stories and anecdotes of many of the people who have been intimately involved during this period of development. There is even a chapter contributed jointly by the editors of all the major international anaesthesia journals, outlining their predictions for the next ten years of the specialty.

The launch took place at a special event during the American Society of Anesthesiologists' recent meeting

Rod, recently elected to the Chair of the History of Anaesthesia Special Interest Group, travelled with his wife Margot to San Francisco especially for the launch. They have been regular visitors to the city over the last six years, including a two-month stay in 2012 when Rod worked closely with Ted and Larry, both of whom live in San Francisco. Speaking at the launch, Rod acknowledged the value of modern communication and email,

suggesting that such a large international collaborative project would have been near impossible just 20 years earlier.

Attending the launch dinner held at the Metropolitan Club were many of the contributors together with invited guests. Although the final production copy of the book is not available for delivery until late November, the publisher, Springer Science, ensured that several advanced copies were available for guests to peruse. The Kindle or e-book version was available before the launch and is already receiving some great feedback. The editors and authors have eschewed any rights to royalties, directing that they be passed to charity.

If you would like to know more about *The Wondrous Story of Anesthesia* or order a copy, this may be done via www.amazon.com.

Image, left: Co-editors, Drs Rod Westhorpe, Ted Eger and Larry Saidman

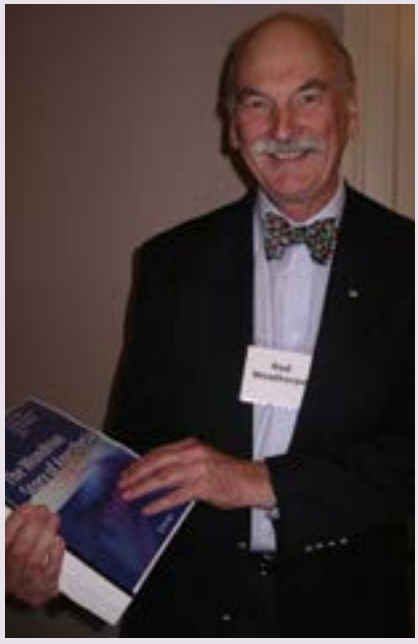
Drs Jing Zhao and Neville Gibbs

Jean Severinghaus, Prof John Severinghaus and Dr Rod Westhorpe

Drs Robert Jones and Jeanette Thirlwell

Dr Rod Westhorpe and wife, Dr Margot Westhorpe

Drs Rod Westhorpe and Estela Melman



Dr Rod Westhorpe

REGULAR

CAREERS IN ANAESTHESIA
MERCY SHIPS—AFRICA MERCY

Dr Vanessa Andean (MBBS, FANZCA, DRANZCOG) is one of several inspiring anaesthetists who have spent time on the Africa Mercy ship helping transform the lives of those in some of the most under-developed countries in the world.

Vanessa spoke to ASA Publications Assistant Stephanie Brown about her work with Mercy Ships and how she came to be involved with such a unique medical charity operating the world's largest independent hospital ship, the Africa Mercy. Over the last 35 years Mercy Ships has assisted more than 2.42 million people from some of the least developed countries. For some, their only hope is the ship and the doctors on board. Vanessa tells *Australian Anaesthetist* of her experience on board.

TELL US A BIT ABOUT YOURSELF, YOUR CAREER AND WHAT MADE YOU START WORKING WITH MERCY SHIPS.

I grew up used to travelling and living in remote parts of developing countries due to my father's work as a civil engineer. It meant I was aware of poverty and reduced access to health care from quite early on, which led to an interest in working in medicine in the developing world.

As a resident I spent 18 months working in Alice Springs, which was a great way to learn about health problems in remote communities but with the back-up of a first-world system. Soon after that I went to work with Médecins sans Frontières (MSF) in Kenya for six months, where malnutrition and infectious diseases in children were the biggest problems. I did another project with MSF in Ecuador managing community pharmacies and then came to Melbourne to do my anaesthetics training.

Towards the end of my specialty training I was offered an anaesthetics post with MSF, so I went to Aceh for a month to work with an MSF plastic surgery team in a local hospital. This was where my ideas crystallised about the kind of health care we should be offering when we descend upon poor communities with grand but often unrealistic plans for transforming the health of local people.

On this particular job, all of the expats—surgeon, theatre nurses and me, the anaesthetist—were working a long way outside their fields of expertise. I was expecting a simple Boyle's machine and instead found myself assembling and using a draw-over circuit, following instructions I'd gleaned from the internet. There was no anaesthetic assistant, no second anaesthetist within 300 km, no recovery room and no ward staff able to reliably manage post-surgical patients, particularly paediatrics. One of my first lists was cleft palate repairs in babies all under 8 kg—hardly a specialty of mine, even in Melbourne with full support. The only option as I saw it was cancellation of all the babies and we proceeded with more peripheral surgery in older patients.

Interestingly, there was quite a lot of pressure from many quarters in the MSF establishment to go out on a limb and do the cases, with the rationale that we can't expect to offer poor people the same safety or expertise that we would expect in our own countries. This is a stance I have enormous difficulty with, particularly in the non-emergency setting, when in this case children could have died from the effects of essentially elective surgery.

Dr Vanessa Andean in theatre aboard the Africa Mercy

While aid work does require a lot of flexibility, I feel that doing things in poor communities which we would consider dangerous at home is unacceptable.

Hundreds of people queue for hours or days

So after that experience I put aid work on the back-burner until I could find an organisation that would allow me to provide a proper anaesthetic service to patients. It's quite a difficult proposition—safe surgery and anaesthesia require a complex organisation and infrastructure, from reliable water and electricity to trained staff and good sterilising procedures and some vital pieces of equipment.

The concept of a hospital ship like Africa Mercy provided a solution for many of the problems I'd encountered—the ship is fully self-sufficient in terms of infrastructure and works like a developed-world hospital. Patients are able to get all their care there, and all hospital staff live on board. Also, because it's such a complex system offering so many services (from cleaning to cooking to a school), there was an opportunity for my non-medical husband to participate as well. He's a school teacher by trade and usually teaches French, but ended up working as a cleaner during our first trip to the ship and will be an interpreter on our next trip in March 2014.

The Africa Mercy in port

PRACTISING AWAY FROM A MODERN HOSPITAL MUST HAVE ITS LIMITATIONS. IS IT SIGNIFICANTLY DIFFERENT FROM MELBOURNE?

Part of the attraction of Mercy Ships was that it does provide modern facilities. It's quite a strange feeling to walk through a converted Danish train ferry to find four fully equipped operating theatres, particularly on the days when the ship is listing slightly to one side. Across the hallway are the wards which, although crowded, also run like conventional hospital wards. The staff are from all over the world, with North America, Europe and New Zealand heavily represented, and there were at least four other anaesthetists on board most of the time, so there was always plenty of help. So it's a great contrast to the substandard equipment and professional isolation I've come across with other organisations.

Of course there are differences between working on the ship and working at home, but from a technical point of view nothing superhuman was expected of me and most problems could be solved with a bit of patience and flexibility.

THE LANGUAGE BARRIER MUST BE A HUGE CHALLENGE, PLUS KEEPING PATIENTS CALM AND AWARE OF WHAT IS GOING ON—ENSURING THEY UNDERSTAND THE EFFECTS OF ANAESTHESIA IN PARTICULAR.

Language and cultural differences are a big cause of stress to patients. The ship hires a lot of local interpreters to help smooth communication and they're present at all stages of the patients' care—at screening, on admission, in theatre, in the ward.

Screening day

Guinea is an old French colony and I found that about 60% of patients spoke good French, with another 20% or so able to get by in French. A significant minority did only speak local languages though. I'm lucky to have worked in France and to speak French, so I was able to speak directly to most of my patients and I found it made a huge difference to my ability to explain procedures and to reassure them. Interpreters helped with those who didn't have any French but it's always a less effective interaction.

A strategy that worked really well was getting pre-op patients to speak to patients I'd already anaesthetised, which was easy as they were all accommodated on the same wards. Patients were much more reassured by talking to a fellow Guinean who had obviously survived surgery than by the explanations of a doctor from the other side of the world.

REGULAR

Screening day

IN AN AVERAGE DAY, HOW MANY PEOPLE WOULD YOU SEE? ARE YOU INVOLVED IN THE SCREENING PROCESS?

As an anaesthetist I was working on booked lists, so I would see patients who had already been screened and prepared for surgery. The turnover is slower than we're used to at home but we'd get through four or five hernia repairs in a day or the same number of club foot operations. Some of the large head and neck cases would take all day.

Guinea is a country that has almost no health system to speak of so the need is enormous and far outside the remit of one hospital ship. The interface between the huge numbers of people with problems and the services offered by the ship occurs at screening days. Hundreds of people queue for hours or days. The ship offers very specific services, so only a fraction of those who come for help can actually be offered something. The services are surgical only and cover cataracts, benign head and neck tumours, cleft palates and lips, inguinal hernias, paediatric orthopaedics and some obstetric fistulas. There is physio and rehab follow-up for orthopaedics but anything that requires ongoing treatment such as cancer is beyond the scope of the program.

ARE THERE SOCIAL AND CULTURAL DIFFERENCES YOU ENCOUNTER THAT YOU HADN'T REALLY CONSIDERED BEFORE EMBARKING ON THIS?

A big difference between a city like Conakry and Melbourne is the lack of security. Crime fuelled by poverty is enormous, as is political violence. Local people are philosophical about it but we were perturbed by the number of deadly riots and political murders that happened, even in the short time we were there.

WHAT ABOUT WORKING WITH CHILDREN? ARE THERE ISSUES OF CONSENT OR THOSE THAT HAVE NO PARENTS OR GUARDIANS TO SPEAK OF?

Because the surgery is elective and African families are often big, all of the children I saw were accompanied by a relative of some kind. Consent followed the same process as it did for adults, using interpreters.

IT IS COMMON FOR A PATIENT TO STAY IN A MEDICAL SETTING FOR SIGNIFICANT PERIODS OF TIME POST-SURGERY, OR DO THE DOCTORS COMPLETE FOLLOW UPS IN THEIR HOME TOWNS?

Step-down for patients is arranged at a hostel-type centre on land where

CHILDREN ON THE MERCY SHIPS: BEFORE, DURING AND AFTER SURGERY

patients can go once they leave the ward. It's staffed by expat nurses and local staff, and patients still come back to the ship for follow-up appointments. Once patients go home, however, the potential for follow-up is almost zero, which is why operations are chosen that will not need ongoing care.

