AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • JUNE 2016

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Speaker Abstracts

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PROFESSOR OLLE LJUNGQVIST

Professor Olle Ljungqvist received his medical degree and obtained his PhD on glucose metabolism in hemorrhage at the Karolinska Institutet in Sweden. He completed his residency and held several clinical positions in gastrointestinal surgery at the Karolinska Hospital and was appointed Professor of Surgery, Nutrition and Metabolism in 2005 at the Karolinska Insitutet.

A/PROFESSOR DAVID CANTY

Dr David Canty is an anaesthetist and Director of Simulation and Senior Lecturer for the Ultrasound Education Group, Department of Surgery, University of Melbourne, where he researches and teaches a wide range of ultrasound techniques, with a particular interest in echocardiography.

PROFESSOR STANTON NEWMAN

Professor Stanton Newman is Professor of Health Psychology and Dean of the School of Health Sciences at City University London. He has published over 350 research papers and chapters as well as 18 books. One of his areas of specialisation is the impact of surgery and anaesthesia on the brain.

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WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The September issue features of *Australian Anaesthetist* will focus on World Anaesthesia Day and the development of anaesethesia and practices over the years. If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 18 July 2016.
- Final article is due no later than 27 July 2016.

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

REGULAR

ASA EDITORIAL FROM THE PRESIDENT

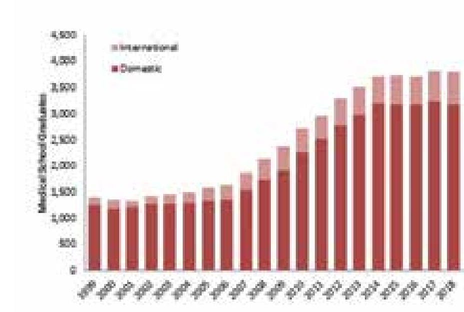
DR GUY CHRISTIE-TAYLOR
ASA PRESIDENT

In 2003[1] the Australian Medical Workforce Advisory Committee (AMWAC) in its guide to the planning process for specialist medical workforce planning in Australia articulated the following guiding principles:

- The Australian community should have available an adequate number of trained specialists, appropriately distributed to provide the services it requires.
- The community is best served when specialists have high standards of qualification and work with a high level of ongoing experience.
- Standards of practice will be highest if specialists perform a reasonable volume of work.
- The best assurance of standards is a high quality requirement for entry to practice and a high quality requirement for continuing practice; and
- All Australian citizens should have access to a good standard of specialist care irrespective of geography and economic status. In achieving this, convenience to the patient should be balanced against the quality of services that can be distributed to meet that convenience.

I believe that the above principles remain a very sound guide to assist workforce planning and remain completely relevant today.

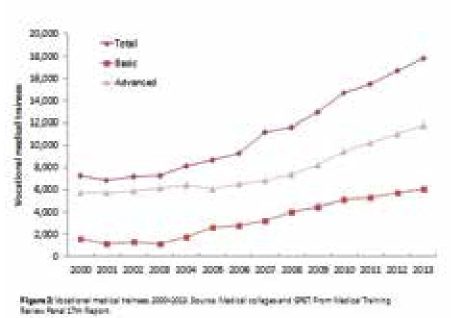
Based on our current understanding, can

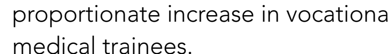


we draw any reasonable (incontrovertible?) conclusions about the current workforce situation?

Well I think we can reasonably conclude that we are producing a sufficient number of medical students (See Figure 1) to achieve the stated aim of self-sufficiency as articulated in HWA 2025[2].

As seen in Figure 2 these medical students are translating into a

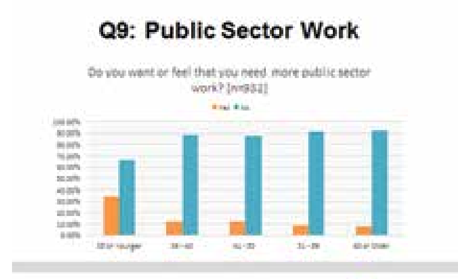




proportionate increase in vocational medical trainees.

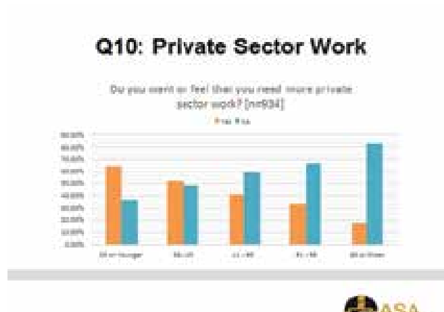
As stated in the paper[2], generally AMWAC would consider 20% of the workforce working over 80 hours per week as a potential indicator of a workforce shortage.

Examination of the data below from the ASA's workforce survey would indicate that there is considerable spare capacity for additional work and there is no indication of 20% of our workforce working 80 hours per week.



We can reasonably conclude that there is not a workforce shortage in anaesthesia and based on the numbers of medical students and vocational medical trainees this is unlikely to change in the near future.

The recent willingness of governmental agencies to even contemplate removing anaesthesia from the Skilled Occupation List is a strong indication of the



recognition that, at the very least, there is not a workforce shortage.

The great challenge in the short-term is to provide workable and practical solutions to getting the workforce to where clinical need and work opportunities are! We need to address the so-called 'maldistribution'.

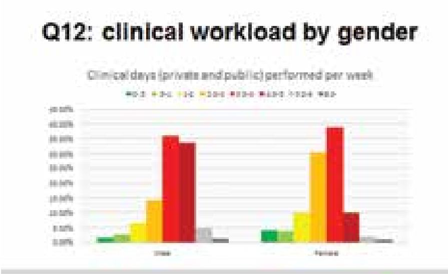
This edition of the Australian Anaesthetist attempts to provide insights into this very difficult issue and to offer some approaches and solutions.

In particular I would draw your attention to the article by our Vice President, Assoc. Professor David M Scott. David is based in Lismore and has a particular passion for rural and regional issues and practice. He challenges us to shift our thinking from merely pointing out the problem to one of recognising it in all its complexity and finding and offering solutions. From our recent meeting with the Prime Minister's Senior Adviser (Social Policy) and the Minister for Rural Health's Senior Adviser it is clear that the issue of rural and regional health provision is a crucial one and that Government is constantly and urgently seeking solutions to these issues.

We as a speciality must do all we can to tackle this issue. It is in our patient's best interests to have access to highly trained specialists and it is right and appropriate that those specialists are locally trained.

Any reference to a potential oversupply or underemployment of anaesthetists, whilst situations of failed supply and persistent shortage remain, will not be countenanced by government or employing authorities. It is very difficult to prosecute an oversupply argument whilst there remain area of need appointments that are unfilled and sites that simply cannot attract a local FANZCA. Why such situations persist and what the drivers are, need to be addressed. Continuing to generate a larger and larger workforce, who remain persistently unwilling or unable to go to these sites is counterproductive and wasteful. Addressing why and what the specific issues are that continue to drive this situation is crucial to achieving the general principle that all Australian citizens should have access to a good standard of specialist care irrespective of geography and economic status.

It is tempting to argue that the circumstances in rural and regional Australia that prevent specialists going to them are beyond our bailiwick as a speciality or Society as they relate to such diverse issues as geographical isolation, infrastructure, schooling and education, work opportunities, lifestyle opportunities and so on. The challenge for us is to seek innovative solutions that mitigate those issues as far as possible, allowing us to provide a high quality service where it is needed most. It might well be that sharing the burden more evenly is part of the solution and that part of our broader social responsibility is to provide services to those areas from the resources available within our metropolitan boundaries. Perhaps we need a shared-work model or a 'twinning' of metropolitan hospitals or large private practices with their regional or rural counterparts? The Society might need to become more actively involved in the coordination and planning of locum services.



This is without doubt a long-standing and very challenging problem. What has changed is that we now have an expanding, locally trained workforce with the manpower to begin to address these issues. We need to find answers-it's as simple as that.

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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

REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

At its meeting in March, the ASA Board decided to develop amendments to the Constitution with a view to presenting them to members for consideration at the Annual General Meeting, which is being held as part of the NSC in Melbourne later this year. These amendments will implement a more contemporary and best practice governance structure that will ultimately enhance the effectiveness of the Society in representing members and serving their needs.

Under the existing Constitution, the Board (often referred to as Council) has 13 members. It is currently the governing Board and its members are Directors, with the full legal obligations and responsibilities of Directors of the company. The amendments to the Constitution will implement governance reforms that are based on a dual system of governance. Under this structure, Members will elect their State Chairs and Office Bearers, who along with the Chairs of the major Committees eg. the Professional Issues Advisory Committee and the Economics Advisory Committee and others will form the Council. This Council will then appoint a smaller Board of Directors. This model has been successfully implemented in Australia in a range of membership associations and not-for-profit organisations, including the AMA Federal and NSW Branch.

Under this model the members of the smaller Board will have the legal responsibility of Directors and will be responsible for "running the business of the Society". The larger Council will be responsible for policy matters relating to the profession and the role of Councillor will not have the legal status of a Director. The dual structure enables delineation of duties between the two bodies – Council and Board, allowing each to be more productive and effective. Also, some members may wish to contribute without being subject to the legal obligations of a Director and this new structure will provide an opportunity to do so as a member of Council.

The new Board will have up to nine members and the Council will have up to 18 members. The option for Council to appoint an 'external Director' to the Board which has always been available, remains if that was considered beneficial to the Society in the future. It is well documented in governance literature and various good governance guidelines that there is a widespread and ongoing trend towards smaller boards; and that through enhanced communication, higher levels of engagement and greater flexibility, smaller boards are more effective at decision-making.

The Australian Institute of Company Directors describes a large board in the not-for-profit sector as one with ten or twelve directors. Australian Institute of Company Directors states that:

> Those new to directorship may think that a large board offers the opportunity to add a wider array of skills and experience. However, there comes a point where the size of a board becomes unwieldy, difficult to control, and diminishes the board's deliberation and decision-making effectiveness (eg. speed of decision-making, ability to reach a consensus).

Research has also shown a direct correlation between board size and organisational performance – the smaller the board, the better the organisation performs as a whole.

The Council will be elected by members, using the same election process currently in place. Council will be responsible for matters relating to the profession and health policy. Council will review and consider policies, recommendations and reports of its committees, and will act as a forum to identify, discuss and debate emerging issues of relevance to members, and the speciality. This will be the forum where particular state issues can be progressed, by State Chairs who will be members of Council.

Another key role of the Council will be to elect the President and Vice President, and to appoint the other Board Directors. Council will appoint the Board and also review its performance. In appointing Board Directors, Council will give consideration to the strategic needs and priorities of the ASA at that time and in the immediate future.

The Board will manage and direct the business of the Society. It will develop

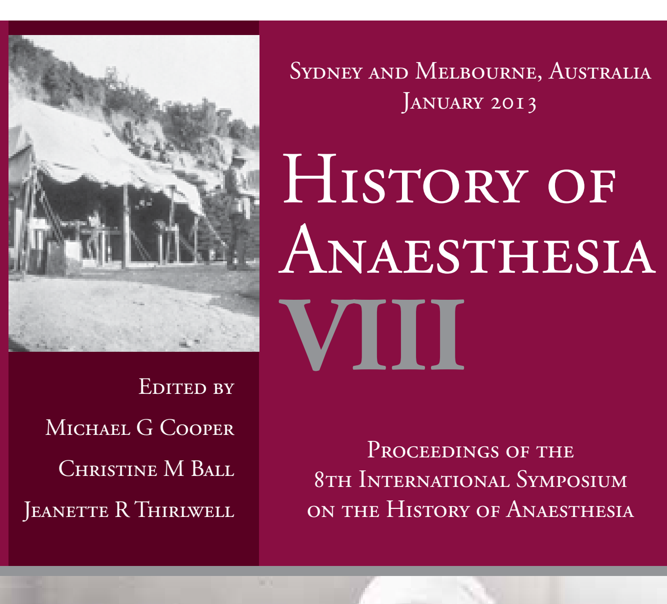
strategy in conjunction with the Council and it will have responsibility for the implementation of that strategy. The Board is responsible for the performance of the organisation and has the usual governance responsibilities, including risk management and compliance.

The necessary amendments to the Constitution to implement these governance reforms are being developed for presentation to members at this year's annual general meeting. Further details will be provided to Members over the next few months. This is an exciting development for the Society. Should you have any questions please feel free to contact me.

Finally, I'd like to thank those members that completed our recent member survey. With 20% of members completing at least some of the survey we have a good representative sample. Congratulations to the winners of the complimentary NSC registration – Stephanie Phillips, Anthony Michael and Kim Rees. The survey results are currently being collated and analysed and the outcomes and recommendations will be presented to members later in the year in Australian Anaesthetist.

CONTACT

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



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REGULAR

LETTERS TO AUSTRALIAN ANAESTHETIST

PROFESSOR TERESA CRAMOND—OBITUARY

Thank you for an excellent Obituary of the late Tess Cramond. I would like to point out that Tess was a second part examiner, and together with Doug Joseph, were my examiners when I sat my second part exam in 1967. As I walked into the room there was another person present who was obviously an observer. Tess told me not to worry as he was just 'the doorman'. We had a discussion on the Shires theory about hydration during surgery. She corrected my ideas as she had worked with Shires in Dallas. I obviously amused her and Doug by pointing out that I warmed blood in a ten litre bucket. Some weeks later Doug stated to me that they thought I had trained in country hospitals as I was still warming blood this way. Nevertheless I did actually pass that exam.

Dr Ian Rechtman
Melbourne, VIC

Dear Sir,

As evidence continues to mount for the adverse effects associated with the transfusion of blood and blood products,[1-5] it also continues to mount for the benefits of point of care (POC) coagulation monitoring in the management of haemorrhage.[6-7] We quote the conclusion of Theusinger OM, Stein P and Levy JH in a recent review:[8] "The use of POC devices with evidence-based algorithms seems mandatory in the bleeding patient independent of bleeding origin (traumatic vs surgical). The use of factor concentrates, compared to the classical blood products, is cost-saving and beneficial for the patient and also in agreement with the WHO-requested standard of care. The uncontrolled use of blood products such as FFP, RBCs and platelets without POC control seems to be inadequate with regard to the actual evidence in literature. Furthermore, the use of factor concentrates seems to be in favor for better outcome and cost saving".

POC testing is currently completely unfunded by Medicare or private health funds. However an obvious source of funding for this already exists. That is item No is 22002: "A transfusion of blood or bone marrow already collected, when performed in association with the administration of anaesthesia." We have never understood why the act of hanging a bag of blood, a very simple task, was rewarded with the same number of units as performing a much more demanding task such as an awake fibreoptic intubation. Not only is this against the spirit of the RVG, i.e. rewarding anaesthetists for using their clinical skills in their management of the patient, but as the adverse effects of blood transfusion are becoming more widely appreciated it may actually give the anaesthetist an incentive to do something which may be detrimental to their patient's welfare. While we are not suggesting that anaesthetists would ever knowingly transfuse a patient that they did not consider in need of blood, nevertheless a financial inducement for giving blood may lower the threshold at which they do so.

When the RVG was introduced it was done on the basis that implementing it would remain cost-neutral to Medicare. With Medicare currently reviewing the merits of item numbers in the Medicare Benefits Schedule, and in the spirit of cost neutrality, the opportunity exists to do the right thing at no extra cost by using the 2202 item number to fund POC coagulation testing during major bleeding. This would bring funding into alignment with both WHO and National Blood Authority Guidelines.

