AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • DECEMBER 2016

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World Congress highlights • History of ASA logo

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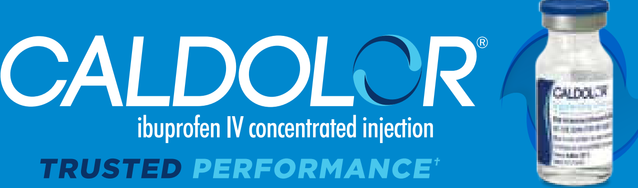

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SAVE THE DATE
7-10 OCTOBER 2017

INVITED SPEAKERS

Professor Michael Avidan
Professor, Anesthesiology, Washington University. Director, Institute of Quality Improvement, Research and Informatics (INQUIRI) and Division Chief, Cardiothoracic Anesthesiology.

Dr Philipp Lirk
Attending Anesthesiologist at the Academic Medical Center, University of Amsterdam. Head of Regional Anesthesia Service, he is also in charge of two international academic exchange programs.

A/ Professor Marjorie Stiegler
A/ Professor of Anesthesiology at the University of North Carolina, Director of the Consortium for Anesthesiology Patient Safety and Experiential Learning.

Professor David Story
Foundation Chair of Anaesthesia at the University of Melbourne, and Head of the Anaesthesia, Perioperative and Pain Medicine Unit. Senior Investigator, ANZCA Clinical Trials Network

The ASA NSC – *future dates*

OCTOBER 6-9
Adelaide

SEPTEMBER 20-24
Sydney

For all enquiries please contact: Denyse Robertson E: drobertson@asa.org.au

www.asa2017.com.au

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WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The March issue of *Australian Anaesthetist* will focus on perioperative care. If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 7 January 2017.
- Final article is due no later than 18 January 2017.

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

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ASA EDITORIAL FROM THE PRESIDENT

A/PROF. DAVID M. SCOTT
ASA PRESIDENT

This is my first editorial in Australian Anaesthetist as President of the ASA. I work in Lismore, Northern NSW in mixed public and private practice and have been actively involved in the ASA and the Australian Defence Force for more than 25 years. I have a strong interest in regional anaesthesia and have co-authored a book[1] and iPhone App[2] on the subject. I have held many posts in my time including department chair, supervisor of training and was closely involved in the ANZCA curriculum renewal a few years ago. I am now here to serve the ASA and its membership in advancing the interests and education of Australian anaesthetists.

At the recent AGM held at the NSC in Melbourne the membership approved, along with a new president, a new constitution[3] and as a result a new corporate structure. This structure brings the ASA in line with other Australian not-for-profit organisations in regard to board structure and size, and also establishes a Council who has a greater input into the future direction of the ASA. The board now has the President, Immediate Past President, Vice president, Treasurer and Executive Councillor with two members of the Council to make it complete.

As part of the ASA initiative to address the rural anaesthesia workforce problem I travelled to Canberra with Dr Jim Bradley, Mr Mark Carmichael and Mr Chesney O'Donnell for meetings with the Hon David Gillespie Assistant Minister for Rural Health, and also the senior leadership of the Rural Doctors Association of Australia (RDAA). These meetings were most helpful and we are now developing strategies with relevant stakeholders, including ANZCA, RDAA, ACRRM and the Rural SIG to address this long-standing problem.

The Immediate Past President, Mark Carmichael and I travelled to Noosa Heads for a one-day meeting to discuss perioperative medicine at a meeting sponsored by the Peri-operative SIG. This meeting included representatives from the Australian and New Zealand Associations of Geriatrics and Palliative Care Medicine, RACS, NZSA, and ANZCA. All anaesthetists are perioperative physicians, we all take careful histories and thorough examinations and make comprehensive plans for the intraoperative and post-operative care of our patients. Perioperative medicine is also the major point of difference between an Anaesthetist and a technician who administers drugs for anaesthesia. Politicians and health economists see task substitution as way of saving money, by using lesser-trained personnel to perform what they see as a simple task. Anaesthesia is in fact a complex task with a very high stakes risk profile where a minor error can lead to severe disability or death.

Our profession is under attack from decision makers who do not understand that an anaesthetist brings so much more to table than just the act of anaesthesia. Our active involvement in perioperative medicine is crucial to develop better processes in preoperative optimisation of our patients, and better acute care in the immediate postoperative period, as well as ensuring we provide the best care during surgery. This project is very important and the ASA intends to work with the Perioperative SIG to develop this aspect of our profession to ensure policy-makers understand the value anaesthetists bring to the health system, and ensure it is appropriately funded to provide better outcomes.

Since the last edition of AA the Presidents met with their counterparts from Great Britain and Ireland, Canada, USA, New Zealand and South Africa at the Common Interests Group Meeting, at the World Congress of Anaesthesiology in Hong Kong. Many issues were covered including the increase of 'bundled payments' in the USA. This is a major concern as a funding model as it changes from direct funding to the anaesthetist to a lump sum payment, which is then divided up by the recipient. Anaesthetists have to demonstrate their value to that recipient, who will be seeking to minimise payment to all, in order to maximise profits. Again, proving our worth both in the operating room and outside of it is crucial.

The World Federation of Societies of Anaesthesiologists (WFSA) also met and elected new presidents. They also presented on the Safe Access to Surgery and Anaesthesia program[4], which, currently over five billion people in the world do not have access to. They also introduced policy to the WHO stating that they believe anaesthesia is a medical act

and must be medically led for the safety of patients. They further clearly stated that an anaesthesiologist is a peri-operative physician.

At the end of October, I met with the College President Prof David A. Scott, Chair of the MBS Review Prof Bruce Robinson, and Chair of the Anaesthesia Clinical Committee Assoc. Prof Joanna Sutherland to discuss the MBS review and how it may impact on our specialty. This was an introductory discussion and provided some indication as to where it was believed savings could be made. It was apparent that, unlike other specialties, there is no pretense that outdated procedures were an issue in anaesthesia practice; rather, the opening statement by Prof Robinson related to concerns about large out of pocket (OOP) bills for patients. His focus was also on items in the therapeutic and diagnostic section of the RVG. This includes items such as 22012 (pressure monitoring), 22025 (arterial line insertion), 22002 (blood transfusion) and 22018 (respiratory monitoring), which, apart from 22002, have all shown significant increases in claims over the last few years. Prof Scott and I were strongly opposed to some of the suggested changes made by Prof Robinson to the RVG.

The Anaesthesia Clinical Committee is now constituted and includes the following eleven members, all of whom have been appointed in an individual capacity, with some of the seven anaesthetists having current ANZCA and ASA roles:

- Assoc. Prof Joanna Sutherland (Chair)
- Dr Tim Weston: https://anaestheticgroup.com.au/doctor/dr-timothy-weston/
- Assoc. Prof. John Stokes: https://www.jcu.edu.au/college-of-medicine-and-dentistry/about-us/staff-a-to-z/associate-professor-john-stokes
- Dr Mark Reeves: http://www.burnieanaesthesia.com.au/about.htm
- Dr Jodi Graham: https://healthengine.com.au/anaesthetist/wa/nedlands/dr-jodi-graham/p3825
- Dr Jim Bradley: Past President ASA
- Dr Genevieve Goulding: Past President ANZCA
- Dr Penny Burns (lecturer in General Practice): https://www.westernsydney.edu.au/staff_profiles/uws_profiles/doctor_penelope_burns
- Ms Ruth Bollard (surgeon): http://specialistsondrummond.com.au/ms-ruth-bollard/
- Dr Margaret Schnitzler (surgeon): http://www.northernsydneycolorectal.com.au/our-doctors/dr-margaret-schnitzler.
- Ms Helen Maxwell-Wright (public representative)

Details of the Anaesthesia Clinical Committee can be found at the website: http://www.health.gov.au/internet/main/publishing.nsf/content/MBSR-committees-anaesthesia-clinical#mem.

I find it disappointing that four members of the Anaesthesia Clinical Committee are not anaesthetists, and who, with the best intent, cannot have the intimate knowledge of anaesthesia that best informs a consideration of the Anaesthesia RVG. I note with further disappointment that as far as I know there have been no anaesthetists appointed to any of the surgical Clinical Committees, despite the fact that anaesthetists are intimately involved with many of the procedural services that surgeons provide.

I encourage you to engage with any members of the Anaesthesia Clinical Committee that you may know and share your views on the review process. The role of the Clinical Committee, through the MBS Review Taskforce, is to provide recommendations to the Minister that will allow the MBS to deliver on each of these four key goals: affordable and universal access, best practice health services, value for the individual patient, and value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by Clinical Committees and Working Groups. The Taskforce has asked the Clinical Committees to undertake the following tasks:

1. Consider whether there are MBS items that are obsolete and should be removed from the MBS.
2. Consider identified priority reviews of selected MBS services.
3. Develop a program of work to consider the balance of MBS services within its remit and items assigned to the Committee.
4. Advise the Taskforce on relevant general MBS issues identified by the Committee in the course of its deliberations.

An increase in utilisation of some Therapeutic and Diagnostic services beyond the baseline growth in anaesthesia has been identified by the MBS Review with these items now facing close scrutiny. I expect we will face proposals requiring a tighter definition for claiming the numbers, or alternatively the bundling of these items. The Review also appears to be canvassing: bundling preoperative assessment into basic units; reducing base units for some high volume procedures (like lens surgery); bundling invasive monitoring for some complex cases (e.g. cardiac anaesthesia); looking to combine line insertion and pressure monitoring together, and changing age modifiers.

The RVG is a schedule that the ASA campaigned for long and hard. It ensures that anaesthesia billing is independent and future-proof. It is simple and robust, well designed and fit for purpose, and does not require any change. Who would want to go back to a system that required anaesthetists to use anaesthetic item numbers for up to 13 different upper endoscopic GIT procedures that are catered for now by the use of item 20740, or for the eight lower endoscopic GIT procedures that are catered for now by the use of item 20810?

I would encourage my colleagues to

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consider carefully the reason for the use of any services which might be seen as 'discretionary' on the part of anaesthetists. It is likely that if these item numbers are to remain in the RVG they will be subject to closer scrutiny for anaesthetists who frequently claim them.

The ASA notes that the ongoing Medicare freeze has led to a fall in no-gap billing, and with that, more OOP expenses for our patients. This is to be expected. I encourage our members to ensure they obtain the best quality informed financial consent, and that the AMA fee of $83.00/unit to be your maximum fee (unless there are extenuating circumstances).

Finally, as the festive season approaches, on behalf of the ASA I would like to wish all our readers and their families all the best, and a happy safe and prosperous New Year.

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1. http://oxfordmedicine.com/view/10.1093/med/9780199684236.001.0001/med-9780199684236
2. http://rapocketguide.com/
3. http://www.asa.org.au/UploadedDocuments/ASA%20Constitution/ASA%20Constitution%20September%202016.pdf
4. http://www.thet.org/news/lancet-commission-calls-for-universal-access-to-safe-affordable-surgical-and-anaesthesia-care

CONTACT

To contact the President, please forward all enquires or correspondence to Sue Donovan at: sdonovan@asa.org.au or call the ASA office on: 02 8556 9700.

Notice a post Winter spike in your latest energy bill?

Make It Cheaper, the official energy partner of the Australian Society of Anaesthetists (ASA), continues to successfully identify reasons to help members* save money on their electricity.

You may have noticed a spike in your energy bill post Winter, well as of the 1 July 2016, many of Australia's major electricity retailers increased their rates, with hikes of around 10-12%[1]. When a price change occurs it is the perfect time to check your current plan to see if you can find something that works better for you.

Make It Cheaper are here to check your plan to ensure you aren't overpaying for your electricity with the new rates in place. Just think – a five-minute conversation with Make It Cheaper could unearth some massive savings for your business and home.

FOR A FREE QUOTE

Call the ASA Members Hotline directly on **02 8077 0142** or

Email a recent energy bill with contact details to **asoca@makeitcheaper.com.au**

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*In NSW, QLD, VIC and SA only

[1] - Mozo, 11th June, 2016

2017 MEMBERSHIP

Thank you for your ongoing support of the ASA.

We continue to implement the ASA's vision of **supporting**, **representing** and **educating** on behalf of our members to enable the provision of safest anaesthesia to the community by remarkable growth and changes.

You would have received your 2017 membership invoice by early December. If you have not received yours, please contact the Membership Services Team on 1800 806 654 or email membership@asa.org.au

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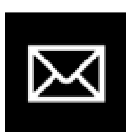

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Payment is due by 28 February 2017

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ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

In late August, just prior to the 16th World Congress of Anaesthesia, the Society hosted the 2016 Common Issues Group (CIG) Meeting in Hong Kong. This meeting, held annually, brings together the office bearers and executives from the American Society, the Association of Anaesthetists of Great Britain and Ireland (AAGBI), Canadian Society, the South African Society and our close friends from the New Zealand Society of Anaesthetists. The CIG provides a wonderful platform for the sharing of information and the discussing of issues that face the profession around the world.

During the meeting certain issues were prominent. It became apparent that for our American colleagues the matter of nurse anaesthetists and scope of practice is taking up a considerable amount of their time and resource both in terms of manpower and finances. At the same time the question of how many anaesthetists to train and the work opportunities when training is complete, is a concern for all societies. The welfare of anaesthetists is indeed an issue for all member societies, with the AAGBI being extremely active in this area. In Australia support and assistance is available through the Welfare Special Interest Group, which operates under the auspices of the Anaesthetic Continuing Education (ACE). Importantly, Doctors Welfare which is a 'Quick Link' on the ASA website, provides access to a wide range of resources which focus on this issue.

The CIG, is a unique and valuable resource which provides the ASA with an awareness of what is happening within the speciality on a world scale. It provides invaluable information, contacts and insight on issues which could only be obtained through such engagement.

The World Congress of Anaesthesia, co-hosted by the World Federation of Societies of Anaesthesiologists and the Society of Anaesthetists of Hong Kong was held immediately following the CIG. This timing allowed for a meeting with the European Society of Anaesthesiology, leading to a greater understanding of how it works and its areas of focus. With well over 500 Australian delegates attending the World meeting, Australia was indeed well represented.

Mid-September saw the staging of the highly successful 2016 National Scientific Congress in Melbourne. Congratulations must go to all concerned who put together such a wonderful program both academically and socially. In particular, thanks must go to Dr Simon Riley (Convenor) and Professor Colin Royce (Scientific Convenor) and the hard working committee who made this Congress such a memorable one.

As members know the Annual General Meeting is staged during the Congress. This year's meeting took on extra significance as amendments to the Constitution were put to the meeting. It is pleasing to report that all seven amendments were approved meaning that the Society now has a smaller Board of Directors charged with running the business aspects of the ASA and a Council which will attend to the policy issues which impact on the speciality.

As part of the meeting, the Society took the opportunity to recognise the significant contribution of Dr Elizabeth Feeney. Dr Feeney a Past President of the Society, was awarded the Gilbert Brown Award, which acknowledges outstanding and meritorious service to the ASA. I am sure everyone will join with me in congratulating Dr Feeney on this award.

The NSC in Melbourne also saw a changing of the guard in terms of the leadership of the ASA. After a highly successful two year term as President, Dr Guy Christie-Taylor stood down, with A/Prof David M. Scott being elected President. Dr Christie-Taylor has been instrumental in building a focus on engagement with government and developing strong ties with ANZCA in areas of mutual interest. He has made a strong contribution to the ASA and I am sure all members thank him for his efforts. Dr Peter Seal from Victoria, was elected as the Vice President for the next two years.

Engagement with Government on all levels remains a key aspect of the Society's work. Over the past 18 months the Society has met with various senior

Federal government ministers and their advisors, in order to promote the ASA's position on matters such as the MBS Review, Workforce and revalidation to name a few. This aspect of the Society's work continued in October with a delegation of the President, A/Prof David M. Scott, Specialty Affairs Advisor Dr James Bradley, Policy Manager Mr Chesney O'Donnell and myself meeting the Minister for Rural Health Dr David Gillespie. The primary purpose of the meeting was to discuss ways of providing reliable and high quality anaesthesia services in regional areas of Australia. Such engagement is essential if the Society is to influence change within the health care system, which is one of the key aspects of its work.

At the same time the Society has successfully reactivated its Public Practice Advisory Committee with A/Professor Alicia Dennis from Melbourne as its Chair. This committee will focus on those issues which are critical within the Public Hospital Sector and will help ensure that the ASA is meeting the needs of all anaesthetists within Australia. The Society is indeed thankful to A/Prof Dennis for taking on this role.

Much has happened and much continues to happen, and the ASA intends to remain active in those areas which impact on the members.

ANNUAL GENERAL MEETING 2016

Outgoing ASA President Dr Guy Christie-Taylor

Dr Guy Christie-Taylor presents Dr David M. Scott with President's Medal

Dr David M. Scott addresses the AGM

Dr Mark Sinclair presents on behalf of the EAC

Treasurer Dr Andrew Miller presents the ASA financial position

CEO Mark Carmichael provides an overview of the ASA activities

LETTERS TO AUSTRALIAN ANAESTHETIST

IN RESPONSE TO DR DAVID M. SCOTT – THE RENAISSANCE OF REGIONAL ANAESTHESIA

With interest I was reading Dr David M. Scott's article on the history of regional anaesthesia, particularly his hopes for a new drug that will selectively target sensory nerves and spare motor function.

I was faced with the same issue when embarking on orthopaedic private practice last year. The surgeon preferred patients to mobilise within hours of their knee joint replacement – impossible with a 'dead leg' as well as with pain scores of 10!

When I started experimenting with volumes, concentrations and additives I came to the conclusion that simply lowering the local anaesthetic concentration there comes a point where the LA predominantly affects sensory nerves. I now use Ropivacaine 0.1% (20ml) for all my femoral nerve blocks; in order to achieve a longer duration of the block, I add 4mg of Dexamethasone into the LA solution. I seem to be getting about 24 hours out of them now, with patients incredibly comfortable and able to mobilise with the physiotherapists.

I no longer need PCAs, IV fluids or O2. 'Detaching' patients from all hospital equipment aids their mobility and does not seem to be necessary. Just adding oral analgesia with Paracetamol, Targin and Pregabalin plus PRNs completes the recipe.

A new drug would be ideal – but I wonder if we can also get more value out of the ones already on the market.

Kind regards,

Dr Stefanie Gubbay FANZCA DESA
Dundowran Beach, Queensland

WORLD ANAESTHESIA DAY SEMINAR

I write to thank you for the invitation to the seminar to celebrate the history of anaesthesia (16th October, 2016). It was very instructive and thoroughly enjoyable Compliments and thanks are due to all involved: presenters of papers, chairmen, and ASA staff members.

It was very good to spend time with respected colleagues and to benefit from the erudition of some really accomplished anaesthetists.

With gratitude and best regards to all.

Dr George M. Boffa
Ashfield, NSW

CONGRATULATIONS TO DR KERRY BOYTEL

Congratulations to ASA retired member Dr Kerry Boytell from New South Wales for being the Healthcare Professional category winner in the Macular Disease Foundation 'mEYE World Photographic Competition 2016'. This was Kerry's third consecutive win in this category. To view the winning photographs please visit http://www.mdfoundation.com.au/page1220128.aspx.

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.

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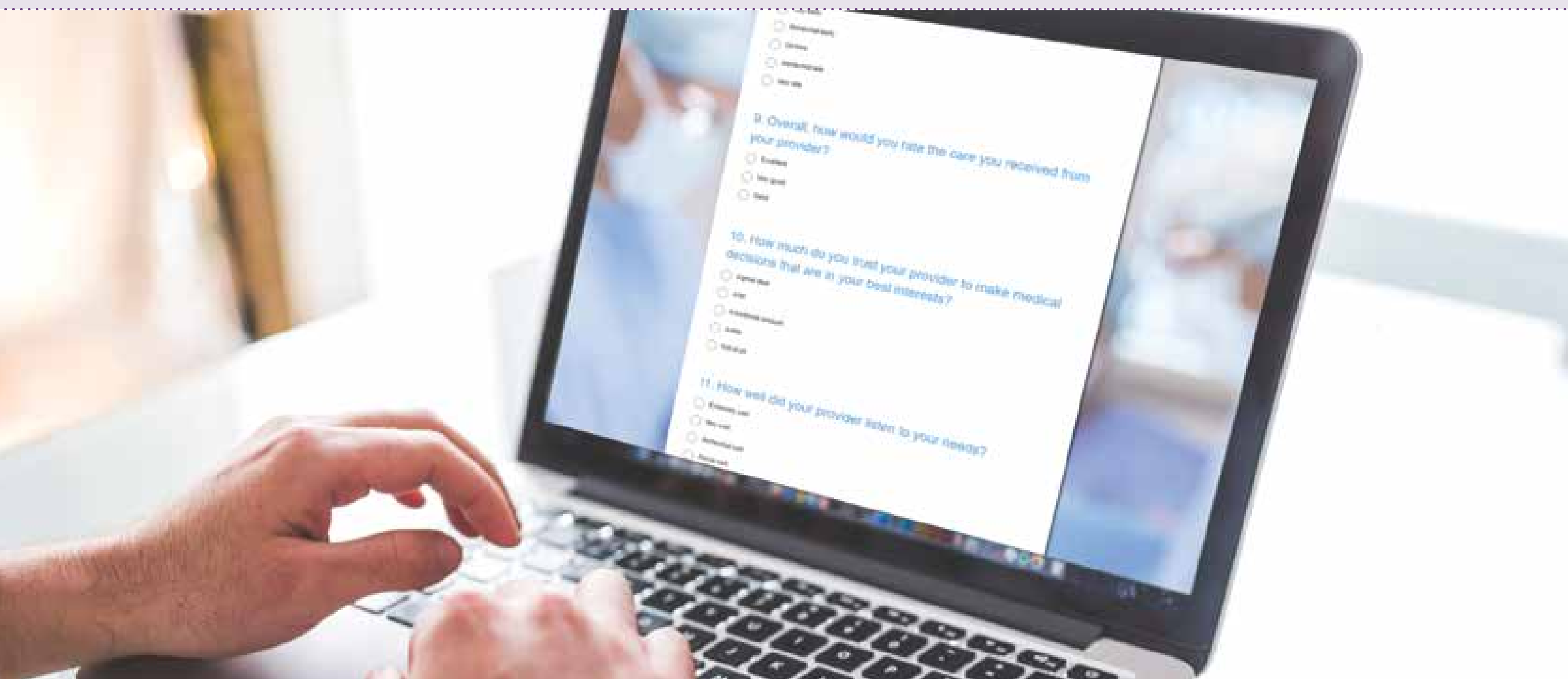

WHITECOAT AND PRIVATE HEALTH INSURANCE

Dr James Miller argues that *Whitecoat*, the private health insurer (PHI)-funded ratings website, is designed to enable PHIs to gain further control over the costs of health care provision.