THERE ARE A GREAT DEAL OF FACIAL AFFECTATIONS THAT ARE TREATED. DO YOU HAVE TO EXPLORE NEW TECHNIQUES TO OVERCOME THOSE LESS-THAN-COMMON PROBLEMS?

The ship does specialise in benign head and neck tumours and has a long-term surgeon who has many years of experience with them, so at screening days these problems are sought out. Because of the lack of access to any care these tumours are often much bigger and more deforming than anything we would see at home. A significant number of patients are very close to complete airway occlusion, so awake fibreoptic intubation and awake tracheostomy are commonly used.

There's no enormous difference compared to other first-world hospitals, although WHO surgical checklists are adhered to much more strictly than in many Australian hospitals, a very necessary safeguard given how multinational the theatre teams are.

Vanessa visiting a patient on her ward rounds

IT MUST BE DIFFICULT SEEING SO MANY PEOPLE WHO HAVE SUFFERED FOR SO LONG. WHAT WOULD YOU SAY IS THE MOST CHALLENGING ASPECT OF THE PROJECT?

It is very difficult to work in a country knowing that most people's health needs will never be met and that even desperate and tragic cases will be turned away or never even make it to the ship screening days. On a day-to-day basis I really had to concentrate on achieving the best possible outcome for the patient in front of me and they were usually delighted with what we were able to do for them. If you think about the magnitude of the country's problems too much it's easy to become overwhelmed.

TELL US ABOUT YOUR MOST REWARDING EXPERIENCE SINCE BEING INVOLVED IN MERCY SHIPS.

I always loved my evening rounds on the wards, seeing my patients from that day who were amazed and delighted to have got through their surgery, as well as those from several days earlier who were improving and getting ready to go home. The presence of families added lots of colour to the wards, and there were usually card games, lots of jokes and the odd bit of singing and dancing going on.

Photos courtesy of Michelle Murrey, photographer of the Africa Mercy, 2012

ALL ABOARD THE AFRICA MERCY

If you'd like to find out more about joining Mercy Ships or making a contribution, go to www.mercyships.org.

WANT TO SEE MORE?

SBS is due to air a documentary on Mercy Ships—*The Surgery Ship*, produced by Media Stockade in late 2013.

The documentary centres on a unique boat offering lifesaving surgery that sets sail for Africa. The dedicated staff on board have just one year.

Each episode of the documentary will feature two to three medical stories. The stories range from big to small, from extremely serious to the occasional humorous problem. Every episode is filled with inspiration for both doctors and patients as they take part in a truly individual and challenging situation.

If you would like to view the trailer for *The Surgery Ship*, go to http://mediastockade.com/#projects-0.

SOCIAL MEDIA

You can also visit their Facebook page: www.facebook.com/TheSurgeryShip.

REGULAR

ANAESTHETISTS IN TRAINING
TIPS FOR JOB INTERVIEWS

Dr Vida Viliunas (FANZCA) is a specialist anaesthetist currently working in both public and private practice in Canberra. She is also an examiner for the final fellowship exam. In this issue, Vida offers some advice to help GASACT members prepare for provisional fellow or junior consultant job interviews.

Got a job interview coming up? Many of us are uncomfortable with selling ourselves or walking into a room full of people ready to ask questions for which we feel unprepared. The solution is to learn and develop some skills.

AIM

The aim is to present yourself effectively at an interview to get the job you want.

In order to be chosen, you should distinguish yourself from the other applicants:

- What has been your path to date?
- What are your special interests?
- What have you done to advance those interests?
- Reflect (yes, you have to) on your motivations, choices, goals and planned trajectory.

The harder you work, the luckier you get. Solid preparation will also contribute to managing the stress of an unfamiliar, high-stakes situation.

PREPARATION

- Practice being interviewed and telling your story.
- Do some research—on the facility, its culture, on the head of department and on the staff and their research or publications. Use multiple sources: check facility websites and Google the staff or other applicants.
- Ask others about their interview experiences and techniques.
- If you can discuss the job with the previous employee, all the better. With reference to this, prepare your approach to the potential questions (see below).
- Ensure that you know the job description—check whether there are any options for you to choose (e.g. NICU/PICU/retrieval/rural service).
- This article will give you a sample of interviewers' favourite questions—an important part of preparation is anticipating questions and developing responses that will distinguish you from the other applicants.
- Update your CV, choose your referees carefully, update them if necessary (look for referee 'gaps') and notify them. Bring a couple of extra copies of your CV to the interview.
- Just like a first impression, your CV has about ten seconds to make a visual impression: select layout to ensure visual clarity, be a ruthless editor and use a covering letter to match your skills now with the job description. CV preparation is a subject for another article.

COMMUNICATION

Delivery and deportment

- Focus on the speaker. Paying attention will allay your anxiety. Listening is not just waiting for your turn to talk.
- Go in well rested and alert. Do not make excuses—don't tell them you are tired and emotional or have just come from a big night out. Anaesthetists are familiar with working long hours.
- Be formal (that does not mean unfriendly). Wear a businesslike outfit, watch your body language (sit up straight and have a firm handshake), watch fillers (meaningful silence is better than saying "um" or "ah") and turn your phone off.
- Be succinct, then be quiet and wait for the next question. It is probably better to let the interview panellists make the jokes and respond with polite acknowledgement.

There is only one opportunity for a first impression—that happens in the first few seconds of an encounter

- Be punctual—early is better.
- Be respectful (but not intimidated or obsequious), honest, direct and to the point (a bit like the exam). If the question is unclear, ask for it to be rephrased.
- Do not lie.
- Weave your past achievements into your story. Candidates are evaluated on past

performance being a predictor of future contribution.

- Soft skills being tested include your work ethic, communication, likeability and organisational 'fit', time management and prioritisation, and ability to perform under pressure (the story within the story of the interview).
- Being on the spot in an interview is hard. If you have prepared well, you still might have to use a phrase like "I would need some time to think about that". Don't be afraid to pause and think.
- Think about this: unless the interviewers have already made up their minds, they want to know that their search is over; they want it to be you… help them make it so.

CONTENT

- What is your story? What is your career trajectory? Broad brush areas include your background (academic and a bit of extracurricular or volunteer), qualifications, experience and reasons for applying.
- Think about your aptitude, your particular passions, initiatives and motivations.
- Just as you have an anaesthesia plan for a patient, you should develop a plan for your career. Tailor your story to the job for which you are applying: match your special skills and distinguishing contributions to the needs of the prospective employer.

RESEARCH

There are a gazillion websites about job interview skills—among them:

- http://www.impactfactory.com/gate/new_job_interview_skills_hints_and_tips/fungate_174-1103-91240.html
- http://careers.theguardian.com/careers-blog/star-technique-competency-based-interview
- http://www.kent.ac.uk/careers/intervw.htm.

QUESTIONS

Here are some interviewer questions that you can use to prepare some possible responses.

- If you could work anywhere in the world, where would it be?
- Why do you want to be an anaesthetist?
- Walk us through your CV. (Do not read through it—highlight the compelling features and match your strengths to the job description.)
- What will be the main differences between your last job and this one?
- What did you hate about your last job?
- What are your greatest weaknesses?
- How do you handle stress/crisis/failure/success/misconduct/conflict/moral dilemmas/conflicting religious beliefs? (Make sure that your response is consistent with your interview performance. Having an example of a stressful situation and how you have dealt with it might be useful.)
- What additional training would you like to undertake in the short or long term?
- Where do you plan to be in X years?
- If you could have a superpower, what would it be?
- Non-work questions: How would you solve Sydney's traffic problem?
- What questions do YOU have for the panel? (Beyond "When will you let me know?")
- What do you learn from your mistakes? (For example, persistence, the value of learning from any outcome or that there is rarely only one way to achieve X.)

Skills-related questions can be found at http://bit.ly/1fxu5xA.

Questions for you to ask them

- I have the job description—what are your hopes for an outstanding performance?
- Having spoken with X (outgoing job holder), they had hoped to achieve Y. Can I do Y or try Z?
- My particular X (research/academic/workplace/systems) interests are Y; my research on this institution/department seems to indicate that that might be possible here.
- Elaborate on a particular strength if you think it has not been showcased during the interview.

Questions not to ask or subjects best left alone

- When can I take time off?
- Can I arrange my own roster?
- Do not 'badmouth' previous positions or people (it's a small world).
- Do not dwell on personal problems, politics, religion or race.

Illegal questions

There are many topics that are off limits—but we all know it happens: age and family status (and intentions), for example.

You can be truthful, but vague (address the question generally, without answering): "My X is not an issue for my performance in this job", "I will be able to perform all duties that the job entails" or "My X (sex/religion/pregnancy) will not interfere with my ability to do the job".

Being prepared is probably better than being outraged during the interview.

FOLLOW-UP

Consider sending a thank you email even if you don't get the job. It's a small world and there may be a second round of interviews.

Use this as an opportunity to highlight what special skills you would bring to the job.

Best wishes to you all!

REGULAR

WEBAIRS NEWS

Since our last update, the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) has released an app version of WebAIRS and presented at the September 2013 National Scientific Congress in Canberra writes Adj Prof Martin Culwick (FANZCA).

This Web-based Anaesthetic Incident Reporting System (WebAIRS) article will cover:

- recent and future presentations and publications,
- mobile app, and
- recent alerts.

RECENT AND FUTURE PRESENTATIONS AND PUBLICATIONS

There are currently 61 sites registered with WebAIRS and 1957 incidents have been reported as of September 2013. Data from these incidents were used in a presentation entitled 'Lessons from critical incident reporting in anaesthesia' at the ASA National Scientific Congress in Canberra, September 2013. This was a joint session with Prof Keith Ruskin, who presented 'Judgement, decision-making and risk management: lessons learned from aviation', and Prof Colin Mackenzie, who presented 'Video task analysis in healthcare'. Profs Keith Ruskin and Colin Mackenzie were both international invited speakers.

MOBILE APP

ANZTADC and WebAIRS have released a mobile version of WebAIRS. The original development of the incident reporting page was performed by Dr Pieter Peach, the local WebAIRS administrator at Cabrini Hospital, Malvern, Victoria, and forwarded to WebAIRS for consideration. The web app was then further customised for the WebAIRS website to include a mobile login and to save the data in the database.

A screenshot of the application is shown. The mobile version can be reached at www.anztadc.net/mobile/mobile.aspx and a demo version can be viewed at www.anztadc.net/demo/mobile.aspx. There are also enhanced registration assistance links, frequently asked questions and further development of the morbidity and mortality reporting tool.