If such a change was introduced, we believe that Medicare has the potential to save considerable money with improved patient outcomes and less use of allogenic blood product.

Yours sincerely,

Dr Matthew Duncan FANZCA
& Dr Sue Clarke FANZCA
Wesley Anaesthesia & Pain Management
Brisbane, QLD

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ADVERTORIAL

MULTIMODAL MANAGEMENT OF ACUTE PAIN: DOES THE CURRENT APPROACH TO PERI-OPERATIVE ANALGESIA NEED TO CHANGE?

A presentation by Dr. David Gronow & Dr. Daniel Sajewski:

International experts at the ASA Congress in Darwin (September 2015) on the current approach to peri-operative pain management and the use of Caldolor® for analgesia and management of inflammation. The full video presentation can be accessed at www.caldolor.com.au

DR. DAVID GRONOW

DR. DANIEL SAJEWSKI

Multimodal Analgesia

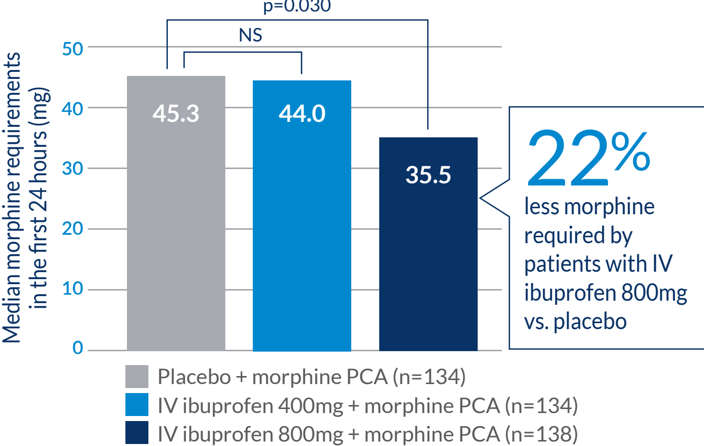
The primary objectives of post-operative pain management are to provide analgesia, facilitate return of function, reduce the incidence of chronic pain, reduce the risk of opioid dependency, minimise side effects, and provide patient satisfaction.[1-4] The sooner pain relief is provided the better the overall outcome, and this applies to both major and minor surgical procedures.[3,4] Evidence is accumulating that optimal pain relief requires an ongoing multimodal approach, using a combination of analgesics that block pain perception at different sites in the peripheral and central nervous system.[1,4]

A multimodal analgesic approach may offer the best opportunity to improve patient response.[4]

Dose Ranging Study

The dose ranging study by Southworth *et al.* identified IV ibuprofen 800mg as the optimal dose to reduce post-operative pain in a multi-centre, randomised, double-blind, placebo-controlled trial of 406 patients undergoing elective orthopaedic and abdominal surgeries. Ibuprofen 800mg demonstrated a significant reduction in morphine usage compared to the 400mg dose and placebo.[5]

REDUCTION IN MORPHINE USAGE WITH IV IBUPROFEN IN THE ITT POPULATION[5]



Adapted from Southworth *et al.* 2009[5]

ITT population: All patients who received at least a partial dose of IV ibuprofen or placebo. IV ibuprofen was administered every 6 hours. NS = not significant. PCA = patient controlled analgesia.

Adverse events and abnormalities in laboratory measurements, including bleeding, renal effects, and serious adverse events, were not significantly different between IV ibuprofen 400mg, 800mg and placebo groups (p value not reported) and this finding is replicated in other pain studies.[5,6]

Orthopaedic Pain Study

The orthopaedic pain study was a multi-centre, randomised, double-blind trial of 185 adult patients undergoing major orthopaedic procedures.[7] The aim was to determine whether pre- and post-operative administration of IV ibuprofen could significantly decrease pain (assessed with movement and at rest) and morphine use when compared with placebo.[7] Patients who received IV ibuprofen used less morphine, woke up in less pain, and remained in less pain throughout the post-operative period.[7]

PATIENTS ADMINISTERED IV IBUPROFEN 800MG AT INDUCTION OF ANAESTHESIA EXPERIENCED:[7]*

32%	26%	31%
less post-operative pain at rest†	less post-operative pain with movement†	less mean rescue morphine use†

*IV ibuprofen 800mg was administered pre-surgery and every 6 hours over 24 hours, plus morphine PCA (vs. placebo plus morphine PCA). †6-28 hours after first dose of ibuprofen or placebo, all p<0.001 vs. placebo.

This treatment effect was observed during a post-operative time interval when pain intensity and opioid requirements are generally highest.[4]

Administering a higher dose of IV ibuprofen (800mg) initially can reduce both post-operative pain and morphine requirements.[5,7] Consider IV ibuprofen (Caldolor®) as part of multimodal analgesia during surgery, with the flexibility to continue post-operatively on the same molecule in an oral or IV formulation.[6]

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FEATURE

RURAL GP ANAESTHETISTS: A PROMISING FUTURE!

Dr Ewen McPhee President of the Rural Doctors Association of Australia (RDAA) writes about the future of rural GP Anaesthetists.

Along with GP Obstetricians and GP Surgeons, GP Anaesthetists have for decades been the backbone of procedural medical care in rural and remote Australia.

Supported by their specialist colleagues (sometimes locally, but often from distant locations), multiple generations of rural GP proceduralists have helped ensure the continued availability of local frontline emergency and other medical care in rural communities – and, through this, ensured not only the survival of many rural patients but also the survival of many rural hospitals.

Rural procedural medicine has also helped to underpin continued access to general practice services in numerous rural towns. This has perhaps been most evident when procedural services have been discontinued by health administrators in some locations, and local GP proceduralists have found it necessary to relocate elsewhere.

Of course, the communities then don't just lose a procedural doctor, but also a GP!

While many of the current cohort of rural GP proceduralists are nearing retirement age, there is definitely hope on the horizon with some states starting to see the benefit of reinvigorating rural generalist training programs and rural procedural training.

In Queensland, a solid rural generalist training pathway backed up by a competitive remuneration and support package (including guaranteed leave and locum support) has seen this program regularly oversubscribed in terms of applicant numbers. A commitment in Queensland to reinvigorate rural hospital services, including obstetrics, in various parts of the state is also seeing the re-opening of previously closed rural maternity units.

In encouraging more future doctors to take up rural procedural careers, it is critical to provide them with an opportunity to experience the interesting and rewarding nature of rural practice.

Rural procedural practice can provide it all – not only the excitement and technical challenges of emergency care and other procedural work, but also the ability to form long-term professional relationships with your patients, often across a number of generations, through your general practice work.

It really is the best of both worlds – and getting this message out to medical students and junior doctors, and enabling them to sample this for themselves, is critical.

To this end, we welcomed the Federal Government's announcement last December that it will create a new Integrated Rural Training Pipeline which will help retain medical graduates in rural areas

by better coordinating the different stages of training within the regions.

Through this approach, more health practitioners will be able to complete the different stages of their medical training, from student to specialist, in rural areas, and of course, experience the rewarding nature of rural practice at the same time.

There are three components of this new measure:

- Up to 30 new Regional Training Hubs will enable students to continue rural training past university and into postgraduate medical training. The hubs will be located at existing rural training sites.
- A Rural Junior Doctor Training Innovation Fund will be targeted at rural-based interns to enable them to spend some of their training year in rural general practice. We welcome this initiative as acknowledgement of the importance of prevocational exposure to rural general practice – it will provide some alternatives to the Government's former, highly-successful Prevocational General Practice Placements Program (PGPPP) that unfortunately was discontinued.
- A targeted expansion to the Specialist Training Programme, to provide up to 100 new training places in rural areas – 50 in 2017 and another 50 in 2018. This will enable the Specialist Training Programme to provide up to 1,000 ongoing places by 2018. This is another positive step towards securing a numerically adequate and well-supported rural medical workforce, as well as delivering doctors who can help to meet the diverse healthcare needs of rural communities.

RDAA has been calling for these initiatives over many years, and they should assist in delivering more well-trained young doctors into rural practice, including procedural practice.

We now look forward to seeing more detailed information about these measures, particularly in terms of the role of the universities and Rural Clinical Schools and how other stakeholders will be consulted and involved in their implementation, monitoring and evaluation.

But what is also required to complete the picture is a commitment by the Government to provide an improved range of supports for those doctors, both generalist and specialist, who work in rural and remote communities.

For many years, RDAA and the AMA have jointly advocated for a Rural Rescue Package that would encourage and support more GPs, other specialists and registrars to work in rural areas.

The supports and incentives provided to doctors under this Package would take into account the greater isolation involved with rural practice, both for doctors and their families; and the increased costs, context and complexity of rural practice.

The Package would also recognise, through additional incentives, those doctors who bring to their communities essential advanced skills in a range of areas such as obstetrics, surgery, anaesthetics, acute mental health and emergency medicine.

In the lead-up to the federal election, we will be lobbying strongly for the introduction of such a Package, as this would greatly assist in enticing the next generation of doctors, including procedural doctors, into our country communities. The AMA and RDAA Rural Rescue Package, *Building a sustainable future for rural practice*, can be found at www.rdaa.com.au (under Policies).

It is also critical that we ensure rural GP Anaesthetists and other proceduralists are not pressured (either by themselves or health administrators) with an expectation that they can (and should) 'do it all' in terms of treating locally the full range of complex cases they will encounter.

Our potential future rural procedural GPs need to know that they will be working under a model of supported independent clinical practice, with their training and subsequent work as a rural GP proceduralist underpinned by a strong and supportive relationship with specialist colleagues who understand and respect the more isolated settings in which they are working.

They also need to know that they will be supported by the provision of clear boundaries around the extended areas of procedural practice under which they are working. It is critical that rural GP proceduralists feel empowered to call upon specialist support when they need it, as this will help to ensure they retain all-important resilience in the rural setting.

Providing quality and affordable locum relief for rural obstetricians and anaesthetists is also an important part of ensuring resilience in rural practice, and this has been ably provided for many years by the highly-successful Rural Obstetric and Anaesthetic Locum Scheme (ROALS).

ROALS grew from the Specialist Obstetrician Locum Scheme (SOLS), which was devised and developed by RDAA and co-managed with a number of other organisations, including the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and the NSW Rural Doctors Network. ROALS provided subsidised locum relief to many rural obstetricians and anaesthetists over many years, and was funded by the Federal Government.

ROALS has now been amalgamated into a new multi-professional locum program called the Rural Locum Assistance Program (or Rural LAP), funded by the Federal Government and managed by Aspen Medical – see more at www.rurallap.com.au.

It is critical to ensure that affordable locum support continues to be readily available for rural GP and specialist obstetricians and anaesthetists, as the ability (or otherwise) to take leave for rest or upskilling can be a significant 'make or break' factor in whether they remain in rural practice. We are hopeful that Rural LAP will continue the fine record of achievement that ROALS set in this regard.

FEATURE

THE USE OF LOCUM ANAESTHETISTS IN A NSW RURAL ANAESTHETIC DEPARTMENT

Dr Len Bruce Director of Anaesthesia at Wagga Wagga Base Hospital talks about the use of locums at his hospital.

The 2013 ASA Member Survey indicated that only 12% of anaesthetists (perhaps 400) practise in areas with a population of less than 100,000. With a population of around 63,000 Wagga Wagga is one of these areas.

We have the same barriers to recruitment as many rural areas. In our experience we find that uprooting of a young family is one of the most significant barriers. When a family has settled in a metropolitan area for four to five years they find it difficult to leave careers and support structures behind to move to rural areas. Rural medical students and rural vocational trainees are more likely to return; we have two of our own trainees who are currently provisional fellows and who will hopefully stay on as consultants obtaining their fellowship. We have recruited International Medical Graduates (IMGs) in the past, but Wagga Wagga has not been an area of Medical Workforce Shortage since 2011 which makes this a less practical option.

Our theatre and pre-admission clinic sessions have increased from 52 per week in 2011 to 65 per week in 2016. In 2014 a new private day surgery unit with three operating theatres opened, which has placed additional pressure on our limited anaesthetic resources. With ongoing recruitment, our Senior Staff has increased from eight Visiting Medical Officers (VMOs) and one Staff specialist to 14 VMOs and one Staff Specialist in 2016.

Even with increased staffing numbers we find that we have around 20 sessions per week which cannot be covered by resident staff and we are obliged to use locums to ensure that all our commitments are fulfilled.

There have always been concerns about the use of locum staff to fill vacancies. Locum work has potential inherent risks for the clinician and the health care organisation. The doctor is presented with an unfamiliar environment which can be very challenging in the perioperative setting where team work is essential. The risks relating to continuity of care is less of a problem in anaesthesia and emergency medicine. The issues with an unfamiliar workplace can be overcome with appropriate orientation, but getting to know your nursing and medical colleagues is a longer process. Rural areas can have fewer resources and less access to specialist back-up which can be challenging for junior specialists. One of the great benefits of working in rural areas is the hospitality of the staff and this does help our locum doctors to fit in very quickly. Using a pool of regular locums could however negate most of these potential risks. The risks for the organisation are the same for any new employee in regards to their skills and ability to adapt to a new work environment.

One of the main issues with a locum staffing model is cost. Headlines such as this one from the Sydney Morning Herald of March 27, 2011 sums up many people's sentiment: "Hospitals pay $6000 for Kiwi weekend warriors". There is very little incentive for doctors to relocate to the country if they can earn more as a locum. We have therefore reduced our locum rates by 20% since 2011. Assuming a 10 hour workday which would be normal in our theatres, a locum anaesthetist working at our hospital would earn 5-10% less than a junior VMO or a year 1 staff specialist. The health organisation does however have additional costs which include agency fees of between 10 and 20% as well as travel and accommodation costs. Some of these costs are offset by private patient billings by the health service, but locums are still a more expensive option.

It would then seem as if there is little benefit in utilising locums due to cost and risk for all parties involved. This has however not been our experience which we believe is largely attributable to our philosophy to recruit only high quality clinicians who can function in a clinically challenging environment. We do not employ locum staff that would not be considered suitable for a permanent position.

We use only locum agencies which are on the NSW Health Register of Medical Locum Agencies. We do occasionally use non-agency locums which in most cases are previous trainees from our department. The documentation requirements are very strict and we have very high expectations from locum agencies that we deal with in this regard. We have found over time that the majority of our locums are being supplied by one of the large agencies. This has allowed us to build up a solid professional relationship which allows us to manage any potential issues at an executive level. The Locum Agency is very aware of our needs and requirements and it does allow them to match us with applicants suited to our organisation.

It is important to highlight the fact that the recruitment process for locums is the same as for permanent staff at our hospital, with the exception that a formal interview is not held and the appointment is not discussed at the Medical and Dental Appointment Advisory Committee. It ensures that the candidate's skill set is appropriate for our needs and we have had to decline experienced applicants who did not have recent obstetric or paediatric experience. Locum contracts are only valid for three months and therefore all locum appointments are reviewed every three months.

We also reduce the risks for the clinician, by avoiding them starting on weekends. They are orientated to the theatre complex by one of the senior staff members and the clinical nurse unit manager of the operating theatres. They are normally allocated low risk theatre lists until they find their feet. They are also allocated a trainee as appropriate. Senior support is always available in the form of the duty consultant and in the case of paediatrics, one of our specialist paediatric anaesthetists. Over weekends there are two consultants and two trainees on site between 08:00 and 17:00.