The ABC 7:30 segment 'Doctors sound warning over online patient reviews' (29 September 2016) raised a number of issues pertaining to the private medical system whilst reporting on *Whitecoat*, the PHI-funded ratings website for doctors. The issues raised:

- that patients currently have no way of independently assessing specialists they are referred to;
- that PHIs have patient's best interests at heart; and
- that price is not a measure of quality;

failed to be properly explained or investigated let alone proven. It also again put the burden of proof on the medical profession to provide justification for reasonable fees, without suggesting insurers take responsibility to assist their customers to understand the terms of their policies. Patients should be encouraged to gain an appreciation of the private health system, its purpose, and the true costs associated with it.

The *Whitecoat* website is PHI funded. It is promoted as a Tripadvisor-like ratings site for medical specialists. The ratings are largely determined by encouraging patient feedback on their medical bills and subsequent out-of-pocket expenses. The stated purpose for providing this information is to enable patients to make informed choices in regard to quality of care. This is a falsehood. The purpose of this site is clearly designed to enable the PHIs to gain further control over the costs of care provision, by increasing pressure on practitioners to adopt a no-gap model. In doing so the PHIs have identified a commercial opportunity. The tension between the goals of the funds' desire to reduce and control costs and the fair remuneration for specialists is a real one, and it is not being pursued by the funds for the benefit of patients. It is being pursued for profit. We know this because health funds have increased member premiums year on year for the past five years, despite a freeze on premiums paid to specialists for over the same period.

…health funds have increased member premiums year on year for the past five years, despite a freeze on premiums paid to specialists for over the same period.

These premium increases have simply contributed to the funds' profits and capitalisation.

Further evidence of the profit vs benefit focus of the PHIs is the increased number of 'junk policies' that have flooded the market place to capitalise on the Private Health Insurance Rebate policies of successive federal governments. These insurance products, as summarised in the AMA's Private Health Insurance Report Card 2016, provide grossly inadequate, or simply no cover for the most basic of procedures. The ability for the general population to decipher the terms and conditions of these policies and the financial implications that result when entering the private health system is dubious to say the least.

As highlighted in the Report Card, different insurers pay vastly different benefits for same medical service. For example, the uncomplicated delivery of a baby will be rebated $2,150.35 by one fund, while another pays $832.74 – a difference of 158%. For members of these funds to expect the same service and quality of care without having to pay any out-of-pocket expenses would result in a large disparity of income between two different specialists, or the same specialist heavily discounting their service for one patient vs the other. Neither situation is adequate in the commercial world in which private health care sits. Yet the out-of-pocket expenses reported by patients will be used by *Whitecoat* as a surrogate marker for quality of service, regardless of the negative impacts such practices. The purpose being to eradicate gap-payments from the system which will have the effect of driving down the quality of service provided.

I know that some colleagues believe that providing a no-gap anaesthesia is paramount, and that it is a sign that they are providing a good service. This view was supported by one commentator during the 7.30 segment who stated that disparity in specialist fees for the same procedure is evidence of a broken system. I would argue the opposite is true, and evidence that this commentator has ignored the fundamentals of economics. The ACCC encourages the self-determination of fees, and this will result in outliers. To compare a procedure performed by one doctor versus another solely on their bills potentially ignores the overall value of the service provided. I agree that patients must have avenues to compare and contrast these, but the value one person places on a good or service does not have to equate to that of another. Using the example given, the specialist providing the $10,000 prostatectomy may rate far more favourably than the one providing the $400 one because if Whitecoat is to work as reported, it is the overall service that is being ranked, not the cost. The value derived from the service provided at $10,000 may well superior. Whether intended or not, it is difficult for bulk-billing practitioners to provide a premier service – across all fields of medicine – and it is the service which is being purchased.

Being a business person I understand that fees charged must present a valued representation of the service being provided. For anaesthetists this means setting a unit price independent of health insurance dictation that represents the sum of, the costs of providing the service, the costs of mitigating the risks of providing the service, and remuneration for your skill and expertise. This requires conscious thought and effort, not to mention hard work to maintain a level of service equal to the rates charged. An independent rating system would support this. Further adherence to the 'preferred' provider model undermines our autonomy and ultimately the quality of care provided. To help counter this I advocate all practitioners charge appropriately for the service they provide. If you perceive your service to be adequately priced around that of the rebate rate, charge that rate, and charge the same rate to each patient no matter what policy they have purchased. Send the patient the bill and have them deal with their insurer. Without doing so you are perpetuating the idea that private healthcare is free, and that health funds have a right to dictate costs. It will also encourage patients to question their funds, read their terms and conditions and source more adequate policies.

…*Whitecoat* is further evidence of the drive by the PHIs to affect the model of private health care provision towards that of the Americanised system of health insurer provided care.

PHIs were not established to provide private health services, but as financial vehicles to help account for risk, and mitigate the costs of the private health consumer. The increased presence of PHIs in the field of health provisions – think BUPA optical and dental shopfronts – is a disastrous development for the Australian health system as a whole, and for both the practitioner and consumer. Disappointingly, *Whitecoat* is further evidence of the drive by the PHIs to affect the model of private health care provision towards that of the Americanised system of health insurer provided care. Specialists must resist the pressure to devalue their services, and help educate patients on the true costs of private health care. Due to inadequate insurance cover, patients will have out-of-pocket expenses. Many may leave the private sector, but this will result in funds having to respond, and hopefully slow the drive to replicate the failed American model of care that insurance companies are so keen to achieve in Australia as ultimately it is the one that improves their profit margins at the expense of all else.

FEATURE

ASA 75TH NATIONAL SCIENTIFIC CONGRESS MELBOURNE 2016

The Diamond Jubilee of the Australian Society of Anaesthetists' National Scientific Congress was held in Melbourne in September: the 75th National Congress since the first held in Melbourne in 1935. A fantastic time was had by all the attendees at the magnificent Melbourne Convention and Exhibition Centre, writes Convenor Dr Simon Reilly.

Our Scientific Convener Professor Colin Royse performed an outstanding job producing what I believe was one of the best scientific programs for an Australasian meeting. It's the science that makes a great meeting and talking with attendees, all highlighted the meeting as having some of the best content that they had seen and heard.

The Scientific Convenor has a very difficult job to bring fresh ideas and fresh speakers to an audience who are already well travelled and educated and I believe Colin did this extremely well. One of the key elements is to have excellent invited speakers. Our speakers were not all anaesthetists but came from related areas of medicine, which highlights the diversity that is required in the practice of modern anaesthesia.

The Congress was officially opened by President Guy Christie-Taylor and we were welcomed to the country by Aboriginal Elder Bill Nicholson. We all appreciate the importance of the Wurundjeri culture, the importance of the land, and how privileged we were to be holding our conference on their land. Bill's son, Damien performed on the didgeridoo and stunned the audience with his performance.

The Kester Brown lecture was delivered by one of our invited speakers, Ms Carolyn Canfield, an independent citizen-patient and huge advocate for the engagement of patients in the management of their own illness and well-being. Kester himself was on stage to present Ms Canfield with her award for the oration and gave us a special reflection on his life experiences particularly related to his work

in developing conferences and medical education.

The scientific program was full, deliberately full to give every member an opportunity to improve their knowledge and skills in particular following our two major themes of perioperative medicine and clinical ultrasound. Our other invited speakers to help with this journey were Professor Olle Ljungqvist, Professor of Surgery at Örebro University Hospital, Sweden and an expert in the area of Enhanced Recovery after Surgery, Professor Stanton Newman a neuropsychologist well renowned for Post-Operative Cognitive Deficit research and assessment of cognition after surgery and Dr David Canty, our Australasian visitor and Cardiothoracic anaesthetist who is very involved in ultrasound teaching in theatre and PACU.

As well as the four ASA invited speakers we had additional four speakers visit Melbourne to give talks sponsored by various members of the health care industry. Professor Friedrich Puhringer, from the University of Tubingen in Germany, Dr Martin Kuper an anaesthetist from Homerton University Hospital in London, Professor Mike Scott consultant anaesthetist and intensivist at Royal Surrey in the UK and Professor Stanton Shernan, Professor of Anaesthesia at Harvard Medical School in the USA. These speakers are influential and well respected academics and as such we were pleased to be able to have them contribute to our program.

As always our invited speakers were insightful, engaging and challenged our thinking and all sessions were well attended – refresher lectures, plenaries, SIG sessions, workshops and small group discussions. However, these eminent speakers are just the icing on the cake. The real work is done by the incredible input from our Australasian anaesthetists, giving lectures, running workshops and organising small group discussions. Without their support through presenting, chairing, facilitating and assisting we would not have such an excellent program. Thank you to all.

All of the plenary talks and many of the refresher lectures have been recorded and are available via the Events and Education section on the ASA website.

On Monday 19th September Dr Guy Christie-Taylor presented the Geoffrey Kaye Oration and challenged our understanding of what Workplace Culture actually means. In particular, he highlighted that success or failure in our organisations will be heavily influenced by the people within the organisation and the constraints and opportunities that as a totality form the culture through which the organisation operates. These issues are not only important for the ASA but also to anaesthesia, our hospitals and to healthcare.

As always our invited speakers were insightful, engaging and challenged our thinking and all sessions were well attended – refresher lectures, plenaries, SIG sessions, workshops and small group discussions.

The AGM was held on Monday afternoon, where reports and constitutional changes were made and adopted. Our new President A/Prof David M Scott formally took over the presidency; congratulations David. Prize and award winners were announced – congratulations to Dr Natalie Kent who was awarded the Gilbert Troup Prize, and to Dr Andrew Messmer for the ASA Best Poster Prize and Dr Diyana Isak for the second best poster. The Kevin McCaul Prize was awarded to Dr Patrick Tan. The PhD Research grant was awarded to Dr Julie Lee. Dr Elizabeth Feeney was awarded the Gilbert Brown award for outstanding service to the Society and to Anaesthesia. The Ben Barry Medal was awarded to Professor Michael Paech for outstanding contribution to the Society's journal, Anaesthesia and Intensive Care.

Tuesday afternoon saw a break from the traditional closing session with a formal Q&A focused on the global refugee crisis, asylum seekers, international welfare, and the Australian Government's immigration and border protection policies. Many thanks to Ms Sally Warhaft, Associate Professor Munjed Al Muderis, Adjunct Professor Frank Brennan, Mr David Manne and Professor Louise Newman for their input and preparation in this interesting and important afternoon discussion which again shows our diversity as a specialty. I would also particularly like to thank Peter Seal for his work in organising this session

We spent nearly three years planning this meeting and we could not have done it without such an energetic and committed committee, the back-up of all the staff at the ASA and our conference organisers International Conference and Exhibitions.

Committee meetings were mostly held at my place and I have to thank my wife, Tania for helping to feed and water the group who would often arrived straight from work hungry and thirsty. Many on the committee have very full practices which would often made it difficult for them to get away on time and they would always be dashing off to answer phone calls.

Colin was responsible for the Scientific component with help from various subcommittees. Roberta Deam, Usha Padmanabhan and Suzi Nou looked after workshops and Michelle Horne, Zoe Keon-Cohen and Peter Seal were in charge of the Small group discussions. The social program was ably looked after by Jenny King, Usha, Michelle and myself. Rod Westhorpe, past ASA president and now Victorian RAG chair looked after the Retired Anaesthetists and was able to add his years of experience to any discussion. Renald Portelli, Mark Sandford and Andrew Schneider shared their

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enormous knowledge gained from hosting and designing the scientific component of previous NSC's to help bring this one to fruition. Our trainee representatives were Debra Leong, Kellie Brick and Liam Twycross. We also had Craig De Kievit from Hamilton representing the GP anaesthetists. Many members made use of the teleconference facilities particularly those interstate such as Denyse Robertson the ASA Senior Events Coordinator, other representatives from ICE and often Piers Robertson and Nicola Morgan. As you can imagine when everyone was there the committee could get very noisy.

I would personally like to thank all those who volunteered their time on the committee for making the conference such an enjoyable experience and for making my job as Convenor so much easier. I would also like to thank Piers Robertson the Federal NSC Officer and Denyse Robertson who were a great support to me during the journey.

The meeting got off to a great start on the Friday with three satellite meetings including the Welfare SIG, the Overseas Trained Specialist Anaesthetists and a Perioperative Surgical Home Workshop at Peter MacCallum Cancer Centre. As well as theses we had a range of offsite intensive workshops in Paediatric, Obstetric and Adult Emergency Responses held at Epworth and St Vincent's Hospitals

Friday also saw an afternoon of golf at Metropolitan Golf Club a truly magnificent Melbourne sand belt course. The afternoon, organised by Scott Nicolson, saw a group of 22 enjoy lunch before tee off from 13:30 with the eventual winners being John Rose (NZ) and Moira Westmore (WA). Jenny Carden (Vic) was just beaten by Moira on a countback. Nearest the pins were Laszlo Szolansky (CH) and Livy James (Qld).

Later in the afternoon a large number of delegates congregated to register and to enjoy informal drinks and nibbles outside the Melbourne Room in the MCEC, with panoramic views over the Yarra River and Melbourne.

On Saturday night we had a very entertaining evening at the Australian Centre for the Moving Image with its incredible permanent exhibits as well as their sensational special exhibition on the work of the talented film director, Martin Scorsese. We were also entertained by a great jazz band – Yellow Bird – as well as some roving entertainers including the incredible work of conjurer Dr Vyom Sharma who was great to watch. Afterwards guests dispersed into the many bars and nightlife areas in the surrounding streets to further enjoy the friendly environment which highlights ASA meetings.

On Monday evening we held the Gala Dinner at Melbourne Park the home of the Australian Open Tennis. Many enjoyed a pre-dinner tour of the underground labyrinth which is Melbourne Park. The dinner was a fantastic success. A great comedy skit from the trio of Bondorama highlighted several Bond Films in 20 minutes. A number of members from the audience were coerced to help with the performance including Richard Grutzner who had to play the evil villain Ernst Stavro Blofeld. Well done to all those who participated and thanks for being such good sports.

As part of the celebration of the society's 75th Diamond Jubilee we held a raffle for a diamond pendant. All 250 tickets were sold and the prize drawn at the Gala dinner. Congratulations to Dr Erica Hewson who was the winner and thank you to all who bought tickets. We were able to raise over $20,000 for Lifebox which was an excellent achievement.

Following the formalities, the dancing continued to the big band sound of the Baker Boys until we were all ushered. Many took the last bus which made an extra stop at the Melbourne bar, Lilly Blacks where a modest contingent partied on into the small hours.

Thank you also to all those who donated their unwanted satchels to the School of Hope in Vanuatu. We donated over 300 satchels to the school. Well done and thanks to Eric Moyle for organising this.

In summary we learnt an incredible amount in four days. In particular:

- That we can make a big difference to patient outcomes if we follow researched and validated programs such as ERAS.
- That we need to monitor and research patient outcomes not just until they leave hospital but until much later to make sure the procedures we are involved in will the desired effect.
- We need to be more careful not to over hydrate our patients.
- We may need to give more blood to higher risk patients and we certainly need to optimise their preoperative iron levels.
- We need to re-engage in regional anaesthesia and in particular with Epidurals for major surgery.
- Ultrasound is the great disruptor and although we have been using it for years to improve nerve blocks and vascular access it will now revolutionise the way we manage acutely ill patients in the Theatre, PACU and the ward.
- And finally as Carolyn pointed out it is the patient who we must keep at the centre of all this and it is the patient who owns and needs to be part of the determination of their destiny.

Next year's National Scientific Congress will be in glorious Perth October 7th to 10th and encourage you all to attend as it is sure to be a great meeting. David Law as Convenor, and Daniel Ellyard and Dale Currigan as Scientific Convenor are putting together a marvelous combination of medical education and social stimulation on the banks of the Swan River at the Perth Exhibition and Convention Centre.

I look forward to seeing you there.

ASA WELCOME DRINKS

The NSC convenors talking to the President

Welcome reception

Enjoying a laugh with colleagues

Industry reps chatting to attendees

Relaxing with colleagues

Exhibitors mingling with guests

Catching up with friends

FEATURE

AUSTRALIAN CENTRE FOR THE MOVING IMAGE

Attendees enjoying the evening

Audience participation – a must

Having a laugh

Guests mingling

Getting hands-on

Performer

Car from Mad Max

The Scorsese Exhibition

PRESIDENT'S COCKTAIL RECEPTION

Former presidents John Hodgson and Richard Grutzner with their wives

Past presidents Wally Thompson and Kester Brown with their wives

Invited speaker David Canty with David Elliott

ANZCA President David A. Scott and Neville Gibbs

Mike Scott and Martin Kuper

Convenor Simon Reilly, Anna Granger, Greg Deacon and Mike Scott

AIC editors Neville Gibbs, Linda Weber, John Loadsman and Vida Vilinus

Specialty Affairs advisor Jim Bradley with Leonie Mulcahy and Mark Carmichael

FEATURE

ASA GALA DINNER

The 2016 NSC Organising Committee and President

Honouring the ASA

Attendees enjoying pre-dinner drinks

Some members of the Organising Committee

Attendees assisting with Bondorama

Delegates hit the dancefloor

The NSC 2017 Committee

Bakers Boys entertain the attendees

President David M. Scott addresses the group

Guests mingling

2018 Scientific Convenor Kate Drummond with Sue and Guy Christie-Taylor

Dr Piers Robertson and diamond raffle winner Erica Hewson

The two David Scotts

Helping celebrate the NSC

Convenors, their wives and guests

Pre-dinner drinks

Dressed to impress

Richard Grutzner as Ernst Stavro Blofeld with Bondorama performer

FEATURE

SCIENTIFIC CONVENOR WRAP-UP

In designing the scientific program we looked for hot topics that were emerging worldwide and designed two major themes around this.

The first is Enhanced Recovery After Surgery (ERAS) which is being developed in various guises (ERAS, Perioperative Medicine, or Perioperative Surgical Home). Whatever the name, the concept revolves around teamwork and considering the whole patient journey from pre-admission, through surgery and to hospital discharge and beyond. This challenges our usual focus of intraoperative and early postoperative care. However, it makes a lot of sense and early science is supportive of better outcomes. If we (anaesthetists) want to play a role or lead this change of practice, we need to upskill in medicine and be prepared to spend a portion of our time outside of the operating room. So a part of the theme was devoted to learning about ERAS (and be convinced it is a good idea) and part devoted to upskilling in perioperative medicine.

What will differentiate anaesthetists from other providers in the perioperative space? We do understand acute pain and fluid management, but anaesthetists have been the leaders in the adoption of clinical ultrasound to improve our diagnosis in real time. The concept of using ultrasound to aid clinical assessment and perform procedures means we have to upskill in multiple areas of clinical ultrasound at least at a basic level. Applications such as basic TTE, lung US, peri-arrest and DVT scanning complements our already accepted uses such as vascular access and nerve blocks. Competence in bedside use of clinical ultrasound will help to position anaesthetists as practitioners who can help with the whole patient journey. So the second major theme complemented the first and provides encouragement for anaesthetists to get on board, and an opportunity though workshops to acquire practical skills.

The themes were lead by our wonderful international speakers and complemented by an impressive lineup of Australian speakers, many of whom are internationally renowned for their work. The workshops complemented the themes by providing hands-on learning opportunities for delegates.

A special thanks to our international speakers, Olle Ljungqvst, Stanton Newman, Martin Kuper, Mike Scott, Fritz Puhringer and Carolyn Canfield for ERAS, and Stanton Shernan and our Australasian Speaker David Canty for clinical ultrasound.

We considered that a well-balanced program needs something for everyone. To this end we included a large number of SIG sessions, research sessions, AIC session, nearly 40 workshops and 40 small group discussions, and including a large number of ANZCA accredited emergency response workshops. I can only thank the huge contribution of so many people who presented, ran workshops and small group discussions. A special thanks to Careflight who trained over 150 delegated in CICO.

We wanted to finish the program in style and Peter Seal delivered the goods. The debate on how we treat immigrants in the 'Beyond our Borders' session was delivered to a full house and was appreciated by all. The feedback for that session was exceptional and finished the conference on a high note.

My personal highlights were many but included the appreciation from delegates on the two major themes of the meeting. The plenary talks were exceptional and all challenged how we think. From Stanton Shernan telling us that clinical ultrasound is disruptive, to Carolyn Canfield fundamentally challenging the way we think of the patient journey – actually the patient owns their own journey and we must encourage and facilitate that. Our ERAS speakers gave a very convincing story that ERAS is a mechanism to improve patient outcomes and make best use of our resources, and that we need to lead the movement. Stanton Newman gave us a great insight into cognition after surgery and how many people may be affected by cognitive decline. Importantly, we need to be measuring recovery long after the patient has left the hospital. This extension of the patient journey beyond our care is a whole new area of medicine and one that we should be involved in. What we do in the operating room could have impact long after the patient has gone home. David Canty told us why we all need to adopt clinical ultrasound and some ideas on how to get there. Our Immediate Past President, Guy Christie-Taylor gave us an inspirational talk for the Geoffrey Kaye oration. I was also delighted to hear Kester Brown deliver his reflections on his career, some of his research and achievements, and his hope for the future. Having learned from Kester many years ago, it was an honor to hear his lecture. He has been a wonderful contributor to anaesthesia and the ASA. I also did the paediatric ALS workshop and not only enjoyed it but felt more skilled to deal with paediatric cardiac emergencies. The feedback has been really great in all areas of the program and I do believe that we achieved our aim of an interesting program with something for everyone.

I must thank the committee for their tireless efforts and advice on the program, but in particular must thank Simon for his leadership, Usha Padamabhan, Bertie Deam and Suzi Nou for running the workshops and Michelle Horne, Zoe Keon-Cohen and Peter Seal for running the SGD program. A special thanks to Piers Robertson for his wealth of knowledge and advice.

It was an honor to be asked to be the scientific convener and I encourage you all to attend the next meeting in Perth.