RECENT ALERTS

Recent alerts include these reports:

1. WebAIRS has received an alert that two patients within the space of a week have bitten through the wall and into the lumen of a Pro-Breathe Armourflex laryngeal mask airway (LMA) (Proact Medical). Both cases occurred during the emergence phase after eye surgery. At the WebAIRS site one of the anaesthetists performed a comparison bite test with this model LMA and a standard reinforced endotracheal tube. He easily bit through the wall of the Pro-Breathe LMA but was unable to bite through the standard reinforced endotracheal tube. The manufacturer has been contacted and a response will be published when available. The company literature recommends the use of a bite block with the device (which they also manufacture).
2. WebAIRS has been notified of an alert regarding a single lumen peripherally inserted central line. The catheter has a guidewire to stiffen the catheter during insertion. In the case reported, the guidewire was not removed prior to commencing the infusion. The catheter subsequently fractured and the guidewire migrated, requiring surgical

removal, which was fortunately possible percutaneously. This incident reinforces the need to carefully read the manufacturer's instructions if the user is not familiar with the device. Although it is possible to infuse liquid through the catheter with the guidewire in place, the guidewire should be removed prior to commencing the infusion. The company has been contacted and a response will be published in the next issue of *Australian Anaesthetist*.

WebAIRS thanks the reporters for these interesting alerts. We plan to release more de-identified alerts in coming WebAIRS reports. ANZTADC will be grateful if future unusual reports are flagged as alerts when reported. Also remember to report problems with LMAs or other devices as suggested via WebAIRS or directly to ANZTADC@anzca.edu.au if not registered with WebAIRS.

For more information, please contact:

Adjunct Professor Martin Culwick, Medical Director, ANZTADC

E: mculwick@bigpond.net.au

Administration support:

E: anztadc@anzca.edu.au

To register, visit www.anztadc.net and click the registration link on the top right-hand side.

A demo can be viewed at www.anztadc/net/demo.

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

Dr Mark Sinclair (MBBS, FANZCA, FRACGP), Chair of the Economics Advisory Committee (EAC), reports on the recent activities of the Committee.

MEDICARE BENEFITS SCHEDULE (MBS)

The introduction of new MBS items to fund the use of ultrasound in anaesthesia practice has now been before the Medical Services Advisory Committee (MSAC) for over two years. The application is at the stage of "collection and assessment of the available clinical and economic evidence". As discussed in the last edition of *Australian Anaesthetist*, the Health Technology Assessment group will perform this task rather than the ASA itself due to the requirement for extremely high-level economic analysis of the application. This Health Technology Assessment analysis will not result in any financial charges to the ASA, and MSAC has assured us that we are allowed input at all stages of the process. The Department of Health and Ageing (DoHA) has informed us that an initial assessment report will be made available to the ASA in mid-January 2014 with any comments from the ASA due within two weeks. The Evaluation Sub-Committee of MSAC will assess both reports at its February meeting and report to the full MSAC in early March. The ASA will again be given two weeks to assess and make comments on this Evaluation Sub-Committee report.

The other two ASA applications, relating to nerve blocks performed for postoperative analgesia and complex initial consultations in the practice of pain medicine, are at an earlier stage. The Decision Analytic Protocol (DAP) documents for both applications are due to be released on 21 November, and once again the ASA will be given two weeks to comment. Members will recall the DAP is a document purporting to discuss the applicant's reasons for making the submission and the clinical nature of the service, as well as posing a number of initial questions regarding the evidence behind the proposal. The first draft DAP for the ultrasound was a poorly written document, clearly authored by people with very little knowledge of the nature of the service. The ASA has liaised with DoHA and MSAC about this, and hopes the two upcoming DAPs will be of better quality. Nevertheless, MSAC has allocated a period of six months to discussion and finalisation of the DAPs.

An opinion piece on current MSAC processes and their timelines can be found in the 'Point of View' article on pages 14 and 15.

The other role of MSAC, that of assessing existing MBS items to ensure they "reflect contemporary evidence, improve health outcomes for patients, and represent value for money" is also ongoing. Members will recall MBS *Relative Value Guide* (RVG) items relating to cardiopulmonary bypass services are being assessed and that MSAC appears to have enthusiastically embraced the arguments of the clinical perfusion profession (non-medical practitioners), which has been lobbying for some years to have funding for medically qualified perfusionists (with specialist anaesthetists responsible for over 91% of Medicare claims) removed. To date most medical input has been ignored or overlooked. The medical perfusionists on the assessment committee continue to work hard to ensure MSAC is aware of the essential nature of the services they and their colleagues provide. We are grateful to Drs Nigel Symons (ASA representative), Joe Power (National Association of Medical Perfusionists of Australia), Andrew Jackson (ANZCA) and Andrew Mulcahy (AMA, taking over from previous AMA representative Dr Liz Feeney) for their ongoing work on this issue.

MSAC has also assessed the funding of bariatric surgical procedures and made significant changes to the applicable MBS surgical items. There is now a requirement for "clinically severe obesity" (body mass index over 40, or between 35 and 40 if there are medical complications of obesity) in order for the items to apply, although the items will still apply for lower body mass index patients if the surgeon decides the surgery is necessary. The DoHA staff involved in this process also altered the applicable RVG item (20791) without any consultation with the

anaesthesia profession. Unfortunately, this has resulted in a descriptor that appears to apply to any surgical procedure performed on an obese person. Members have been strongly advised only to apply this item to anaesthesia for bariatric surgical procedures. The DoHA is aware of the error and will correct the descriptor. The MBS document itself will not show this change until January 2014.

Several other RVG item descriptors are being altered as a result of an initiative to remove gender references from government documents. Fortunately the DoHA has involved the EAC in these discussions from the beginning. These changes will also be delayed until 1 January 2014. Further information on MBS item 20791 and the RVG items affected by the gender reference issue is available on the ASA website at www.asa.org.au.

DEPARTMENT OF HUMAN SERVICES (DHS)

As members will recall from previous correspondence, the National Medicare Compliance Scheme is now underway. A number of members have contacted the ASA after receiving requests from Medicare to either review their processes to ensure billings were correct, or to go one step further and provide a report on each individual claim which is "of concern" to them.

The DHS has targeted anaesthetists who are statistical 'outliers' for the after-hours emergency item 25025, and any anaesthetist who has billed for over 16 hours of work in a single 24-hour period. There have also been instances of claims for outpatient consultation item 17690 on the same day as admission to hospital, which contravenes the item descriptor. The other issue which appears to concern the DHS, namely situations in which an anaesthesia claim is submitted but no surgical claim has been identified, has not been the subject of any audit activity as far as the ASA is aware.

At this stage, all claims for 25025 brought to the attention of the ASA have been shown to be appropriate. The 'outliers' are simply anaesthetists who have a greater than average on-call commitment (in some cases 24/7). The cases of 16-hour days have all been shown to be correct, or have simply been the result of clerical errors (e.g. wrong date listed on the account). Most cases of the 'incorrect' use of 17690 were also clerical errors, but some claims have indeed contravened the 'same day as admission' restriction.

Members are again reminded to ensure all MBS item descriptors are adhered to. Even 'honest mistakes' will result in a demand for repayment of Medicare funds and, in some cases, an administrative financial penalty.

The ASA is aware that some members have found the tone of the Medicare communications overbearing, or even offensive (especially those whose only 'wrongdoing' is to provide an excellent after-hours service). The ASA has already discussed this issue with the DHS and hopes some improvement will occur as a result.

MEDIBANK HEALTH SOLUTIONS

At the time of writing, there is nothing further to report on the funding of services to serving Australian Defence Force personnel. Medibank Health Solutions is adamant that a $55.00 RVG unit value will be applied, but at this stage the requirement to sign a contract (which still has a number of issues in the view of the

Economics Advisory Committee 2013–2014

Position	Name	State
Chair	Dr Mark Sinclair	SA
ASA Immediate Past President	Dr Andrew Mulcahy	TAS
EAC Immediate Past Chair		
AMA Craft Group Representative		
TAS EAC Officer		
PIAC Chair	Dr James Bradley	QLD
ASA Past President and Life Member		
PPAC Representative	Dr Mark Colson	VIC
GASACT Representative	Dr Raviram Ramadas	WA
NSW and ACT EAC Officer	Dr Callum Gilchrist	NSW
QLD EAC Officer	Dr Timujin Wong	QLD
VIC EAC Officer	Dr Renald Portelli	VIC
SA/NT EAC Officer	Dr Tim Porter	SA
WA EAC Officer	Dr Robert Storer	WA
Committee Member	Dr Graham Mapp	QLD
Committee Member	Dr Ian Woodforth	NSW
President (ex-officio)	Dr Richard Grutzner	VIC
Chief Executive Officer (ex-officio)	Mr Mark Carmichael	NSW
Secretariat Contact/Policy Advisor (ex-officio)	Mr Chesney O'Donnell	NSW
Secretariat Contact/Policy Assistant (ex-officio)	Ms Danielle Ashford	NSW

INSIDE YOUR SOCIETY

ASA) has not been enforced, with non-contracted anaesthetists still being paid at AMA rates. Further information will be provided as it comes to hand.

COMMITTEE UPDATE

I regret to inform members of three resignations from the EAC. Drs Malcolm Albany (NSW), Cameron Gourlay (Tas) and David Olive (Vic) have left us in order to pursue other professional activities. We thank all three for their enthusiastic and valued input into EAC activities. Dr Callum Gilchrist has been appointed to the position of NSW and ACT Representative. An up-to-date committee listing is provided on the previous page.

Again, it has been a very busy year for the EAC and I am, as always, extremely grateful to the members of the Committee for their tireless efforts on behalf of the profession. The economic and political climate of the last few years has made our task extremely challenging, but this simply highlights the need for the ongoing work of the EAC and the ASA.

The EAC congratulates Dr Liz Feeney, ASA Past President and AMA Anaesthesia Craft Group Representative, on her election as AMA Federal Treasurer and particularly thanks her for her EAC input over many years. We also congratulate ASA Immediate Past President and Immediate Past EAC Chair Dr Andrew Mulcahy on succeeding Dr Feeney to the post of AMA Craft Group Representative. We look forward to his continuing expert input on EAC matters. I also thank Dr Greg Deacon (Past ASA President, Past EAC Chair and ASA Life Member), who has retired from EAC duties but still provides his expert advice and assistance as needed.

The EAC is also grateful for the input and support from the ASA team at North Sydney, led by CEO Mark Carmichael. In particular I thank Policy Officer Chesney O'Donnell and Policy Assistant Danielle Ashford for their ongoing efforts. We as anaesthetists are merely enthusiastic amateurs in matters such as policy development and implementation and in the modern world the assistance of people with such expertise is invaluable.