As mentioned earlier we aim to use a pool of regular locums who provide cover on a rotational basis. We prefer blocks of at least five to seven days to allow the anaesthetists to familiarise themselves with our service. Our current pool of locum anaesthetists includes provisional fellows, newly qualified specialists who are establishing themselves in metropolitan areas and senior consultants who are scaling down. We encourage our locums to participate in all our departmental activities, including morbidity and mortality meetings, academic meetings and registrar teaching. We have been very fortunate to have highly qualified locums with specialised skills including Pain Fellowships, Paediatric Transplant Fellowships, TOE- certification etc. It is very useful for us to have access to such expertise in a rural centre and our locum colleagues are normally more than happy to share their expertise with us. The use of locum consultants also allows us to maintain contact, albeit on an informal basis with metropolitan centres. Our locums enjoy the variety and challenging nature of our work and especially the newly qualified consultants enjoy the increased responsibility in a supportive environment.

The use of locums has been a valuable recruitment strategy for us, because all six

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permanent appointments since 2011 have been anaesthetists who have have worked for us as locums in the past. I believe that the concept of 'try before you buy' is extremely valuable for the anaesthetist and the organisation.

Locums provide a flexible option to manage our workforce. It allows staff to take leave as required which is an essential component of a sustainable workforce. It allows us to increase capacity at short notice which was the case when we were required to conduct waitlist initiative lists in the past.

While sufficient resident specialist staff is the ideal situation and most definitely the aim of every health service, the use of locums will form part of many rural medical staffing models for the foreseeable future. There are appropriate indications for the use of locum anaesthetists, as well as risks and benefits. The responsibility of any health service is to minimise the risks and maximise the benefits to our patients, staff and the organisation. The solution is simple: appropriate candidate selection, orientation and support.

A locum appointment in a rural area will then be a rewarding and not just lucrative experience for the anaesthetist. Most of all it gives our rural patients access to the same high standard of specialist healthcare as their counterparts in metropolitan areas which is undoubtedly the aim of any health service.

The ASA welcomes your feedback and comments on the use of locums especially in regional and rural areas of Australia. Please send these to editor@asa.org.au.

Promoting the mental health of doctors

Poor mental health among doctors has far-reaching effects. As well as the personal impact for the individual and those close to them, colleagues, peers and patients can also be affected.

Doctors experience a range of risk factors for anxiety and depression including heavy workloads, long working hours, shift work, work-effort imbalance, bullying and harassment in the workplace, abuse/mistreatment from patients and home-work stress.

Findings from the National Mental Health Survey of Doctors and Medical Students in 2013 suggests that 3.4 per cent of doctors are currently experiencing very high psychological distress compared to the wider community figure of 2.6 per cent, and one in ten doctors had suicidal thoughts in the past year.

To address these issues, *beyondblue*, in collaboration with the Mentally Healthy Workplace Alliance, has developed Heads Up. Heads Up is a resource that offers practical tools and advice, including information tailored to the medical profession, designed to assist hospitals and health services create mentally healthier workplaces.

To find out more about creating a mentally healthy service or how to look after your own mental health in the workplace, visit **headsup.org.au/doctors**

FEATURE

RURAL ANAESTHETIC RECRUITMENT—THOUGHTS FROM THE NEW ENGLAND

Dr David Rowe, Chair of the Rural SIG, provides insight into rural anaesthetic recruitment.

The number of anaesthetists in Australia is steadily growing and over recent years I have found it increasingly common to hear discussions at major national conferences about competition for work in metropolitan areas. I live and work in Armidale NSW, a town of 25,000 sitting on the Great Dividing Range about two hours inland from Coffs Harbour. It is almost 20 years since a specialist anaesthetist with an Australian undergraduate medical degree and Australian fellowship was recruited to the town. Over those 20 years the hospital has recruited procedural GPs, a Career Medical Officer and at least five overseas trained doctors (I include myself as one of the overseas trained doctors with a London MBBS although I did much of my anaesthetic training in Queensland).

Recruitment has been a constant challenge during my time in Armidale with several advertising campaigns – one lasting almost three years, over the last decade failing to attract any interest from Australian doctors. Unsurprisingly this challenge has prompted much reflection and I have developed a number of personal views over the years as to the reluctance of Australian doctors to live and work in rural towns and I appreciate the opportunity the ASA have given me to share them.

PROCEDURAL GPs

The rural anaesthetic workforce is made up of a combination of specialists with an ANZCA fellowship and a significant number of GPs with procedural anaesthetic skills overseen by the Joint Consultative Committee Anaesthesia (JCCA), a tripartite organisation with input from ANZCA, the Royal College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).

The size of the town and hospital largely determine the viability of maintaining a specialist workforce or relying on GPs and simply boils down to the number of clinical sessions available in a week.

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Within the Tablelands sector of the New England region Armidale is the only town able to sustain a specialist anaesthetic workforce with 20 to 24 theatre sessions a week and a further six clinic sessions in the public hospital. Anaesthetic services are maintained in Inverell and Glen Innes, largely to ensure 24 hour emergency cover for local obstetric services, which are provided by two or three procedural GPs in each town who have access to roughly one list per week. This is a very valuable service not only allowing women the chance to stay at home to deliver but the elective lists, for relatively minor surgery on fitter patients, reduce the need for and cost of travelling up to 500 kms in a round trip to access the Armidale Rural Referral Hospital.

There are however some issues with procedural GPs that were raised at a forum during the 2015 Rural Special Interest Group meeting. The first issue was the objectivity of the assessment at the end of training which consists of a viva very often involving the local training supervisor. The second issue is the growing disparity in Continuing Professional Development requirements of ANZCA and the JCCA, particularly with ANZCAs move to include the Practice Evaluation and Emergency Responses sections. It was felt that a Diploma of Rural Anaesthesia with a national assessment and CPD requirements along the lines of the DRANZCOG (Obstetric Diploma) would help ensure good quality anaesthesia is maintained in towns too small to maintain a specialist workforce.

SPECIALIST TRAINING

There are two aspects of fellowship training programs that I think hinder rural recruitment. The first is the desire across many medical disciplines to sub-specialise which requires training to be done in large metropolitan centres and the second is the relative lack of opportunities to train in rural towns.

Anaesthetists have perhaps not gone quite as far down the line of sub-specialisation as say the physicians who now train Cardiologists, Neurologists, Endocrinologists and a multitude of other ologists but no General Physicians to look after the stroke patient with pneumonia on a background of diabetes and atrial fibrillation. However there are areas of anaesthetic practice that are sub-specialities in metropolitan areas, notably paediatric and obstetric anaesthesia, which need to be provided by rural anaesthetists. Sub-specialisation at the provisional fellow level has the potential to leave fellows nervous about providing care across a full range of sub-specialities and leave them feeling ill equipped for rural practice. The professional challenge for rural anaesthetists is to maintain a level of skills and experience across a range of sub-specialty areas and be a 'general' anaesthetist and a rural provisional fellowship program could aid this.

Exposure to rural areas is limited during post-graduate training, however there is a strong sense amongst those that are based in rural areas, that if more trainees spent time in rural towns a few of them might see the light and become tree changers. There are challenges for very small departments to become accredited for training, especially if they rely on International Medical Graduates, as a minimum of two ANZCA Fellows are required in the department. Another deterrent for some in having trainees in rural areas is the fact that basic trainees are generally sent to smaller peripheral hospitals where they have to be supervised in everything they do. Consultants in rural hospitals are generally first on call and have to do after hours cases themselves and may see having a basic trainee with them as just something to slow down an after-hours case. An advanced trainee doing a rural provisional fellowship would be a valuable addition to a small department and would be able to participate in the on call roster.

PUBLIC AND PRIVATE A PARTNERSHIP

The balance between seeing medicine as a business to make money from or as duty to provide a service for all members of society is sometimes difficult. As a UK undergraduate and junior doctor my expectation was to work for the National Health Service and do a bit of private work on the side, whereas the Australian career path seems to favour private practice with bit of public work on the side.

On call commitments are a necessary, but sometimes onerous and disruptive part of life as an anaesthetist. The reality of working in a small rural town is that there is a finite amount of elective work that will limit the number of anaesthetists it can sustain in meaningful employment, and therefore have available for a roster. Over the long term it is seen as preferable not to be doing on call more often than one in four, so there is a concept of a critical mass to maintain a viable department and a private unit in a town will increase the amount of work available.

In many rural towns the public hospital provides the majority of after-hours emergency theatre cover with smaller private facilities often not having access to theatres out of hours. It is therefore vitally important that all specialists in town recognise their duty to commit to the public on call roster to share the burden.

My final comments about on call commitments and remuneration relate to the NSW Staff Specialist Award. The award pays a flat rate for participating in the on call roster and therefore discriminates against rural specialists who are likely to be on call more often than their metropolitan colleagues and have limited junior support, meaning they are more likely to be called in overnight. Recruitment of staff specialists to rural NSW might improve if the Award recognised their increased out of hours workload.

FAMILY

The timing of post-graduate training, usually late twenties to late thirties, coincides with a time of life when many people lay down roots and will therefore tend to stay where they have trained. Many trainees will have bought a house, probably got married and may even have started a family and it is a big ask to relocate a young family.

Spousal employment opportunities in rural towns may be limited and the quality of schools are often cited as reasons for not relocating. Another consideration is leaving familial or peer support groups with a degree of uncertainty over being accepted into new social networks, although this is an issue with any move and can be eased if there is support and some social networking with colleagues.

Spending time with children, especially when they are young, is important and rural life offers reduced commuting times so I am regularly able to drop my children off at school at 8am on my way to work where I can still have the first patient asleep on the table at 8.30 as well as being home for a family meal most evenings. This is however balanced against a weekly night on call and one weekend a month which does take me away from the family.

FINAL THOUGHTS

Every country town has its own feel and unique selling points. I feel very fortunate to have stumbled across Armidale thanks to some old nursing friends of my wife. I have found a great niche where the climate suits an expat pom, there are good schooling options for the children, my wife runs her own business and there is enough going on in town to keep us occupied from week to week, including a symphony orchestra so I can indulge my non-medical interest of playing the oboe, whilst being within easy reach of Sydney or Brisbane once or twice a year to go to a football match or visit the theatre.

I'd like to finish by quoting the old Northern Territory tourism slogan – "If you Never Never go you'll Never Never know". Rural specialists all agree that the more doctors who experience rural life via training or locum placements, the more likely a few will decide to move to the town permanently.

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FEATURE

GENERAL PRACTICE ANAESTHETICS— A PERSONAL VIEW

Dr Charles Nadin a GP Anaesthetist in Bunbury, Chair of the General Practitioner Anaesthetists Committee (GPAC) and a Board Member of the Joint Consultative Committee on Anaesthesia (JCCA). Dr Nadin currently works full time in Anaesthetics in Bunbury in the southwest of Western Australia, close to Margaret River.

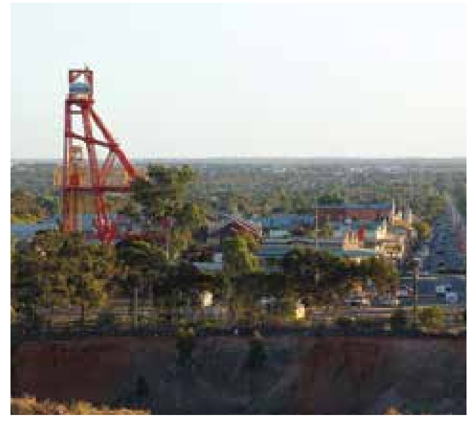
I have had both the pleasure and privilege of being a GP Anaesthetist for some 33 years – and I still love it. I began my anaesthetic training in Bath, the Georgian capital of England. This was to be a short lived anaesthetic career in the UK as a late night phone call from a friend in Kalgoorlie offered a job as a flying doctor that came with the promise of adventure and much more. I could also see the writing on the wall for the NHS. I had completed a Diploma of Anaesthetics from the College of Surgeons, a quaint arrangement, and had also sat the primary before making the move from the cold, wet and overcast northern hemisphere to a place destined to be always sunny, very sunny or extremely sunny, albeit sometimes excessively.

Subsequently, in 1983 I stepped off a plane in that historic golden city and before long I was on board a small twin engine Piper Navajo winging out of 'Kal' as a medic for the Royal Flying Doctor Service (RFDS) supporting a region covering 250,000 square kilometres. I was to perform that role for nearly two years. Kalgoorlie services a population of 30,000 locally and another 20,000 spread across an area that is twice the size of the UK.

The RFDS in Kalgoorlie was delighted I had anaesthetic experience and that proved to be an invaluable skill that would be called upon time after time. Without backup in what are still remote frontiers with limited resources, I was effectively on my own with a steep leaning curve ahead (often flying by the seat of my RM Williams). Experience came quickly out of necessity, and improvisation was my essential partner on the job. The tray top of a truck was available when it became necessary to insert a chest drain, or the ground for intubating someone prior to transport. The days when I was not on

RFDS duty I was often co-opted to do anaesthetics at the Kalgoorlie Regional Hospital to provide relief for the one and only specialist who had recently arrived. The RFDS is a must do for any anaesthetic trainee as it involves so much improvisation. The reward is definitely in the rarely available practical experience. I often recall, times flying back to base after a particularly heavy day, the skilled pilots treating me to extraordinary aerial vistas of the massive flat red landscape vivid in the crystal clear light. The flight deck was an extraordinary office – I had become a member of the 'prop set'. This country was World Heritage-listed long before Bath was similarly proclaimed. Not so comforting was looking out over a pitch black moonless landscape for the headlights of a Land Rover marking our approach to a rough dirt strip. Now I understood why the Pope kissed the ground on landing!

And so Kalgoorlie was an eye opener for me. Aside from my medical work I loved it for the gold rush era architecture, the people, the good friends I made and the feeling that it was somewhat a frontier place, although today it is an outback city and no longer just a miner's town. The amazing goldfields light gifted me a perfect opportunity to indulge my passion for photography and pioneer history, which led me to publish a book in 2012 on the Eastern Goldfields.



After some time in Kalgoorlie I took on a position as a Neonatal Registrar in Perth. The neonatal ICU was hot and noisy, so whenever the outback retrieval jobs came up, flying to remote places to collect sick neonates, I opted to do them. The bush still beckoned me! That experience would prove invaluable on my return to Kalgoorlie.

I returned to Kalgoorlie in 1991, invited and very welcomed indeed, by the resident Specialist Anaesthetist, Geoff Baimbridge, with whom I had worked previously. It was a busy life, sometimes onerous, split medically between general practice and anaesthetics. Kalgoorlie Regional Hospital had two theatres, two General Surgeons, one Orthopaedic Surgeon, one Obstetrician/Gynaecologist and some GP Obstetrician/Surgeons. We had 700 deliveries per year and two busy theatres. We also covered casualty, major trauma and, as I had experience in neonates, I did a lot of resuscitation and transport. The case load from a catchment of 50,000 people was varied and included many Aboriginal people, old and new mine workers, families and so on, all with a multitude of medical issues. We provided a seamless 24/7 medical service with no formal contract, basically on good old common-sense and goodwill. However, when the Health Department introduced contracts in late 1990s much of that disappeared overnight. Holiday cover in Kalgoorlie was often hard to secure from our city cousins – few rushed to help. Often we had to cover ourselves while each took a break and continue to provide a 24 hour service. In one instance this lasted nearly six weeks for me, far from ideal but a reality – as it is for most WA country hospitals.

A change of Specialist Anaesthetist added extra dimensions to our skill set as a result of his incredible experience working in South Africa. He predated ultrasound – we never had such a machine either while I was there – yet he was a deft hand and a great teacher of such skills.