Professor Colin Royse
NSC Scientific Convenor

SESSIONS & WORKSHOPS

Convenor Simon Reilly introducing the invited speakers

Scientific Convenor Colin Royse welcomes the speakers for the Great Debate

Stanton Newman address the audience

Kester Brown AM speaks about the history of the ASA logo

Hilmy Ismail

Guy Christie-Taylor presents Kester Brown AM with his 50-year Membership Award

David M. Scott introduces the 'Beyond Our Borders' guests

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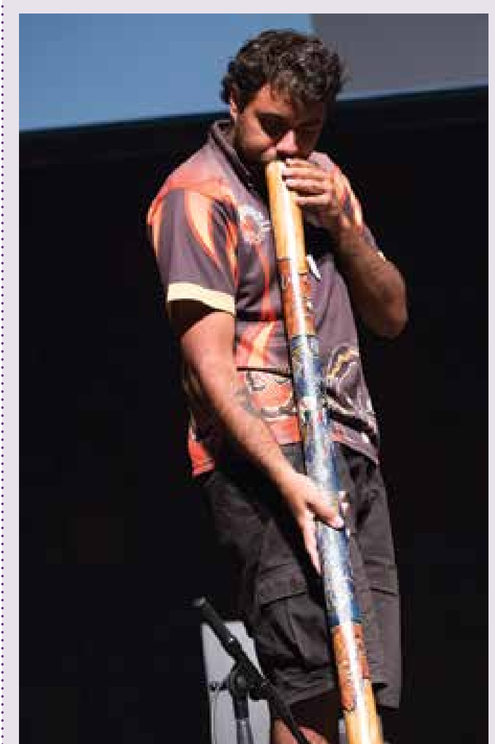


Damian Nicholson from the Wurundjeri tribe

Prof. Olle Ljungqvist addresses the audience

David Canty talks about 'Ultrasound for Everyone'

David A. Scott presents Olle Ljungqvistwith his speaker gift

Industry speaker Mike Scott

Carolyn Canfield

Jane Brown, Chair of Obstetric SIG

Guy Christie-Taylor reflects on his younger years

Martin Kuper speaks on 'Large scale implementation of surgical quality improvement programs'

Questions from the floor

'Beyond Our Borders' L-R: Sally Warhaft, Frank Brennan, Munjed Al Muderis, David Manne and Louise Newman

Concurrent sessions

Error reduction strategies session

Attendees getting practice

Hands-on workshop

Ultrasound workshop

Sponsored lunchtime session

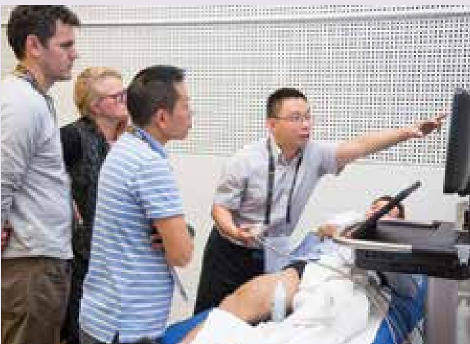
Practise makes perfect

PACS workshop

Ultrasound workshop

Welfare SIG session

Workshop


Learning new skills

FEATURE

Workshop

David A. Scott

Questions from the floor

Interested audience at a session

Learning new methods

Airway workshop

Workshop

Obstetric SIG session

Paediatric workshop

Paediatric workshop

Careflight session

Getting hands-on experience

EXHIBITION & EXHIBITORS' DRINKS

Chatting with industry rep

Checking out some new products

Getting hands-on

ASA Booth

Checking out the booths

Relaxing with friends

The Fisher & Paykel team

Chatting at exhibitor's drinks

Enjoying drinks

ASA board members at exhibitor's drinks

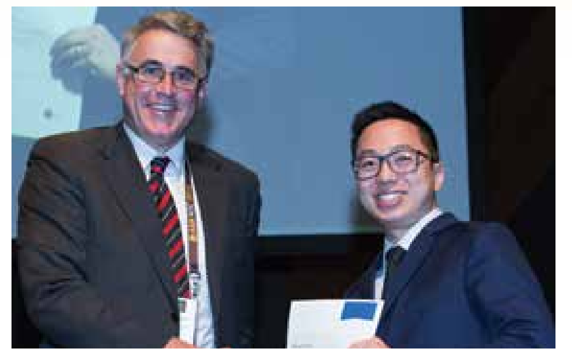
Enjoying exhibitor's drinks

Informal chat over a wine

2016 AWARDS, PRIZES & RESEARCH GRANTS

WINNERS ANNOUNCED

Kevin McCaul Prize



Dr Patrick Tan
High flow humidified nasal oxygenation in pregnant women

ASA PhD Support Grant

Dr Julie Lee
Rotational Thromboelastometry (ROTEM) in Obstetrics

Gilbert Troup ASA Prize

Dr Natalie Kent
Neostigmine induces restrictive ventilatory impairment pattern in awake healthy volunteers

ASA Best Poster Prize 1

Dr Andrew Messmer
Levels of Oxygen in Labour (LOL) Study

ASA Best Poster Prize 2

Dr Diyana Ishak
Remifentanil Patient-controlled Analgesia in Labour – the Effects of Implementing a More Restrictive Protocol

Jeanette Thirlwell *Anaesthesia and Intensive Care* Best Paper Award

T.J. Byrne, B. Riedel, H.M. Ismail, A. Heriot, R. Dauer, D. Westerman, J.F. Seymour, K. Kenchington, K. Burbury
Fast-track rapid warfarin reversal for elective surgery: extending the efficacy profile to high-risk patients with cancer.

The Ben Barry Medal

Professor Michael Paech

Professor Michael Paech has been an editorial board member since 1994, and an editor since 1998, making him editor for 18 years.

Professor Paech has been an efficient and helpful editor, both to authors and production staff, and his standing in the anaesthesia community has brought the journal into high repute.

Professor Paech has an extraordinarily distinguished career independent of his role with Anaesthesia and Intensive Care. This makes his contribution to the journal all the more impressive, given his many other commitments and research activities.

Gilbert Brown Award

Dr Elizabeth Feeney

The Gilbert Brown Award has been presented to Dr Elizabeth Feeney, an anaesthetist with an interest in risk management, safety and quality in healthcare, and medical indemnity.

Dr Feeney completed a Master of Health Law at the University of Sydney in 2004, during which time she also developed a keen interest in health care policy and effecting positive policy change through effective clinical input.

This resulted in Dr Feeney undertaking a variety of representative and leadership roles at the Australian Medical Association and the Australian Society of Anaesthetists.

In addition to her role as a former president of the Australian Society of Anaesthetists, Dr Feeney also acted as a director of AMA Limited, where she also serves as chair of the board.

Dr Feeney has also been made an honorary member of the New Zealand Society of Anaesthetists in recognition of her assistance to and support of the presidents of that organisation. She remains on the board of the Australian Medical Publishing Company, publishers of the Medical Journal of Australia.

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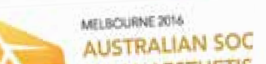
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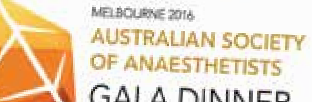
AUSTRALIAN SOC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MELBOURNE 2016
AUSTRALIAN SOCIETY
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GALA DINNER

FEATURE

INTRODUCING THE ASA VICE PRESIDENT

DR PETER SEAL
ASA VICE PRESIDENT

Dr Peter Seal was elected as Vice President at the AGM in September 2016, here he gives a brief introduction.

I was introduced initially to the fascinating world of anaesthesia during the 1980s when I worked in the operating theatre of a small private hospital during student holidays from Monash University. After marveling at the skill of the anaesthetists, I was most fortunate to experience my very first term as an intern in the anaesthetic department of the old Prince Henry's Hospital in Melbourne. In seemingly no time, I was intubating patients and performing spinals. I was hooked from then, and never since have regretted choosing this craft as my vocation. At the suggestion of a wise mentor when I was a resident at Geelong Hospital in 1990, I joined the Australian Society of Anaesthetists without hesitation. I have benefitted from this membership to this day.

After training at St Vincent's Hospital in Melbourne, I was admitted to the esteemed ranks of our colleagues in 1998, and added an intensive care medicine fellowship in 2002. As a sole practitioner, I have the privilege and joy to care for patients in both the public and private domains. I have been able to develop a close liaison with registrars as a Supervisor of Training from 1999 to 2013.

I was invited to join the ASA Victorian Committee of Management in 2005, and from that time I have been able to appreciate at close range what the ASA has been able to provide for its members. From 2007 to 2013, I was the committee's Education Officer, and was responsible for the organisation of four Combined Continuing Medical Education state meetings that we conducted in 2008, 2010, 2012 and 2013. I also convened the ASA Victorian Rural Meeting in 2011. I was a member of the Organising Committees of the two ASA National Scientific Congresses Melbourne hosted in 2010 and 2016, when I helped to coordinate the Small Group Discussions for both.

I was elected as the Victorian State Chair in 2013, and served in this role and thus on the federal ASA Council until the beginning of 2016. In 2014, I was co-opted on to the then federal Executive as the Representative of the other State Chairs. I have taken on the position of the national Vice President, and it as been a considerable and somewhat surprising honour to do so. Already I have established a warm and valuable working relationship with our President, David M. Scott. I will continue to assist David in any constructive capacity that I can over the next two years.

A solid background of social justice has underpinned my nurturing, formation and education in a large family. I have a firm commitment to the ongoing attempt to eradicate bullying, discrimination and harassment from our medical workplace. During my term of state chairmanship, there has been a positive focus regarding professional equity. I can report that on the Victorian Section Committee of Management, we can be proud that we have achieved gender parity in terms of numbers. In addition, Victoria now has its first female State Chair in over 60 years. There is still much to be done in this sphere, particularly across the entire country.

In the years ahead, another crucial area of priority for the ASA will be its re-engagement with two vital subgroups of our anaesthetic community, our trainees and the staff specialists in public hospitals. Our Society exists for the benefit of all anaesthetists, not exclusively those working in private practice. In addition to those dual pillars of ASA expertise and capability, the Economics Advisory Committee and the Professional Issues Advisory Committee, a revamped Public Practice Advisory Committee has been charged with the brief to provide a significant concentration on and possible direction to those working in the numerous departments of anaesthesia around Australia. The ASA is the institution that truly can provide support, representation and education from the cradle to the grave of a career in anaesthesia.

On a personal level, my wife of more than 23 years is Geraldine, and she continues to be a wonderful source of advice, guidance and stability. She is a chartered accountant, my practice

manager, and mother of our three wonderful children aged between 11 and 17 years old. Andrew is about to complete Year 11, while his sisters Caitie and Ali, are nearing the conclusions of Years 9 and 5 respectively. Thankfully, they share my love of sport. I retain a passion for cricket along with our CEO Mark Carmichael, and Australian rules football primarily through the Geelong Football Club. Like many in our number, I embrace activity and remain an avid long distance runner. I see it as a personal source of ongoing vitality and mindfulness.

I regard that one of the essential ingredients of true leadership includes a fundamental ability to serve, and to do so with effective communication. I anticipate whatever is held by the future.

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FEATURE

THE GEOFFREY KAYE ORATION

Dr Guy Christie-Taylor presented the Geoffrey Kaye Oration at the ASA National Scientific Congress 2016.

Geoffrey Kaye was "arguably the most influential anaesthetist in Australia."[1] He helped start the Australian Society of Anaesthetists in 1934 and was instrumental in founding the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1952. We could leave the discussion there; but it is far more interesting and compelling to examine why he was the subject of 'wounding remarks', why '49' failed and why he ultimately withdrew from the anaesthetic community? Does an examination of this man and his relationship to the speciality cast some light on the 'culture' of not only our Society but of that of our speciality? Does an examination of our origins, in which he played such a central role, help us to understand our present state and empower us to deal more effectively with our current challenges? What do we mean when we talk of the 'culture' of an organisation, what are the current determinants of our culture, do we grasp the destructive potential of a 'wrong' culture, does leadership determine culture, does 'culture eat strategy for breakfast' and can we fix culture? Does our culture contain the seeds of our own destruction or is it our culture that has, and will continue to sustain us?

Well, let us begin our cultural and historical journey at two addresses in Melbourne.

The first is 161 Drummond Street Carlton, a home that sold for $960,000 in 2007.

The home was inhabited in the late 1800s by David Adam Brown and his Australian born wife, Mary Elizabeth (Smyth) who were married in the Clarendon Street Presbyterian Church in South Melbourne on April 7th 1893.

Of note is that just two years prior to this in May of 1891 a young man of 32 died during chloroform administration at the Melbourne Hospital. This was the precursor to the Royal Melbourne Hospital and was located at that time in a 10-bed, two-storey cottage on the corner of Lonsdale and Swanston Streets. At inquest, the City Coroner declared that an expert should supervise chloroform administration. "It appeared to him, that cases of death under chloroform occurred far too frequently at the Melbourne Hospital. Students were allowed to give chloroform without any supervision. The wonder was not that deaths should occasionally occur, but that they did not happen more frequently.[5]

It is of note as well that in 1891 the inevitable happened: a spectacular crash brought the boom in Melbourne to an abrupt end. Banks and other businesses failed in large numbers, thousands of

shareholders lost their money, tens of thousands of workers were put out of work. Although there are no reliable statistics, there was probably 20% unemployment in Melbourne throughout the 1890s.

Melbourne had 490,000 people in 1890, and this figure scarcely changed for the next 15 years as a result of the crash and subsequent long slump. Immigration dried up and emigration to the goldfields of Western Australia and South Africa began.

The moderate recession began in 1890, there was a brief recovery in 1891, but a full-blown depression from 1892.

David Brown counted as a good friend a certain James Christie, also resident in Carlton.

So apart from being good friends and residing in the same neighbourhood what did these two men have in common?

Well they are my great-grandfathers. Which might come as a bit of a surprise when considering my accent. So what am I: a Scottish, Presbyterian, Victorian or an Anglican, South African, South Australian or maybe just a mixed up blend of all those cultural elements? What I would ask you, are the determinants of your particular 'cultural make up', what is it that determines the values and beliefs that define you?

But let us shift to a posher part of town: 49 Mathoura Road Toorak Gardens. Otherwise known as 'Beswicke'. The home was built in 1888 by renowned architect John Beswicke and has been meticulously restored within its original footprint. The home sold in 2012 for $5,220,000

Geoffrey Kaye inhabited the home in 1951 and tragically this home could have been ours – all of ours! This was for a while the headquarters of the ASA. It could have been our 'Ulimaroa'.

So what exactly happened at 49 Mathoura Road and was Geoffrey Kaye's '49' an early example of a failed attempt at 'culture change'?

Anaesthesia's recognition as a specialty was at the heart of '49'.[2] Kaye hoped his work "increased (the) status of anaesthetists and promoted acceptance of anaesthetics as a specialty" – one characterised by "departments of anaesthesia distinct from surgery, with salaried university faculty conducting clinical research at affiliated hospitals".

Kaye hoped that Australian anesthesia would gain international prominence by incorporating the elements of clinical anesthesia practiced in the United Kingdom and the anesthesia research seen in the United States.

One of Kaye's long-time goals was to build a great 'diffusion centre' of scientific and technical information for the Australian Society of Anaesthetists. This centre would house a library, museum, meeting spaces, apparatus, a journal of the highest calibre and machinery and laboratory facilities. In 1951, when plans for the Faculty of Anaesthetists were approved, Kaye established the Society's 'centre of excellence' at 49 Mathoura Road, Toorak, Melbourne.

The ASA however likely viewed the centre as a 'stable place for its records, secretariat, its museum and its library' and by 1955 the promise of '49' had failed. The mutual misunderstanding of the goals of '49' may be partly explained by the ASA's failure to state its intent for the centre at the outset.[2] The argument has been put that the ASA was too small and only 5years removed from its 'rebirth after the war' to sustain Kaye's grand vision for the centre. This was a period of transition for the burgeoning specialty, with few 'qualified members' and "only the early beginnings of salaried Services and Departments."

Kaye blamed the failure of '49' on a lack of support from the ASA[2] and its membership. Kaye's attitude was one that the work required to maintain the centre and fulfil its mandate should have been done as a matter of obligation, interest and pride, by members of the Society. It may well be that he failed to understand the situation of the ordinary anaesthetist. Practising physicians in difficult economic times were trying 'to make their way in a new environment, with young families to support'. And I might add were more likely to be inhabiting the likes of 161 Drummond Street than Mathoura Road?

He wrote in exasperation: "How does one get members of a Society to WORK? We have given 'em every amenity, but all they want is a monthly meeting – if someone else gets it up for them! The older men are tired, tied and over-taxed: the younger men are cynical and their attitude is summed up by the naval adage, 'Blast you, Jack; I'm on the raft!' Till they work for their Society, they won't really value it – and how does one induce 'em to begin working?"[3]

He went on to lament: "The Australian Society reminds me very much of what I saw at Petra, viz. a stupendous facade with nothing very much behind it."

Members showed '49' to visitors, but did not use it. Members attended regular meetings at the facility, but only if others managed the logistics. Members were not interested in "making use of the darkroom or workshop, or assisting in the duplication and distribution of the newsletter, or keeping the grounds in order, nothing could be further from their thoughts."

He went on: "The whole show ['49'] is thrown back upon individuals, and mighty few of them at that. For this lamentable state of things, I do not blame entirely apathy in our members: it is all part of what one might call 'the tyranny of the Private Case.' Our fellows live by private practice, and they dare not miss a case, lest they forfeit their surgeon's goodwill and patronage for the future. Hence, the most sacred obligations are at the mercy of the surgeon's telephone calls. One can see the hopes of better times only in some form of national medical service, which by relieving anaesthetists from economic insecurity, might set them free to follow

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their own bent on occasions. Such a service could easily be brought in, in this country, by a turn of the political wheel.[3]

"If I like to cut the lawns, or paint the fences, or fold the newsletters into an envelope, that's OK: it's my 'hobby,' but they have no obligation to help in it! In consequence, I have had to point out to my Committee, that '49' is not serving the purpose for which I designed and equipped it.

"I was amusingly naïve to suppose that, if one gave chaps facilities, they'd want to make use of them. My American friends warned me of what might happen, but I wouldn't listen. They can chant in unison, like so many black crows, those blessed words, 'We told you so!' The joke is on me."[3]

Kaye noted that Macintosh, at the opening ceremony for '49,' predicted its failure to Kaye's sister because the anaesthetists were not behind it. In the same letter, Kaye in part blames his anaesthetist colleagues, declaring, "Certainly, those who entered the specialty at the end of the war were a pedestrian lot, looking for an easier life than in other forms of medical practice..."

Although Kaye did express some level of understanding about the plight of the practicing anaesthetist, we do not know if that translated into actions consistent with that understanding. Further, even if Kaye was wholly sympathetic with their troubles, the perception that he was not sympathetic contributed to the failure of '49.'

Kaye's faults can in part be attributed to his deep and binding love of what '49' could have meant to the Australian anaesthesia community. Kaye felt that he was "gambling in 'anaesthesia futures' for heavy stakes." Kaye took the failure as a personal one, and he withdrew from the anaesthesia community.[3]

In fact, Kaye carried the anger for many years. In correspondence in 1981, Wilson suggested that Kaye took it too personally. Kaye objected "By thunder it was, and not without reason."[3]

In the same 1981 letter, Kaye recounts decades-old slights. "I was the subject of wounding remarks in those years. One was an accusation of 'election-rigging'." "Another accusation that hurt was that I was trying to 'make myself the director of the ASA'." Indeed, Kaye recounts the comment from the Society's president that '49' was ""my hobby, as his was gardening'." Kaye also noted, "The nub lies in your remark about personalization, if we may use a noun so barbaric. Had the ASA of 1950–1955 been made-up of Dalys or McCauls, the scheme would have worked."

We do not know if the idea of '49' had an effect on the subsequent success of Australian anaesthesia. Wilson seems to think so, writing in a letter to Kaye that "...the failure of the project had an effect of cementing the society." Or perhaps its most enduring legacy is the estrangement of Kaye. We can only speculate how that may have helped or hindered the development of anaesthesia in Australia.[3]

Walter Mushin writing in an essay on anaesthesia's history states: "It is not enough to rake over the ashes of the past, or to examine in ever-increasing detail the lives of our pioneers unless we can extract from the process a greater understanding of our present-day problems and so a greater likelihood of solving them.

"Between the two world wars interest in anaesthesia was confined to a mere handful of men who had to stand up to what almost amounted to the contempt of their colleagues, because it was still widely held everywhere in Europe and the United States that anaesthesia was an occupation that hardly demanded a medical education."

We owe a debt of gratitude to Rupert Hornabrook who had the courage (sense, gumption, gall, insight?) to write in the AMJ in 1914: "Some of the difficulties the anaesthetist has to contend against... One of the greatest difficulties the teacher has to contend with is the inborn idea that any fool can administer an anaesthetic." He related the remark of a senior Melbourne surgeon that "a dray- man could administer chloroform."[4]

In 1927, a senior surgeon at the Alfred hospital told Geoffrey Kaye, when contemplating a career in anaesthesia, "Why waste your opportunities". Kaye recalled that anaesthetics was poorly regarded as a specialty, the province of the physically handicapped or those who had failed in other branches of medicine. The surgeons of the day found that the best anaesthetists were the medical orderlies of the 1914 War, "because those blokes did as they were told".

The first years of the Society were difficult times. Non-anaesthetists did not appreciate the necessity of a separate society; the BMA did not take kindly to the establishment of a group 'in opposition' to the State Sections of Anaesthetics; the members of the Executive were idealistic in their expectations of the Society; and the general members struggled to make a living. Nevertheless, Kaye's dogged efforts as secretary ensured that the Society survived.[1]

So might we attribute this outcome to Kaye's failure to grasp the prevailing 'organisational culture' of the early emerging specialty? Is the 'organisational culture' different today; do we even have a grasp of what our 'culture' might be? What exactly do we mean or understand about organisational culture?

'All eyes are on culture as the cause and the cure.'[6]

'Bullying is endemic in surgery; common in training and the surgical workplace; and central to the culture of surgery.'[7] This powerful generalisation about the 'culture' of surgery is made by the Expert Advisory Group on discrimination, bullying and sexual harassment advising the Royal Australasian College of Surgeons (RACS), in its report to RACS.[7]

RACS has therefore logically committed itself to working to make changes in three key areas; the first of which is 'Cultural change and leadership'.[8]

The report[7] also made reference to a 'Culture of fear and reprisal' and made it clear that it's authors support the notion put forward by Major General David Morrison to his personnel that "everyone is responsible for culture."

It is somewhat ironic that a culture of competition and perfection could have given rise to a culture of 'bullying'.[7]

So where else has 'culture' been invoked as the cause of harm and chaos? Was it a culture of 'every dollar counts' at BP that lead to the Deepwater Horizon disaster[9] and the US's worst ever oil spill, or 'lapses in character and culture' that lead to the 2014 Veterans Administration scandal in which clinical delays were alleged to have caused scores of deaths as well as the 2008 Mid-Staffordshire scandal which showed pervasive clinical lapses and gaming of the system to meet targets[10], or was it a 'club culture' as described in the Kennedy Report[11] that lead to the Bristol Children's Heart Surgery scandal, or was our Prime Minister correct to invoke 'big cultural issues' as being central to the recent behaviour of the banks in which ''Some, regrettably, as we know have taken advantage of fellow Australians and the savings they've spent a lifetime accumulating"?[12]

So if the above examples are true then it seems reasonable that the Australian Institute of Company Directors should intend over 2016 to focus on boardroom culture by continuing to work with governance leaders to "drive performance through culture." The AICD continues to believe that directors creating and nurturing the 'right culture' or setting the right tone from the top are crucial to organisations success.[13]

Greg Medcraft, Chairman of the Australian Securities and Investment Commission upped the ante recently when he issued a veiled threat that the watchdog might move to extend the laws to enforce corporate culture if certain companies fail to lift their standards.[14]

As far back as 1997, an issue of Quality in Health Care was devoted to considerations of organisational change in health care calling it the 'key to quality improvement.' In discussing how such change can be managed one of the authors asserted that 'cultural change' needs to be wrought alongside structural reorganisation and systems reforms to bring about ' a culture in which excellence can flourish.'[15]

The Labour Government elected in 1997 in the UK made quality the central reform issue in the NHS.[15] Its strategy aimed to:

- Define appropriate quality standards
- Deliver health care congruent with those standards
- Monitor to ensure that uniformly high quality of care is achieved.