If you would like to contact any members of the EAC, please email policy@asa.org.au.

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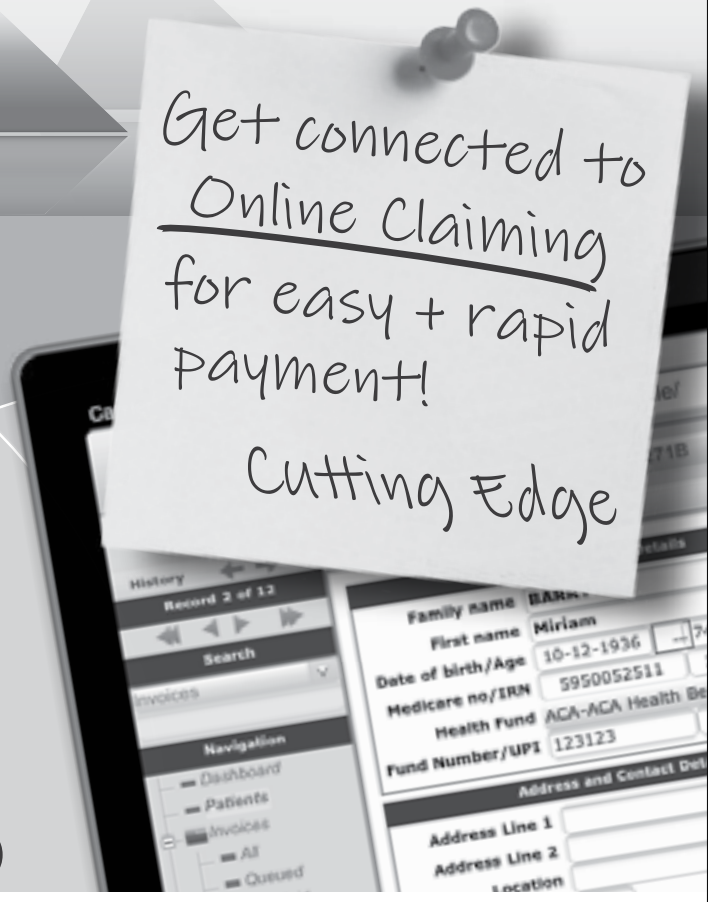

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INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

Another year and another NSC has prompted Chair Dr James Bradley (MBBS, FANZCA, FFARACS, FRACGP) to consider and review PIAC's progress. During the ASA NSC in September, Dr Bradley rode the route 100 bus around the 'highlights' of the National Capital.

Canberra is 100 years old this year—a remarkable thought—and when I say 'highlights', I am referring to the vistas, the magnificent boulevards, the old and new Parliament houses, the Australian War Memorial, the National Museum, Australian National University and the various Federal Government departmental offices. Canberra is in fact a magnificent capital, uniquely Australian as intended and certainly one of which we can be proud. It was very fitting that the 2013 National Scientific Conference, addressing 'Art and Science', would be held in Canberra in this centennial year. It is as though so much of what we have dealt with in recent years as a 'representative' professional organisation has originated from Canberra. Looking back over the last two terms of Parliament I am unable to nominate anything that has made our lives as anaesthetists perceptibly easier—with the possible exception of National Registration (I was able to write a repeat prescription for an antihypertensive).

In recalling the last 12 months, the Professional Issues Advisory Committee (PIAC) has underwritten the ASA's contribution to Health Workforce Australia's Advisory Group on Nurse Endoscopy, the submissions to the National Medical Training Advisory Network and the Treasury discussion on "Reform to deductions for education expenses" and attended the Medicine in Australia: Balancing Employment and Life (MABEL) Research Forum and the National Clinicians Network Forum. The National Medical Training Advisory Network may ultimately work to the benefit of the specialty and profession, and indeed the broader community, but it has much work to do. I am uncertain as to whether any of the other endeavours will deliver good news to us as a specialty, or whether any or all of these activities will be supported in their current form by the new Federal Government. Beyond that, PIAC has received many member enquiries, mainly from within the 'private sector', in relation to a number of professional matters, most reflecting difficulties in dealing with management and involving at time 'notifications' to the Australian Health Practitioner Regulation Agency.

However, there has been a change of government and the landscape in healthcare at a Federal level will change. The direction of the change is uncertain but the Coalition has published its policies. They include plans for certainty in relation to funding (through 'activity-based funding') and a determination to cut administration and bureaucracy, with support for more local as opposed to centralised management. Support for private health insurance once fiscal circumstances allow is expressed. The National Health Reform Agreement seems likely to remain in place. The Pharmaceutical Benefits Advisory Committee is to have its independence restored and monies are to be provided to support up to 100 additional intern places each year in private hospitals and non-traditional settings.

It has been an ongoing continuing concern of PIAC that bodies established by the previous government were paralleling the activities of the established stakeholders (read College and Associations/Societies) in the quality and safety area. A particular concern in relation to the promulgated standards of the Australian Commission on Safety and Quality in Health Care was expressed on a number of occasions. It is reasonable to say that dialogue with these bodies was usually unsatisfactory. Whether there will be a reconsideration of the extent of the role of these bodies, their costs and their success or otherwise remains to be seen.

A member survey was conducted earlier this year and identified concerns, especially among younger practitioners, with workforce issues: the size of the anaesthesia workforce, the number of vocational trainees in the specialty and the access of newer specialist members to a case-mix and caseload that enables 'consolidation' of skills hard gained during advanced vocational training. On 7 December the Society will hold a 'Workforce Summit' intended to address

these concerns. It is hoped that the issues will be fully examined by this Summit and that the Society can develop some constructive recommendations in relation to how they might be addressed. 'Workforce issues' will likely be the major focus of PIAC over the next Society year.

Finally, a revamping of the Society website has been completed, in which PIAC has both professional and patient oversight in relation to the content as it is reviewed and re-presented.

I wish to thank all members of PIAC for their support over the last year, noting in particular Peter Devenish who has stepped down and Michelle Horne, Phil Morrissey and Simon Macklin who have joined. The continuing members are Paul Cook (Qld), Liz Feeney (NSW), Simon Reilly and Antonio Grossi (Vic), Stuart Day (Tas), Richard Clarke (WA), Phil Morrissey (ACT), Andrew Mulcahy (AMA and Past President), Rod Mitchell (ANZCA Q&S Committee nominee), Mark Sinclair (EAC), Guy Christie-Taylor (Vice President), and Richard Grutzner (President). I wish also to thank Chesney O'Donnell (Policy Advisor), Danielle Ashford (Secretariat) and the CEO (Mark Carmichael).

INSIDE YOUR SOCIETY

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

In the 2013/2014 year, the Overseas Development and Education Committee (ODEC) will be involved in projects in a number of countries with an emphasis on Fiji, Tonga, Timor Leste, Cambodia, Laos and Mongolia. ODEC will be working with the national anaesthesia societies of these countries to improve the standard of anaesthesia and pain management. Usually assistance is focused on education and training, but we are also involved in safety and monitoring via the Lifebox project. Dr Rob McDougall (FFARACS) reports on ODEC's programs.

ASA ODEC VOLUNTEER DATABASE

The ASA has established a database of specialist anaesthetists who are willing to volunteer for humanitarian aid and/or development work.

The ASA is often contacted by representatives from charitable organisations, non-for-profit medical organisations, non-government organisations, the Australian and New Zealand governments and other national governments seeking appropriately trained and experienced anaesthetists to assist in anaesthesia care provision. The ASA database is used to both provide anaesthetists with overseas work opportunities and to provide organisations with the names of anaesthetists interested in working abroad. When contacted by an organisation, the ASA ODEC Chair will provide contact details for anaesthetists who have registered with the database. Organisations will not have direct access to the database. To read more about the ODEC volunteer database and submit your details, please see the ASA website.

14TH ASIAN AUSTRALASIAN CONGRESS OF ANAESTHESIOLOGISTS

The 14th Asian Australasian Congress of Anaesthesiologists will be held in Auckland from 21 to 25 February 2014. The Congress is the major World Federation of Societies of Anaesthesiologists event for 2014, and it is the first World Federation of Societies of Anaesthesiologists affiliated congress in our region since the 1996 World Congress of Anaesthesiologists in Sydney. This meeting is a joint meeting with the Australasian Symposium on Ultrasound and Regional Anaesthesia and will also host the 2014 Pacific Super Meeting, which will see anaesthetists from Micronesia, Papua New Guinea, Timor Leste and the Pacific gather together for the first time. ASA members are urged to attend the Asian Australasian Congress of Anaesthesiologists, and more information can be found at www.aaca.com.

Delegates and speakers from the recent Pacific Society of Anaesthetists Refresher Course held in Tonga, July 2013.

LIFEBOX

The ASA continues to welcome donations for Lifebox. ASA-raised funds have helped to provide oximeters for Fiji, the Solomon Islands, the Cook Islands, Tuvalu, Tonga, Samoa and Mongolia. In addition to receiving oximeters, nursing and medical staff in these countries have received education in how to use the devices and the World Health Organization Surgical Safety Checklist.

PSA REFRESHER COURSE

The annual Pacific Society of Anaesthetists (PSA) meeting was held in Tonga in July. The meeting was attended by over 40 anaesthetists from around the Pacific, representing ten nations. The quality of the presentations and teaching sessions was excellent with the majority of sessions being run by Pacific doctors. At the meeting, Dr Kenton Biribo was elected President of the Pacific Society of Anaesthetists. Dr Biribo was also the Pacific Visitor at the ASA National Scientific Congress in Canberra. A number of ASA members contributed to the meeting and special thanks must go to those who provided locum coverage in numerous locations such as Tonga, Fiji, Tuvalu and the Cook Islands.

PACIFIC FELLOWSHIP PROGRAM

The Pacific Fellowship program continues to make a valuable contribution to anaesthesia training in Fiji. In 2013, Drs Evelyn Cheng and Simon Hendel spent three months in Suva at the Fiji National University. They assisted the Pacific anaesthesia trainees in preparing for exams and provided clinical cover at CWM Hospital. If you are interested in participating in this program, contact Dr Justin Burke on j.burke@alfred.org.au.

ODEC is currently planning to establish a similar program in Timor Leste. Enquiries should be directed to Dr Brian Spain at Brian.Spain@nt.gov.au.

LOCUM IN FIJI

The Fijian Ministry of Health is seeking interest from Australian anaesthetists for locum attachments of up to 12 months to work in Suva, Lautoka or Labasa. Please contact Dr Rob McDougall by email at rob.mcdougall@rch.org.au.

INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

The last 12+ months have seen our Retired Anaesthetists Group (RAG) enjoy location walks, lunches and tours in different parts of Australia. Below is a collection of some of the key activities over the last year and a half.

TOUR OF HISTORIC HUNTER'S HILL—2012

On Wednesday 12 September 2012, a small group of enthusiastic retirees set out from Hunter's Hill Hospital for a 4 km walking tour of Australia's oldest 'garden suburb'. Named after John Hunter, First Fleet Captain of the Sirius and, later, second Governor of New South Wales, the Hunter's Hill Municipality, established in 1835, contains 1244 listed heritage items. Much of the early development of the suburb was carried out by French immigrants, particularly the brothers Jules and Didier Joubert, who employed over 70 Italian stonemasons to carry out a massive building program in an area which became known as the 'French Village'.

We viewed three churches: the Congregational Church (1875), built by the master Swiss stonemason Antonio Bondietti; the Anglican All Saints (1888), with its exquisite stained glass windows and Henry Berington organ imported from London; and the St Peter Chanel Catholic Church (1890), named after the French missionary martyred on the Pacific island of Futuna.

We visited several notable heritage houses, including Lyndcote (1858), built by Charles Jeanneret; Merimbah (1863), commissioned by Count Gabriel de Milhau following his exile from France during the 1848 revolution; Passy (1856), formerly the French Embassy in Australia; the National Trust 'Vienna' (1871), former home to the village's German lamplighter and his Irish wife who managed the adjacent dairy and orchard; and Woodstock (1845), the oldest building in the Municipality.

Other sites of interest were the Garibaldi Inn (1861), named in honour of the Italian patriot Giuseppe Garibaldi who united Italy in the 19th century; Kelly's Bush, site of the world's first Green Ban (1971); the location of the notorious former Radium Hill Company (1909) in Nelson Parade, where measurable levels of radon and a high incidence of malignancies have been reported; and Mort's Woolwich Dock (1900), once the largest dry dock in Australia.

We stopped for morning coffee at Ricciotti's, alongside the Garibaldi Inn, and had lunch at the Woolwich Pier Hotel. It was a beautiful morning and the walk was thoroughly enjoyed by all.

Morning coffee at Ricciotti: Dr Rosemary Coffey, Dr Richard Young, Dr Richard Bailey, Dr Thomas Voss

At All Saints Church: Dr Richard Young, Prof David Gibb, Dr Richard Bailey, Dr Kenneth Oldroyd, Dr Rosemary Coffey

Overlooking the Lane Cove River: Dr Thomas Voss, Dr Rosemary Coffey, Dr Richard Bailey, Dr Kenneth Oldroyd, Dr Richard Young, Dr Brian Pollard

RAG LUNCHEON—HOBART NSC 2012

On Sunday 30 September 2012, the RAG gathered for a luncheon as part of the ASA NSC held in Hobart.

Back Row Prof John Gibbs, Dr Rod Westhorpe, Dr Michael Claxton, Dr John Richards, Prof David Gibb, Dr Michael Hodgson, Dr Robert Harrison

Front Row Prof Ross Holland, Dr Jeanette Thirlwell, Dr Patricia Mackay, Dr Donald Maxwell, Dr Gordon Kellerman, Dr John Paull, Dr Diana Khursandi

RAG LUNCHEON—EDGECLIFF NSW 2012

A luncheon for retired anaesthetists was held at the Society's previous Head Office, Edgecliff, on Wednesday 28 November 2012. We were very pleased on this occasion to be joined by members of the HALMA committee following their meeting held at Edgecliff on the same morning. As usual, the library and museum were open for viewing prior to the luncheon and several members had availed themselves of this opportunity. This was an enjoyable occasion attended by 24 retirees and their guests. On behalf of the Retired Anaesthetists Group I would like to thank the Society for providing the venue and sponsoring our get-together on this day.

RAG VISIT TO HISTORY OF ANAESTHESIA EXHIBITION—SYDNEY 2013

On Tuesday 16 April 2013, the RAG visited the History of Anaesthesia Exhibition held at the Fisher Library, University of Sydney.

Prof David Gibb, Dr Graham Grant, Dr Richard Bailey, Dr Rosemary Coffey, Dr Harry Lorang, Dr Serge Bodlander

Lunch at the Law School Cafeteria, University of Sydney

Dr Graham Grant, Dr John Warden, Prof David Gibb, Dr Vera Gallager

Dr Des O'Brien, Dr Dick Fear, Dr John Warden, Dr Donald Fraser

Dr Donald Maxwell, Dr Charles Chen

INSIDE YOUR SOCIETY

RAG GROUP MEETS IN MELBOURNE VIC—2013

On Tuesday 7 May 2013, the RAG met in Melbourne, Victoria.

Dr Diana Khursandi, Dr Rod Westhorpe, Prof John Gibbs

Dr Lindy Roberts, Dr Pat Mackay

Dr Mary Dwyer, Dr Janice Gillies

Dr Rod Westhorpe, Prof David Gibb, Dr Kester Brown

General scene

Prof David Gibb, Dr Jean Allison, Dr Andrew Bacon

Mr Robert Edeson, Dr John Crowhurst, Dr Walter Thompson

Dr Robert Gillies, Dr Jane Baker

Dr John Crowhurst, Dr Kester Brown, Dr John Paull

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ASA

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INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

Anna Gebels, Curator of the Harry Daly Museum, reports on three exciting new additions to the History of Anaesthesia Library, Museum and Archives (HALMA), to be featured in our brand new North Sydney location.

NEW ACQUISITIONS

In the midst of the relocation to our beautiful new premises in North Sydney we have found the time to accept into our collection three wonderful new items. HALMA would like to thank Dr Peter Isert and the late Dr Charles Sara for their generous donations. All three will feature in our new exhibition, which is due to open early in 2014.

Wembley Gas Oxygen Apparatus c. 1939, donated by Dr Peter Isert

The Wembley Gas Oxygen Apparatus is significant for its rarity. Similar in design and function to the British Oxygen Co.'s *Queen Charlotte* apparatus for gas-air analgesia, the patent for the improved apparatus was registered in May 1936. However, we believe that this particular apparatus was a later model, as the gas cylinders are located at the rear of the case, further increasing the 'compactness' of the apparatus, as described when on display at the Glasgow Medical Exhibition, April 24 to 28 1939.

The earliest and still one of the safest anaesthetics, nitrous oxide is manufactured and distributed by the British Oxygen Co. throughout the United Kingdom. Nitrous Oxide, air and oxygen are administered by means of the well-known Wembley range of apparatus … These appliances are distinguished by extreme compactness and portability, the smaller models being made in suitcase form, and also by the absence of external tubes and gasbags.

British Journal of Nursing, March 1939

Artificial Manual Breathing Unit Resuscitator c.1957, donated by the late Dr Charles Sara

The Artificial Manual Breathing Unit apparatus for resuscitation and suction was introduced in the late 1950s. The suction pump (pictured) consists of a concertina bag which causes suction by expanding. When placed on the floor it was operated by compressing with the foot, leaving both hands free to operate the mask and self-expanding latex rubber bag. The two devices combined made it possible for patients with respiratory emergencies to be treated in the field, thus making anaesthesia possible in the most primitive of circumstances. The apparatus was used by Dr Charles Sara.

Coxeter Anaesthetic Apparatus c.1926, donated by Dr Peter Isert

An anaesthetic apparatus permitting the supply of pure air, nitrous oxide and ether in regulatable proportions, the Coxeter Anaesthetic Apparatus was developed by Lord George Wellesley and manufactured by Coxeter and Son Ltd. Patent for the design was applied for in 1925.

The Harry Daly Museum is currently closed whilst we develop our exciting new exhibition. However, you can still explore the treasures within at https://ehive.com/account/4493 or follow the links from the ASA website.

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin, Chair

As we approach the end of 2013, it is time to reflect on where we have been and where we are going. The Society is for the members and by the members. To that end, development and expansion of the membership in South Australia in both trainee and specialist groups is of paramount importance. We have sought to engage the private practitioners and discover their views on the relevance of the ASA to their practice. We seek to maintain the membership of trainees as they progress through to specialist positions, a time that traditionally sees a lapse in membership. This will remain 'work in progress'. This year we have been ably supported by Dr Adam Badenoch (as senior GASACT rep), as well as Drs Chelsea Hicks and Brigid Brown (as junior GASACT reps).

The public hospital specialists are a large group in South Australia, and we need to ensure that their voice is heard and their opinions sought. Rural GP anaesthetists and solo practitioners are also in our sights as two groups who are often left 'out of the loop'.

The long-running enterprise bargaining negotiations for salaried staff at the public hospitals are on the brink of being finalised as I write. Our most sincere thanks go to the South Australian Salaried Medical Officers Association for their commitment to ensuring that a two-tier Consultant grade has been avoided and safe hours of work have been protected, whilst allowing flexibility in the workforce to enable appropriate matching of expertise with workload.

Finally, congratulations to those ASA members who have successfully passed the ANZCA Part 2 examination recently.

TASMANIAN COMMITTEE

Dr David Brown, Chair

On behalf of the Tasmanian Regional Committees for ANZCA and the ASA, we would like to invite you to the 2014 Combined Annual Scientific Meeting (ASM) to be held in Hobart on the weekend of 1 and 2 March 2014.

The theme of the meeting is 'State of (the) Art', highlighting ultrasound use in obstetric anaesthesia. A unique feature of the meeting will be the applied anatomy and ultrasound workshops. Professor Jose Carvalho from the University of Toronto will be the keynote speaker.

Dissected cadavers, prosected specimens, skeletons and anatomical models will be utilised to facilitate a review of the relevant anatomy. Ultrasound facilitators using state-of-the-art ultrasound machines will be on-site to enable participants to relate ultrasonic images to anatomical structures using live models and fresh cadavers.

VICTORIAN COMMITTEE

Dr Peter Seal, Chair

34th Annual ANZCA/ASA Combined CME Meeting

This was a highly successful meeting, convened for the second consecutive year by the ASA and held in July at the Sofitel Hotel. A record number of 238 registered. The theme was 'MythBusting in Anaesthesia', and the highlight was a session dedicated to malignant hyperthermia, during which 90-year-old ASA retired member Dr Jim Villiers delivered a truly extraordinary account of the first recorded case in 1960 from which a patient was resuscitated and managed successfully. He was recognised with a deeply heartfelt and deserved spine-tingling standing ovation. Drs Peter Seal, Usha Padmanabhan and Zoe Keon-Cohen were the co-convenors.