The 'golden era' of medics – that of being left to get on with the demand work, based on local expert opinion, came to an end when bureaucracy superseded the medical model and our ability and the hospital's ability became managed by staff with little or no clinical skills who were trying to avoid all risk, undermining specialists and inconveniencing patients who would have to travel 600kms. Some of the significant long-standing staff left, their shoes filled by temporary fly-in/fly-out medical staff, which still continues today. However I'm glad to say the Specialist Anaesthetist is still there today, along with a number of locums who help him out.

In 2007, realising the best professional years were behind us, my wife and two young daughters left the goldfields to settle in Bunbury. I was offered firstly a locum at St John of God Private Hospital (SJOG) and for me as a GP, it was and still is, a fantastic opportunity. I now work as a GP Anaesthetist (GPA) between public and private hospitals in Bunbury with a great team at SJOG, which includes a group of fellow specialist anaesthetists. The on-call is a mere one in nine, I have set my own clinical parameters and my specialist colleagues are incredibly supportive and great to work with, sharing their immense clinical knowledge and skills. I am incredibly fortunate to have trained in a busy District General Hospital (NHS) in the UK, particularly the traditional 'deep end' anaesthetics training, followed by nearly 20 years in an outback setting doing anaesthetics.

SO—BEYOND 2016?

I never believed there would come a day when there would be a surplus of new Fellows struggling to find work in the cities with many of them reluctant to venture out to regional or remote areas. I would still recommend new Fellows look for work in our varied regions. As GPAs in the regions we can work alongside our Fellows, and not feel paranoid about taking work from them. GPAs are still good value for

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the health service since they are multi-skilled and are able to work as a general practitioner, care for medical inpatients at the local hospital, care for the elderly in aged care facilities, provide cover in the Emergency Department as well as work as a GP anaesthetist. GPAs continue to provide the majority of anaesthetic care in rural and remote regions.

TRAINING OF GPAs

As Chair of GPA at the ASA I presented a paper to the ASA Council in 2013. In it I set out the need for an official qualification for GPAs – a Diploma of Anaesthetics (DA). My reasoning was to ensure that all future GPAs would receive an intense but well-structured training based on the JCCA Curriculum by Specialist Anaesthetists. This would include simulation training along with a robust and standardised examination process. This would ensure that our future GPAs could hold their own in remote and rural places often without specialist back up and still provide a safe service based on great training and maintenance of CPD. My expert colleagues on the ASA Council unanimously agreed with this suggestion to my delight. The proposal was sent to the three Colleges that form the JCCA (ANZCA, RACGP and ACRRM). The JCCA supported this proposal knowing that ANZCA would be the obvious choice to make it happen, being the keeper of training and standards. This proposal is currently before ANZCA. We have had some positive meetings between Colleges recently. Inevitably, ANZCA is concerned that a DA would be perceived as competitive qualification by Fellows. Nothing could be further from the truth as GPAs are not trying to take work away, but to provide excellent service where Fellows don't work. We are here to complement the anaesthetic services that are provided to all of Australia to such a high standard. A formal qualification would be seen by credentialing committees as a way of ensuring that GPAs had reached a certain standard. A similar CPD programme, such as that developed by ANZCA would be required to maintain currency to practice. Remember we already have a Diploma in Obstetrics and a Diploma in Child Health here in Australia, so this is not a new concept.

GPAs are a great alternative where Specialists Anaesthetists cannot provide services; we need to work together as partners (as mates). The contentious issue of sedation is just one example where both GPAs and Specialists should only ever be used. Sedation is not for the faint hearted, as we all know. Having the correct training and professional backup, we are able to provide a safe service. I get concerned when I hear of poorly trained medics or in the future, nurse anaesthetists, providing such a service. I so hope we can avoid this at all costs by working together.

FEATURE

RURAL ANAESTHESIA: A CALL TO ARMS—WHAT CAN OUR PROFESSION DO TO MAKE A DIFFERENCE?

Vice President of the ASA, Associate Professor David M Scott works in regional New South Wales. Here he discusses the maldistribution of the speciality and suggests the profession takes the lead in addressing the problem

As you have read from the other authors in this edition of Australian Anaesthetist there has been a long-standing problem with the rural workforce. The ASA believes, based on a member survey, that there is an excess of anaesthetists, though other sources believe there might be the right number, but they are predominantly working in the capital cities. This maldistribution is not unique to anaesthesia, but rather applies to almost every medical group.

Successive state and federal governments have been provided with this information and have unsuccessfully attempted to address the situation. There have been attempts to bond students to provide services to rural areas, but this doesn't always work – lives and relationships change as students progress through their training and it becomes difficult to force people to go to places against their will. Those that do go to the bush generally leave as soon as they can.

Filling gaps with International medical graduates (IMG) has been attempted, and forcing them to stay by placing a moratorium on provider numbers has

FEATURE

produced a situation where these people have been lured to remote areas where they are isolated and sometimes bullied by hospital administrations. They have been told not to complain or their registration will be revoked and they will have to return home. This process often also depletes the often-sparse medical services of the country from where they have come.

The current flooding of the workplace with junior doctors is the latest poorly conceived attempt to address the situation. We are currently seeing burgeoning numbers of junior doctors who are having increasing difficulty finding employment or training positions, and this is predicted to become worse in the future.

Why has government been unable to solve this problem? In my opinion this is because they have not understood the complexity of the situation. We as a profession have been happy to point out the problem, but not the solutions. It's a little like rock stars writing protest songs about what is wrong with the country, and being ineffectual when placed in a position to do something about it.

It is clear that Federal and State governments struggle with this problem. Recently the Prime Minister offered to the states the opportunity to levy tax for health and education, thus giving them direct responsibility for spending on these portfolios. The states declined the offer. It is a strange situation where the Federal government provides funds to the states for health, but has no influence at all on how the state chooses to spend the money. It is little wonder therefore that arriving at a solution to address the medical mal-distribution situation by government is probably impossible. So even if throwing money at the problem would be a solution it's not achievable because of jurisdictional obstructions.

The reasons for this maldistribution are manifold and relate predominantly to social and professional issues. Proximity to family, educational facilities, other services, employment opportunities for spouse and familiarity with their home environment make most city dwellers reluctant to seek permanent employment in rural and remote places.

Retaining specialists in remote and rural areas is also difficult as there is a problem with maintaining skills. Many remote areas do not have a volume and variety of cases that will maintain a specialist's skills, so professional stagnation occurs. Combined with this, in rural centres many anaesthesia services are provided by General Practitioner Anaesthetists (GPA).

The GPA is crucial to the provision of rural and remote anaesthesia, they are very capable of providing services for less complex procedures in generally healthier patients, and are skilled at patient selection. They fill their week with a mixture of anaesthesia and looking after their general practice patients, and have a fulfilling career. There is not enough work to fully employ a specialist anaesthetist, without taking all the GPA work from them, but then the specialist would have to be on call 24/7 – clearly an untenable position.

At the same time the GPA will need the support and advice of a specialist when a complex emergency arrives (e.g. an isolated local who has received minimal antenatal care and presents in eclampsia and requires urgent delivery). This combination of GPA and specialist anaesthetist works well for the community and patients – but doesn't provide sustainable specialist employment. It may be that these centres will never be able to attract permanent specialists who are trained in Australia.

Where solutions have been achieved, it has been through innovative application of the local awards, and imaginative discussions on how to adapt to the local environment. The solutions have however been local, and their applicability to other regions is variable at best. They usually occur in coastal centres where there is some other feature that attracts the specialist (for Lismore it's the proximity to Byron Bay and the surf!).

So then, what can we, as a profession do to address these problems and ensure a high standard of anaesthesia care for all Australians both metropolitan and rural? Clearly lobbying government is not going to be successful - their structural dysfunction prevents any meaningful intervention by federal jurisdictions and the states can't agree on anything. It is not possible to make real changes to the work environment to render work in remote and isolated rural centres more attractive. Maybe it's time to look at what has worked in some places.

In South Australia, the Royal Adelaide Hospital provides ongoing support to Port Augusta for specialist anaesthetists. Port Augusta typifies the rural centre described above and the people of the town have needs for specialist care. This program of a large teaching hospital 'adopting' a smaller rural hospital has worked well over many years. From talking with the specialists who volunteer for this service it is clear that they find the work rewarding and useful. It also provides an opportunity for a different experience and a change of pace on an intermittent but regular basis. Port Augusta benefits in getting an up-to-date workforce that is current in anaesthesia practice and the GPA cadre receives excellent support and ongoing education from the visiting specialist.

What is there stopping the rest of the country from providing the same thing to other underserviced hospitals? The ASA is considering developing collaboration with a locum service to facilitate such a process. This company would be responsible for providing logistic support, documentation, transport and accommodation for specialists who would be prepared to volunteer to support these rural and remote hospitals.

It should be noted that this company is already doing this, but it is quite ad hoc and occasionally the locums employed are in the twilight of their careers, and possibly not well suited to the rare but challenging difficult cases. The ASA would help coordinate departments and individuals who would like to provide this essential

public service thus giving greater reliability of a high standard of care.

This process would provide a doctor led solution to the problem, and hopefully stop successive governments from undertaking increasingly poorly informed attempts at solving the problem. This would also provide employment for more metropolitan based specialists – effectively any department that adopted a rural centre would be able to employ an extra staff specialist at no extra cost, as this would be met by the rural hospital.

I ask you to consider this as a form of public service which will be easy to do and will be much appreciated by the rural communities. It will demonstrate to our politicians that we are capable of solving difficult problems and help them to appreciate to importance of engaging with anaesthetists when making plans for the future of our profession.

What are your thoughts on locums? Have you been a locum? Are you interested in becoming one?

Please send your thoughts and comments to editor@asa.org.au

FEATURE

NSC 2016 INVITED SPEAKER ABSTRACTS

MRS CAROLYN CANFIELD
VANCOUVER, CANADA

Honorary Lecturer in the Faculty of Medicine, University of British Columbia in Vancouver

CAN THE PATIENT LEAD THE PERIOPERATIVE TEAM?

Kester Brown Lecture

As surgery becomes more complex and takes on more vulnerable patients, care that skimps on responsibility for the whole patient may dangerously raise the likelihood of harm from common post-operative complications, sometimes with catastrophic results.

One such case will demonstrate the compounding hazards of system-centric, fragmented and hierarchical perioperative care. Not only are patients at risk, but the 'second victim', the healthcare worker involved in care failure, can suffer needlessly from avoidable harm.

Older system-centric metrics like 90-day all cause mortality and 30-day re-admission rates would appear to lose out to more nuanced and helpful indicators of quality and performance that can trigger remedial action in real time and process improvement with retrospective analysis. When cultural change accompanies a more integrated role for patients throughout the perioperative journey, we are reminded that we are truly 'all in this together'. Everyone can benefit from greater accountability and ownership of outcomes.

Linking up clinicians with patients in networks of sustained collaboration for improvement can bridge discouraging silos of specialisation and the chasms that may disconnect practitioners from each other. Strengthening relationships of trust is fundamental to better care and to generating the intrinsic rewards of working in healing arts. Only then can we hope to sustain a robust culture that constantly renews its resolve for improvement.

Maintaining a creative focus on and with the patient can indeed lead the Perioperative Team to excellence.

PATIENT-LED RECOVERY: DESCRIBED, PLANNED AND DELIVERED

In other care settings, the 'Patient Revolution' is energising an emerging environment of well-informed shared decision-making for individualised care planning and patient-reported outcomes. So it is too in the perioperative arena.

The concept of elective surgery implies that the patient seeks, or 'elects', a surgical procedure to achieve a functional advantage, or to delay a functional decline. What if this patient-identified functional goal were the measure against which rehabilitation and recovery were measured for to characterise success in the intervention?

Co-production of a complete perioperative plan would allow patients and their various perioperative teams to develop informed expectations, pre-operative physical conditioning, confidence in their care team, and an individualised rehabilitation plan, all of which underscores a personal incentive to participate fully. A functional goal for the surgery could guide design of a customised regime to fit in with the patient's social setting and capacity. Monitoring such a plan's completion might address recovery over a longer duration for a deeper meaning of what patient-oriented 'success' means in elective surgery.

WHAT MATTERS TO THE PATIENT – AND HOW TO FIND OUT?

Patient values, voice and participation are increasingly 'leading' the perioperative team's care delivery and measures of performance. How do we know when

SESSION TIMES

Kester Brown Lecture – Can the patient lead the perioperative team?
Saturday 17 September, Plenary Room 1, 1500–1600

Patient-led recovery: Described, planned and delivered
Monday 19 September, Plenary Room 1, 1100–1300

What matters to the patient – and how to find out?
Tuesday 20 September, Room 203, 1100–1300

recovery is going well or badly? How do we know if care is well supported or alienating? Does the model of care build a greater trust, or despair and a sense of betrayal? What's missing in care planning as it is translated into action? Co-designing successful access to candid reflections on the perioperative experience requires inquiry methodologies created and evaluated with patients.

Patient-centred care also depends on learning from patients what makes good care, where practice closes gaps and how to build in habits to strengthen care delivery. Developing open-ended questions, collecting and reporting the learning, and supporting organisational innovation would exemplify a continuously learning patient-centred culture.

Patients appreciate knowing their experiences and insight are valued for improving care quality and safety to benefit future recipients of care. Collaborative processes can build a skilled pool of peer coaches to contribute to many facets of care for the next wave of patients through their perioperative regime.

2016 ASA ANNUAL GENERAL MEETING

Please join the election of the ASA Board of Directors, reports from key Office Bearers and the presentation of the Awards, Prizes and Research Grants.

Time: 2.30pm on Monday, 19 September 2016
Venue: Plenary Room 1
Melbourne Convention & Exhibition Centre

Visit **www.asa.org.au** for previous minutes and related documents.

FEATURE

DR DAVID CANTY
MELBOURNE, VICTORIA, AUSTRALIA

Senior Lecturer and Director of Ultrasound Simulation
Ultrasound Education Group, Department of Surgery, University of Melbourne

Adjunct Associate Professor
Department of Medicine, Nursing and Health Sciences, Monash University

VMO Anaesthetist
Royal Melbourne Hospital and Monash Medical Centre

ULTRASOUND FOR EVERYONE – WHY, WHEN AND HOW TO GET THERE

The use of ultrasound is the modern day revolution in anaesthesia and acute care medicine. The use of ultrasound in the acute care specialties of anaesthesia, intensive care, emergency medicine and surgery has evolved from discrete, office-based echocardiographic examinations performed by radiologists or cardiologists to the real-time or point-of-care clinical assessment and interventions by the acute care physician[1]. Some of the more popular and emerging techniques include transoesophageal and transthoracic echocardiography, lung and abdominal ultrasound, ultrasound guided nerve blocks and vascular access. However ultrasound is used for an ever-increasing number of uses in medical, surgical and paramedical specialties. Ultrasound guided nerve blocks and vascular access are becoming routine and even mandatory in some centres. It makes sense to see the target and guide the needle to the correct place rather than inserting a needle blindly deep into the body, where complications may occur from needle misdirection.

Transoesophageal echocardiography is now routinely used by anaesthetists during cardiac surgery and increasingly used in intensive care and in non-cardiac surgery. 'Focused' transthoracic echocardiography or focused cardiac ultrasound (FCU), is a limited scope (as compared with comprehensive examination) echocardiographic examinations, performed by the treating clinician in acute care medical practice, aimed at addressing specific clinical concerns. Not only can transthoracic echocardiography improve diagnostic accuracy of cardiac pathology but it can more accurately guide haemodynamic monitoring and treatment. Out of all ultrasound procedures this is perhaps the fastest growing, as it can be used in so many settings such as preoperative assessment, intraoperative and postoperative haemodynamic instability, intensive care, emergency department and in out of hospital settings. Lung ultrasound is emerging as an effective tool for rapid diagnosis of acute respiratory pathology, probably representing the last nail in the coffin for the stethoscope. There is evidence that diagnosis is improved with ultrasound examination, yet data showing change in management and improvement in patient outcome are few and an important area for future research.