It was in the delivery of health care that a consideration of organisational culture was seen as having the most to offer.

In articulating the strategy needed to deliver this new care official documents stressed the interlinking of three different strands: clinical governance, life-long learning, and professional self-regulation. Underpinning and binding each of these was the notion of 'cultural transformation as a primary driver to deliver improved quality of care.' Specifically "Achieving meaningful and sustainable quality improvements in the NHS requires a fundamental shift in culture, to focus effort where it is needed and to enable and empower those who work in the NHS to improve quality locally."[15]

Some of the desired 'cultural changes' are listed below:[15]

	Vision for the NHS, mid 1980s to mid 1990s (General Management and The Internal Market)	*Vision for Labour's "New NHS", late 1990s (The Third Way)*
Macro/system level factors		
Basis of economic relationships:	Competition (contracts)	Cooperation/partnership (long term service agreements
Governance:	Market discipline	"Third Way"
Key objectives:	Efficiency	Efficiency/equity/quality
Rate of change:	"Big bang"	Evolutionary
Locus of change	Top down	"Everyone's business"
Flows of information:	Confidential/commercially sensitive	Open/transparent
Basis of performance assessment:	Finance/activity/volume	"Balanced scorecard"
Micro/clinician level factors		
Basis of practice:	Professional judgement	Evidence based
Basis of control:	Mutuality trust	Audit, external verification
Clinical performance information:	Confidential	Publicly available
Participation in audit (e.g. confidential enquiries	Discretionary	Mandatory
Accountability:	Largely opaque (professional self-regulation)	Transparent: corporate and clinical governance
Public confidence:	High	Diminished
Continuing professional development:	Discretionary	Mandatory
Ethical basis:	Hippocratic oath/patient first	Corporate objectives

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Old expectations	*New expectations*
Physician responsible only for individual patient	Physician responsible for individual patient and populations of patients
Individual clinical responsibility for patient	Team or group, and patient, responsibility
Credibility and trust largely based on professional mystique and prestige	Credibility and trust based on data and documented evidence of effective practice
Profession determines performance and accountability criteria	Profession and others (governments, purchasers, public, community groups etc) determine performance and accountability criteria
Physician accountable to patients and the profession	Physician also accountable to health care organisation and external groups
Organisations exist to serve individual physician's interests	Organisations exist to serve patient, community and physician interests

And accompanying this was a desire for a 'new moral fabric' (see table above).[15]

An examination of the above tables might well give the reader pause for thought as one recognises how many of these changes have come to profoundly impact our current practice and it might be useful to acknowledge where they had their origin?!

If culture is such an apparent key ingredient for success (or for failure!) are we able to define it? Is there a clear definition of organisational culture?

It is interesting to note the comments made by John Traphagan in his recent article in the Harvard Business Review (HBR) entitled 'Why Company Culture is a Misleading term':[16]

"Today, the idea that organizations have cultures is rarely questioned by the media, by corporate executives, or by the consultants who make a living helping organizations improve their 'cultures.' Organizational culture is assumed to be important to making sure that employees are happy and productivity is good. At the same time, the concept, meaning, and function of culture rarely garners much thought. When I ask business people to define culture – or even when I ask students in my class on organizational culture to do so – it turns out to be difficult. I either get a simple definition, such as 'the values of a group' or I get 'interesting question' and something of a blank look as a response. The problem here is that while we use the term 'culture' constantly, most of us give very little thought to what that term means and how its use influences behavior and thought within organizations."

He goes on in more detail to explain: "In fact, anthropologists – the group of academics who first used the term in an analytical sense – have never really agreed on what exactly culture means. In the 19th century, E. B. Tylor defined culture as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society." Most of the definitions of culture used in books about organisational culture and values follow the Tylorian definition. Culture is the values, practices, beliefs, etc. of a group of people. In other words, culture is everything; which basically means it's nothing from an analytical perspective. The only really useful aspect of this definition is that culture involves groups (society) and that those groups share something. Otherwise, it's pretty vague."[16]

In a paper in the HBR[17] in May 2013 Michael Watkins wrote: "If you want to provoke a vigorous debate, start a conversation on organizational culture. While there is universal agreement that 1 it exists, and 2 that it plays a crucial role in shaping behavior in organizations, there is little consensus on what organizational culture actually is, never mind how it influences behavior and whether it is something leaders can change."

This is a problem, he goes on to argue, "because without a reasonable definition (or definitions) of culture, we cannot hope to understand its connections to other key elements of the organization, such as structure and incentive systems. Nor can we develop good approaches to analyzing, preserving and transforming cultures. If we can define what organizational culture is, it gives us a handle on how to diagnose problems and even to design and develop better cultures."

In his paper he distilled the feedback he received to the following potential definitions or conceptualisations of culture:

Culture is how organisations do things, in large part; culture is a product of compensation; organisational culture defines a jointly shared description of an organisation from within; organisational culture is the sum of values and rituals which serve as 'glue' to integrate the members of the organisation; organisational culture is civilisation in the workplace; culture is the organisation's immune system; organisational culture [is shaped by] the main culture of the society we live in, albeit with greater emphasis on particular parts of it; it over simplifies the situation in large organisations to assume there is only one culture… and it's risky for new leaders to ignore the sub-cultures; an organisation [is] a living culture… that can adapt to the reality as fast as possible.[17]

At the core of a modernist approach is the view that organisational phenomena (including cultures, structures and performance) are concrete entities, which can be systematically described and

explained. If, as this approach suggests, culture is something that an organisation has, then it may be possible to create, change and manage culture in the pursuit of wider organisational objectives. It is clear looking at the examples sited above and in reading the management literature that this is all based on the (possibly false?) assumption that cultures are an attribute of an organisation and are open to manipulation.

A post-modern perspective on organisational culture would not focus on culture as a means of control. It would instead encourage dialogue on the nature and course of change amongst stakeholders, particularly those who have traditionally been disenfranchised or marginalised from such discussions.[15]

A recent discussion in the HBR written by Jay Lorsch and Emily McTague[6] suggests that there is an emerging opinion, particularly amongst CEOs who have lead major transformations within their organisations that culture in not something that you fix. Rather, in their experience cultural change is what you get after you've put new processes or structures in place to tackle tough business challenges like reworking an outdated strategy or business model. They all show in a range of settings that culture isn't a final destination but that it morphs right along with the company's competitive environment and objectives.

John Traphagan[16] suggests:

"The problem with the term 'culture' is that it tends to essentialize groups: it simplistically represents a particular group of people as a unified whole that share simple common values, ideas, practices, and beliefs. But the fact is, such groups really don't exist. Within any group characterized as having a culture, there are numerous contested opinions, beliefs, and behaviors. People may align themselves to behave in a way that seems as though they buy into expressed corporate values and 'culture,' but this is just as likely to be a product of self-preservation as it is of actually believing in those values or identifying with some sloganized organizational culture.

And he goes on:

"So I think we need to stop using the term 'culture' to talk about what's going on in our organizations. By using the culture concept, we tend to artificially ossify the diverse, complex, and constantly changing social environment that is any organization. As a result, it becomes easy to misinterpret or misunderstand the nature and influence of power, conflict, cooperation, and change in relation to both individual and group behaviors. Corporations and other organizations do not have cultures; they have philosophies and ideologies that form a process in which there is a constant discourse about the nature and expression of values, beliefs, practices, ideas, and goals. This discourse happens in sales meetings, interactions with customers, board meetings, and in conversations around the water cooler. It's a constantly moving target."[16]

If defining and understanding our conceptualization of organizational culture is hard enough then it is even more sobering to consider how complex the problem in health is when you attempt to explain the NHS (or our own health system!) with a simple sketch (see next page).[18]

From the above it can be readily appreciated that the culture within an organisation may be far from uniform or coherent and that looking for commonality might be less rewarding than an examination of differences. Some cultural attributes may be seen across an organisation others may be prominent only in some sections of that organisation. Thus different cultures may emerge within different occupational or professional groups. Hence we have the emergence of subcultures. Some of these might be malleable and others resistant-giving rise to the so-called 'counter culture'.[15]

Organisations receive many cultural influences from outside the organisation and these influences may be at odds with the internal culture.

For all the influence in defining and assessing organisational cultures the crucial generic question of whether and how organisational culture impacts on organisational success operformance remain empirically, poorly explored.[15]

A simple causal relationship between cultural characteristics and success has not yet been demonstrated-unsurprisingly; any relationship is highly contingent on definitions of success and a wide range of other internal and external factors. Such evidence as exists is equivocal at best.

In the concluding remarks to their paper[15] Hu Davies et al say: "In the UK the Governments quality strategy emphasizes the importance of cultural transformation. If such an approach is to bear fruit a number of assumptions that are implicit in the approach must be verified as having some substance. Firstly there must be such a thing as organizational culture; secondly, the nature of this culture must have some bearing on clinical performance and health care quality; thirdly it should be possible to identify particular cultural attributes that are facilitative of performance and finally there must be some hope that interventions and management strategies can have a predictable impact on cultural attributes as a precursor to bringing about performance improvements."

At the very least this paper[15] demonstrates that these assumptions are far from trivial or self-evident. Indeed empirical thinking illuminates contention rather than consensus.

This in turn suggests that a more sober assessment of the task of cultural transformation in health care is warranted.[15]

We see emerging in our healthcare environment a number of 'cultures', which

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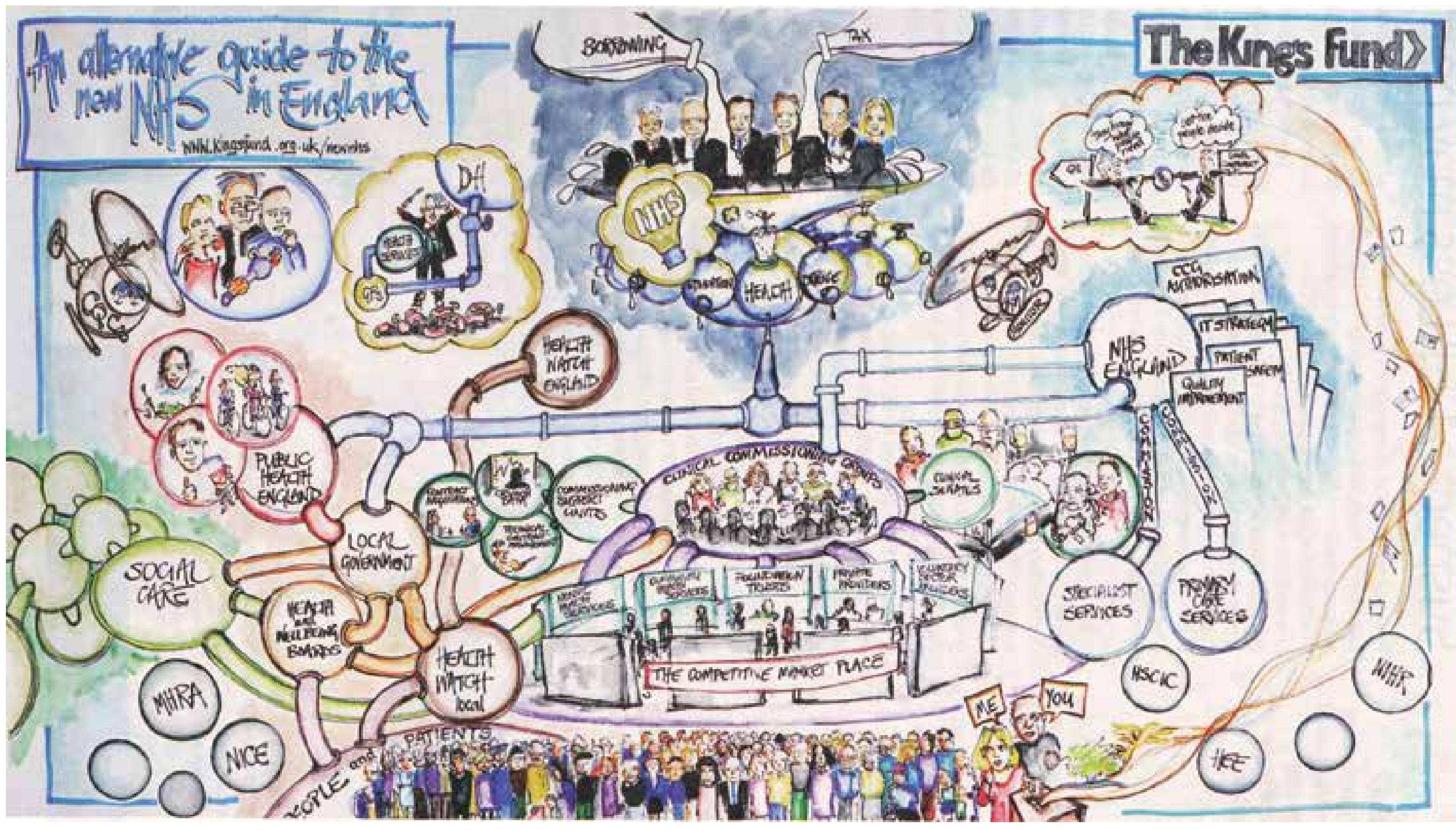

Image courtesy of The King's Fund, London. http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

have an impact on how we deliver care.

Medical Taylorism: advocates of this, lecture clinicians about Toyota's 'Lean' practices arguing that patient care should follow standardised systems like those deployed in manufacturing automobiles. The Electronic Health Record has become a key instrument for measuring the duration and standardising the content of patient-doctor interactions in pursuit of the 'one best way'. The authors of a critique of Taylorism[19] believe that the standardisation integral to Taylorism or the Toyota manufacturing process cannot be applied to many vital aspect of medicine. Arguing that if patients were cars we would all be used care of different years and models with different and often multiple problems many of which had previously been repaired by various mechanics. Moreover those cars would all communicate in different languages and express individual preferences regarding when how and even whether they wanted to be fixed. The inescapable truth of medicine is that patients are genetically, physiologically, psychologically and culturally diverse.

Instead of gaining happiness minutes clinicians are increasingly experiencing dissatisfaction and burnout as they're subjected to the time pressures of Taylorism and scientific management in the name of efficiency.

Michael Porter's 'Value' culture[20]: the underlying notion here is that healthcare is shifting focus from the volume of services delivered to the value created for patients with 'value' defined as the outcomes achieved relative to the costs. The argument goes that providers, payers, patient advocacy groups and regulators can come together to create a process to agree on a minimum sufficient set of outcomes for each important medical condition.

Choosing wisely culture[21]: perhaps the most visible effort so far to reduce inappropriate use of medical treatments and tests has been the Choosing Wisely campaign. In this campaign medical societies have identified tests, medications and treatments that are used inappropriately. The success of such efforts however may be limited by the tendency of human beings to overestimate the effects of their actions.

Choosing Wisely may be an ambitious attempt to address the problem of overtreatment but its not realistic to think that any single solution will be effective.

The Choosing Wisely Campaign has recently begun to be addressed by the College via the Safety and Quality Committee and in a recent email seeking

Fellows input the aim of the campaign was described as "to promote a culture where inappropriate clinical interventions are avoided. Improved care is the core objective and each recommendation should be evidence-based."

A patient-centred care culture: is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. The widely accepted dimensions of patient centred care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care. Surveys measuring patients' experience of health care are typically based on these domains.

The phrase 'nothing about me without me'[22] was their guiding principle; this phrase has since been popularised by authors and regulators and is considered synonymous with efforts to advance a vision for patient-centred care.

There is an attempt to foster the notion that the medical specialists have a common 'culture of greed' and that the sustainability of healthcare in Australia is under threat as a result of this.[24] This culture manifests itself in unreasonable out of pocket expenses for the patient and 'bill shock'. Offering to change this culture are the private health insurers who seek to increase their stake in the provision of healthcare claiming that they are able to make savings of $100 billion over 10 years with no change in standard of care.[23] The profession is under a constant barrage of negative press with no apparent end in sight as the culture of the Medicare Rebate Freeze continues.

RACS's idea of 'Building a culture of respect and collaboration in surgical practice and education'[25]. This is one of the cornerstones of the RACS action plan to address DBSH in their profession. It is a very powerful example of an organisation that embraces the idea of culture as an item that is possessed and can be altered to achieve an outcome. As anaesthetists we are at risk of harm from the culture of bullying that appears endemic to surgery and nursing.

A culture of submerging or hiding the truth that trade offs between quality and cost are embedded in budget constraints[10]: this is one of the most destructive and I would argue most pervasive and prevalent cultures to which we are subjected. In discussing the crisis in the VA in 2014 the prevailing narrative was one of breakdowns of character and culture: dishonesty, callousness and ineptitude. In the same way the Mid-Staffordshire scandal resulted in politicians blaming individual perpetrators and one another and the prevailing narrative highlighted lapses of character and culture.

However, closer scrutiny reveals another parallel with important implications for cost control efforts. In both cases performance standards often proved incompatible with resource constraints. Yet the gap between the two remained unmentionable amid pressure to make care both better and cheaper. Outbreaks of dishonesty resulted as personnel tried to finesse failures with fakery. The fakery was discovered and the perpetrators were punished. But the truth that trade-offs between quality and cost were embedded in budget constraints remained submerged.

We need to dispel the myth that we can control costs without forgoing therapeutic benefit. Mounting evidence to the contrary is belying this myth.

Open discussion of how to make real cost-quality trade offs is essential to stopping the progression from impossibility to the breakdown of professionalism and compassion – a progression that leads to scandal.

So how are we to respond to the many cultural challenges above and the challenge of 'culture' as either an attribute that we have or the sum of what we are?

Recognising that there is more to 'organisational culture' than we might have realised and being able to identify where 'culture' and 'cultural change' might be being used to manipulate us are a good first step.

Taking time to ponder (reflect?) what our key assumptions or 'taken for granted' views of the world are and how they are being altered and challenged is insightful. Re-stating and articulating the values that form the basic foundation for our making judgements and distinguishing right from wrong behavior is a crucial and ongoing process and examining the 'artefacts' that are the physical and behavioural manifestations of our 'culture' gives us useful clues as to how we are adapting and evolving.

To try and centre our own thinking it might be useful to re-visit the World Medical Association Declaration of Geneva:

At the time of being admitted as a member of the medical profession:

I SOLEMNLY PLEDGE
to consecrate my life to the service of humanity.

I WILL GIVE
to my teachers the respect and gratitude that is their due.

THE HEALTH OF MY PATIENT
will be my first consideration.

I WILL RESPECT
the secrets that are confided in me, even after the patient has died.

I WILL MAINTAIN
by all the means in my power, the honour and the noble traditions of the medical profession.

MY COLLEAGUES
will be my sisters and brothers

I WILL NOT PERMIT
considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any

FEATURE

other factor to intervene between my duty and my patient.

I WILL MAINTAIN
the utmost respect for human life.

I WILL NOT USE
my medical knowledge to violate human rights and civil liberties even under threat.

I MAKE THESE PROMISES
solemnly, freely and upon my honour.

It is also in our associating via the mechanisms of our Society that we gain strength.

And it is a powerful encouragement to consider the words of Alexis DeTocqueville in his 'Democracy in America': "But what political power would ever be in a state to suffice for the innumerable multitude of small undertakings that American citizens execute with the aid of associations?

"The morality and intelligence of a democratic people would risk no fewer dangers than its business and its industry if the government came to take the place of associations everywhere.

"Sentiments and ideas renew themselves, the heart is enlarged and the human mind is developed only by the reciprocal action of men upon one another."

The challenge for us as a specialty is to determine whether we 'buy in' to the notion of culture as something we own or can identify and hence manipulate. If we do then we need to decide what particular 'cultural characteristics' we most espouse to have; say for example a 'culture of safety and quality' or a 'culture of patient-centredness' and then we need to identify what tools or processes we have at our disposal to achieve the desired 'culture'.

What we cannot do is fall into the category of 'risk-averse' culture (HBR May 2016)[26], which is likely to be an obstacle to innovation.

"The best and hardest work," according to Pixar's President, Ed Catmull, "is done in the spirit of adventure and challenge.. mistakes will be made." We need to regards mistakes not as a necessary evil but as the inevitable consequence of doing something new and we need to rigorously extract value from failure.

As I final word I would ask you to consider the words of Dr Harold Griffiths written in tribute to Dr F.H. McMehan:
It is worth briefly contemplating the profound impact that McMehan had on Geoffrey Kaye. It was largely at the urging of McMehan that Kaye embarked on the many activities that he did. "Friendliness was the keynote of all his activities. He built up the foundation of cooperation, enthusiasm and friendship, which is present more strongly in the specialty of anesthesiology than in any other medical group."

Maybe in all of the complexity and challenge of our professional world we should foster a simple 'culture of friendliness and cooperation'?

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FEATURE

THE WORLD CONGRESS OF ANAESTHESIOLOGISTS

The World Congress of Anaesthesiologists (WCA) comes around every four years. The 16th WCA was held in Hong Kong hosted by the Society of Anaesthetists of Hong Kong from 28th August to 2nd September, 2016 writes Rob McDougall.

Hong Kong proved to be an amazing venue for the WCA. The congress was held at the Hong Kong Convention and Exhibition Centre, which is on Victoria Harbour in Wan Chai on Hong Kong Island. Over 6,000 delegates, from at least 134 different countries attended the WCA. Over 500 Australian anaesthetists attended. The only country with a greater number of delegates was China. The scientific program consisted of 17 different tracks which involved 601 Faculty, 648 speaker presentations, 79 workshops, 54 problem based learning discussions and 964 scientific abstracts presented as electronic posters.

At the opening ceremony, WFSA President, David Wilkinson, highlighted the challenge the world faces in providing safe and affordable surgical and anaesthesia care to the 5 billion people who currently have no or limited access to such essential, basic services. He announced the WFSA's first Global Impact Partners, which are the Laerdal Foundation and Massimo. Presentations from Mr Tore Laerdal, Executive Director of the Laerdal Foundation and Mr Joe Kiani, CEO and founder of Masimo, during the WCA, highlighted the tremendous prospects for these relationships.