ANZCA/ASA Combined QA Meeting

Another well-subscribed meeting took place in October at the College, organised by Drs Andrew Schneider and Usha Padmanabhan.

2016 ASA NSC

The 75th Diamond Anniversary ASA NSC will be coming to Melbourne in 2016. Dr Simon Reilly has been appointed Convenor, with Prof Colin Royse as the Scientific Convenor.

Personnel changes on the Committee

Ms Mary Vassilacos commenced in August as the Victorian State Secretary, taking over from Ms Kirsty Gee. Dr Michelle Gerstman relinquished her role as one of the GASACT representatives. Meanwhile, after many years of diligent service as the General Practitioner Anaesthetists Committee representative, Dr Quentin Tibballs has announced his retirement from this post. Finally, congratulations to Dr Michelle Horne, who has given birth to her second son. Likewise, felicitations to Dr Mark Suss on the arrival of a new daughter.

WESTERN AUSTRALIAN COMMITTEE

Dr Ralf Longhorn, Chair

Our local, hard-working Continuing Medical Education Committee recently hosted our Bunker Bay Update on the theme of 'Enhanced Recovery After Surgery', which was convened by Dr Rupert Ledger from Fremantle Hospital. This was an excellent meeting and rivaled many major international conferences for its quality of presentations. The lectures and workshops dealt with many varied issues, ranging from new theories on the endothelium and its impact on fluid management, interpretation of relevant meta-analyses and analgesia regimes to present-day Enhanced Recovery After Surgery programs with their patient and economic benefits. I can certainly advise our interstate colleagues to look out for future Bunker Bay Updates as they are proving to be worth the travel. Well done Rupert and team.

Dr Peter Brine recently passed away. He was a past president of the ASA and a member for 50 years. His achievements are too many to list but they were acknowledged by him being awarded the Order of Australia. His legacy to anaesthesia in Western Australia will live on.

On our local committee, Dr Paul Kwei has taken up the position of Staff Specialist Representative.

INSIDE YOUR SOCIETY

DR ASHLEIGH A. BISHOP 1938–2013

Following his anaesthetic training in New Zealand, Ashleigh Bishop, fondly known as "Bish", arrived in Melbourne in 1968, spending six months at the Royal Children's Hospital and six months at the Royal Women's Hospital. The following year he spent 12 months in Intensive Care at the Royal Children's Hospital.

Coming to Brisbane in 1970, he spent several years at the Mater Hospitals where he continued to develop his interests in neonatal, paediatric and obstetric anaesthesia.

In 1972 he joined the Narcosia Anaesthetic Group whilst serving as a VMO at both the Royal Children's and the Mater Children's hospitals. During these early years he worked very hard providing obstetric anaesthetic services, becoming one of the doyens of paediatric anaesthesia in Queensland. He retired from Narcosia in 2007. He was Chairman of QLD Regional Committee, FARACS from 1983 to 1984. From 1984 to 1996 he served as final part examiner for the FFARACS. He also served on the executive of Narcosia, including the role of group Chairman.

Ashleigh Bishop's funeral took place on 18 September, 2013. The following eulogy was given by Dr Rob Edwards:

It is not easy to measure the quality of a man's life.

One measure is to look at the number of people who choose to spend time with him: look at the people who feel the need to seek him out, look at the people who go to him for wise counsel on all manner of things.

Another yardstick could be to look at his achievements within his family, community and professional life. To see the positive effects he has had in each of these spheres over several decades.

It could be to measure the unspoken but very tangible respect given by colleagues from very junior to very senior levels whenever he entered a room.

It could even be how passionately he can play piano and sing "God defend New Zealand" at half time during a Bledisloe Cup telecast.

Perhaps equal to all these parameters it could be something as simple as to have some good people say "He was a really good bloke".

On all these measures, Ashleigh Alick Bishop's life was an outrageous success.

Ashleigh Bishop was an inspirational, gifted and pioneering paediatric anaesthetist. He was caring sensitive and usually softly spoken. The smallest sickest premature babies, gentle hand on the bag, the perfect eye for the lines, the coolest head in the most arduous of situations, all with an innate sense. All in the days of very basic monitoring and limited drugs. We salute you.

He taught generations of young "docs", as he called us, not just technical skills and theory, but as much as it can be taught, judgement.

Several weeks ago, on his iconic Queensland veranda, Ash recounted a story that summed up many aspects of his journey. Always keen on sport, he was roped into Melbourne's Royal Children's Hospital AFL team. Being not accustomed to such a strangely shaped ball and such a strange game, it didn't take too long before Ashleigh's nose was spread across his face. After the game, he was sneaked into the Children's Hospital to have it straightened. He awoke post-op to find himself crammed into a little cot, knee chest position with the side rails all up.

Angie had to whisk him away before the day staff found him and so he could start work at 7 am.

There was no evidence that he had been there.

This story highlights several of Bish's many attributes: keen to have a go, a slight irreverence, an impish style and a tremendous commitment. His retelling of this story in his last weeks of life was filled with his laughter. More of his great gifts—humour, storytelling and courage.

For decades to come, anaesthetists all over Queensland and further afield will, on various occasions, ask themselves "what would Bish do?"

Brisbane was very fortunate that following his training in Melbourne he was despatched to us. We here today who were touched by him personally are even more blessed to have known him. Farewell Ashleigh and thank you. I am sure you'll be right Doc.

Australian Society of Anaesthetists Membership Achievements

Queen's Birthday Honours
Member (AM) in the general division:

Dr Francis Xavier Moloney, Orange, NSW.
For significant service to medicine, particularly in anaesthesia.

ASA Pacific Fellowships:

Dr Rhys Thomas, Lambton, NSW
Three-month fellowship, 2012.

Dr Jamahal Luxford, Hawthorne, VIC.
One-month fellowship, 2013.

Every year, the ASA supports and funds three fellowship positions based at the Fiji National University Department of Medical Sciences. Visit the ASA website for more information.

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INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from July to November 2013.

ORDINARY MEMBERS

Dr Anthony John Barnard	SA
Dr Russell J. Cook	VIC
Dr Janette Haq	VIC
Dr Jonathan Gurney Hiller	VIC
Dr Tao-Chern Lee	VIC
Dr Melrex Malan	QLD
Dr Melissa Wendy F McDougall	VIC
Dr Fiona Germaine McManus	WA
Dr Adam Romney Nettleton	VIC
Dr Martine Patricia O'Neill	NSW
Dr Michael Douglas Schurgott	SA
Dr Ann See	NSW
Dr Richard Semenov	SA
Dr Roger William Howard Skilton	VIC
Dr Ingo Weber	SA

ASSOCIATE MEMBERS

Dr Jan Barent Anderson	VIC
Dr Martin Dempsey	NSW
Dr Nazih Hamzeh	NSW
Dr Scott Lewis	SA
Dr Peter Rubert Rischbieth	SA

TRAINEE MEMBERS

Dr James Robert Anderson	WA
Dr Omeed Albazzaz	VIC
Dr Benjamin Jay Brabin	NSW
Dr Gregory Michael Bulman	VIC
Dr Phillipa Bunting	NSW
Dr David Warrick Burns	ACT
Dr Rick Champion	SA
Dr Ian Thomas Chao	VIC
Dr Guangjun Chen	VIC
Dr Peter Correa	QLD
Dr Dale Currigan	VIC
Dr Oliver David	SA
Dr Conor Day	SA
Dr Thananchayan Elalingam	NSW
Dr Zahra Farzadi	QLD
Dr Alex Grosso	QLD
Dr Nicholas Harrington	SA
Dr Annabelle Victoria M Harrocks	QLD
Dr Charles Herdy	QLD
Dr Tushar Indulkar	SA
Dr Rebecca Jeffrey	SA
Dr Swaetha Koneru	NSW
Dr Shannon Laycock	QLD
Dr Nam Van Le	VIC
Dr Kian Chiat Lim	SA
Dr Sheng Kai Lim	SA
Dr Daniel Hsin-Kai Liu	VIC
Dr Jeffrey Mott	QLD
Dr Tim Rance	QLD
Dr Roshan Reginald	VIC
Dr Andrew Kevin Ross	VIC
Dr Rachna Shankar	VIC
Dr Christopher Stone	NSW
Dr Linda Sung	QLD
Dr Farhood Tofighi	ACT
Dr James Trumble	SA
Dr Matthew Van Zetten	NSW
Dr Ben Wilson	ACT
Dr Derrick Nathan Wong	VIC
Dr Phak Hor (Alvin) Yeap	SA
Dr David Edwin Young	QLD

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Drs Prem Narain Rastogi (NSW); Ashleigh Alick Bishop (QLD); Philip John Armstrong and Lelia Harris (VIC); and Peter Brine AM and John Reed Hankey (WA).

If you know of a colleague who has passed away recently, please inform the ASA via asa@asa.org.au.

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ASA

Australian Society of Anaesthetists

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UPCOMING EVENTS

FEBRUARY 2014

Combined Meeting of the 14th Asian Australasian Congress of Anaesthesiologists and the 4th Australasian Symposium on Ultrasound and Regional Anaesthesia

Date: 21–25 February 2014

Venue: SkyCity Convention Centre, Auckland, New Zealand

Contact: The Conference Company, NZSA info@aaca2014.com

Website: www.aaca2014.com

MARCH 2014

Obstetric Anaesthesia SIG Meeting

Date: 21–23 March 2014

Venue: Shangri-La Hotel Sydney, 176 Cumberland Street, The Rocks, Sydney, New South Wales

Contact: Lana Lachyani, ANZCA llachyani@anzca.edu.au

MAY 2014

Airway Management SIG Meeting

Date: 2–4 May 2014

Venue: Singapore Convention and Exhibition Centre, Marina Bay Sands, Singapore

Contact: Hannah Burnell, ANZCA hburnell@anzca.edu.au

Website: http://www.anzca.edu.au/fellows/special-interest-groups/airway-management/airway-management-sig-meeting-2014.html