In the future, the practice of surface ultrasound will evolve into the everyday clinical practice as ultrasound-assisted examination and ultrasound-guided procedures. This evolution should start at the medical student level and be reinforced throughout specialist training. The key to making ultrasound available to every physician is through education programs designed to facilitate uptake, rather than to prevent access to this technology and education by specialist craft groups. Simulation and automated on-line education are the current most scalable solution to the ever widening gap in demand and supply of ultrasound training. An example is the FCU TTE course[2] (University of Melbourne).

References

1. Royse CF, Canty DJ, Faris J, Haji DL, Veltman M, Royse A. Core review: physician-performed ultrasound: the time has come for routine use in acute care medicine. Anesth Analg 2012. 115(5) 1007-1028.
2. Canty DJ, Royse AG, Royse CF. Self-directed simulator echocardiography training: a scalable solution. Anaesth Intensive Care 2015. 43(3) 425-427.

CLINICAL ULTRASOUND: LEARNING HOW TO PERFORM US GUIDED PROCEDURES

Why would you attempt to insert a needle deep into the body without looking? There is the risk of damaging adjacent nerves, vessels and in some cases pleura and peritoneum. The reason is that portable ultrasound units have only become affordable and available in the operating theatre environment in the last 20 years, and it has taken this time for anaesthetists to develop skills and training programs. Research has since demonstrated that both ultrasound guided regional anaesthesia and central vein catheterisation are associated with improved efficacy and fewer complications than the traditional landmark techniques. Societal guidelines strongly recommend routine ultrasound use for central vein catheterisation but this has not occurred yet for regional anaesthesia. However the technique is the same, and can be

SESSION TIMES

Ultrasound for everyone – Why, when and how to get there?
Monday 19 September, Plenary Room 1, 0930–1030

Clinical Ultrasound: Learning How to Perform US Guided Procedures
Monday 19 September, Room 203, 1100–1300

Peri-Arrest: Should we all learn lung US?
Tuesday 20 September, Room 203, 1100–1300

adopted for other procedures such as chest drain insertion and removal of foreign bodies.

Although ultrasound equipment is increasingly available, the learning curve for ultrasound-guided procedures is long. This is because the current learning method, the apprenticeship model, requires close supervision by a practitioner who can teach as well as perform the technique, a patient that requires the procedure, and exposure to more patients for practice and maintenance of skills, as well as considerable dexterity and commitment to learning. ANZCA has done significant work in encouraging its trainees to acquire these skills by formalising the curriculum and mandating on-line reporting of assessment. There is an increasing number of hands-on workshops available, which are effective at teaching how to perform ultrasound, but do not provide tuition on ultrasound guided needle placement, as this is unethical on human volunteers.

To address this problem, there is an increasing number of ultrasound simulators becoming available with life-like human anatomy allowing the learner to use ultrasound to both locate and guide needles to target nerves and vessels. The skin is made from self-sealing rubber, allowing many punctures before replacement. Successful arterial and venous cannulation may be simulated by aspiration of either red or blue dyed water respectively, and the arterial system can be simulated by intermittent pressurisation with either a hand or automatic pump. These simulators show promise but they still require close supervision with a trainer, and current literature is restricted to use of the simulators to enhance existing training workshops. The answer to the rapidly expanding gap in demand and supply of ultrasound may rest with on-line automated courses. These are scalable they enable self-directed learning of ultrasound guided procedures, requiring only brief tuition, access to the internet and the simulator laboratory.

PERI-ARREST: SHOULD WE ALL LEARN LUNG US?

Over the last few decades, there has been a rapid uptake in the clinical use of an abbreviated or focused form of transthoracic echocardiography, also termed focused cardiac ultrasound (FCU). This is separated from conventional echocardiography by its use by the treating doctor to guide decision-making in real time at the 'point-of-care'. FCU is increasingly used by anaesthetists and critical care physicians to improve speed and accuracy of diagnosis in patients at increased perioperative cardiac risk and during haemodynamic instability. FCU is used to diagnose presence or absence of acute cardiac pathology, such as ventricular, valve and pericardial fluid, and abnormal haemodynamic states, such as hypovolaemia and vasodilation.

The indications for FCU have been extended recently to cardiac arrest, where guidelines recommend its routine use[1], and it has been incorporated into an ACLS algorithm[2]. In addition to diagnosis of cardiovascular abnormalities, ultrasound can also be used to diagnose cardiac rhythm, and other non-cardiac causes of cardiac arrest such as acute lung pathology and intra-abdominal bleeding. Even though the initial rhythm check may show asystole (non-shockable rhythm) FCU may demonstrate myocardial movement of fine ventricular fibrillation, a shockable rhythm, FCU may also reveal pulseless electrical activity and its cause, which could prompt specific life saving therapies, such as drainage of pneumothorax, pleural or pericardial effusion, or emergency management of pulmonary embolus or acute myocardial infarction.

Lung ultrasound may also assist in the management of perioperative respiratory distress and has been shown to approach the accuracy of CT but is available at the bedside and does not require patient transport or exposure to ionising radiation. Ultrasound can also be used to guide life-saving invasive procedures such as pericardiocentesis and thoracocentesis, as well as guiding insertion of central venous and arterial catheters, and guiding post-resuscitation care.

There have been a number of FCU protocols designed for rapid assessment in peri-arrest or cardiac arrest. They have evolved from the initial use of ultrasound in trauma to detect intra-peritoneal bleeding, FAST[3], with the subsequent addition of diagnosis of pleural and pericardial fluid, eFAST[4]. Recent

FEATURE

protocols have included assessment of pneumothorax and ventricular function, for example RUSH[5], FEEL[6] and FATE[7]. The most recently developed protocol, iHeartScan™ Peri-arrest[8], includes a more comprehensive evaluation of the heart (addition of valves and vasodilation), lung (added pulmonary oedema and consolidation) and other abdominal pathology (added abdominal aortic aneurysm and intra-peritoneal air).

The use of ultrasound in peri-arrest is consistent with the evolution of the concept of discrete organ-based ultrasound examinations, such as transthoracic echocardiography, to whole body ultrasound 'ultrasound assisted examination', and 'ultrasound guided procedures', and is represents a valuable skill for the perioperative physician.

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PROFESSOR OLLE LJUNGQVIST
SWEDEN

Professor of Surgery, Örebro University, Sweden

WHAT SURGICAL COMPLICATIONS SHOULD THE ANAESTHETIST KNOW ABOUT?

This lecture will focus on how complications affect short and long term outcomes. It will discuss how care pathways such as ERAS and changes in surgical techniques impact the development of complications. Working as a multi professional team to review outcomes jointly and how to address management of complications is likely to be the best way to understand how to manage them and to reduce their occurrence. Some specific surgical complications and the signs of these complications will also be reviewed.

ERAS – A METABOLIC JOURNEY

Enhanced Recovery After Surgery (ERAS) was initiated by two surgeons interested in nutrition and metabolism in surgery; Ken Fearon Edinburgh and Olle Ljungqvist in 2001. They formed the ERAS Study group and coined the name. It was their intention to put nutrition and metabolism back on the surgical agenda. In addition to metabolism, ERAS also has its roots in Fast Track surgery.

This presentation will cover a short overview of ERAS, and give an update on the development of ERAS[1]. From this perspective, the role of metabolism as a way of understanding some of the effects of employing ERAS in daily practice will be presented.

This lecture will discuss how metabolic changes and metabolic management caused by injury and surgery can impact recovery after surgery, and how the different ERAS elements recommended in the ERAS Society Guidelines influence metabolism and ultimately recovery. The basics of insulin resistance, a key development in the catabolism of surgical stress, and its impact on outcomes is presented[2]. The principles of ERAS using multi modal approaches to manage recovery and avoiding complications will be discussed.

Further reading

1. Ljungqvist O. ERAS-Enhanced recovery after surgery: moving evidence-based perioperative care to practice. JPEN J Parenter Enteral Nutr. 2014;38(5):559-566.
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OPTIMAL FEEDING IN THE PERIOPERATIVE PERIOD FOR DIFFERENT OPERATIONS

Making the gut work is an important clinical goal in the recovery after surgery for the vast majority of patients. This entails the patient being able to eat normal food and have bowels moving. In many units this is an important component of discharge criteria. The nutritional management of these 'normal' patients coming for elective surgery involves two main aspects; supporting the return of gut function/avoiding postoperative ileus and securing a metabolic state that allows anabolic management of the nutrients consumed. This lecture will discuss how to support gut function. Indications for days of preoperative nutrition, preoperative carbohydrate treatment, and postoperative nutritional measures will be discussed on the basis of patients with some of the more common nutritional and metabolic situations as well as their capacity to use the gut.

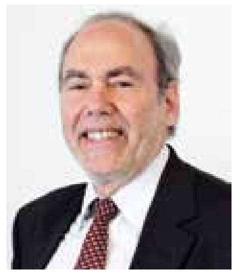
SESSION TIMES

What surgical complications should the anaesthetist know about?
Saturday 17 September, Plenary Room 1, 0830–1030

ERAS – A metabolic journey
Sunday 18 September, Plenary Room 1, 0830–0930

Optimal feeding in the perioperative period for different operations
Sunday 18 September, Plenary Room 1, 1100–1300

FEATURE



PROFESSOR STANTON NEWMAN
LONDON, UK

Professor of Health Psychology and Dean of the School of Health Sciences at City University London

COGNITIVE RECOVERY AFTER SURGERY – THE ELEPHANT IN THE ROOM

Over 60 years ago following a number of reports from his patients and their families regarding problems with cognitive function after surgery, Bedford[1] published a retrospective observational report of 251 older patients who had surgery with anaesthesia. He stated that minor degrees of dementia were common in this group of patients and that 7% of patients experienced extreme dementia. He concluded with a salutary warning: "Operations on elderly people should be confined to unequivocally necessary cases."

The existence of cognitive problems in patients was of great concern to both anaesthetists and surgeons especially with widespread increase in all forms of surgery. It is therefore not surprising that following this initial retrospective report a large number of studies have been conducted on what has become known as Post Operative Cognitive Deficits (POCD).

The bulk of early studies focused on cardiac surgery and in particular coronary bypass surgery and valve replacement (Newman et al[2]). Key to the early studies on POCD was the attempt to establish the extent of the problem and its persistence. Cardiac surgery had matured from reliance on hypothermia to operate on the heart through to much more sophisticated equipment to mimic the heart and the lungs. It was the equipment used in bypass surgery that became the focus of many studies. After the advent of off pump cardiac surgery and the detection in some studies of the existence of POCD, questions were raised as to whether the equipment was the principal causal agent of POCD.

Many researchers began to focus on other forms of surgery and established that there may be cognitive deficits in some patients following non-cardiac surgery (Newman et al 2007[3]). Studies here focused on whether certain types of anaesthetic agent or type, or surgery were more likely to lead to POCD and whether certain patient characteristics such as age put patients more at risk.

The whole area of POCD has been littered with methodological issues and these have frequently focused on how POCD is assessed and what is the optimum time to perform these assessments. The issues include the selections of tests and the statistical analysis of the findings from these tests through to the definition of POCD.

This talk will consider the presence of cognitive problems and recovery following surgery and anaesthesia and will also examine some of the methodological issues that are present in the area.

References

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2. The Brain and Cardiac Surgery: Causes of Neurological Complications and their Prevention. With MJG Harrison. Harwood Press, 2000
3. Postoperative cognitive dysfunction after non-cardiac surgery. Newman, S., Stygall

CAN WE INFLUENCE BRAIN RECOVERY AFTER SURGERY?

The first step in trying to improve outcomes for patients following surgery is to have a system of measuring the problem. Neuropsychological Assessment provides the tool that has been used to look at the functioning of the brain by examining in this context cognitive changes in patients following surgery and how these change over time. Many studies have been conducted that have used neuropsychogical assessments although the number and range of tests that can be used in surgical studies are constrained by the time available to make such assessments.

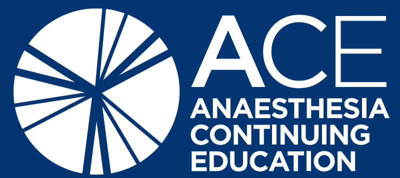
Studies using neuropsychological assessment have focused on all aspects of surgery and anaesthesia. These have included the type of anaesthetic, the equipment used, the behaviour of both the surgeon and the anaesthetist as well as how wards are organised.

The extent to which we can make changes to improve recovery will be presented in this session.

SESSION TIMES

Cognitive recovery after surgery – The elephant in the room
Sunday 18 September, Plenary Room 1, 0930–1030

Can we influence brain recovery after surgery?
Monday 19 September, Plenary Room 1, 1100–1300



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

BEYOND HW2025: AUSTRALIA'S FUTURE HEALTH WORKFORCE REPORT

In this article, Dr James Bradley has reviewed how the predictions made by the HW2025 report for the anaesthesia workforce in 2012 have been superseded by a revised modelling scenario prescribed by 2014's *Australia's Future Health Workforce—Doctors* report, with this new modelling being used to produce the *Australia's Future Health Workforce—Anaesthesia* report, due for release shortly.

HW2025 (*Health Workforce 2025: Doctors, Nurses and Midwives*) was a three volume report published in 2012 by Health Workforce Australia (HWA) which addressed medical and nursing healthcare workforce needs to 2025. Volume 3[1], examined the medical specialist workforce, and has been reported and analysed on a number of occasions in *Australian Anaesthetist*. Its findings in relation to anaesthesia had been that there were:

- Minimal concern in relation to replacement rate within the specialty.
- Slight concern in relation to the average age of the specialist workforce.
- Moderate concern in relation to dependence on specialist international medical graduates.
- Moderate concern in relation to the duration of the specialist training program.

HWA used a 'detailed' workforce modelling process in HW2025 to model health care utilisation rates in the public and private sectors, the former through modelling of inpatient separations and analysis of National Hospital Morbidity data; the latter through modelling of volume of MBS items and analysis of Medicare data. This modelling process

is understood to have formed the basis for the examination of all specialties, including anaesthesia.

'Population age priorities' were then combined with 'demand forecasts' prior to analysis by the 'HWA National Health Workforce Planning Tool' to enable practitioner 'baseline' and 'scenario variables' to be analysed to calculate the required specialist workforce, expressed as full-time equivalents (FTEs).

While 'stakeholder input' into the process was asserted, the ASA believes that input (in the case of anaesthesia) was effectively restricted to the State Health Departments and ANZCA with limited, at best, input from the private sector and the representative organisations.

NATIONAL MEDICAL TRAINING ADVISORY NETWORK: NMTAN

Following the release of HW2025, the Federal and State Health Ministers charged "NMTAN" (the National Medical Training Advisory Network) with further work in this area, with representation to come from "all the key stakeholder groups in medical education, training and employment" (the Executive Committee of NMTAN numbers 21, and includes the AMA (but not the ASA, or indeed most specialist representative bodies) along with three College representatives nominated by the Committee of Presidents of Medical Colleges, and various other parties.

In 2015, consequent to disquiet conveyed to the ASA by anaesthetists concerned about a possible oversupply in the anaesthesia workforce, and following a representation by ASA, ANZCA and AMA to Government, a further review of future anaesthesia needs beyond HW2025 was undertaken by HWA/NMTAN. The ASA met with Federal health workforce officials on two occasions during this review, with the pending report *Australia's Future Health Workforce – Anaesthesia* seen by the ASA during its development allowing some opportunity for comment.