Each track had its highlight, but we all converged for the Harold Griffiths Symposium, which was the major plenary session of the meeting. The

WFSA President, David Wilkinson, Dr Atul Gawande, Head of the Harvard School of Public Health, Head of Lifebox and Tore Laerdal, Executive Director of the Laerdal Foundation

Tore Laerdal speaks about Laerdal Medical

Attendees at the Harold Griffiths Symposium

two speakers for this session were Mr Tore Laerdal and Dr Atul Gawande. Tore Laerdal is Executive Director of the Laerdal Foundation, chairman of Laerdal Medical, and managing director of Laerdal Global Health. Mr Laerdal outlined the history of Laerdal Medical and how, as a two-year-old, his father saved him from drowning and was then inspired to use his skills as a toy manufacturer to develop resuscitation training manikins. He also presented projects supported by Laerdal that focus on helping reduce maternal and newborn mortality in low resource settings. Importantly, Mr Laerdal spoke of his views on how industry can partner with organisations, such as the WFSA, to improve access to care and quality of care.

Dr Gawande needed little introduction and is a surgeon, Head of the Harvard School of Public Health, Head of Lifebox and a best-selling author. He spoke of his father's upbringing in rural India and told the story of access to anaesthesia in the village where he still has family. He outlined the strong case for affordable surgery and the challenges that we face in developing sustainable systems. "People think that it's about having enough expertise – anaesthesiologists, surgeons, nurses," he said. "But it is much more than this – it requires somehow building infrastructure, procurement systems, management. And yet as economies grow, numerous countries have managed to do it."

I was involved in the paediatric track, as Chair of the Paediatric Scientific Sub-Committee. The paediatric track had a faculty of 35 from 22 countries. The majority of sessions were aimed at non-specialist paediatric anaesthetists and there was strong representation of anaesthetists from low and middle income countries. Highlights from the workshops included the Managing Emergencies in Paediatric Anaesthesia simulation course, which was run onsite in a room with amazing harbour views by an international faculty and the Can't Intubate, Can't Oxygenate Workshop run by Australia's own Dr Stefan Sabato.

Another highlight of the WCA was the cultural program and, in particular, the very moving and educational plays presented by the Hush Foundation, founded by Dr Catherine Crock, from Melbourne. 'Hear Me' explores medical error, bad behaviour amongst staff and patient safety. 'Do you know me?' examined issues in aged care. Both were co-written by Dr Crock and Alan Hopgood, an award-winning Australian playwright. The Hush Foundation also supported the appearance of musician and composer, Joe Chindamo, who was a highlight of the opening ceremony.

Aside from the educational program, the WCA serves as the forum and main meeting for the World Federation of Societies of Anaesthesiologists (WFSA) and all its committees. The WFSA is made up of over 130 societies of anaesthesiologists representing over 150 countries. The WFSA aims to be the foremost global alliance of anaesthesiologists, working together with national, regional and specialty organisations to facilitate and promote the highest standards of patient care. The general assembly, where all major decisions of the WFSA are ratified, was held on the first day of the WCA. The ASA

Highlights from the workshops included the Managing Emergencies in Paediatric Anaesthesia simulation course, which was run onsite in a room with amazing harbour views by an international faculty and the Can't Intubate, Can't Oxygenate Workshop run by Australia's own Dr Stefan Sabato.

Pacific Fellows with Dr Chris Bowden, ODEC Chair and Dr Sereima Bale, Senior Lecturer in Anaesthesia, Fiji National University

Attendees at the WCA

was entitled to five voting delegates (out of a possible 352) and we sat alongside the other six delegates from our region (Australia, New Zealand and the Pacific), which is arguably the biggest geographic WFSA region but definitely the smallest in terms of population. Whilst we are a very small group in world terms, our region is strongly represented in the WFSA.

At the general assembly the following appointments to WFSA committees were ratified: Dr David Pescod (WFSA Council), Assoc Prof Alicia Dennis (Scientific Affairs), Dr Chris Bowden (Education), Dr Roger Goucke (Chair of Pain Medicine), Dr Michael Cooper (Chair of Paediatrics), Dr Amanda Baric (Publications) and Assoc Prof Nolan McDonnell (Obstetrics). In addition Dr Phoebe Mainland has been co-opted again onto the Safety and Quality of Practice Committee. Dr Wayne Morriss (New Zealand) was made Director of Programmes and Professor Alan Merry (New Zealand) became Treasurer.

The WCA also saw the launch of the Safe Anaesthesia For Everybody – Today 'SAFE-T' campaign: made up of the SAFE-T Network and Consortium, bringing individuals, organisations and industry together to advance patient safety and the International Standards for a Safe Practice of Anaesthesia.

The goal of the SAFE-T Network is to raise awareness of the need for safe anaesthesia as an essential element of safe surgery, the lack of provision, and the need to take action, by advocating together and gathering data to 'map the gap' in access to safe anaesthesia.

It is by mapping this gap in Actual Provision vs. the International Standards that strong evidence can be provided to Ministries of Health, other governmental bodies and decision makers to ensure more is being done to close the gap.

For the first time, the WFSA now has two Presidents for the next four years. Dr Gonzalo Barreiro (Uruguay) will be President for the next two years and will be succeeded by Dr Jannicke Mellin-Olsen (Norway). Both have served the WFSA in a number of roles for many years and they can be expected to continue the work of the WFSA in uniting anaesthesiologists and promoting safe anaesthesia for all.

Another highlight of the WCA was the attendance of 51 international scholars, who received support from a number of sources to attend the meeting. The ASA supported Dr Tildena Mandaveh (Vanuatu), Dr Colombianus Dasilva (Timor Leste) and Dr Maika Seru (Fiji). Dr Akuila Naqasima (Fiji) received joint support from the ASA and NZSA. A number of other Pacific anaesthetists were sponsored by NZSA and ANZCA. Dr Selesia Fifita, anaesthetist in Tonga and WCA scholar, explained: "I've enjoyed meeting people from other countries and seeing what their experiences are like. It's good that we see other people are experiencing the same things we are [in the Pacific Islands]."

The closing ceremony of the WCA included a magnificent presentation from the Czech Society of Anaesthesiology and Intensive Care Medicine, who host the 17th WCA in Prague from 6-11th September 2020. This attractive destination will be sure to draw many ASA members and perhaps we can look forward to reclaiming the crown of the society with the most delegates at the WCA?

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FEATURE

16TH WORLD CONGRESS OF ANAESTHESIOLOGISTS

Dr Jean Allison recently attended the 16th World Congress of Anaesthesiologists in Hong Kong and provides an overview of the event.

The ASA and Peter Seal facilitated my attendance at the 16th World Congress of Anaesthesiologists (WCA) in Hong Kong, for which I am extremely grateful. It was the 14th WCA in which I had participated. At the Hong Kong meeting, I was the only registrant who had been present at the very first WCA at Scheveningen in the Netherlands in 1955.

The Society of Anaesthetists of Hong Kong (SAHK), under its President Mike Irwin, did an excellent job in organising the congress. Professor Tony Gin had prepared a really interesting scientific programme – all colour-coded, such as blue for obstetrics, yellow for pharmacokinetics, and orange for humanities and history, which were the sessions that I mostly attended.

At the Opening Ceremony, after a magnificent red dragon was wheeled about, the formalities began despite a false start with a faulty sound system. Both Mike Irwin, and then David Wilkinson, the World Federation of Societies of Anaesthesiologists (WFSA) President, spoke and announced the WFSA awards.

An Australian anaesthetist presented the Hush Programme, which provides music for hospitals, particularly in induction rooms. She then introduced her collaborator, who played a piano piece, which was followed by several compositions that he performed with five members of the Hong Kong Philharmonic Orchestra. All of the items originated from the Hush Programme. The proceedings ended with lion dances.

There was a reception afterwards in the Trade Exhibition. We were interested to see a lengthy queue for the fortune teller, and not so long lines for the other attractions.

The highlight of the WCA was the Harold Griffith Oration. Tore Laerdal recounted how his father, a toymaker, made the Resusci Anne, and how Norway was the first country to teach all children resuscitation. The Chairman of the Lifebox Foundation, Dr Atul Gawande, described his ancestral village in India, and how surgery and public health go hand in hand. In particular, how efficient and well run hospitals contribute to the economy of the area in which they are located. Both received standing ovations.

Dr Peter Seal, Vice President of the ASA, provides some background information on Dr Jean Allison.

DR JEAN ALLISON

Dr Jean Allison is a retired anaesthetist who recently celebrated her 89th birthday. She spent the vast majority of her career in Hong Kong. Jean was born in northern Victoria and raised near Melbourne, where she graduated in medicine in 1951. In 1953, she sailed to Britain, and spent the next decade in London, Glasgow, Melbourne and Glasgow again, working, training and graduating in anaesthesia. In 1963, she took up the role as deputy Director of Anaesthesia at Prince Henry's Hospital in Melbourne.

In 1965, Jean moved to Hong Kong where she became a pioneer of the anaesthesia community for more than 25 years, during which time she was based almost exclusively at the Alice Ho Miu Ling Nethersole Hospital. She was President of the SAHK in the mid 1980s, and was Chair of the Organising Committee of the extremely successful 7th Asian and Australasian Congress of Anaesthesiology in 1986, hosted by Hong Kong. She was a foundation fellow of the Hong Kong College of Anaesthesiologists.

Jean returned to Melbourne in 1993, when she retired. She has been on the Committees of the Victorian Retired Anaesthetists Group, and the AMA Retired Doctors Group. In addition, she was part of the AMA Peer Support Group, and remains a most productive participant on the ASA Victorian Section Committee of Management.

She contributes to other non-medical committees, and still partakes in the occasional bushwalk. Jean is a Life Absent Member of the Ladies Recreation Club and The Helena May, both in Hong Kong, and is an active member of the Lyceum Club in Melbourne.

Dr Jean Allison

The five 'first'* FFARACS in Hong Kong with the cup presented by the Dean, Faculty of Anaesthesiology, Professor T. Brophy. Back row: (from left) Y.C. Sit*, J. Lam*, S. Kwong, Z. Lett, C. Chen*, F. Shin*. Front row: (from left) A. Lam*, N. Butt, J. Allison. Photo courtesy of The Society of Anaesthetists of Hong Kong and The Hong Kong College of Anaesthesiologists.

FEATURE

AUSTRALASIAN SYMPOSIUM ON ULTRASOUND AND REGIONAL ANAESTHESIA 2017

ASURA Convenors Drs Neil MacLennan and Jenny Weller detail what attendees can expect at ASURA 2017.

Since the first symposium in 2008, ASURA has established itself as the principal regional anaesthesia meeting in Australasia. In 2017, ASURA will focus on the important area of education in regional anaesthesia. Most anaesthetists believe that regional anaesthesia offers benefits to patients, from improved post-operative pain control to reduced complications, earlier hospital discharge and even lower mortality[1]. However, proficiency in regional anaesthesia remains variable. By focusing on regional anaesthesia education, ASURA 2017 aims to foster learning in this important clinical field. In a recent editorial in Regional Anesthesia and Pain Medicine[2], one of our keynote speakers, Prof Ed Mariano, highlights the patient benefits of regional anaesthesia, whilst acknowledging that as a specialty, we still fall short of training anaesthetists with a "core competency in regional anaesthesia".

ASURA 2017 hosted by the ACE tripartite Regional Anaesthesia SIG will address important areas of regional anaesthesia education with content for both novices and experts. Topics include the role of simulation in learning, current education theory, assessment of skills during training, and the use of social media as a learning tool. In addition, we will feature a broad programme of contemporary regional anaesthesia topics, with a mix of both plenary and small group sessions. As with previous ASURA meetings, we have a full complement of regional anaesthesia workshops for hands-on training.

Our international keynote speakers combine expertise in both education and regional anaesthesia. Ed Mariano is Professor of Anesthesiology, Stanford

University School of Medicine, San Francisco. His research interests include the development of techniques and patient care pathways to improve postoperative pain control with of focus on regional anaesthesia. He has a particular interest in the role of simulation-based training of residents in regional anaesthesia techniques. Other keynote speakers are Viren Naik – Professor of Anesthesiology at the University of Ottawa, and Associate Professor Glenn Woodworth from Portland, Oregon. Prof. Naik has extensive experience as an educator and will share how education theory can help those learning, or teaching regional anaesthesia. A/Prof Glenn Woodworth is the Regional Anesthesia and Acute Pain Medicine Fellowship Director at Oregon Health and Science University in Portland, Oregon. In addition to his clinical duties, A/Prof Woodworth is an active education researcher and is particularly interested in the assessment of competency, the effectiveness of different educational methods in medical education, and the use of education technology. A/Prof Woodworth has pioneered the development of the Anesthesia Toolbox. Our international speakers will be supported by an experienced Australasian faculty from both the regional anaesthesia special interest group and education communities.

ASURA 2017 is being held at the recently renovated Peppers Noosa Resort from Thursday 23 to Sunday 26 February. We are drawing on the beautiful local area for social programme activities and the conference dinner. Make sure to join us for the Conference dinner being held at the Noosa Boathouse – price of attendance includes the cruise down the river to take in the gorgeous sunset. Other optional activities include yoga on the beach and a wine and cheese tasting. Make sure to keep checking www.asura2017.com.au for any changes.

Registration is now open and workshops are filling fast. The organising committee encourage you to join us in Noosa for an enjoyable, and educational ASURA!

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HISTORY OF THE ASA LOGO

The recent member survey highlighted that many members do not fully understand the origin of the current ASA logo. The current ASA ether bowl 'symbol' has been a representation of the Society since its acceptance by the Federal Executive in Perth in October 1978.

In early 1976 Brian Pollard, then President of the Society, voiced the opinion at the Federal Executive Meeting that an image of kangaroo jumping over a map of Australia did not convey the feeling of the Society – nor was it unique to it.

The society's former badge

Later that year it was agreed that a design committee would be appointed to develop a more suitable logo. The committee comprised of:

- Michael Bryce – Fellow of the Royal Australian Institute of Architects and an Associate of the Industrial Design Institute of Australia
- David McConnel – President ASA
- John Hains – Queensland Chair ASA.

The following points were considered in the development of a new design:

1. Elements of the original design which were considered of merit should be retained;
2. it needed to reference to an element of anaesthesia;
3. it should be unique, easily recognised and easily reproducible for printing purpose;
4. and, it must be accepted by the Society as a suitable form of identification.

Several ideas and concepts were discussed over the next couple of years including imagery of a staff and serpent, yin and yang, wings, poppies, hands, kangaroos and syringes. It wasn't until the Federal Executive Meeting held in Perth in October 1978, that the 'ether bowl' image was approved.

The logo we now recognise as the Society's logo depicts a stylised two-dimensional hand holding a bowl from which vapours are rising. The decision of the image to be a circular form was as to remain compact and to lend the authority of a 'seal'. The final design was produced in black and gold. The Australian colours of green and gold were considered, but the use of black and gold was maintained as a link to the Faculty of Anaesthesia. Unfortunately, gold embossed printing was expensive so a slightly different yellow (Pantone 118) was selected as the colour.

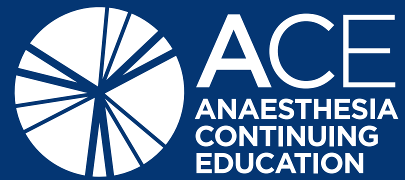
Over the last five years the Society has been focused on using the whole logo including the ASA and Australian Society of Anaesthetists wording – as the ether bowl image can be misinterpreted.

The above logo can only be used by or approved for use by the ASA Head Office and is a registered trademark.

ASA MEMBER LOGO

In 2013, the Society developed a logo for members to use to show their membership of the organisation.

The member logo is a registered trademark and can be downloaded from the member section of the ASA website or you can email membership@asa.org.au to get a copy of the logo and the guidelines for use.



INVITED SPEAKERS

Edward R. Mariano, MD, MAS (Clinical Research)

Dr. Mariano is a Professor of Anesthesiology, Perioperative and Pain Medicine at Stanford University School of Medicine. His research interests include the development of techniques and patient care pathways to improve postoperative pain control and other surgical outcomes, and he has published over 100 research articles and book chapters.

Viren N. Naik, MD, MEd, MBA, FRCPC

Dr. Viren Naik is the Vice President, Education for The Ottawa Hospital and Professor of Anesthesiology at the University of Ottawa. He has 20 years experience as an educator, and is now focused on leading interprofessional education initiatives at his hospital to enhance the learning environment and improve the patient experience.

Glenn E. Woodworth, MD

Dr. Woodworth began his medical training in San Diego culminating in finishing his residency at the Mayo Clinic in Rochester, Minnesota. He currently is the Regional Anesthesia and Acute Pain Medicine Fellowship Director, and Associate Professor at Oregon Health and Science University in Portland.

For further information please contact events@asa.org.au

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FEATURE

EMERGENCIES IN ANAESTHESIA COURSE: YANGON, MYANMAR

Dr Jennifer Reilly writes about the Emergencies in Anaesthesia Course held in February this year.

Dr Amanda Baric and A/Prof David Pescod from The Northern Hospital, Melbourne travelled to Myanmar to run the Emergencies in Anaesthesia course at two university hospitals in Yangon, Myanmar.

Emergencies in Anaesthesia is a two-day course developed by Dr Baric and A/Prof Pescod, consisting of lectures, skills stations, and PBLs. Topics include principles of crisis management, a systematic approach to the management of anaesthetic emergencies, management of airway, respiratory and cardiovascular problems, and advanced life support. This was the third time the course was run in Myanmar, and for the first time, a simulation component was introduced.

The course was preceded by an instructor briefing for local consultant anaesthetists. Sixteen local anaesthetists identified as potential future instructors attended.

The two-day Emergencies in Anaesthesia course was delivered at University of Medicine 1 and University of Medicine 2. Each course had 24 registrars as formal participants, plus additional consultant observers. Eight trainee instructors delivered some of the teaching on each course. Formative assessment was used in the ALS workshops. Summative assessment included a pre- and post-course multiple choice test.

Participant feedback indicated the most useful components of the course were the airway and cardiac life support skills stations. The simulation component was completely new to participants, and despite needing some local adaptation, it was popular part of the course.

As in Australia, anaesthesia in Myanmar is a medical specialty performed by doctors with formal postgraduate education and training in anaesthesia. Instead of a specialist college, training is provided by four university medical schools and their affiliated teaching hospitals in Myanmar's

two largest cities, Yangon and Mandalay. Short, focused training courses did not exist for anaesthetists in Myanmar prior to the introduction of Emergencies in Anaesthesia.

The course was sponsored by Phillips and their local business partner JJ Pun. Sponsors were in attendance each day and set up a display at the course, and provided defibrillators for demonstration use during the course.

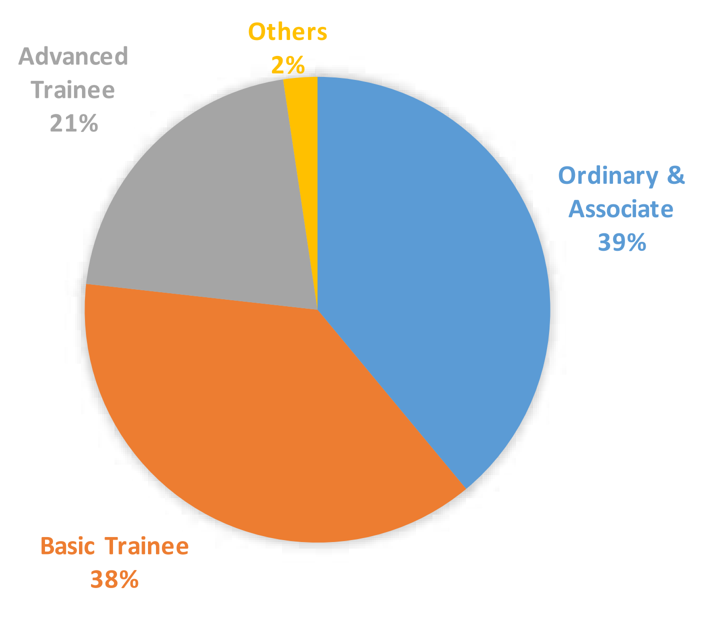
Led by Dr Baric and A/Prof Pescod, course faculty included Dr Michelle Chan, Dr Amardeep Nanuan and Dr Stefano Sabato from Melbourne, Dr Jennifer Reilly from Newcastle, and Dr Ebrahim Bham from Perth. Instructor travel and accommodation was self-funded.

A number of senior local anaesthetists including the Professors of Anaesthesia and the Secretary of the Myanmar Society of Anaesthesia were instrumental in arranging the course, including participants, logistics, course materials and venue. We were invited to return to provide further teaching in 2017.

Stefan Sabato, Amardeep Nanuan, David Pescod, Michelle Chan, Amanda Baric and Jennifer Reilly

2016 IN REVIEW

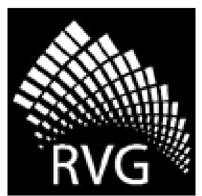
MEMBERSHIP UPDATE: 278 NEW MEMBERS



602 responses from the member survey

ASA APPS

Anaesthesia and Intensive Care downloads: 178% increase from 2,188 to 6,094



Relative Value Guide downloads: 52% increase from 883 to 1,344 downloads

Australian Anaesthetist magazine: 160 downloads

POLICY UPDATE

155 Policy queries with 96% resolution rate

908 Workforce Survey responses

8 Government submissions

2016 IN REVIEW

MARKETING & COMMUNICATIONS

24% increase in website page views since October 2015

25% increase in new users since October 2015

5,000+ visits to Harry Daly Museum online collection

President enews

> 50% open rate

> 20% click rate

>1,2k likes

>1,8k followers

>1,3k followers

EVENTS UPDATE

1,000+ attendees at the NSC 2016

494 people downloaded the NSC App

Over 25 events including trainee, state, social and combined ANZCA CMEs

50 attendees at the annual Practice Managers Conference

Note: All information and statistics updated as at 17 October 2016 for the period of January to October 2016.

REGULAR

HOW WILL YOUR KIDS BE ABLE TO AFFORD TO BUY A PROPERTY?

Stuart Wemyss has some suggestions on how you can help your children buy their first property.

My sons will turn 10 in January next year and I worked out the Melbourne median price could be circa $1.4 million by the time they are 20 years old. This means that a 10% deposit plus stamp duty will cost them over $200,000! Where will a 20 year old get that sort of money as a deposit? As a parent, what can (and should/shouldn't) I do to help them?

LESSONS ABOUT MONEY START AT HOME… START YOUNG

It is really important to teach children some important lessons about money whilst they are young so that by the time it comes to buy property, they exhibit all the correct disciplines. Some of these key lessons include:

- Always spending less than you earn so that you are able to save and invest for the future. Consider the 50%, 40% and 10% rule… which involves saving 50% of their pocket money, spending 40% and donating 10%.
- How saving towards a long term goal is necessary for almost everyone and that it's very rewarding – help them set a goal and save towards it.
- The power of compound interest. That is, starting early and saving regularly e.g. if you start saving $100 p.a. at age 10 you will have $43,500 by age 60 whereas if you start at age 35, you'll only have $6,900.