JUNE 2014

NSW Winter Continuing Medical Education (CME) Meeting

Date: 21 June 2014

Venue: The Hilton, Sydney, New South Wales

Contact: nswevents@anzca.edu.au

Website: www.nsw.anzca.edu.au/events

OCTOBER 2014

ASA National Scientific Congress

Date: 4–7 October 2014

Venue: Gold Coast Convention and Exhibition Centre, Gold Coast, Queensland

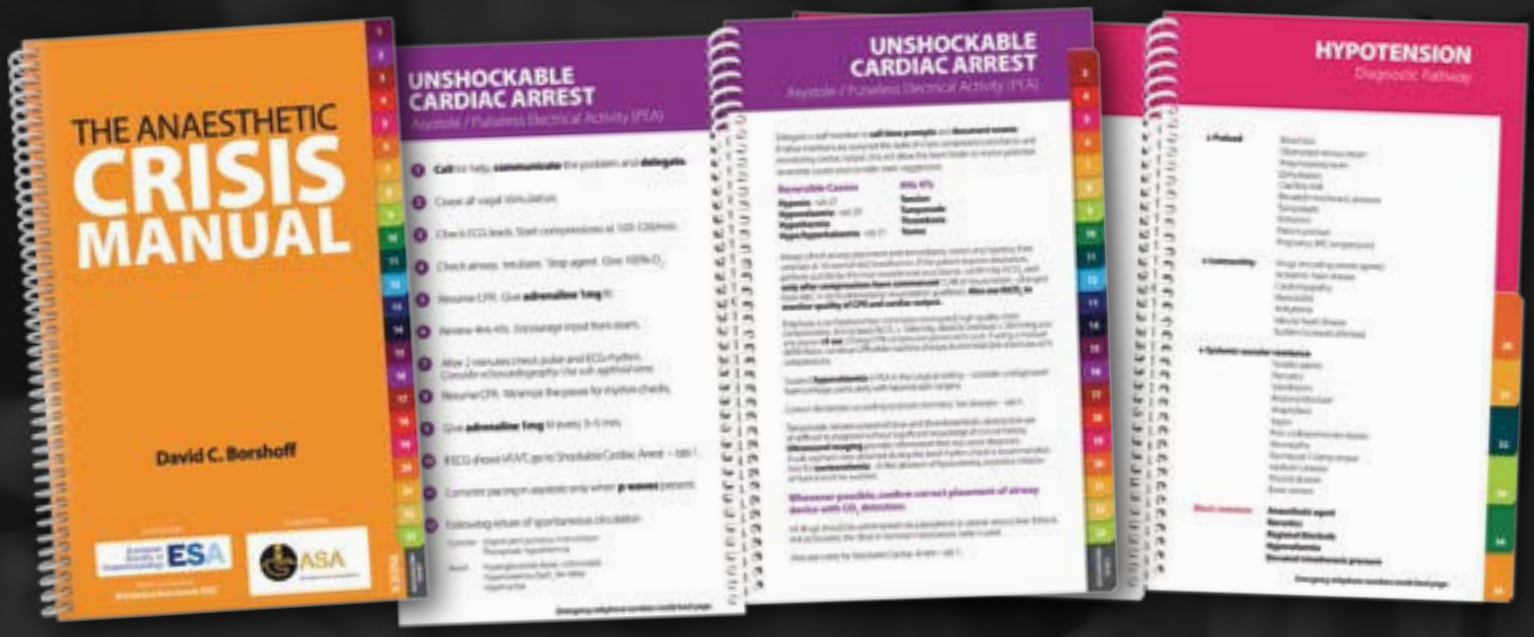
Website: www.asa2014.com.au

Contact: Robert Campbell, ASA Events@asa.org.au

For more information on events to attend, go to the ACECC website: www.acecc.org.au.

ACECC
Anaesthesia Continuing Education Coordinating Committee

THE ANAESTHETIC CRISIS MANUAL



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LIFESTYLE

CYCLING THE RONDE VAN VLAANDEREN 2013

Cobbles and mud. Blood and sweat. Passion and pain. These ingredients have helped establish a 100-year-old tradition. The Ronde Van Vlaanderen, or Tour of Flanders, celebrated its centenary this year and it was as gruelling as ever, writes keen cyclist Dr Lew Targett (FANZCA, FFARACS).

'De Ronde' has always been associated with terrible weather, and the driving rain, wind and hail have been responsible for helping define the race's identity.

For those cyclists who are slow learners (like me) you get to do the course the day before, on the Saturday; the event is called the 'Ronde van Vlaanderen Sportive'.

If you are real hard core you can do the full course, which is 256 km. Or, perhaps more sensibly, you can do the 133 km course, which misses the first 100 km or so—a pretty flat stretch—but you still get to do all the iconic climbs (or Bergs, as they're known) with all the pain and suffering of the cobbles. A no-brainer.

Along with my riding mate, Steve Hicks, we chose the so-called short course.

> The theory with cobbles is to ride over them really fast, say at 40 km/hour, hold the bars loosely and you will be fine

It had been pretty cold in the lead-up to the event, snowing most days. On the morning of the ride it was -2°C, so we put every bit of warm gear in our bags. With five layers on we didn't really look like the typical 'anorexic' cyclist!

It's a very big event. There were 16,000 riders this year. However, the good thing

THE RONDE VAN VLAANDEREN

Start:
Bruges

Finish:
Oudenaarde (as of 2011)

Editions:
97 (as of 2013)

First race:
1913

Biggest challenges:
The short sharp hills and cobblestones

Dr Lew Targett at the starting line

is that, although you have transponders, which are electronic timing chips, it is not a mass start so you can set off whenever you like, sort of.

Unfortunately, at the bottom of the first climb, the Koppenberg, at least 1000 riders had got there before us. It was chaos. Completely shambolic. Half a kilometre up, it was a standstill. Riders were everywhere, all over the shop, falling off their bikes. So we walked to the top through the most mud I've seen for a while, then off we went. By then the field was split and the going was okay, except for the cobblestones.

The theory with cobbles is to ride over them really fast, say at 40 km/hour, hold the bars loosely and you will be fine. Well I tried that and lasted about 100 m. Riding over cobbles is like nothing else, everything turns into one great blur of bumpy, vibrating activity. And the faster you went the worse it was; rather than floating over the cobbles I was crashing through, trying to hold a straight line and not get taken out by the hundreds of other riders right next to me.

As there are 16 Bergs on the Parcours you spend a lot of time climbing on cobbles and, to make matters worse, there were even cobbles on the flat stretches!

SO, HOW DID IT GO?

GREAT! This is another 'must do' event that every serious cyclist should try at least once in their life. Belgium is a great country to go riding in, and the event is well organised with lots of food stations and marshals to keep you from getting lost.

Half the race seemed to be on goat tracks and tiny narrow cobbled climbs, all of which were impossibly steep, mostly between a 9% to 21% gradient, but short; the longest, the Kwaremont, is only 2.2 km, but that's enough on the slippery cobbles that threatened to ruin your day big time if you crashed out.

Steve and I managed to finish unscathed in a little over six hours, which included a few photo opportunities. I even did a 'piece to camera' for a local Brussels TV journalist I'd met in the hotel the night before, and I saw him on the course at the top of a climb. I only lost five minutes, though it probably won't be seen on Australian television.

The weather was brilliant, if really, really cold. The average temperature was 2°C, but there was no rain, not too much mud and only a bit of snow after the end of the race. It was just a fun day.

After the race, we spent the next day at the Cycling Museum in Oudenaarde, and we had a guided tour with Freddy Maertens, the Belgian cyclist, who came second in this event and was famous for holding the winner's jersey for the entire Vuelta on one occasion. It was fascinating and, as if it couldn't get any better, after lunch Fabian Cancellara, who won the 2013 race, was present in the Museum (along with around 500 fans) and was given a cobblestone with his name engraved to put in the building's 'Walk of Fame'. Totally cool, as my kids would say.

The next weekend brought the 'Hell of the North' Paris Roubaix. The Sportive is the day before on the Saturday and is only 175 km, although this includes 50 km of cobblestones! That's like riding from Melbourne to Franskston on cobblestones—it was so much fun! We got to ride around the famous velodrome in Roubaix at the finish and even had a chance to get into the hallowed showers afterwards for a wash.

LIFESTYLE

EXAMPLE 1

ANAESTHETIST AND ARTIST: PAINTING IN RETIREMENT

Australian Anaesthetist knows that life doesnt stop after practice. Dr Kester Brown (MBChB, FANZCA, FFARACS, FRACGP), retired anaesthetist and longtime art enthusiast, writes of his passion for painting.

Winston Churchill said, "I could not have borne the burden of my responsibilities without painting". I concur with this view. I began painting while interning when the windows in the hospital were painted for Christmas with poster paints. Watercolour painting at school did not excite me, although I had a good teacher. Oil painting appealed to me; if you didn't like the result you could paint over it. So for 20 years I painted in oil. For about four of those years I used only the three primary colours (red, yellow and blue) and white so that I learnt how to mix colours and achieve a variety of tones.

Watercolour was different. You use washes of colour beginning with the lightest and adding darker areas as you progressed. In 1980, I rediscovered watercolour. I found I could do quick small sketches in 15 to 30 minutes; they dried quickly and they were easily transportable (in my camera bag, with water in a 35 mm film cartridge). From then on I used them frequently while travelling and must have done about a thousand all over the world. Later I began using acrylics, particularly for bigger paintings, because they are water soluble, an advantage when cleaning the brushes. They also dry much more rapidly than oils if you are working on-site, but sometimes this can be a disadvantage on hot summer days or in the very dry Antarctic climate. In such circumstances, you have to paint very quickly or use something to retard the drying time.

Painting as a hobby complements photography because when you paint there are nuances you can notice, whereas the camera just takes in the image. Painting makes you more observant. Looking at paintings, you can note how the artist achieved certain effects, which adds to the interest both as an observation and as something to try to achieve. For example, green is a very difficult colour to convey accurately. In Australia, the addition of a little brown (burnt umber) to

LIFESTYLE

the green (or mixture of blue and yellow) creates a colour more like the eucalyptus leaves. I learnt that by watching a painting demonstration.