AUSTRALIA'S FUTURE HEALTH WORKFORCE: AFHW

Importantly, it needs to be understood that *Australia's Future Health Workforce – Anaesthesia* will on its release supersede the predictions made for the anaesthesia workforce by the HW2025 report, and in doing so will have used different modelling processes from those used in HW2025. The new predictions are based on revised scenario modelling requirements that have been prescribed by the content of the *Australia's Future Health Workforce – Doctors* (AFHW). This report was published by HWA in August 2014 prior to HWA's own abolition in October 2014[2].

AFHW contains "agreed guiding principles" which are to support:

- Training the medical workforce to match community requirements in both specialties and location.
- Matching supply and demand for training against various trends and advances.
- Cost-effective and efficient medical training.
- The provision of information about future service needs.
- Prioritisation of Australian trained medical graduates, but with OTDs to fill workforce gaps.
- The recognition of the balance between service delivery demands and training needs, with mechanisms "to adjust the training system in relation to career opportunities, choices and expectations of doctors at all levels, specialties and roles[sic]".

The multiplicity of stakeholders (financial and non-financial), training authorities and healthcare facilities involved in the 'medical training pipeline' is illustrated in Figure 1 from the AFHW report.

The importance of rational workforce planning is stated to be underpinned by the need to deal with both entrants (medical graduates) and exits (retirees, for whatever reason) to and from the medical workforce, and the need to address "the

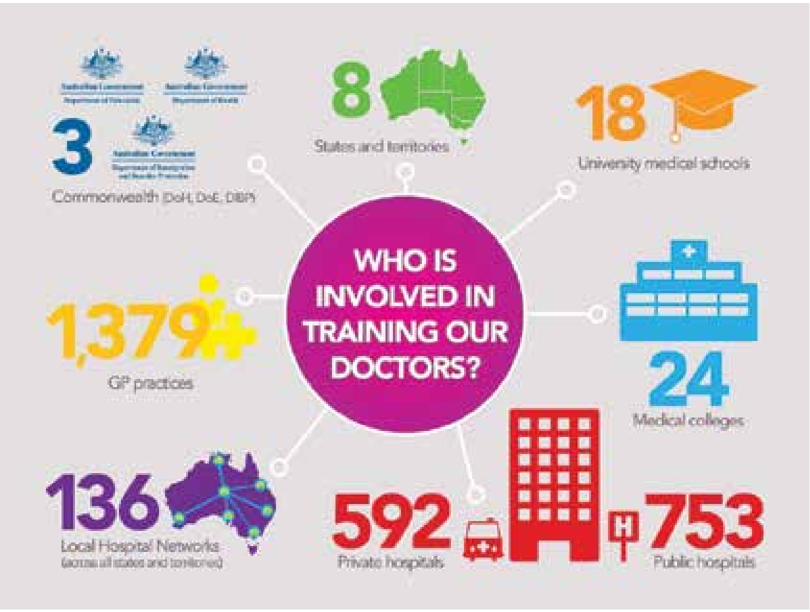

Figure 1

FEATURE

lack of coordination across the 'medical training pipeline', between governments, universities, medical colleges, and the various employers, achieving alignment so that what the nation needs from doctors in the future is achieved".

As mentioned earlier, AFHW has modified the multiple modelling scenarios used in HW2025 to provide for a "single combined scenario based on the best possible protection future" to incorporate:

- Constraining the growth of the medical workforce to the long-range forecast for growth in GDP.
- Achieving a productivity gain of a total 2% by 2030.

AFHW does note that HW2025 had determined that a specialty and location imbalance was possible, that the current training system was inefficient and uncoordinated, that there would not be enough vocational training places for medical graduates, and that Australia would continue to remain highly dependent on international medical migration. AFHW's does not retreat from HW2025's direction in this area: AFHW's 'combined scenario' predictions are for an overall medical practitioner workforce surplus of 3791 in 2016, 5989 in 2020, 5833 in 2025 and 7052 in 2030, if workforce supply remains unchanged. Australia is noted to have 3.6 medical practitioners per 1,000 population, a number exceeding all other English speaking countries, and exceeded only by five northern European countries. The initiator of these predicted surpluses is the rapid increase in the number of commencing medical students from the early 2000s with a tapering off over the last five years, but a continuing increase in the number of international medical students, along with the increase in the number of advanced vocational training positions (43% between 2008 and 2012).

AFHW notes differences in growth rates across different specialties (Figure 2), and states that the relationship between future medical workforce requirements and the workings of specialty training is unclear. This is indicated in Figure 2.

The consequent recommendations of AFHW are then, in summary, to:

- Keep medical school intakes [domestic and international] constant for 2015.
- Ultilise immigration settings to balance projected supply and demand [this would see a gradual reduction in temporary medical migration].
- Update workforce modelling annually to determine the requirements for future adjustments.
- Prioritise future policy work to better understand prevocational years and the overall capacity for, and distribution of, vocational medical training.

Importantly, this latter recommendation is stated to be important in that the increased number of domestic graduates provides the opportunity to plan to deliver training that more closely matches community requirements rather than

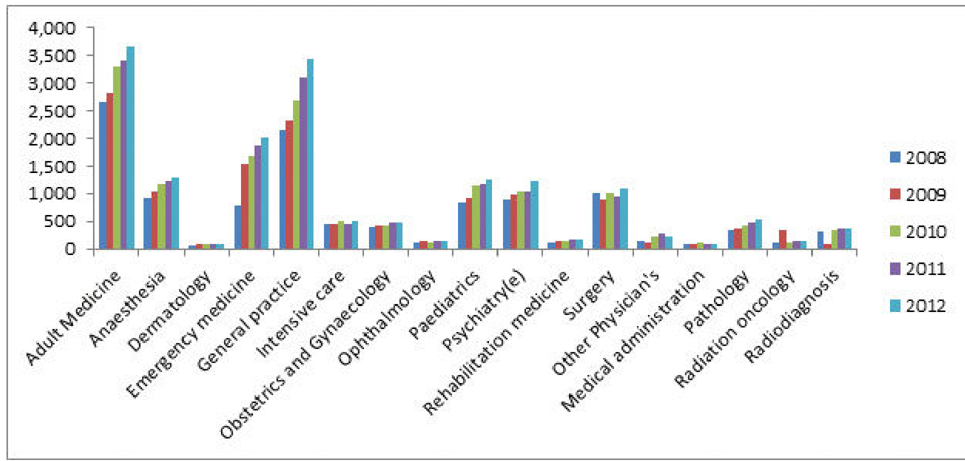

Figure 2: Growth in specialty advanced vocational training positions 2008-2012 (AFHW report)[1]

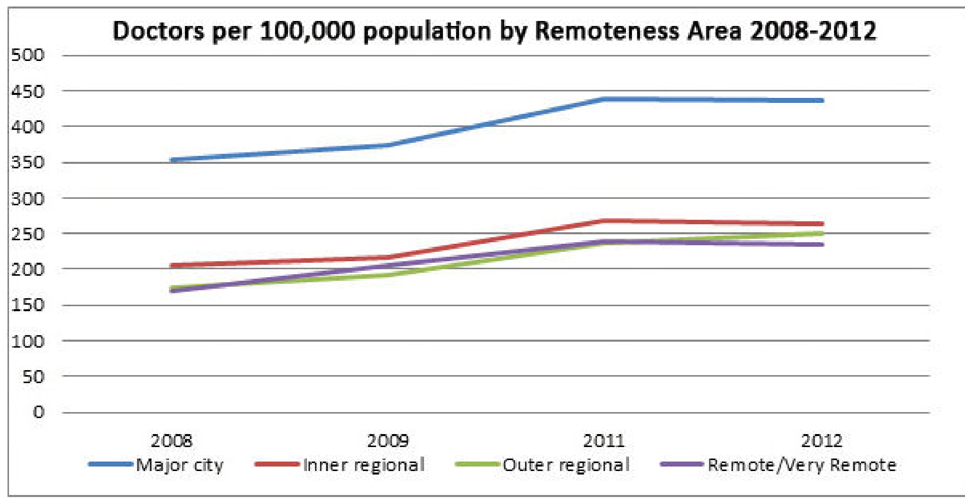

Figure 3: Doctors by Remoteness Area 2008-2012 (Chart 3, AFHW report)[1]

trainee preference or the immediate service delivery needs of public hospitals.

AUSTRALIA'S FUTURE HEALTH WORKFORCE—ANAESTHESIA

What do we know about the findings of *Australia's Future Health Workforce – Anaesthesia*?

The report is expected to be released in June 2016, and the ASA expects that it will suggest that the anaesthesia workforce is currently adequate, with the 'training pipeline' able to sustain this adequacy, and that the frequently touted 'maldistribution' of specialist anaesthetists is in line with the distribution (or maldistribution) of those other specialties relevant to the provision of services which require anaesthesia. Expressed in a different way, all high-level specialty services, which require the support of various specialties and subspecialties, can be seen in this context as distributed or 'maldistributed' to major cities, where they can be more efficiently and sustainably provided. The chart on the facing page (Figure 3) from the AFHW report illustrates this reality.

Australia's Future Health Workforce – Anaesthesia and its findings will be critically addressed by the ASA later this year, with the assistance of the findings of the 2016 ASA member survey which will have been conducted by the time that this article appears.

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FEATURE

BULLYING—WHERE'S THE PROBLEM?

Professor Simon Willcock is a GP and the Director of Primary Care at the Macquarie University Hospital. He is also the Chair of the Avant Mutual Group and a board member of the Sydney North Health Network, the NSW Doctors' Health Advisory Service and a member of the NSW AMA Council of General Practice. In this article, Professor Willcock provides insight into the problem of b ullying, in the medical workforce.

Bullying in the medical profession has been recognised for as long as any of us can remember but we have failed as a profession to effectively address or prevent it. Recent high profile incidents reported in the media have highlighted the need for a more effective approach to an insidious problem.

The media reports have been framed within a context of vertical bullying perpetrated by a senior person in a position of power or authority upon a vulnerable junior professional. The reported incidents when taken at face value are truly egregious, including incidents of significant sexual harassment and interference with the ability of a trainee to appropriately progress through training. Colleges and other professional bodies have responded to emotional stories amplified by an eager media by analysing and agonising over their systems and processes. Many institutions have committed to policies of 'zero tolerance' and crossed their fingers that the problem will disappear. This reactive approach is not likely to result in meaningful change.

Some years ago I was a parent at a school forum where the subject was bullying. At one point the presenter asked if any of the audience had ever engaged in bullying behaviour. Three of us put our hands up, while the other fifty or more people in the room sat resolutely on theirs, making me realise that most of us don't fully understand what bullying behaviour is, and confuse the behaviour with the stereotype of the serial bully.

Bullying behaviours are part of the human condition. Bullying is a complex construct, defined as "any repeated unreasonable behaviour that could be considered to be humiliating, intimidating, threatening or demeaning to a person, or group of persons, that creates a risk to health and safety. Bullying can be intended or unintended, direct or indirect and inflicted by one or more persons"[1]. By this definition most of us have been guilty

of bullying behaviour at different times. It is easy to recognise the notorious bullies of history including Stalin or Hitler, but Winston Churchill and Abraham Lincoln also acted at times in ways that meet the definition. Even Ghandi or Mandela would likely have acknowledged that they may have at times been responsible for another person's unwarranted discomfort.

In modern society the act of bullying is usually contextualised in the playground or the workplace, within a reductionist paradigm of bully versus victim. However, as with most common and contentious issues the reality of bullying is much more complex. If we are to be serious as a profession about eliminating it we have to understand the factors that lead to bullying, and to be honest about our personal roles and responsibilities.

If we accept that we all have the capacity to be responsible for bullying behaviour, whether intentional or not, we need to analyse the circumstances under which this happens. A numerically small number of people are undoubtedly serial bullies who use bullying as a regular behavioural style, and the dialogue that has developed over the past year is largely aimed at limiting the damage done by this group of people. However, more often the behaviour labelled as bullying has been the inadvertent or unintended act of a person who had no intention of causing discomfort and who would be distressed to know that they had done so.

We therefore need to examine the various contributory factors to what may be perceived and reported as bullying behaviour. These factors can broadly be considered as personal, professional or environmental, and may overlap in any specific context.

We each have fixed trait personality factors that may include dysfunctional components such as poor tolerance of uncertainty, obsessiveness and introspection, each of which is common (and indeed valued) among medical practitioners. In addition some doctors exhibit more problematic personality traits such as narcissism or sociopathy. These traits significantly determine our behaviours and responses in stressful situations. While the serial bully will display these behaviours consistently, many episodes labelled as bullying occur in a context where the perpetrator is not perceived to be a serial bully, or where their actions are interpreted differently by a range of observers. We need to remind ourselves that variable factors such as the emotional state of those involved in the bullying activity (including perpetrators, recipients and bystanders) will affect the interpretation of the activity. The presence or absence of anxiety, depression or burnout can significantly affect the way in which we behave, the way in which we interpret the behaviour of others, and the way in which we respond to behaviour that we consider inappropriate.

In terms of professional factors, the context of the behaviour is highly relevant. Clinicians have many role dynamics to master, including the patient doctor relationship, itself in a state of flux in the digital era when patients are able to access information and negotiate their treatments. In addition to this evolving clinical role we interact with colleagues as educators, mentors, advisors, supervisors and line managers. Unless the appropriate behaviours are defined for each of these interactions there can be confusion for both parties and divergent interpretations of the behaviours displayed in any particular interaction.

It is not surprising that most reports of bullying occur within stressful environments, and in particular in acute care clinical settings such as hospitals. Such environments are 'high stakes', with a high degree of work stress, minimal tolerance of error or poor outcomes, high (and accelerating) rates of change, and a stressed workforce operating in different clinical silos.

With these factors in mind, consider the dynamic between the supervisor and his or her trainee. Over a relatively short period of time the supervisor is expected to induct the trainee and outline the scope and limitations of their duties, to provide teaching and clinical supervision, to assess the trainee's performance and to offer themselves as mentor and role model for the developing clinician. Additionally, a good supervisor is expected to be familiar enough with the individual circumstances of each trainee to adapt and personalise the experience, without of course overstepping any boundaries and causing distress to the trainee. For their part the trainee is expected to be familiar with the requirements of their training role, to provide consistent and reliable service in their employment role, and to prepare themselves for the next stage of assessment and or training. After a period of time, often months and rarely more than a year, supervisor and trainees change partners and commence this intricate dance in a new pairing. It is perhaps surprising that most of the time things go well!

More complicated are the situations where bullying is suspected, observed or reported in a setting where the relationship between the various parties is less clearly defined. The person who is angry or derogatory in the workplace, or who is perceived to have a dislike for certain people based on factors such as race, gender or personal affiliations is often readily recognised but ineffectively managed.

As clinicians we should have the ability to apply some form of diagnostic process to the behaviours. If they are of recent onset and out of character they likely may be a manifestation of some form of personal issue for the protagonist, such as depression, that is manifesting as anger and irritation. If the behaviour is more constant, then we may be dealing with a situation where the perpetrator is unaware of the consequences and inappropriateness of their behaviour, and at the worst level may be completely

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insightless. Each of these situations requires a diagnostic approach as to the causation of the behaviour and an appropriately tailored response

As clinicians we know that prevention or early intervention are the most effective approaches to a range of disease processes, but often fail to apply this principle to inappropriate workplace behaviours. The reasons are understandable. Becoming directly involved in a dysfunctional interpersonal dynamic places ourselves at risk, and even if we are prepared to accept this risk we may lack the skills and resources to positively resolve the situation. However, 'doing nothing' is akin to watching a patient waste away and hoping that they will spontaneously recover rather than instituting an investigation into the source of their increasingly obvious problem.