There are some great tips on the Australian government's Money Smart website.

PROPERTY HAS ALWAYS BEEN EXPENSIVE

We need to remember that there has never been a time in recent history where property hasn't seemed expensive. Most of us struggled to buy our first property but we did it. We sacrificed. We compromised on what our 'first property' looked like – and where it was located. We worked hard to start climbing the property ladder. It's almost a rite of passage. Talk to your kids about that. Tell them how hard it was. Tell them how much it helped you. Children role model a lot of behaviour from their parents and sharing your struggles will help them learn from your successes and mistakes. It will prime them to learn that buying a property is important, buying a property is difficult and buying a property requires some short term sacrifices and hard work.

IF YOUR KIDS ARE STILL QUITE YOUNG SHOULD YOU BUY SOMETHING FOR THEM NOW?

Sometimes I meet clients who want to buy an investment property for each of their children. This might sound good in principle, but might not necessarily work well in practice. Firstly, properties grow at different rates so how will you deal with any differences in value? What about the capital gains tax and stamp duty consequences which may crystallise when you transfer/sell/gift the property to them? In addition, you might not want to help your kids in the same way at the same time. For example, if one of your children has some money management concerns or an addiction, gifting them a significant amount of wealth probably isn't in their best interest. In short, if helping your kids is something you might want to do in the distant future then it's very difficult to make plans now given the high level of uncertainty.

Instead, the best approach is to look after yourself first. Make sure that your financial future will be well provided for. If you take action today and do everything possible to build wealth safely, then there's a good chance that you will be in a strong financial position to help your children if and when the time is right. Invest for yourself first.

EDUCATE THEM ABOUT WHAT MAKES A PROPERTY INVESTMENT-GRADE

The first property a person buys is the most important property they will ever buy in their life. The reason is that if they get it 'right' and select an investment-grade property, it will propel their financial position forward. However, if they buy a dud, it might end up being more of a liability than an asset.

YOUR CHILD MIGHT HAVE TO REDEFINE WHAT THEIR FIRST HOME LOOKS LIKE

It might be nice for your child to be able to afford a top quality investment-grade property in a blue chip suburb. However, if that is too much of a stretch then they might be better off buying something more affordable – albeit in a slightly inferior location. When you climb the property ladder you often have to start from the bottom. There's nothing wrong with starting small and working your way up. It is possible to find investment-grade property for upwards of $450,000.

TWO WAYS YOU CAN HELP YOUR CHILD

You can help your child buy property by supporting them with a deposit and/or cash flow. I discuss each option below.

Option 1: Help with a deposit

I appreciate that saving enough cash for a deposit can be very difficult. Property prices can often increase at a faster rate than a person's ability to save. In this case, a property purchase becomes more and more out of reach.

Helping your child overcome the deposit hurdle can be a very valuable thing indeed. However, in my opinion, it's important that they can afford the loan in their own right (from a repayments perspective) before you offer assistance. That is, firstly, they need to have sufficient surplus cash flow to meet the loan repayments now and in the future when interest rates rise. Secondly, they need to have sufficient financial stability to warrant taking on a large commitment such as a loan. For example, some younger people can be rather transient and/or uncertain about what they might be doing in the future employment-wise. If this is present they might not be ready to commit to a property acquisition. A child has to 'want' to buy property themselves.

If you would like to help your child with a deposit, there are a few options that you can consider to help you do this. Which option suits you best depends upon your circumstances and it is something we can help you determine. Some options include:

- The most popular way to help your child is via the provision of a Family Guarantee. This is best explained using an example: Your daughter would like to buy a property for $600,000 and she has cash savings of $30,000. Given the total cost of the purchase (in Victoria) will be circa $618,000 including stamp duty and so on, she will need to borrow $588,000 or 98% of the property's value. The maximum a bank will lend is 95% – so clearly she doesn't have enough cash. However, as her parent, you can offer a limited guarantee for $135,000 as additional security for her loan. This guarantee can be secured by equity in your home or an investment property. In summary, the $588,000 loan is secured by the property itself worth $600,000 and your limited guarantee for $135,000 ($735,000 of security for a $588,000 loan resulting in an 80% loan to value ratio). The benefits of offering the guarantee are:

  1. Your daughter can borrow the full amount (of $588,000) assuming she has enough income to qualify for the loan
  2. Your daughter avoids the cost of lenders mortgage insurance (an upfront fee charged by the bank) which will save her approximately $15,000 to $20,000; and
  3. You can request the bank to release the guarantee when the property's value increases and/or the loan amount reduces to such a point that the loan to value ratio is less than 80%. In our experience, this typically occurs within five years.

  Of course you need to think carefully before providing any guarantees as you are at risk of having to pay the guaranteed amount in the event your daughter defaults on the loan.
- You can borrow the required amount and on-lend it to your daughter. Using the same example, your daughter needs $588,000 whereas 80% of the property's value is $480,000. Therefore, if you lend your daughter $108,000, she will only need to borrow 80% from the bank and she'll avoid mortgage insurance. Your daughter will need to prove to the bank that she is able to service both loans i.e. the $108,000 you lent her and the 80% loan. The advantage of this structure is that you don't have to provide a guarantee which voids some paperwork and perhaps legal costs.
- You can loan your daughter money from savings or perhaps your SMSF (if it's from your SMSF you must ensure its lent on commercial terms and you don't breach the 5% in-house assets cap – get advice). Given term deposit and cash interest rates are very low at the moment, parents (particularly retirees), might be better off lending money to their children and enjoying a higher interest rate.
- You may like to co-own the property with your daughter. Since she is short $108,000 in cash you could use your own funds and own 17.5% of the property (as tenants-in-common). The advantage of this option is that your daughter isn't responsible for your share thereby reducing the cost of servicing a higher loan. However, one major downside is you will trigger stamp duty and capital gains tax in the future if or when you sell/transfer/gift your 17.5% share in the property to your daughter. I would think very carefully about co-owning property with a child as it can be expensive to unwind and difficult for your child to use the equity in the future.
- You can gift $108,000 in cash to your child. If you choose this option, please read my comments below under 'protecting your family's wealth'.

One thing that you should consider is making sure that your child has enough

'skin in the game' as coined by Warren Buffett. That is, it is a good lesson and motivator if you require your child to contribute a meaningful amount of cash as a deposit. Doing so will likely force them to think very carefully about making such a commitment and ensure they take full responsibility for the financial outcomes.

Option 2: Help with cash flow / affordability

This form of assistance might be necessary if you would like your child to buy a property but they cannot afford to service the loan amount required to do so (because they don't have enough income).

From a professional financial planning perspective, I have a problem with providing this level of assistance as I believe that you are teaching your child the wrong lessons about borrowing. We should be teaching our kids to borrow well within their affordability limits – not the other way around. Debt is a wonderful servant but a terrible master.

Putting that professional concern aside, if you do want to assist with cash flow, lenders will want you to act as a co-borrower and want you to have a material amount of ownership of the property (i.e. 10% to 20% on title as tenants-in-common). As a co-borrower you will be jointly and severally liable for the entire debt. Also, being on title may be costly to change in the future as mentioned above.

On the whole, I don't like this option and believe that if your child cannot qualify for the required loan amount by themselves, then they should not borrow.

PROTECTING YOUR FAMILY'S WEALTH

Imagine helping your child buy a property. They then enter into a relationship with a domestic partner and cohabitate. The relationship subsequently breaks down and the partner instigates a family court action seeking to split assets on a 50/50 basis. In this event, your family risks losing 50% or more of any assistance you have provided your child.

There are a few things you can do to protect your family's wealth and you should seek professional advice. Firstly, if you are providing any cash as a deposit, make sure its structured as a loan, not a gift, so that it's a personal liability to your child. You might secure this loan with a caveat over the property to formalise it. Secondly, educate your child about the merits of arranging a cohabitation agreement (which is like a pre-nuptial agreement) to protect the assets that they had when they entered into the relationship.

On a completely unrelated matter, if you have helped one child but not the other/s (because they are not all of age yet), you might consider including an offset clause in your wills so that your executor can equalise the distribution of your estate.

ONE OF THE BEST LESSONS A PARENT CAN TEACH… BUT DO SPEAK TO US FIRST

Educating your children about money and investing (including investing in property) can be one of the most valuable lessons a parent can teach their children. Helping them buy a property as soon as practical and sensible will have significant positive compounding effects on their financial standing. However, there are lots of pitfalls and considerations to take into account so don't hesitate to reach out to us for a confidential discussion if this is something you are thinking about.

For more information, please contact:

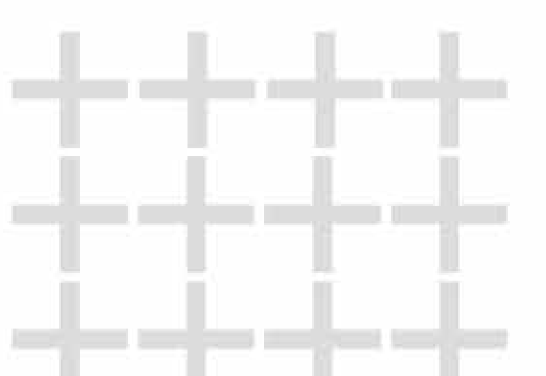
Web: www.prosolution.com.au

Stuart Wemyss
Email: *swemyss@prosolution.com.au*

Phone: +61 3 8624 4610

Stuart Wemyss is an independent and licenced chartered accountant, financial planner and mortgage broker with over 18 years' experience in financial services. He founded ProSolution Private Clients in 2002.

We work for you, not the banks!



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NSC 2016 RECORDINGS ARE NOW AVAILABLE INCLUDING:

- **Welcome Plenary** – Dr Guy Christie-Taylor, Dr Simon Reilly, Prof. Colin Royse
- **Kester Brown Lecture:** Can the patient lead the perioperative team? – Ms Carolyn Canfield
- **What happened before is now history** – Dr Kester Brown
- **The Great Debate:** Who owns the patient? The doctor, the hospital, the insurer or the patient? – Prof. Olle Ljungqvist, Ms Carolyn Canfield, Dr Gareth Goodier and Mr Stan Goldstein
- **Geoffrey Kaye Oration** – Dr Guy Christie-Taylor
- **Beyond our Borders – Q&A Forum**
  Dr Sally Warhaft, A/Prof. Munjed Muderis, Adj/Prof. Frank Brennan, Mr David Manne and Prof. Louise Newman

For further plenary and session recordings please visit the Education & Events/ NSC Presentations page on **www.asa.org.au** (*member log in required*)

WEBAIRS NEWS

The NSC was a hive of webAIRS activity. Medical Director, Dr Martin Culwick, along with A/Prof Kersi Taraporewalla, hosted two webAIRS workshops. They gave an overview of the capabilities of webAIRS and its usefulness in the clinical setting.

On the final day of the congress, a session was dedicated to error reduction strategies and how we can learn from the examination of incidents. In an engaging two hours, chaired by Dr Gregory Deacon, attendees learned about the analysis methodology known as the bowtie diagram, responding to crises and how the human brain responds in a high stress situation such as an unexpected serious operating theatre incident. Dr Culwick closed the session with further evidence of how incident reporting can provide a unique opportunity for learning and practice improvement. There are several webAIRS presentations planned for conferences in 2017, which should be as engaging as those presented at September's NSC.

webAIRS has now collected more than 4000 incidents reported by the hundreds of anaesthetists registered in the system. Most users choose to connect their registration with a site. This allows for de-identified, local level data to be accessed, displayed and discussed at M&M meetings – one of webAIRS most useful features in the clinical setting.

Incident Categories 17/10/16

Respiratory/Airway
Other Organ
Neurological
Miscellaneous/Other
Medication
Medical Device/Equipment
Infrastructure/System
Cardiovascular
Assessment/Documentation
0 500 1000 1500

INCIDENT BREAKDOWN BY CATEGORY – OCTOBER 2016

Every report submitted to webAIRS is contributing to the process of bi-national quality improvement through data analysis and reporting. In early 2016, ANZTADC formed a Publications Group to oversee the examination of data and subsequent publication of articles. A series of reports derived from the first 4000 incidents is planned for 2017. The analyses will include the four big A's – awareness, anaphylaxis, aspiration and airway. Mortality data, hypotension and medication errors are also being investigated.

Did you know that reporting in webAIRS earns you two CPD credit points in the practice evaluation category? The end of the triennium for continuing professional development is 31 December 2016. If you are not already registered in webAIRS, and earning CPD points, this is easily done so via link on the webAIRS landing page. There are different registration options for individuals and organisations be they hospitals, day surgeries or private practices. All reports are de-identified and are a valuable contribution to this important, anaesthesia specific, quality assurance activity.

Need further information about webAIRS? Follow the links on the home page (www.anztadc.net) to download an information brochure and register online, or contact ANZTADC at anztadc@anzca.edu.au

INSIDE YOUR SOCIETY

POLICY UPDATE

ASA Policy Manager Chesney O'Donnell and Policy Officer Elaine Tieu give an overview of the economy of health.

INTRODUCTION

Australians have been the beneficiary of free and subsidised universal healthcare from our world-class health professionals and public hospitals for over 30 years. Through Medicare, the Australian Government provides access to a range of medical services. Ours is a unique mix of both public and private healthcare systems but still intrinsically linked to the machinations of both a macro top down view and micro bottom up view economy. Examples have been provided to better explain these factors which influence our healthcare system.

MACROECONOMICS – HOSPITALS

The ASA was represented by the policy team at the 2016 Melbourne Institute Forum on the Macroeconomics of Uncertainty & Volatility. Healthcare presented itself as an interesting case study. Arguments concerning privatisation have presented the proposition that market forces in healthcare are good for patient care. The public's expectation is that doctors act in the best interest of patients but while lying on the operating table patients rarely think about the effect that market forces have when shaping "the performance of their medical team."[1] Esteemed economist and keynote lecturer at the forum, Professor Nicholas Bloom, has argued that in a remote area with only one hospital nearby "you should be worried. Without competition, what's keeping it on its toes?"

In a metropolitan area Professor Bloom would argue that with half-dozen hospitals nearby, doctors are competing for patients hence quality care is positively influenced by the free market. Hospitals in the United Kingdom, where the National Health Service (NHS) regulates prices and provides care for all, removing costs as a source of competition has been affected by the GFC and the national budget. Does this create a negative impact and burden on doctors and hospitals? Should Australia move away from the public system? The private sector has been carrying some of the weight but how effectively?

This increase in concentration of the hospital market is of concern in the USA where suggestions have been made that independent providers have been absorbed and overshadowed by powerful regional monopolies. Hospital administrators argue that mergers provide improved "efficiency, access to care, and quality of care, and may lower costs because in theory, the more care a hospital provides, the more efficient and less expensive it should become."[2] Smaller hospitals can then gain better access to larger hospital facilities and technology. Health economists grow 'weary' in that when "individual hospitals merge into larger systems, they gain a larger share of the consumer health market" resulting in a rise in cost for consumers who then request, via their private health insurers, to pay for more medical care and procedures.

Jon Leibowitz, the former chairman of the US Federal Trade Commission, argued that "If you want to do something about controlling costs in healthcare, you have to challenge anticompetitive hospital mergers."[3] Studies show markets which possess a hospital monopoly are exposed to "significant price increases" and variants as well as large dispersions overall in relation to inpatient hospital prices and in prices for "seven relatively homogenous procedures".[4] It also shows that a disparity of hospital prices within "regions is the primary driver of variation in healthcare spending for the privately insured."[5]

This raises some interesting questions as it relates to Australia. How will similar forms of privatisations work here? Will it have a positive or negative impact? Recently five regional NSW public hospitals inclusive of Bowral, Maitland, Wyong, Goulburn and Shellharbour were planned by the state government to be privately constructed and effectively operated on behalf of the government. According to NSW Health Minister Jillian Skinner, these hospitals will continue to treat public patients. The government aims to spend $1 billion to upgrade these hospitals.[6]

MICROECONOMICS – MEDICAL SERVICES ADVISORY COMMITTEE

In an alternative micro view of the economy, the government is also responsible for the efficient allocation of its limited resources for the delivery of health services and medical interventions which provide best quality of care for all Australians. These decisions are based off advice from the Medical Services Advisory Committee (MSAC) whose role is to conduct careful appraisals of the costs of the intervention and the additional health outcome benefits gained from it. MSAC assesses the clinical- and cost-effectiveness of new health services on the fundamentals of microeconomics, whereby these analyses can inform budget-efficient decisions, and resource allocation decisions within the healthcare system.

There are a number of economic evaluation methods that can be utilised, which include the following:

- Cost-effectiveness analysis
- Costing study
- Cost-minimisation study
- Cost-benefit analysis

- Cost-utility analysis
- Cost-consequence analysis

COST-EFFECTIVENESS ANALYSIS

The most commonly used economic evaluation tool is the cost-effectiveness analysis. It shows the relationship between the costs and health benefits of treatments and medical interventions which have a common health outcome result. These outcomes are reported as unambiguous clinical indicators such as cases detected, deaths prevented, life years gained. Figure 1 compares the costs (in dollars) and outcomes (in life years gained). From this graph, it can be difficult to ascertain which treatment is cost-effective.

The differences in cost and outcomes for each medical intervention are more clearly illustrated when presented as a cost-effectiveness plane (Figure 2), and is used to evaluate the relative efficiency of the different medical interventions and help in making more informed decisions.

For medical interventions that are more expensive and less effective, these are depicted in the NW quadrant, Figure 2. As such there is little justification for funding, and thus are rejected. Often existing treatments fall within this quadrant. Medical interventions that lie in the SW quadrant, Figure 2, are cheaper but are also not as effective as its comparator intervention. Often the poorer countries will consider these interventions due to their budget constraints. However in reality, these interventions are uncommon. The SE quadrant depicts new medical interventions that have positive clinical outcomes at a lower cost. These treatments would be readily accepted. However, medical interventions that fall within this quadrant tends to be the exception rather than the rule. Most commonly, new medical interventions lie in the NE quadrant, whereby any gain in clinical health outcome is accompanied with an increase in cost. Following on from the example in Figure 1, according to the

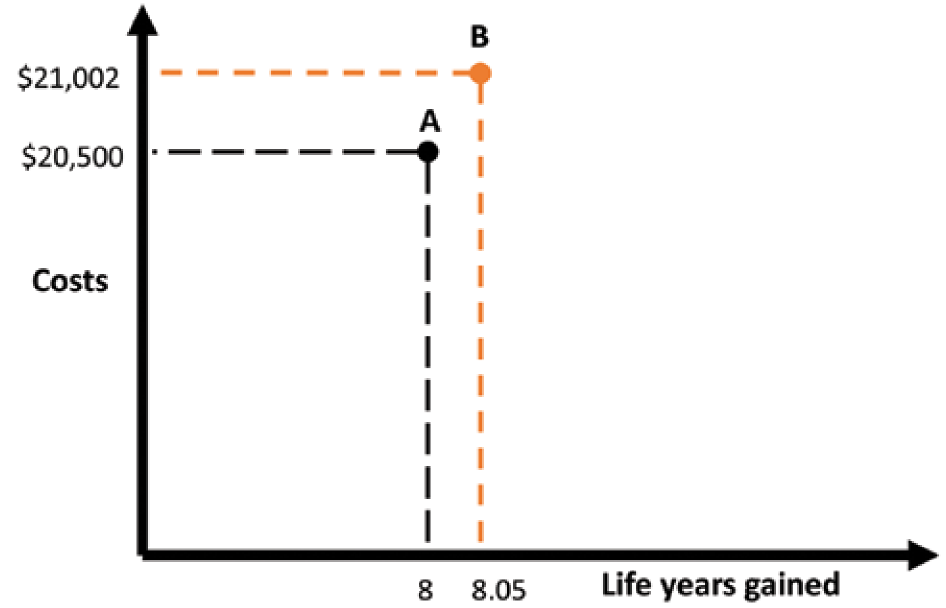

Figure 1: Hypothetical treatments A and B have outcomes expressed in life years gained at costs expressed in dollars.

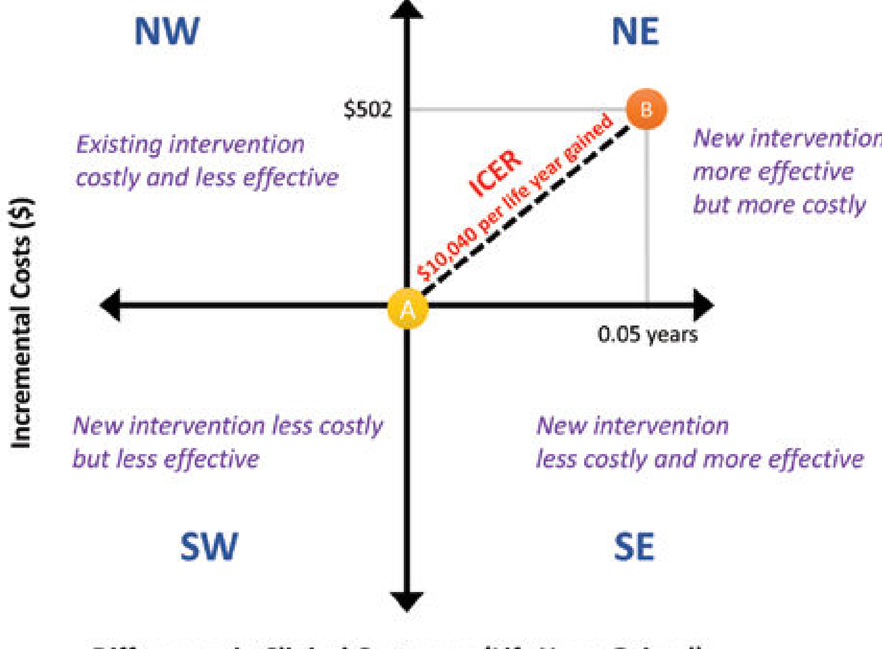

Figure 2: The cost-effectiveness plane, showing the characteristics typical of medical interventions that fall within each quadrant. The slope between treatments A and B is the incremental cost-effectiveness ratio (ICER), which is important for determining thresholds of spending.

cost-effectiveness plane (Figure 2) the new medical intervention (B) is more effective than intervention A, as it results in an extra life year gained at a cost of $10,040. This value is called the incremental cost-effectiveness ratio and is defined by the difference in cost between two possible interventions, divided by the difference in their health outcome. It is important in determining the acceptable threshold a decision maker is willing to pay for any given intervention.