I have had very little formal instruction but I was fortunate to have a number of artist friends from whom I received valuable tips about painting which I have incorporated into my techniques over the years. These are the important ones:

1. Learn to mix colours. If you put a row of seven jars with some red, yellow and blue diluted in water in three of them, you can mix and produce close to the colours of the rainbow. Red and yellow makes orange, yellow and blue makes green, red and blue makes purple or indigo—essentially the colours of the rainbow. In addition, if you mix all three you can create brown.
2. When painting landscapes or pictures with depth, the foreground will be darker than the background, which will be paler. This gives a feeling of depth and can be seen when looking at rows of hills fading into the distance (Example 1). In Example 2 the patch of light blue sky beyond the row of trees gives the view depth. If it is blocked out the scene becomes foreshortened.
3. Perspective is important if you are painting buildings, boxes, roads etc. Lines converge at a distant point so that the lines going away from you are not parallel but converge. Look at the tracks at a railway station and you can see this (Example 3).
4. Reflected images are darker than the actual image.
5. When painting, for instance, a bowl of fruit, the curved appearance is achieved by painting the under curve darker and the upper curve lighter. This can be enhanced by use of a dot of white paint where the light falls (Example 4). White patches of paint can make a picture come alive. John Constable was credited with making paintings more vibrant. If you visit the National Gallery in London and look at his 'Cornfield' you can see that he used spots of white on the leaves to make them glisten. Shadows are darker and are often painted with a deep blue or indigo.
6. When painting landscapes with trees there is a lot of light and shade in the leaves. In addition, when painting eucalypts many painters use some blue on the trunk. This can be seen on some of Hans Heysen's great paintings of trees in the Adelaide Hills.
7. Another fascinating feature to observe is when there are tiles on the floor or lines are drawn to converge towards a distant point in a painting. The lines will follow you as you walk across in front of the painting. A good example is seen in Tiepolo's 'Cleopatra's feast' in the National Gallery of Victoria in Melbourne. Having this pointed out to people has "made their day" on many occasions!

These tips might encourage some of you who read this to give painting a try, or it may help others to look at paintings in a new way. You can paint on-site outside (en plein air) or inside using photographs, sketches or subjects that are static—fruit, flowers or people. Portraits where the subject's eyes are not parallel but slightly tilted are usually more interesting. This is also a useful tip in portrait photography.

Learning to paint provides a relief from the stressful routines of life and is an enjoyable occupation to have when you retire. Many people take lessons, but I have learnt ideas from different people and also by looking at paintings, rather than having formal classes. It can be very relaxing and time consuming if you want it to be.


EXAMPLE 2


EXAMPLE 3


EXAMPLE 4

LIFESTYLE

EVERYONE WANTS TO BE AN ASTRONAUT

Dr Antonio Grossi (MBBS, FANZCA) reminisces about when he was 11 years old and dreamed of doing something great in the years to come, like becoming an astronaut, flying a space shuttle or at least a special plane like the new A380.

Recently I had the pleasure of meeting a real astronaut at the Melbourne 2013 Annual Scientific Meeting. Not only was he an informative and entertaining speaker, but also a truly pleasant chap. I could barely wait to race home and tell my 11-year-old son whom I had met.

When I was his age, I thought if I did well at school in physics, mathematics, chemistry and English, perhaps I could obtain a place in a prestigious science course at university. After further postgraduate training I could apply for an accredited training position to become an astronaut. After paying my training fees, I could enrol in a 'world-class' astronaut training program. Finally, if I worked very hard and passed challenging exams, the 'Australian and New Zealand College of Astronauts' would admit me as one of their fellows. I could now look forward to a productive career as an astronaut being involved in flying space shuttle missions.

At some point, however, sadly these dreams have become nightmares for some.

The government, driven by its own political agenda, thought it would be a great idea to allow anyone to become an astronaut. They thought everyone deserves a space shuttle flight (fully rebate-able on the Commonwealth Space Benefits Schedule) and the more astronauts the country produced, the more likely this would be to occur. Furthermore, there had been a longstanding problem of maldistribution of astronauts across the country and, surely, increasing the numbers would solve this problem. After all, fixing the other problems such as terms and conditions of remote astronauts, providing professional support, locums so they could take realistic annual leave, appropriate on-call arrangements, support for spouses and help with the education of their families was far too difficult.

In reality, not everyone gets to fly the space shuttle, the A380 or even the 747. These flights are expensive and producing more astronauts does not mean more flights become available. It does produce a number of underemployed astronauts who

are quickly becoming deskilled because they are missing out on flying hours.

The government, driven by its own political agenda, thought it would be a great idea to allow anyone to become an astronaut

Health Workforce Australia has been commenting for some time that, based on projected population growth, Australia will require an increase in certain sections of the Australian medical workforce. The various colleges have diligently been training up hundreds of specialists to meet these projected demands. The elephant in the room roars. If there is little funding for these services and inadequate infrastructure and staff to open beds, then the demand for medical services will not be met. With projects such as the National Disability Scheme, the Gonski reform to education and the National Broadband Network, there is an increasing downward pressure on the costs of medical expenditure relative to Gross Domestic Product.

Suddenly there is a relative oversupply of astronauts, with serious quality and safety implications. Within this dangerous void, who will regulate which astronauts are still competent to fly which missions? Who will protect the public if the profession has failed to self-regulate? What will be the agenda of these self-appointed regulators? Even other areas such as research, teaching and peri-flight support services require independent funding. How will the oversupply be addressed? Who is responsible to now 'unscramble the omelette'?

Currently, in Australia there are approximately just over 27,000 fixed-wing pilots, 3100 helicopter pilots and, as an estimate, approximately 360 pilots who fly the A380. Not everyone gets to fly the A380. The average A380 crew flying experience is in the order of 26,000 flying hours. The standards are maintained so that the public can have confidence in the safety of their flight. The costs involved in 'bending the metal' are so large that the airline companies rigidly maintain standards as risk mitigation strategies.

Within this dangerous void, who will regulate which astronauts are still competent to fly which missions?

Fortunately, I just became an anaesthetist. Tomorrow I will go to work, look after patients and aim to help them through their surgery safely. I am glad I did not become an astronaut.

2014 Combined AACA and ASURA

Early bird registration closes 6 December

21-25 February, Auckland, New Zealand

Why you should register now for the 2014 Combined AACA and ASURA...

Although it has a complicated name, the 2014 Combined AACA and ASURA is actually pretty simple. It's not the world congress (WCA). And it's not the ANZCA ASM or the ASA. But it is arguably the most important anaesthesia meeting in NZ since the AACA was held here back in 1986. Think of it as an Asia-Pacific version of the WCA with a large extra dose of regional anaesthesia. The best reason for a Kiwi anaesthetist to consider attending the meeting is the quality of the scientific programme.

Although it is only a four day meeting, we have packed an awful lot into it. First, we have 8 international keynote speakers. And these guys are really good. Second, all your favourite speakers from around Australasia will be there to complete the programme. Third, we have a really big PBLD and workshop programme with the opportunity to get some small-group teaching with your favourite faculty.

Sure, we will throw in a great dinner on the waterfront and it will be an excellent chance to catch up with your friends and colleagues, but the highlight is the programme.

So, go to the website (www.aaca2014.com) and register now before all the good workshops are taken.

Keynote Speakers

Vincent WS Chan
MD FRCPC
Professor, Department of Anesthesia, University of Toronto, Ontario, Canada

Admir Hadžić
MD, PhD
Professor of Anesthesiology Department of Anesthesiology, St. Luke's - Roosevelt Hospital Center, New York

Mark F Newman
MD
Merel H Harmel Professor and Chair, Department of Anesthesiology, Duke University Medical Center, North Carolina, USA

Steve Shafer
MD
Professor of Anesthesiology, Columbia University New York, USA

Lee A Fleisher
MD
Robert D Dripps Professor and Chair, Department of Anesthesiology & Critical Care, Professor of Medicine, University of Pennsylvania, USA

Paul Myles
MBChB MD
Professor/Director, Department of Anaesthesia & Perioperative Medicine, Alfred Hospital and Monash University, Melbourne, Australia

Warwick Ngan Kee
MBChB MD
Professor and Director of Obstetric Anaesthesia, Department of Anaesthesia and Intensive Care, The Chinese University of Hong Kong

Ban Tsui
MD, PhD
Professor, Department of Anesthesia and Pain Medicine, University of Alberta Hospital, Edmonton, Canada

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The Australasian Symposium on Ultrasound & Regional Anaesthesia

Discover Auckland

Auckland is a city of incredible diversity. World-class shopping, superb food and wine, stunning scenery and plenty of action and adventure – it's all here.

If you're heading to Auckland for the 2014 Combined AACA and ASURA congress, make sure you get out and explore. There's so much to see and do, whether you have a few spare hours or a few spare days.

On the water

With an incredible harbour setting, getting out on the water in Auckland is a must. With everything from relaxing harbour cruises to sea kayaking, fishing charters, whale and dolphin spotting and match racing, you'll be spoilt for choice.

Take a day trip to one of the many beautiful islands dotting the Hauraki Gulf – walk up Rangitoto Island's volcanic cone for amazing views or discover Waiheke Island, New Zealand's own 'island of wine'.

Wining, dining & culture

Auckland is bursting with eclectic restaurants, cafés and bars, from casual bistros to five-star dining. Relax with a chilled glass of wine overlooking the harbour, join the locals for fresh fish and chips at the Auckland Fish Market or treat yourself to fine cuisine at one of the many eateries lining the waterfront. Viaduct Harbour, Wynyard Quarter and Britomart precincts all offer great dining at any hour and buzzing nightlife after dark.

For a culture fix, wander through the galleries at the Auckland Art Gallery Toi o Tāmaki or catch a daily cultural performance at the Auckland Museum.

Action & adventure

Head up the Sky Tower, the tallest building in the Southern Hemisphere, for incredible 360-degree views across the city – the brave can even 'SkyJump' off it or 'SkyWalk' around the exterior on a narrow walkway 192 metres above ground.

For more adventure, climb up and over the Auckland Harbour Bridge, or leap off it in New Zealand's only ocean-touch bungy. Or take a spin around the harbour on a jet boat ride, canyon down waterfalls or go 4WDing through the forest.

Shopping

It's easy to indulge in some top-notch retail therapy when you're in Auckland. The beautifully restored historical buildings in Britomart are home to the flagship stores of New Zealand's most internationally successful designers, alongside top international fashion and beauty labels. The inner-city suburbs of Ponsonby, Parnell and Newmarket are all great spots for boutique shopping and a leisurely lunch.

Explore Auckland

Auckland isn't just a great city, it's a whole region full of things to see and do. And with so many experiences so close by, it's easy to hop from one adventure to the next.

Just a 12-minute ferry ride across the harbour is the seaside village of Devonport, with it gorgeous Victorian villas, cafés and art galleries, plus the fascinating gun emplacements, maze of tunnels and incredible views at North Head.

Less than an hour north of the city centre is the picturesque Matakana region, known for its boutique wineries, superb farmers' markets and organic produce, or head to the wild west coast's rugged black-sand surf beaches and lush native rainforest. Find out more at aucklandnz.com

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		Standard	$1955	$1722
	Weekend	Earlybird	$1095	$964
		Standard	$1250	$1101
Trainee	Full	Earlybird	$575	$506
		Standard	$690	$607
Other health professional	Full	Earlybird	$575	$506
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