No-one can condone any aspect of truly egregious bullying behaviours, but we must recognise the need to diagnostically examine the circumstance of each case to ensure that all details are understood and all perspectives gained. This can only be done effectively by an independent assessor who is not enmeshed in the allegations of bullying or the potential outcomes from such allegations.

Once the diagnostic process has been satisfactorily undertaken, there must be a rapid intervention at the earliest possible time, with the nature of the intervention determined by the results of the diagnostic process. Simply referring a perpetrator to a code of conduct will rarely achieve a satisfactory resolution, and unless all parties (including the observers of the bullying who have their own views about the behaviour) are effectively engaged in the process it is likely that there will be a less than satisfactory outcome.

In summary, every organisation or institution involved with the employment, training or supervision of medical professional needs to ensure that a structured set of processes and policies are in place, including:

- Effective induction and orientation of all new entrants to the system, including managers, supervisors, workers and trainees. This induction should clearly explain the organisational processes and the expectations for all new entrants, and should include reference to systems for dealing with conflict or discomfort. The process should be more than simply waving a 'no bullying' policy in front of the inductees – it needs to provide a vocabulary that explains the complexities of bullying behaviour, including triggers and the ubiquitous nature of bullying.
- Clear delineation of the rights and responsibilities associated with each role. For trainees these will include rights in terms of education, supervision, and being treated with respect, and also the responsibility to receive and respond to feedback, including negative feedback, provided that such feedback is objective, given in a safe environment, and provides opportunities to engage in a remediation plan.
- Early intervention if there is any reported 'breach', with an independent party undertaking the diagnostic process to determine the detailed nature and circumstances of the reported behaviour. This person will ideally be a clinician who understands the intricacies of the particular clinical work or training environment, but who is not directly involved with the supervision or career progression of the involved parties.
- Effective follow-up, designed to determine that the bullying has ceased, has not been redirected towards another individual, and that organisational factors that contributed to the behaviour have been addressed.

An oft quoted maxim is that we are all "victims of victims", a neat exposition of the complex relationship between bullying behaviours and the suffering that we have universally experienced at the hands of others. If we truly intend to eliminate complaints of bullying within our profession we need to collectively assume responsibility for our personal actions and responses.

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FEATURE

'SEDATION'—NOT TO BE TAKEN LIGHTLY

'Sedation' continues to confuse, both semantically and technically, writes Dr James Bradley, ASA Specialty Affairs Adviser. The background to the terminology used in describing this aspect of anaesthesia practice is reviewed, as is the continuing uncertainty surrounding 'sedation' delivered by non-anaesthetists.

The ASA has been contacted on occasion by anaesthetists who have been approached by hospital administrators seeking to define their responsibilities in relation to 'sedation'.

Invariably, the concern relates to 'sedation' administered by non-anaesthetists. Any solution to this concern requires consideration of the content of ANZCA PS09, "Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures".

PS09 is endorsed by the Colleges accommodating surgeons, radiologists, psychiatrists and intensive care specialists, and by the Gastroenterological Society of Australia. So to that extent, it is appropriate to confirm that members of those organisations would be guided by PS09, the understanding being that the Medical Board of Australia would see this as representing good practice.

However, PS09 is not endorsed by the Colleges representing physicians and obstetrician/gynaecologists, or currently endorsed by the dental profession. This independent approach is underwritten by the promulgation of documents addressing 'sedation' by cardiologists (Position Statement on Sedation for Cardiovascular Procedures: http://www.csanz.edu.au/wp-content/uploads/2014/08/Sedation-for-Cardiovascular-Procedures_2014-March.pdf) and 'conscious sedation' by dentists (Endorsement for Conscious Sedation Registration Standard: http://www.dentalboard.gov.au/Registration-Standards.aspx). What advice can be given in relation to 'sedation' administered by or at the direction of cardiologists, or for that matter, other practitioners not constrained by PS09?

When an anaesthetist is present at a procedure where other than general anaesthesia is administered, something loosely termed as 'sedation' is often administered as part of the anaesthesia attendance. This can vary from analgesia (intravenous or otherwise) through to 'deeper sedation' (which can readily progress to the point where

consciousness is lost). Sedation in this context is intuitively understood to be light, moderate or deep. In reality, the terminology is irrelevant to the extent that all levels of sedation are accommodated when the practitioner is credentialled and scoped as an anaesthetist.

PS09 becomes much more difficult to apply when the practitioner administering 'sedation' is not credentialled and scoped as an anaesthetist. This difficulty is compounded by confusion over the terms 'procedural sedation' and 'conscious sedation'.

Essentially, the term 'conscious sedation' is difficult to reconcile with the proposal that it might be achieved by drugs including propofol (PS09 1.1.1). Where the 'sedation' is administered by anaesthetists, PS09 readily accommodates the use of propofol through its various scenarios, but where 'conscious sedation' administered by non-anaesthetists is the intent, the requirements for credentialling, training and clinical support can be seen as complex.

The Australian Society of Anaesthetists (ASA) has been addressing the semantics of 'sedation' since 2005[1], and the American Society of Anesthesiologists certainly since 1999, with revision and reaffirmation in 2004, 2009 and 2013. The ASA also knows that the term 'conscious sedation' is only variably understood by anaesthetists.

In its preamble, PS09 expands the term 'sedation' to 'procedural sedation', and then classifies 'procedural sedation' as 'conscious sedation' or 'deeper sedation'. PS09's definition for 'conscious sedation' canvasses the possible need for airway, respiratory or cardiovascular intervention.

The documents of the American Society of Anesthesiologists, like PS09, address 'sedation' administered by both anesthesiologists and non-anesthesiologists, though the genesis of these documents was driven by forces not experienced in Australia. In American practice, 'conscious sedation' is expressed alternatively as 'moderate sedation/analgesia', this term importantly representing a 'physician service' recognised by American procedural coding systems, with a physician supervising or personally administering sedatives and/or analgesics to allay anxiety or pain during diagnostic or therapeutic procedures. This 'moderate' sedation is defined in American government [Joint Commission] standards, and physicians providing moderate sedation are required to be qualified to recognise 'deep' sedation and manage its consequences.

In defining physician delivered and directed 'sedation' and degrees of 'sedation', as well as the 'safe use of propofol', the American Society of Anesthesiologists uses three separate documents, in contradistinction to Australia (PS09).

The American Society firstly has a position statement on 'Monitored Anesthesia Care' [MAC][2] which distinguishes 'Monitored Anesthesia Care' as a 'physician service' distinct from 'moderate sedation', as defined above. 'MAC' requires an anaesthesia assessment and for the provider to be able to convert to general anaesthesia when necessary. By way of contrast, 'moderate sedation' is not expected to induce depths of sedation such that the ability to maintain an airway would be lost. 'MAC' then allows for the safe administration of 'maximal sedation' – in excess of 'moderate sedation' – and is the preserve of physicians who can utilise all anaesthesia resources.

In a second document[3] first published in 1999 and amended in 2014, the American Society differentiates between levels of sedation, employing the terms 'minimal sedation/anxiolysis', 'moderate sedation/analgesia' ['conscious sedation'] and 'deep sedation/analgesia', where purposeful response to painful stimulation differentiates this level of sedation from general anaesthesia. The document emphasises that sedation is a continuum, with practitioners intending to produce a given level of sedation being able to rescue from levels of sedations deeper than initially intended. Hairs are split to the extent that the ability to rescue from 'deep' when 'moderate' was intended, or from general anaesthesia when 'deep' was intended, is required, though in both cases the ability to manage airway interventions and inadequate spontaneous ventilation is required.

Finally, the American Society published a third document entitled 'Safe Use of Propofol' in 2004, amending it in 2014[4]. In relation to propofol, it affirms that sedation is a continuum, with the potential with this drug for rapid and profound changes in the depth of sedation in the absence of specific antagonists warranting special attention: such that where 'moderate sedation' is intended, the level of care should be consistent with that required for deep sedation ie. in effect, general anaesthesia.

The interest of the Australian Society of Anaesthetists in 'sedation' goes back to 2005, and as with the American Society, reflects a broad professional interest in the topic which is not merely limited to 'guidelines'. Essentially, the position of the Australian Society is that when an anaesthetist is present when diagnostic and interventional procedures are undertaken, the professional service provided is most easily described as 'anaesthesia', and as mentioned above, the terminology is irrelevant to the extent that all levels of 'sedation' are accommodated when the practitioner is credentialled and scoped as an anaesthetist.

In 2009, the ASA sought to specifically address anaesthesia provided by anaesthetists for gastroenterological procedures with an ASA Position statement, which was revised again this year (ASA PS13, 'Anaesthesia for

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Gastroenterological Procedures', accessible at https://www.asa.org.au/ASA/Education_Events/ASA_Position_Statements/ASA/Education_and_events/ASA_Position_Statements/ASA_Position_Statements.aspx).

For relative completeness, the position paper of the Canadian Anesthesiologists Society (CAS) on Procedural Sedation should be mentioned. The CAS defines 'sedation' and distinguishes it from general anaesthesia. However, the terms 'conscious', 'light', 'moderate' and 'deep' are rejected as having become "non-reproducible and difficult to interpret". In their stead, the use of the Ramsay Sedation Scale (RSS) is proposed. This is a six-point scale, originally described in 1974, and its components can be aligned against light, moderate and deep sedation. When considered previously by the Australian Society, the RSS was felt however to be more likely than not to introduce further confusion to a classification that was crying out for simplification. The CAS document can be accessed at https://www.cas.ca/English/Page/Files/97_Appendix%206.pdf

ASA PS13 states that 'anaesthesia' for gastroenterological procedures incorporates techniques variously referred to as analgesia, sedation and general anaesthesia, with the anaesthesia administered determined by practitioner and patient preference and the nature of the planned procedure, with a continuum from sedation (which can be logically and intuitively defined as 'light', 'moderate' or 'deep') through to general anaesthesia, the predictability of which can never be assured. Propofol is almost always used by anaesthetists, commonly but not invariably with midazolam and opioids. Credentialing and 'scoping' in this context requires the ability to manage general anaesthesia, in line with what is advocated by ANZCA PS09 in its scenarios '3', '4' and '5', and when administered by anaesthetists, presents no problems unless inadequate assistance or equipment is provided (ie. a PS09 'Scenario 5' cases are perceived as being 'Scenario 2', or the facilities supporting general anaesthesia are not present).

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REGULAR

HOW TO AVOID INVESTING IN THE WRONG PROPERTY

Stuart Wemyss of ProSolution Private Clients, looks at how to avoid investing in the wrong property.

If you invest in residential property, how can you be sure that it's going to work out for you?

The media often talks about property crashes and bubbles, whether the government should abolish negative gearing, the "housing affordability crisis" and so on. There's always lots of 'noise' about property that puts doubt in people's mind.

If you are going to borrow money to invest in property (and nearly all investors do), you must get a decent amount of capital growth (ie. more than 7% p.a.) to offset the cash flow cost and risk of holding the property. If you cannot be confident of achieving this level of capital growth then my advice would be; invest in something else. So this begs the question: how can you be confident that an investment property will appreciate in value at 7% p.a. or more on average over the long term? The short answer is quality. The longer answer is contained in this article.

The quality of your investments will determine your outcomes

Without a doubt, the quality of your investments will determine 80% of your financial outcomes (i.e. how much money you make). That is, if you invest in high quality assets, you should expect high quality returns. But the reverse is also true. Therefore, to increase the probability of being a successful investor (or put differently, reduce the risk of being unsuccessful), you need to obsess about only investing in the highest quality assets you can afford. A quality property is often referred to as 'investment-grade' property.

What is investment-grade?

Investment-grade properties should double in value every seven to ten years on a perpetual basis (which equates to a 7% to 10% per annum compounding growth rate). There are a two important points to make about this definition:

- Of all the properties that exist in Australia, less than 5% would be considered investment-grade – so I'm not talking about just any old property – just a select few.
- When I say 'perpetual growth', I'm not necessarily suggesting that it's never-ending. I'm really only talking about our lifetime. It is true that, mathematically, property can't double in value forever as eventually no one will be able to afford it. However, there are plenty of investment-grade properties that will double in value every seven to ten years over the next 30 years – and probably even longer. The discussion about property eventually levelling out is a valid one but not relevant to this article or our lifetime.

There are thousands of examples of individual properties that I can point to that have appreciated in value at average rates of 7% to 12% p.a. (compounding) over the past 30 years. Many two-bedroom, single-fronted houses in Prahran, South Yarra and Hawthorn in Victoria (for example) sold in the early to mid-1980s for $75k to $80k. The same properties would be worth in the range of $1 million to $1.2 million today.

Focus 1: Scarcity

Scarcity essentially means that demand will always be greater than supply (as the supply of scarce properties is typically fixed or in decline). Compare two examples: firstly an apartment in a block of 200 versus a Victorian-style, single-fronted, two-bedroom cottage. There's very little scarcity with the apartment because there are literally hundreds and thousands just like it. There is scarcity with the Victorian cottage because no one is building period-style cottages anymore and many are typically located on very (scarce) valuable land. Arguably, supply of these types of assets are in decline whilst at the same time there is increasing demand for them. Conversely, investing in a brand new house in a new residential estate doesn't make a good investment because land supply isn't scarce – it's often abundant. Just like with diamonds, or more correctly pink diamonds, scarcity pushes prices up.

Focus 2: Land value

Every established property's value is made up of two components; land value and building value. It is commonly understood that buildings depreciate over time and land appreciates. Tenants will typically be attracted to properties with more building value (accommodation) whereas investors should be attracted to properties with more land value. That's why newer properties tend to achieve a higher amount of rental income but lower capital growth.

Consider the example of a new apartment worth $550k that is located in a high-rise building. In this situation it would not be uncommon for the building value to be $500k and the attributable land value to be $50k (apartments always have an attributable land value as the blocks tend to sit on valuable land). For this

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property to double in value over the next ten years (value of $1.1m), what needs to happen? Well, the building component will depreciate to say $400k at the very least (probably lower). Therefore, the land value needs to be $700k (being $1.1m less $400k)– so it needs to increase from $50k today to $700k in ten years or 30% p.a. compounding over ten years. I'm sure you agree that this almost certainly won't happen.

Alternatively, consider a 2-bedroom 1930's apartment that is worth say $600k. In this situation, the land value is likely to be $450k and the building value is therefore $150k as the building is 80 plus years old. In the next ten years the building won't depreciate that much – maybe another $30k. Therefore, for the total property's value to double, the land needs to increase from $450k to $1.08m or 9% p.a. compounding.

Of the above two examples above, which one do you think has the most chance of happening? That is why land value is very important and one of the reasons buying property off-the-plan doesn't work.

Focus 3: Proven performance

It is important to check the past sales history of a potential investment property to assess its past performance. The reason for this is that the fundamentals that drive property values tend to be objective (not subjective) and static – or if they do change they take many decades to change. Things like proximity to shopping strips, hospitals, the CBD, arterial roads, architectural style, land size and so forth rarely change. Therefore, if these characteristics have been responsible for driving the value of a property up over the past 30 years, then it's likely that the same growth rate will occur for the next 30 years (assuming these fundamental factors don't change). It's about investing in a sure thing because you do not need to take the risk in investing in a property that hasn't proven it can deliver investment-grade returns.