IMPLICATIONS FOR ASA APPLICATIONS TO MSAC

These basic microeconomic principles outline the underlying principles by which MSAC justifies its funding decisions. This is pertinent to ASA's applications for obtaining MBS funding for Ultrasound in Anaesthetic Practice (1183) and Local Anaesthetic Nerve Block (1308). MSAC's decision to decline funding to the Ultrasound application highlights the differences in opinion between the clinical health practitioner and the fiscal health economics experts. Despite strong evidence that ultrasound is the 'best practice' benefited from reduced complexity, MSAC disapproved the application citing that it presented uncertain cost-effectiveness. MSAC argued that the additional costs of Ultrasound could not be captured in the economic model and that it potentially could lead to additional costs to the MBS. It emphasises that efficiency in health is perceived in different ways, such that MSAC views efficiency in technical terms which addresses the issue of using minimal resource inputs for maximum possible gains in health outcome. This, at times, is in opposition to the allocative efficiency which focusses on achieving the best utilisation of healthcare interventions to maximise the health of society.

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CONTACT US

If you have any questions about the ASA Policy Team or any of the work they and their committees do, please do not hesitate to get in touch.

Email: policy@asa.org.au

Phone: 1800 806 654.

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- Access to the Practice Managers section of the website.

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PRACTICE MANAGERS' MEETING

This year's Practice Manager's Conference was held on 21 October at the Stamford Plaza in Melbourne. The event was well attended with nearly 50 Practice Managers from across the country. The day was divided between lectures with opportunities for question and answers and a closed session in the afternoon where attendees asked questions and talked freely.

Economic Advisory Committee (EAC) Chair Mark Sinclair provided an informative talk covering updates to the MBS Review, MSAC, ACCC, private health insurance and the continual need for maintaining good informed financial consent practices amongst our members. As well as answering specific questions to item number queries, Dr Sinclair also provided a broader view regarding the difficulties associated with uniform lack of indexation amongst the health insurers and Medicare alike.

Other representatives included Policy Manager Chesney O'Donnell who gave an overview of the role of the policy team and highlighting ASA policy team achievements from this year including eight submissions to government as well as ministerial visits with the Minister for Health and the Assistant Minister to Rural Health. The Department of Human Services provided some additional insights into how item numbers are accessed and their complications. TressCox tackled 'hot topics in practice management' including managing employees, performance management, bullying and privacy issues. The collection and disclosure of information and complaints about breaches of privacy in relation to the Privacy Act (Cth) garnered much interest. Discussion was had regarding how complaints are made to the Office of the Australian Information Commissioner and the need for practices to have easy to read policies which cover Australian Privacy Principles Guidelines.

MediTrust examined how processes and workloads can be better managed with improved technological methods and the grouping of health fund calls. Time can be saved by keeping debtors down by setting expectations in advance with IFC consent in writing (SMS, email, online consent). Mark Sinclair delivered a presentation on behalf of Black Collection Services on time-saving tips and the management of debtors. Timelines were given as a measure of fairness and transparency for all involved when attempting to close outstanding invoices.

Presentations from the meeting can be viewed in the member's section of the ASA website under the Education and Events tab.

The ASA would like to thank all the Practice Managers who attended for their open and honest feedback to one another. As always days like this could not be achieved without the valuable support of our sponsors Medical Business Systems, Avant and MediTrust.

The time and location for next year's PMC have yet to be announced.

Policy Manager Chesney O'Donnell, TressCox Lawyers Beth Alston and Lachlan Rees and EAC Chair Dr Mark Sinclair

Peter Granger of MediTrust assisting Dr Mark Sinclair to draw the winner of the 'door' prize

Dr Mark Sinclair, Practice Managers Ms Cheryl Wood (Associated Anaesthetists Group Ltd) and Ms Lexie Harris (Wesley Anaesthesia and Pain Management)

INSIDE YOUR SOCIETY

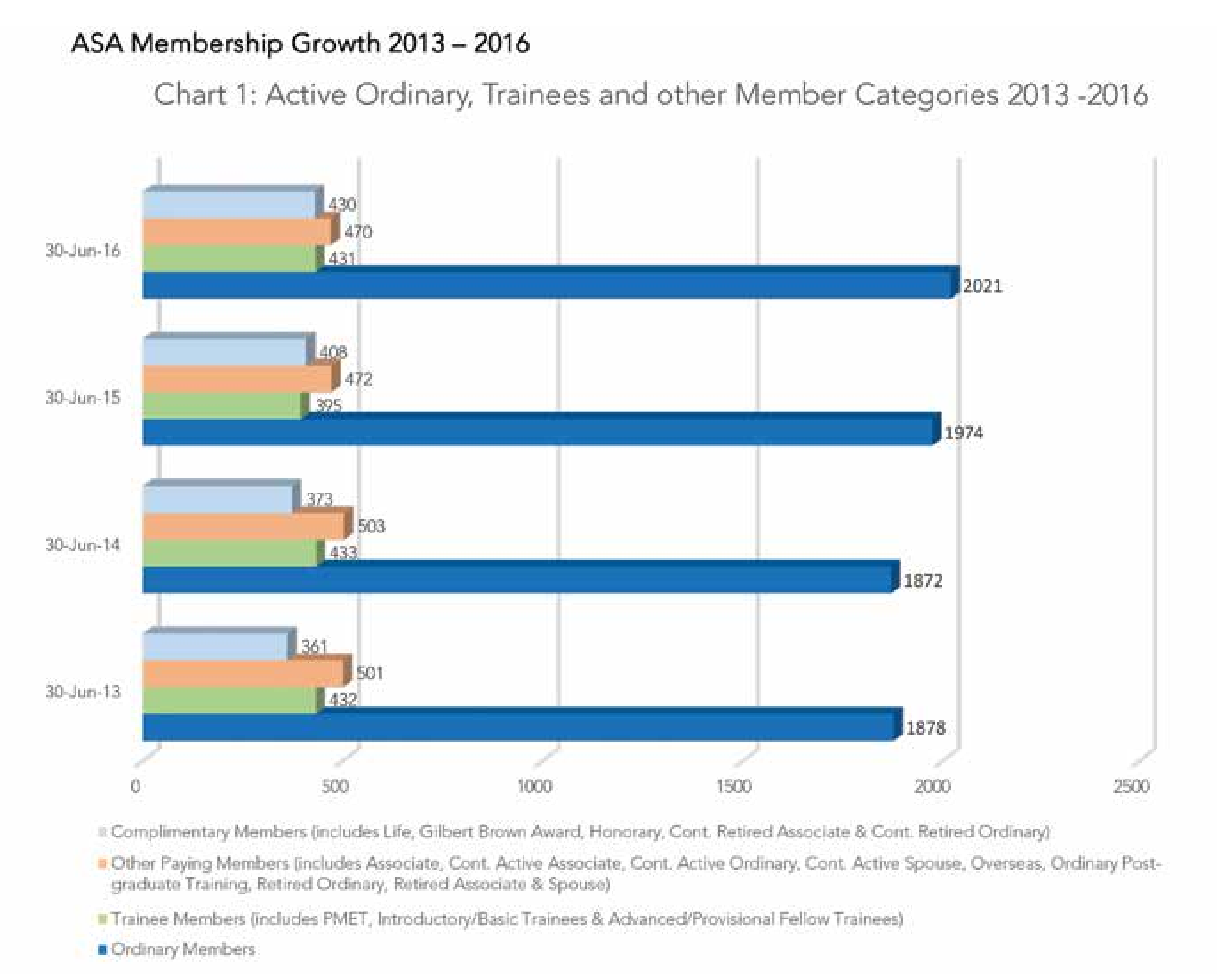
MEMBERSHIP UPDATE

As a professional organisation, the Society continues to 'support, represent and educate' our members to provide the safest anaesthesia across the country. Membership Services Manager, Charles Baker reflects on another productive and busy 2016.

As we approach the end of 2016 another positive milestone has been hit – in that we will end the year with more than 3,300 members which is our highest ever. We have accomplished this not only through our work at head office but also you as our members talking to your non-member colleagues about the ASA.

As with all membership organisations we need to ensure we are meeting the needs our members – we are achieving this in areas such as:

- Representing our members and the needs of the specialty to a variety of bodies including:
  - Department of Health and Ageing regarding funding for non-cardiac ultrasound;
  - Medicare regarding the billing of public patients and auditing activities;
  - Australian Healthcare regarding out of pocket expenses;
  - 15 submissions to senate enquiries.
- Representing members at 19 ministerial meetings, forums and hearings.
- Successful National Scientific Congress meeting in Melbourne; and
- Allocating over $150,000 towards awards, grants and overseas development.



KEY ACHIEVEMENTS IN 2016

Membership growth

During the 2015-16 financial year there has been an increase of 113 Ordinary and 165 trainee members. We have seen a loss of 35 Ordinary and 123 trainee members due to suspension, unfinancial, registration, deceased and other category movements – this loss in trainee members is a key focus for us in 2017.

Chart 1: represents the membership growth for our active trainees, Ordinary and other membership (this includes complimentary and other paying members). This overview highlights our memberships growth over the last three financial years.

We have also implemented a number of new events this year included:

- Trainee Bootcamp to assist in preparing for exams convened by Dr Vida Viliunas in the ACT ;
- State networking and membership events across all states; and
- A World Anaesthesia day workshop.

The Harry Daly Museum and Richard Bailey Library continue to grow – acquiring donations made by our members. The latest feature in our museum was the installation of a curare blowpipe (see June 2016 issue of Australian Anaesthetist for further information). We thank our members for your generosity with your donations to our historical collection.

We were very pleased with the responses we received back from our inaugural member services survey. The results from this survey assist us in developing new and improved services. This year we also introduced the unique URL and one click function to enable you to easily log in to the member's section of the website and pay your membership fees.

PLANS FOR 2017

Next year will continue to be another busy and productive year for the ASA as we focus on new areas of development for our members including:

- Segmented email updates for different sectors within our membership.
- An increase in public practice content through the newly reinstated Public Practice Advisory Committee.
- Better social media engagement.
- Building stronger relationship with governments and industry bodies.
- A review of the ASA Advantage Program offerings.
- Development of additional resources for Practice Managers.
- New events.
- Investigation into new technologies to improve our service delivery.

As we end 2016 successfully, we look forward to your ongoing involvement and loyalty for 2017. On behalf of the ASA I thank you for your continued support.

2017 MEMBERSHIP RENEWALS

We kindly ask members to pay your 2017 membership fees on or before the 28th February 2017.

Please contact the Membership Services Team for further assistance via email: membership@asa.org.au

Over the phone: 1800 806 654

Or by post: PO Box 6278, North Sydney NSW 2059

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

PIAC Chair, Dr Antonio Grossi, provides an update on various issues.

TRANSFORMATIONAL HEALTH

Healthcare is undergoing a profound and rapid transformation[1]. Recently released reports such as 'Targeting zero'[2], reflect a growing focus on outcomes based medicine, and achieving high quality and safety care equally across private and public sectors. Traditional cottage industries will need to modernise and reform to meet these community expectations in a cost effective fashion.

FINANCIAL PRESSURE

Australia's 2015 intergenerational report[3] shows that projected healthcare spending will be unsustainable by 2030. Most of this is due to non-demographic factors such as increased utilisation of healthcare services by people with growing expectations. There needs to be a link between expectations of service and willingness to pay through taxation or collective insurance[5]. Given the lack of funds available to reallocate to health and the electoral unpopularity of raising taxes, healthcare reform is essential to avoid rationing of healthcare services[5].

THE MBS REVIEW

On this background the MBS review into anaesthesia has commenced. Not surprisingly, items that generate large expense for the government have been targeted. These include the preoperative assessment, anaesthesia for cataract surgery, endoscopy, therapeutic and diagnostic items such as arterial line insertion, monitoring, respiratory blood gas analysis, and modifiers such as age. PIAC has been advocating the strong evidence base for the existence of these items. For example there have been multiple coroner's reports6 and professional morbidity and mortality reviews, stressing the importance of the preoperative assessment in maintaining patient safety. Conversely, the integrity of the publically funded MBS is threatened, by rogue practitioners who game the system, by claiming for numbers inappropriately.

TASK SUBSTITUTION

Another way the government may seek to save money is to encourage task substitution[7]. Recently PIAC assisted a member make a submission to their local hospital quality committee that was considering allowing non-medical healthcare workers administer propofol for sedation. Maintenance of professional standards reflected through ANZCA professional documents such as PS09 and ASA position statements such as PS13 is essential to maintaining patient safety.

AUTHENTIC HEALTHCARE TRANSFORMATION REQUIRES HARD WORK

Bohmer[8] explains that effective operational change requires more than government's positive and negative financial incentives and regulatory constraints. It requires local teams taking initiative and responsibility in a sustained fashion over a period of time to redesign work systems to be safer, more efficient and better. To achieve this anaesthetists need the support of management, hospital boards, professional colleges, regulatory bodies and government. Organisations that provide support through routinised process for change, financial support, data collection and interpretation and are mutually committed to their doctors are more likely to succeed.

"Major change emerges from aggregation of marginal change."[8]

ACCREDITATION & NATURAL JUSTICE

PIAC made a submission to the senate committee into bullying and harassment and the medical complaints process. The ASA's own workforce survey shows that around 20% of anaesthetist experience bullying during training or their professional lives and this could increase a further 25% depending on how bullying and harassment is defined. Currently there is little uniformity across the healthcare sector about how medical complaints are managed at a local level. Individual healthcare providers set their own by-laws and facility rules as part of their own hospital governance in relation to investigations of complaints against health practitioners. There is no guarantee of independence, lack of conflicts of interest and procedural fairness. Inability to make adequate representations to these committees prior to a decision regarding suspension of accreditation threatens the presumption of innocence, denies natural justice and due process. The ASA has concerns about the time it takes to investigate and process complaints about unprofessional conduct.

REVALIDATION

The public has a right to expect that their medical practitioners are 'up to date' and 'fit to practice'. PIAC has continued the dialogue with the MBA to determine what a contextually relevant and sensitive revalidation model for Australia may look like.

TRANSITION FROM ACUTE CARE TO INTEGRATED CARE

Governments, healthcare providers and health insurers are exploring a shift from treatment-based care to models that keep people healthy at home. This involves addressing the determinants of disease, practicing preventive medicine, promoting population health and bridging the gap between hospital and community based care. Anaesthetists may be part of this strategic process by value adding to the service they provide, researching ways to address individual patient needs and contribute to avoiding unnecessary hospital admissions.

CONNECTED HEALTH

Fragmentation of healthcare is no longer affordable. Duplication of investigation, services and treatments is expensive, wasteful and generates unnecessary morbidity. Anaesthetists have traditionally been rapid adaptors to new technologies. Exploiting electronic management of healthcare data, including outcomes data, electronic records and medical management systems is a logical way to move forward in this area. Smart hospitals of the future may be hospitals without walls where much of the preliminary work is done virtually and remotely.

MAL-DISTRIBUTION

The ASA continues to work closely with senior government ministers and other stakeholders to develop local solutions to the provision of sustainable regional and rural anaesthesia services.

THINKING LATERALLY AND INNOVATIVELY

The fiscal pressures confronting healthcare and anaesthesia are not new. The rapidly evolving healthcare landscape requires anaesthetist to work smarter, more collaboratively and cooperatively. Intelligent team based solutions may provide the solution to these challenges.

PIAC remains immersed in considering and responding to these matters.

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GET IN TOUCH

If you'd like to contact the Professional Issues Advisory Committee, contact the ASA Policy Team at policy@asa.org.au and your query will be addressed.

All matters are de-identified before being addressed. It is usually possible to provide a written reponse. However, please note that some matters do not lend themselves to one single approach. On these occasions, the outcome is usually a phone call from a member of the committee, accompanied by an email discussion.

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

Dr Mark Sinclair, Chair of the Economics Advisory Committee provides an update on the Medicare Benefits Schedule (MBS) Review and private health insurance.

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

In September, discussion papers from several more of the individual review committees, each addressing the existing MBS items for individual specialties, were released for public consultation. These included gastroenterology, diagnostic imaging (specifically for back pain and bone densitometry), thoracic medicine, and obstetrics. The individual committees are all listed on the MBS Review website at

http://www.health.gov.au/internet/main/publishing.nsf/content/MBSR-committees

Information such as the names of review committee members, or their reports (where completed) can be found by clicking on the relevant link on this page.

At the time of writing, a committee to review the anaesthesia items has been formed. Former ASA President, Life Member, and current ASA Specialty Adviser Dr. Jim Bradley has a seat on the committee, and of course he intends to regularly engage with the EAC. This is perfectly acceptable to the Review Taskforce, which in fact encourages all of its committee members to seek input from their specialist Societies and Colleges.

The only recent discussion paper to be of significance to anaesthesia is that of the MBS Principles and Rules Committee (PRC). This committee has made a number of recommendations, to be put to the Minister for Health once stakeholder input has been considered.

One interesting recommendation is that medical practitioners should undergo compulsory education on MBS rules and regulations, before being allocated a Medicare provider number, and that this should be part of their Colleges' compulsory continuing professional development (CPD) programmes. The ASA has no issue with providers receiving such education. However, the ASA, as the creator of the Relative Value Guide (RVG), and the primary body involved in discussions with the Departments of Health and Human Services (DoH, DHS) on Medicare issues, must be at the forefront of such educational programmes.

The PRC has also expressed concern over the issue of multiple Medicare items applying to the one service. This relates to surgical and procedural claims, and anaesthesia is not specifically mentioned. However, it is essential that the PRC is aware that the claiming of multiple items is entirely appropriate in the RVG for Anaesthesia. In fact, it is this that gives the RVG its strength. Each claim will involve items for the initiation of anaesthesia, anaesthesia time, and in certain cases, patient modifier items, and items for diagnostic and therapeutic procedures. The resulting MBS rebate for each individual patient is therefore calculated on exactly what the anaesthesia service involves, rather than an estimated across-the-board average.

The PRC also supports restrictions on the co-claiming of attendance and procedural items for the same episode of care. Its recommendation is that "when the attendance is necessary for and intrinsic to a procedure, the attendance cannot be co-claimed as a separate service". Again, the ASA will make it clear to the PRC that such a blanket rule cannot be applied to the practice of anaesthesia. A well performed pre-anaesthesia assessment is essential to patient outcomes. It is not merely an 'intrinsic' part of the actual provision of anaesthesia, but an entirely separate and very necessary service.

These and other issues raised by the PRC report have been addressed in an EAC submission to the Taskforce. The submission, and the PRC paper, are available on the ASA website asa.org.au, by following the links News/ASA Submissions.

At the time of writing, we have only limited information as to what direction the anaesthesia MBS review committee will take. However, it is clear that a 'bundling' agenda is prominent. It has been suggested that the pre-anaesthesia consultation could be 'bundled' into the base anaesthesia item (presumably with a lower total rebate). Pre-anaesthesia assessment has been proven to be essential to patient outcomes. Given the MBS review is supposedly aimed at modernisation of the schedule and incentivising best practices, rather than simply cutting costs, any move to cut funding for pre-anaesthesia assessment will be strongly opposed by the ASA.

The diagnostic and therapeutic item section (subgroup 19 of the MBS RVG) will

also be reviewed, either by attempting to 'bundle' such items into the base anaesthesia item, or making restrictive changes to descriptors, or even removing items altogether. A number of items in this subgroup have been subject to an ongoing significant rise in expenditure each year (for example, items for arterial line insertion, invasive pressure monitoring, and advanced respiratory monitoring), and this has attracted attention. The review committee has also noted the obvious 'item drift' evident in claims for anaesthesia time items – that is, the very large number of claims for 16-20 minutes of anaesthesia time, and 31-35 minutes, 46-50 minutes and so on. Clearly it is difficult to defend against the accusation that some anaesthetists are 'gaming' the system. Of course, the vast majority of anaesthesia claims are appropriate. However, the trends apparent in some of the claims data do no favours to anaesthetists who are doing the right thing by the Medicare system, and some anaesthetists' billing practices may place the entire RVG system in jeopardy.

The review committee has also suggested that the basic structure of the RVG, which of course involves several MBS items applying to the same anaesthesia service, could be changed. This would be an entirely negative outcome. The fact that the RVG involves the use of multiple items is actually its greatest strength. It results in each individual patient's rebate being precisely matched to the nature of the service. Any attempt to 'bundle' base, time and other items will result in a return to the days when anaesthesia rebates were based on an estimated 'average' nature of the service, with many inaccuracies and inconsistencies. Any such move will be strongly resisted.

PRIVATE HEALTH INSURANCE

Members will recall that Medibank Private (MBP) has released a number of co-branded reports with the Royal Australasian College of Surgeons (RACS), detailing various statistics related to surgical patient outcomes, and the fees charged by surgeons. Following the May meeting between MBP, ASA and ANZCA, reported on in the previous edition of Australian Anaesthetist, MBP offered to enter in to a memorandum of understanding (MoU) with our two bodies. This involved the sharing of statistical and financial information, and communication with 'outliers' for both clinical and financial statistics, in order to bring outliers closer to the mean.

Both the ASA and ANZCA have no interest in such a MoU.

However, both bodies are quite prepared to have an ongoing dialogue with MBP. Dr. Andrew Mulcahy (ASA Past President and Life Member, AMA Federal Craft Group Representative for anaesthesia, and Immediate Past Chair of EAC) and I attended another meeting with MBP, to discuss some of MBP's concerns about anaesthetists' billing patterns. In some cases, their concern was reasonable. One such case was described in the last edition of this publication – an anaesthetist whose claims for anaesthesia time items were all 23021, 23031, 23041 etc, for all patients across all surgical specialties. Anaesthetists must remain aware that each and every Medicare and private insurance claim is recorded, and data for individual practitioners are easily obtainable by those with an interest in billing compliance. Audits of billing practices are always a possibility. The importance of accurate billing practices cannot be over-emphasised.

However, in most cases the issue of an anaesthetist being an 'outlier' was explainable, for example by having a special interest in an anaesthesia subspecialty such as cardiothoracic anaesthesia, or trauma/emergency work. Likewise, where MBP looked at claims which are rare or unusual, a genuine explanation could usually be given.

Also, because of the fact that MBP statisticians and executives are, as a general rule, unfamiliar with the workings of the RVG, some of their methods of assessing 'outliers' for claims did not yield useful data. This was accepted by MBP, and other more relevant methods of data collection were discussed.

There will of course be further dialogue with MBP, and members should watch for their email inboxes for the ASA President's e-News releases, as well as regularly visiting the ASA website, for further updates.

A meeting was held with representatives of the insurer NIB in August. Various issues were discussed, including the fact that NIB is now the only insurer not offering a 'known gap' product. Therefore, if the NIB rebate (which is one of the lowest available) is not accepted as the full fee, the patient receives only the MBS Fee as the rebate, significantly increasing the 'gap' payable. NIB stated that they are not entirely unopposed to a 'known gap' product. The EAC will follow this up.

The 'Whitecoat' website was also discussed. This website involves a joint effort by NIB, Bupa and HCF. It allows patients to provide feedback on their experiences with their healthcare practitioners. Until now, it has only involved allied health practitioners, not doctors. However, it is now to include the medical profession as well. The intention is not only to rate patient satisfaction with their care, but also to include fee information.

Similar online feedback websites are already in existence. They raise a number of concerns, including the fact that doctors may be tempted to 'cherry pick' their patients, avoiding more difficult or complex cases in order to minimise the chance of negative feedback. Also, it is possible that patients who are disgruntled despite best possible care may bias the feedback. The inclusion of feedback on fees has also has created the concern that this is another attempt to coerce doctors into accepting 'no gap' schemes.

NIB hastened to point out that only patients who have received a service funded by NIB will be eligible to participate, and that all comments will be assessed prior to posting, with inappropriate comments being barred. Also, doctors will be given the chance to read any comments before they are

posted, and doctors will also be able to 'opt out' of taking part in Whitecoat. The terms and conditions pertaining to the NIB 'Medigap' no-gap product have been updated as a result of the changes to Whitecoat, and also allow NIB to publish information about doctors' fee charging patterns. The terms and conditions do however state "You will have the opportunity to opt-out of having your ratings, customer reviews and Medigap participation data published". Members are also reminded that they can avoid being constrained by such terms and conditions, by billing patients privately.

As members are aware, the last indexation of MBS Fees occurred in November 2012, and at this stage the freeze is intended to continue until 2020. Many health insurers have followed suit. At the time of writing, the only insurers to have indexed their anaesthesia rebates for this financial year are St Lukes (0.3%) and NIB (0.5%). The AHSA group of insurers has delayed indexation until January 2017. The AMA fee schedule will be indexed in November, as usual. As always, the ASA encourages anaesthetists to take factors such as the ever-increasing costs of medical practice into account, along with the ongoing failure of rebate indexation, when setting fees for their services.

The freeze appears to have resulted in a decrease in the level of 'no gap' billing by anaesthetists, with Australian Prudential Regulation Authority (APRA) data indicating that its incidence decreased from approximately 86% for the December 2015 quarter, to 76% in the March and June 2016 quarters. At the time of writing, the data for the September 2016 quarter has not been released. This data is publicly available at:

http://www.apra.gov.au/PHI/Publications/Pages/Industry-Statistics.aspx

OTHER MATTERS

The EAC is pleased to note the re-forming of the Public Practice Advisory Committee (PPAC), and we congratulate A/Prof. Alicia Dennis on her appointment as PPAC Chair. As with the Professional Issues Advisory Committee, there will be cross-representation between EAC and PPAC. Economic issues affecting members who practise in the public sector are usually very different in nature to issues in the private sector. The expertise of PPAC will no doubt be of much assistance to our public sector members, in this regard.

Members are also reminded that the EAC is always ready to act on queries related to financial matters in both the private and public sectors, and should feel free to contact the Society at any time, on 1800 806 654, or via the email address policy@asa.org.au.

Are you receiving all the latest information from the ASA?

Make sure you are receiving all the latest information on government and Medicare updates, upcoming meetings and events and news from the Society in the monthly President's email newsletter.

Logon to the members section at www.asa.org.au to check and confirm all your contact details.

Please ensure web@asa.org.au is listed as a safe sender in your email filter.

INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

SOUTH AUSTRALIA

Dr John Crowhurst

The SA group with 80 members, meets for lunch on the second Monday of every odd month at the Kensington Hotel. Several times a year we have a guest speaker and other guests when appropriate.

Our September meeting was held at the Kensington Hotel but attended by only 8 members, as many were away.

A week after our July meeting, 24 of us were taken on a tour of the, almost completed, Adelaide University's Medical Sciences Building which, from 2017, will house schools of medicine, nursing and related departments. As well as viewing the radically different infrastructure and teaching precincts, the Dean of the Medical School, Prof. Ian Symonds and colleagues reminded us of how medical undergraduate teaching has changed since our days. This complemented his presentation on Contemporary Trends in Medical Education, which he delivered to us last May. Most of us agreed that we are more than pleased to have had the teaching and more personal involvement with our teachers and mentors, rather than the intensive interaction with modern IT and 'screens' so prevalent today. However, it was interesting to learn that the use of textbooks seems to be making a comeback with today's undergraduates.

Site visit

Attendees at the RAG luncheon at the NSC

Since our last meeting, two colleagues have died; Dr Lachlan Dickson on 1 August, and Prof. Garry Phillips on 25 July. Garry, originally from Victoria and trained in NSW and London, was a pioneering developer of Intensive Care and Emergency Medicine in Australia and a past President of ANZCA. Both are sadly missed.

Drs Marg Wiese, Scott Germann and I attended the RAG lunch at the NSC in Melbourne in September.

On 6th October several of us attended the launch of the second book: 'Blood Sweat and Fears', a co-author of which is Dr Tony Swain. Dr Brendan Nelson AO, FRACP launched the book and gave a detailed and laudable account of those SA doctors and nurses who had served in the military World War 2; Korea; Malaya and Vietnam (1945 through 1975). They included three anaesthetists: Drs Tony Swain, Dick Willis and the late Herbert Stark. Copies of the book have been donated to the ASA and ANZCA libraries. It may be purchased from www.yourbooksonline.com.au.

GET IN TOUCH

If you would like to be put in contact with a RAG committee in your State, please visit www.asa.org.au.

Or you can call the ASA offices on: 800 806 654.

INSIDE YOUR SOCIETY

ASA TRAINEE MEMBERS UPDATE

Scott Popham, Chair, reflects on the NSC 2016 and the ASA membership survey.

The nomenclature for the ASA Trainee Members (previously known as GASACT members) has undergone a change in the past year focusing on brand recognition.

In early 2017, we see an overall transition of the GASACT Committee to a name that best reflects our Trainee members, this will promote consistency throughout our branding and avoid confusion. The term GASACT will no longer be used in an official capacity (except to acknowledge the inception of the group when it was first formed in September 2000 by the Board).

I would like to encourage all trainees in anaesthesia, intensive care or pain management registered with ANZCA as a registrar, to become a Trainee member of the ASA. This is complimentary in the first two years of training (Basic Training) with paid membership starting from Advanced Training as you progress. For further information or to join, please visit www.asa.org.au/ or feel free to contact the Membership Services Team on membership@asa.org.au.

MELBOURNE NSC

Feedback I have received from trainees who attended the NSC was very positive; both in terms of content of sessions and the social functions. I myself attended various sessions including refreshers, finding the pulmonary hypertension session particularly useful and the analgesia for abdominal surgery very comprehensive. It was also great to listen to international speakers such as Prof. Stanton Newman and Dr Olle Ljungqvist speaking on contemporary topics such as postoperative cognitive dysfunction and ERAS (respectively). Certain sessions also marked the transition of office bearers within the ASA (e.g. the Geoffrey Kaye Oration) – very useful to attend, among other reasons, to keep track of who is who in the ASA.

The trainee specific stream on Sunday was exceptionally well put together, with trainees given the opportunity to meet and have lunch with figureheads within the ASA and ANZCA, as well as several keynote speakers in an informal setting which worked very well. The post-lunch sessions were high yield and focused mainly on exam related topics.

The NSC (as with any anaesthesia themed meeting) is such a useful networking opportunity. As the late Prof. Tess Crammond said during the Queensland ANZCA Scientific Meeting a couple of years ago, you always learn something useful, or make valuable new acquaintances. She was an advocate for attending as many such meetings as possible, and I know her sentiments have certainly rung true for me and are solid benefits of being an active Society member.

I was pleased that Dr Ravi Pullela, trainee member from the Canadian Anaesthesia Society who attended the Congress was made to feel very welcome during his time in Melbourne and learned a lot about the similarities and differences between our countries respective training schemes and anaesthesia provision; his experience mirrors those of ASA Trainee Members who are successful in securing ASA overseas scholarships.

Looking to future meetings, we (your state reps and I) welcome any prospective feedback about what sessions would prove useful to you, to assist with organising relevant events. We are here, after all, to represent and support trainees.

ASA MEMBERSHIP SURVEY

Earlier in the year the head office conducted with their members a Membership Survey. The main purpose of this survey was to engage with members (including trainees) on expectations of the Society membership and assess how well these expectations are being met, as well as providing a strategy for on how improvements could be made in the future.

The main focus areas points of interest from a trainee perspective were as follows:

- **Communication**
  - o Email remains the primary form of preferred and effective communication to members. There is consideration being given to separate email e-news for trainees (this was done for a short time for Queensland trainees whilst I was Queensland Rep and would be useful to expand to all states, on a more regular basis). Trainee engagement with the ASA on social media was higher than with Ordinary Members
- **Publications**
  - o The AAIC Journal remains a popular and well read journal, most members read the hard copy but there is increasing use of the app. At the NSC trainee meeting it was suggested an opt-in option for the hard copy should be considered.

- **Website**
  - o The trainee section of the website has been rearranged by the ASA Head office and is now more user friendly.

PPAC

I am looking forward to participating in the Public Practice Advisory Committee. As Chair, Trainee Member Group, I'm allowed a seat on this Committee and will report back with updates of interest. This committee is undergoing a resurgence in response to recent feedback (including the Member Survey) with terms of reference and meeting dates currently being set.

ASA TRAINEE MEMBERS GROUP – TRAINEE LUNCH & SESSIONS

ASA Trainee Members' lunch, NSC 2016

David M. Scott at ASA Trainee Members' lunch, NSC 2016

Stanton Newman at the ASA Trainee Members' session, NSC 2016

Guy Christie-Taylor addressing the trainees

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

AUSTRALIAN CAPITAL TERRITORY

Dr Mark Skacel, Chair

Local anaesthetist Ross Peake organised a very successful and well attended Regional Pain workshop in Thredbo in early July. I must thank him and all the instructors on the course for volunteering their time and expertise. Personally I enjoyed the workshop thoroughly and learnt a lot from all of my instructors. Ross must have pleased the Snow Gods, as Thredbo provided a great cover of snow for the week. If Ross organises the same workshop in 2017 then I can highly recommend it, especially if you like skiing.

The ACT 'Art of Anaesthesia' meeting was held on the weekend of 15 and 16th October 2016 at the John Curtin School of Medical Research, Australian National University. I must thank Drs McInerney and Palnitkar for co-convening the meeting and producing a great scientific lecture program on the Saturday and educational workshops on the Sunday.

I understand that three of the ACT anaesthesia registrars have been asked to attend for Part 2 oral examinations and from all local ASA members we wish them luck. I must acknowledge the time and effort many of the local consultants have put into preparing the local candidates for exams, but especially Drs Marshall and Viliunas.

The Thomas Lo ASA Registrars Scientific Presentation Awards evening was held in early November with a social function afterwards. This awards evening is named after Thomas Lo, a greatly valued member of the local ASA who gave so much to anaesthesia in the ACT over the recent past. Great to see so many local members support this evening event. Dr Jennifer Hartley from GASACT coordinated the night.

Of interest to all anaesthetists in the ACT is the proposal by Calvary John James Private Hospital to open a private emergency department. It will be interesting to hear how they intend to fund on call services for this new department and which specialist groups will be asked to contribute to this venture.

ACT Health has commissioned yet another external report costing $700,000, into public hospital efficiency. I suppose this is to be expected in an ACT election year.

As the festive season will shortly be upon us, I take this opportunity to wish all local ASA members and their families a Happy Christmas and New Year.

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Josh Hayes, Chair

It's always distressing when you realise another year is almost over. On the up side it means that end of year events makes catching up with colleagues and friends that much easier!

The recent combined ANZCA/ASA Annual Dinner meeting was a well-received event. Delegates heard Professor Stanton Newman talk on 'Assessing cognitive change following surgery and anaesthesia' which provided food for thought and discussion. Many thanks to the organising Committee and sponsors.

The SA Part 3 course occurred on the 26th of November, with thanks going to our GASACT representatives Dr Diakomichalis and Dr Chooi for their hard work. It proved an interesting day of tips and insights for transitioning from Registrar to Consultant and ended with a chance to socialise and pick people's brains in a slightly less formal setting. And all in time to catch the last session of the Australia-South Africa test!

Socialising was again on the agenda on November 4 with an evening to welcome new Ordinary Members as well as celebrate Trainee members nearing Fellowship. This function was well received and a fun reminder that the Christmas party season was about to start.

Best wishes for Christmas and the New Year!

TASMANIAN COMMITTEE

Dr Michael Challis, Chair

Events

The format of our 2017 ASM 'Anaesthesia – the Next Frontier' has changed, and the meeting will now be in mid-March to avoid clashing with the ASURA meeting. Professor Steven Shafer (editor-in-chief of Anesthesia & Analgesia) is our keynote speaker, and invited Australian speakers are Professor Guy Ludbrook and Professor Francis Bowling. We are limiting lectures to Saturday and Sunday mornings, with an

increased number of workshops to take place on Saturday afternoon. This means delegates will not have to miss lectures to attend workshops. Of course, some may wish to use the afternoon to see some of the many exciting things Hobart has to offer, given that this time of year usually provides the best weather in Hobart.

Our winter CME meeting – 'An Anaesthetic Mélange' – at Cradle Mountain in August was very well attended. It was another opportunity to gain CPD points in a pristine part of Tasmania, and we are certain that the destination was worth the effort of getting there. I would like to thank Drs Peter Wright and Daniel Aras for organising the meeting, and Drs Malcolm Anderson and Sandy Zalstein for providing another opportunity for attendees to satisfy 'Emergency Response' CPD requirements by running an ALS refresher.

Industrial Issues

Outsourcing of 'public' operating lists to private hospitals continues in various forms. However, a recent lowlight saw public patients being sent interstate to have elective surgery in private Victorian hospitals. Issues included cost-effectiveness (compared to providing the service locally), responsibility for post-op complications, poor clinical hand-over of information (both ways), and also why scarce health dollars were being sent out of the state. Of particular concern is the fact that there are under-employed anaesthetists who would be willing to provide anaesthesia for these public patients in private hospitals, but it seems anaesthesia provision is an after-thought – it is all about the surgeons. AMA Tasmania is aware of these issues, but the practice has stopped. It remains to be seen if the government repeat this undesirable practice.

Unsatisfactory employment conditions, low morale, concerns about anaesthetist welfare and training, and many other issues have been bubbling away in some parts of the state for some time. Our combined regional ASA/ANZCA committees and the AMA are trying to support our colleagues as best we can, but potential industrial action is on the horizon.

There are significant and serious concerns regarding the state of public health management within Tasmania currently. A letter from the chair of the Royal Hobart Hospital Medical Staff Association to the minister was recently leaked to the media. The letter referred to a loss of confidence in the government's ability to manage the public health system appropriately, poor clinical governance, and disappointment in the lack of clinical engagement, or the active disengagement manifested in some poor decisions made unilaterally by the health department. Hopefully some common-sense decisions are made that are beneficial to the health system as a whole, and satisfy all stakeholders.

Private Health

The pattern of private health funds making changes without involving or informing providers has spread to our Tasmanian fund – St Lukes. Recently it was brought to our attention that they had introduced a new fee schedule that had significant implications for IFC – in essence they had introduced a 'no-gap' only scheme for some providers. After several enquiries, including from Dr Andrew Mulcahy and myself, they decided to reverse their decision and shelve the changes that were apparently introduced one month prior. The unilateral changing of conditions is disappointing (although not unprecedented with other funds), but especially given that St Lukes have traditionally been one of the better funds to deal with. Hopefully there will be some engagement and communication before any future changes are introduced.

Training

A Part 3 Course is planned for mid-January.

WESTERN AUSTRALIA

Dr David Borshoff, Chair

The State AMA has successfully negotiated Public Hospital Doctor contracts for the next three years. Both parties quietly claiming success in achieving the outcome they wanted.

Perth's Childrens Hospital will now be opening in stages after some setbacks with asbestos in the roofing and lead in the water supply, both problems having now been resolved.

The third (for 2016) combined ASA and SJGHC Morbidity and Mortality meeting was held early October. A large turnout enjoyed some interesting discussions on the effective use of the heathcare dollar and anaesthetic decision making in patients with significant comorbidities.

The Part 3 course for advanced anaesthetic trainees was held on November 13. The well attended course helps registrars make the transition to consultant, had once again a group of highly motivated speakers to share their experience.

The regional country conference was held at The Pullman Resort in Bunker Bay on October 22nd and 23rd, convened by Dr Merlin Nicholas from Joondalup Health Campus – the theme 'Ask the Experts'.

Next year, the country conference will be held in Broome, in the north of Western Australia. It will be a chance to get some warm weather during the Australian winter so make plans now, as there has been considerable interest already and numbers will be limited.

Finally, the anaesthetic community was stunned and saddened at the sudden, unexpected death of a highly respected and very talented colleague, Dr Alistair ('Al boy') Davies. The extraordinary number of friends and colleagues who attended both his memorial at the Fiona Stanley Hospital and his funeral in Fremantle, reflected how loved and admired he was in the WA community.

INSIDE YOUR SOCIETY

WORLD ANAESTHESIA DAY – SEMINAR

Photo: Peter Stanbury

On Sunday, 16 October, the Harry Daly Museum and Richard Bailey Library welcomed anaesthetists from around Australia for World Anaesthesia Day. Celebrated annually, this day marks the first administration of anaesthesia with ether by William T. G. Morton in 1846. In the 170 years since this significant event, the practice of anaesthesia has been considerably transformed and developed.

World Anaesthesia Day allows for reflection on the long history of the profession. This year, the Australian Society of Anaesthetists held a World Anaesthesia Day Seminar. Over the course of the day, two presentation sessions were held showcasing a range of special interest areas. The sessions were chaired by Dr Reg Cammack and Dr Rajesh Haridas respectively. The presentation topics shed new light on some fascinating topics and generated much discussion.

Those in attendance were also able to walk through the Richard Bailey Library and Harry Daly Museum. For many, this was their first look at the museum and library since the move from Edgecliff to North Sydney. The attendees provided wonderful feedback and enjoyed viewing the history on display within the exhibition space.

Opening the seminar was a talk by Dr Michael Cooper on the history of hypoxia and aviation. After discussing the history of hypoxia and altitude, Cooper focused on the development and use of the Boothby-Lovelace-Bulbulian or BLB mask in aviation. As part of the talk, a short biography on the manufacturers of the mask was included alongside images of their original designs.

The next presentation, by Dr Rajesh Haridas, focussed on the etymology of the term anaesthesia. Woven into a broader discussion on the history of the term's use, was the letter by Oliver Wendell to W.T.G. Holmes, generally acknowledged to be the first time the term anaesthesia was coined. The presentation further covered other notable individuals who contributed to the widespread adoption of the term including James 'Young' Simpson.

Dr John Paull similarly revolved his presentation around a central personality in the history of the profession. Paull's talk on Dr William Russ Pugh, traced his personal quest to locate a journal Pugh kept on his voyage to Australia. Following leads, Paull was able to locate the journal and have its contents transcribed. Paull's presentation covered some of the main findings from the journal including the health care work undertaken by Pugh on the voyage. A book on the findings is currently underway.

The last session of the day continued to cover a diverse range of topics. Dr Rod Westhorpe's talk on the evolution of anaesthesia in China chronologically followed significant developments beginning from the New Stone Age, circa 10,000 BCE, to today. Traditional Chinese

practices for alleviating pain and the introduction of Western medical practices were comprehensively outlined.

Our second last speaker for the day, Emeritus Professor Laurie Mather, reflected on the first use of ether in 1846 and subsequent clinical and laboratory research that emerged. Through a variety of newspaper articles and medical journals from the time, Mather pieced together a chain of events occurring in the United States and in the United Kingdom post-October 16.

The final presenter was Dr Tamara Eichel on the topic of the Iron Lung and Polio in Zurich during 1951. Before delving too far into the presentation, Eichel discussed her family connection to the topic. Her grandfather, Nandor Eichel, published a paper on the workings of the Iron Lung in 1951. The presentation continued to outline different types of Iron Lung machines before concentrating on improvements made to fatality rates through the introduction of a tracheostomy to treatment.

Each presentation contributed to a broad understanding of the history of anaesthesia and how it can encompass a variety of different perspectives. The Australian Society of Anaesthetists would like to thank the speakers and participants for joining us in what was a wonderful day, celebrating the profession and its history.

Rebecca Lush
Curator, Harry Daly Museum

CONTACT US

Contact us to arrange a visit for curiosity or to conduct your own research. We are open by appointment Monday to Friday, 9am to 5pm. Please phone ASA on 02 8556 9700.

Dr Rajesh Haridas focussed on the etymology of 'anaesthesia'

Dr Rod Westhorpe spoke about the evolution of anaesthesia in China

Dr Tamara Eichel presented a paper on the iron lung and polio in Zurich. Photos: Rebecca Lush

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NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from September to November 2016.

TRAINEE MEMBERS

Dr David Barlow
Dr Sarah Jayne Brew
Dr Suze Dominique Bruins
Dr Leandro Sotto Maior Cardoso
Dr Alison Clark
Dr Jessica Davies
Dr Rachel Lisa Dawson
Dr John Michael Denton
Dr Jack Dixon
Dr Andrew Downey
Dr Laurie Dwyer
Dr Andrew Robin Growse
Dr Michael Iskander
Dr Alison Jarman
Dr Louisa Lowes
Dr Andrew Marks
Dr Matthew Matto
Dr Benjamin James McDonald
Dr Elizabeth Joanne McLellan
Dr Tony James Miller-Grennan
Mr James Richard Murtagh
Dr Francoise Naeyaert
Dr Verity Nicholson
Dr Matthew John Overton
Dr James Padley
Dr Joel Parrey
Dr Richard Seglenieks
Dr Doris Wai See Tang
Dr Peter Francis Webb

ASSOCIATE MEMBER

Dr Philip Johnson

ORDINARY MEMBERS

Dr James Peter Cooper
Dr Philip John Craft
Dr David Dao
Dr Paul Murray Fien
Dr Stefanie Gubbay
Dr Reena Hacking
Dr Michelle Harris
Dr Ji Young Heo
Dr Dennis Ling-Hsiang Huang
Dr Gavin Jones
Dr Iain Cameron Macleod
Dr Jade Radnor
Dr Kieran Paul Somerville
Dr Predrag Stanojlovic
Dr Gavin Teague
Dr Kris Usher
Dr Paloma Gioia Van Zyl
Dr Lee Zimmer

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Gavin Robinson (VIC), Dr Jerome Coombs (NSW), Dr Henri Lorang (NSW).

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

UPCOMING EVENTS

FEBRUARY 2017

Final Exam Preparation Boot Camp

Date: 4 & 5 February 2017

Venue: John James Theaterette, John James Medical Centre

Contact: Vida Viliunas

vidav@goape.com.au

ACE Regional SIG meeting 'ASURA'

Date: 23-26 February 2017

Venue: Peppers Noosa Resort & Villas, Noosa Heads

Contact: events@asa.org.au

OCTOBER 2017

ASA NSC 2017

Date: 7-10 October 2017

Venue: Perth Convention and Exhibition Centre

Contact: events@asa.org.au

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