There are a number of fundamental characteristics that drive a property's value, including:

- Scarcity and land value component, as discussed above.
- Proximity to amenities such as shopping, medical services, parks, schools, public transport, arterial roads and so forth.
- The quality of the dwelling: good natural light especially in living rooms, privacy (visual and noise), security, logical floor plan, attractive architectural style (inside and out), car park on title if it's an apartment, structurally sound building and so forth.

Therefore, before you invest, make sure that the property has demonstrated strong performance in the past.

Learn from other peoples' mistakes

As I said above, the quality of your investments will determine how successful/wealthy you will be. Therefore, if nothing else, your attention should be laser-focused on investing in only the highest quality assets you can find (that applies to property and all investments). To find these assets you should get some advice – or at the very minimum a second opinion. I don't do my own anaesthesia – I come to you for that. I didn't write my own will – my estate lawyer did that. And I don't select the properties I invest in (even despite my personal knowledge and experience) – my trusted buyers' agents do that for me.

Professional advice has two ingredients; knowledge and experience. Knowledge comes from training, reading books, education and so on. Experience comes only with time and practice. One is not a substitute for the other. When you seek professional advice you are benefiting from these two components but arguably, the most valuable is experience. They say that most people learn from their own experiences, smart people learn from other people's experiences and dumb people never learn!

When I meet with a new client I have an opportunity to share my experiences. The fact that I have been advising medicos for over 13 years means I have seen a lot of it before. I probably haven't seen it all but there are very few scenarios or situations that I haven't come across. I have the benefit of hindsight too because I have witnessed the outcomes of both good and poor decisions clients have made. The same is true for a good buyer's agent. They can share their experience with you.

Research shows that there are two common traits of extremely successful and experienced investors. Firstly, they are absolutely fanatical about risk, asking themselves; 'what can go wrong?' and 'can I lose any money doing this?' Once they are satisfied that the risk of losing money is remote to almost impossible (they never want to lose money), only then do they turn their attention to the potential upside being, return. Secondly, these investors only invest if they can exploit the risk-return equation. That is, they are looking to achieve very healthy returns for comparatively very little risk – they don't accept that you need to accept higher risk if you want higher returns. The only way you can take this approach when it comes to property investment is if you pay for professional advice and not try and do it all yourself.

If you are going to do anything, obsess about quality

In summary, you must ensure that all your attention is focused on only ever investing in quality assets. All you need to do to become financially free is to invest in quality assets as soon as your circumstances allow it. Invest as soon as possible so that you benefit from compounding returns. It really is that simple.

We have lots of tools and resources at our disposal to help clients invest successfully (including a network of trusted advisers) so please don't hesitate to ask for our help.

INSIDE YOUR SOCIETY

POLICY UPDATE

ASA Policy Manager, Chesney O'Donnell provides an introduction to Senate Committee Hearings.

INTRODUCTION TO SENATE COMMITTEE HEARINGS

Professional Issues Advisory Committee representatives appeared at a roundtable chaired by the Senate Select Committee on Health to discuss Public Hospital Funding in 2015. Previously the ASA was represented at the Senate Standing Committee on Community Affairs & Out-Of-Pocket in 2014. A Senate Hearing is advocacy at its rawest and presents an exciting opportunity to raise the profile of the ASA while demonstrating an important membership benefit. It also helps to promote ourselves to non-members as an organisation willing to meet with the Federal Government of Australia and advocate for the speciality as a whole. It's a rare opportunity. Strategically there are three stages that the ASA could pursue when it comes to dealing with the Federal Senate/Upper House.

Stage 1: Reference Committees

A References Committee's purpose is to deal with general matters referred to by the Senate. So far we have completed two Committee Hearings[1]. These Hearings are the embryonic stage of policy creation and development in the Parliament. Such hearings deal with broad policy issues and engage with the cross benchers and opposition Senators. The minor parties in the Upper House hold the balance of power and may come into greater significance if we require them to vote against a Government Amendment or Bill that may harm the profession of anaesthesia. The committees we were involved in have been:

- Senate Select Committee on Health 27 November 2015 (Sydney).
- Senate Standing Committee on Out-Of-Pocket Cost 17 September 2014 (Melbourne).

Stage 2: Legislation Committees

A Legislation Committee's purpose is to deal with Amendments and Bills referred to by the Senate and via the Government of the day. It also includes the estimates process and oversees the performance of departments, including their annual reports. One example is the Senate Standing Committee on Community Affairs. Don't be fooled by this innocuous and bland name. At present this is the government's committee. It is chaired and controlled by the current Coalition government. The emphasis here is on what the government wants to past through Parliament. A recent hearing has been the following which gained some attention in the media of late:

Senate Standing Committee on Community Affairs on Health Insurance Amendment (Safety Net) Bill 2015, 23 November 2015 (Canberra).

- In recent events the Committee Chair Senator Seselja announced that the "Turnbull government should publish evidence justifying its planned changes to the extended Medicare safety net to hose down fears they will affect vulnerable patients"[2]. This point of concession may have been influenced by "various stakeholders" who have been actively involved in this hearing and submission process. The changes are expected to save $266.7 million over five years for the Medical Research Future Fund.

Stage 3: Committee Advocacy

The room for debate is usually a bit more limited with Legislation Committees as opposed to a Reference Committee and if we wanted to influence the process by that stage we may have already missed the boat. Legislation Committees are a number crunching exercise. However with past efforts dealing with the opposition and crossbenchers in Reference Committees we may have the power to influence during these Legislation Committee hearings if we wanted a re-examination of an Amendment or Bill. By influencing those who have the balance of power we can try and stop any foreseeable policy changes negative to the profession of anaesthesia. In effect our involvement with relevant Senate Hearings is our insurance policy plan if events were to take a tumble for the worst for the profession of anaesthesia, legislatively speaking. It provides the ASA with a fighting chance to try and influence the process democratically.

CONCLUSION

The ASA is still evolving in our approach when dealing with Senate Committees as a whole. This is a fairly new venture for us. A good start is to first approach the Reference Committees where the issues are broader but the utility of our experienced membership and representatives will be better suited as expert stakeholders. In other words we have more control of the environment since the Senators are generally interested

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to hear our expert advice in order to provide them with some policy ideas, whereas the Legislation Committees can be more legally orientated and targeted towards a specific provision. It's the nitty gritty that's being examined here that may or may not have any far reaching impact. It can also be more adversarial and combative and not because of the complexities of the issues but more based upon the pressure of governance whereby the Government of the day needs to be seen passing effective Amendments and Bills which is the core business of our Parliament.

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CONTACT US

If you have any questions about the ASA Policy Team, please contact us.

Email: policy@asa.org.au

Phone: 1800 806 654.

SENATE SELECT COMMITTEE ON HEALTH — SYDNEY, 27 NOVEMBER 2015

Drs Simon Macklin, James Bradley and Antonio Grossi engage in a group discussion at the Senate Select Committee

Senators John Williams, Deborah O'Neill and Jan McLucas discuss matters at the Senate Select Committee

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WEBAIRS NEWS

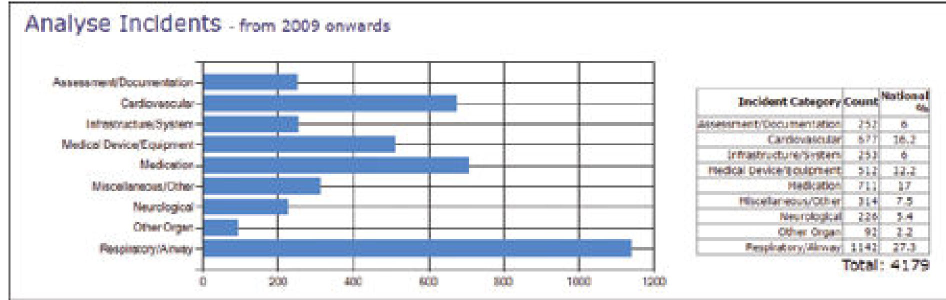
Dr Martin Culwick provides the latest update on WebAIRS.

WebAIRS has collected 4179 critical events, from 3792 reports submitted from October 2009 to April 2016. There are currently 123 registered sites in Australia and New Zealand. A new web page which displays a table similar to the one shown above has been released for the use of local administrators and webAIRS analysers. Local administrators at each registered site are able to review the number of events for the registered site, create illustrations for their morbidity and mortality meetings, as well as a comparison with the bi-national figures (as a percentage). The application is being continuously improved and various filters for analysis will be applied over the coming months. ANZTADC Analysers are able to view all the submitted reports but do not see the details of submitter or the site. The page is in the beta release phase, so please notify ANZTADC if you have any comments or suggestions.

WebAIRS has also released an updated home page (www.anztadc.net) which shows the current incident and site registration statistics, a news section, and more visible login and registration links. Presentations and workshops are also detailed under the banner of "Upcoming events". This includes a webAIRS session 'Error reduction strategies' scheduled for Tuesday 20th September at the ASA NSC in Melbourne. Two workshops are also planned for the ASA meeting and these will attract 2 CME credits per hour in the practice evaluation category.

Also, did you know...

WebAIRS allows individual anaesthetists to submit incident reports without the need to be linked to a registered site? In 2015 an update to the webAIRS registration process made new user registrations automatically default to 'individual'. The option to additionally link to a registered site (or register a new site) is always available and can be taken up at any time. When an incident is logged, the system gives the choice of forwarding it to a linked site or just submitting anonymously. Regardless of the registration type, webAIRS offers users the opportunity to earn CPD points and to contribute to an important service improvement initiative. The first peer reviewed article using webAIRS data is in the March edition of Anaesthesia and Intensive Care.



Incident Category	Count	National %
Assessment/Documentation	252	6
Cardiovascular	677	16.2
Infrastructure/System	253	6
Medical Device/Equipment	512	12.2
Medication	711	17
Miscellaneous/Other	314	7.5
Neurological	226	5.4
Other Organ	92	2.2
Respiratory/Airway	1142	27.3

Total: 4179

For more information, please contact:

Follow the links on the home page to download a webAIRS brochure, or contact ANZTADC at anztadc@anzca.edu.au

To register visit www.anztadc.net and click on the registration link on the right hand side of the page.

A demo can be viewed at http://www.anztadc.net/Demo/IncidentTabbed.aspx

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

Dr Mark Sinclair, Chair of the Economics Advisory Committee provides his update.

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

As members will recall from the most recent EAC report, some MBS Clinical Review Committees established by the MBS Review Taskforce have already met and made reports back to the Taskforce (Diagnostic Imaging, ENT Surgery, Gastroenterology, Obstetrics and Thoracic Medicine). At the time of writing, the Taskforce has not yet made its recommendations to the federal Minister for Health (Ms. Sussan Ley). These committees will also deliberate further, on the relevant sections of the MBS.

Newer Clinical Review Committees that have been formed include those for Dermatology, Endocrinology, Intensive care, Oncology and Renal Medicine. At the time of writing, the ASA has not heard of the results of any meetings held thus far. Members will be informed via our regular updates, such as the President's enews, as further information comes to hand.

At this stage we do not have a definite timeframe as to when a committee will be formed to review anaesthesia MBS items, nor any information as to which individual nominees will be accepted. The only information we have at present is that the review will commence in the "second half of 2016".

ASA Policy manager, Mr Chesney O'Donnell, recently attended a forum specifically convened for members of the secretariats of the various medical Colleges, Societies and Associations. He took advantage of the opportunity to specifically question members of the Taskforce as to how they decided on the make-up of the various review committees. Unfortunately he was not given a particularly helpful answer. Looking at the committees for other specialties, there is a heavy slant towards appointing people from academic backgrounds. The ASA has repeatedly pointed out that we agree such people will be an important part of the process, as knowledge of standards, guidelines and patient outcomes is essential to the task at hand. However, it is an absolute requirement that doctors from a private practice background, who have a level of knowledge of the MBS sometimes not demonstrated by those from a purely academic and/or salaried position, be appointed to the committees. Again, no definitive response has been received to this idea. However, at another very useful recent meeting between senior ASA office bearers and the senior health advisor to the Prime Minister, reported on by President Dr Guy Christie-Taylor in this edition of *Australian Anaesthetist*, there appeared to be some sympathy shown to our position.

As mentioned, members should check their email inbox for further information, which will be distributed when available.

MEETING WITH MEDIBANK PRIVATE (MBP) EXECUTIVES

Dr. Linda Swan (MBP Chief Medical Officer) and Mr. Marc Miller (General Manager, Innovation and Payment Integrity) met with myself, Chesney O'Donnell, and Policy Assistant Josephine Senoga, at the ASA head office in early April. A number of issues were discussed. As members will be aware, over 70% of Australian private hospitals have now agreed to participate in the programme initiated by MBP, regarding hospital-acquired complications. There has been significant concern about the idea that a for-profit insurer could unilaterally deny payments to hospitals, based on the fact that complications prove more costly to the insurer. Dr Swan and Mr Miller discussed several aspects of the programme. They assured us that MBP itself does not investigate specific patient outcomes. MBP keeps detailed statistics on the services provided to its customers, and the outcomes of treatment. Where there is a concern, MBP contacts the hospital and asks the hospital itself to investigate individual cases. The hospital's

report is considered by an expert engaged by MBP, and where the complication is believed to have resulted from a deviation from accepted practices, based on current standards and guidelines, the costs related to the complication will not be borne by MBP. The costs for the basic service (such as a surgical procedure) will still be paid to the hospital. If the hospital involved does not agree with the decision, it has the right to engage its own experts, and MBP has committed to following the resulting advice.

While some of this is reassuring, there is still some concern over the exact details of the process. We do not necessarily know the background and expertise of the people engaged by MBP to investigate such cases. Also, there may be doubt over what constitutes 'acceptable' practices, especially given 'guidelines' are just that, and that individual patient situations may require a deviation from 'guidelines'. However, further meetings with MBP are to be held (see below), where the ongoing MBP programme will be discussed again.

Also discussed were the detailed statistics MBP collects on MBS item claims. It is apparent that these are just as detailed as those collected by Medicare itself, as part of the Medicare Compliance Programme (although MBP of course only has access to statistics relevant to its own customer base). Concerns were expressed about claims by a number of individual anaesthetists, who are clear outliers for anaesthesia time items, or claims for individual diagnostic and therapeutic anaesthesia procedures. Members should be aware that payers such as Medicare and MBP are constantly assessing claim patterns, and that outliers could be subject to questions from these payers. In most cases, as we saw with the Medicare Compliance Programme, these claim patterns are fully justified, and the ASA will strongly support members in such circumstances. However, as always, careful attention should be paid to ensuring MBS claims are accurate. If in doubt, members should contact the Economics Advisory Committee via the Policy team at policy@asa.org.au, before sending out accounts.

MBP are very keen to continue dialogue with us, and have invited the ASA to meet with MBP senior executives at their Melbourne headquarters as soon as this can be arranged. Again, members will be kept up to date with any developments.

MEDICARE SAFETY NET

The EAC has been made aware of billing practices that appear to be taking advantage of the Extended Medicare Safety Net (EMSN). As members will recall, this initiative is aimed at protecting patients who require frequent medical services on an outpatient basis from high out-of-pocket (OOP) expenses. Currently, the OOP threshold for qualifying for the EMSN varies from $647.90 for singles and families with Commonwealth concession cards, and people who receive the Family Tax benefit (part A), up to $2030.00 for other singles and families. When the EMSN was introduced, some specialists began to charge many thousands of dollars for certain outpatient services, knowing that this would immediately qualify the patient/family for the EMSN, and that the patient would have a minimal OOP. One such service was cataract surgery, covered by MBS item 42702. As a result, item 42702 has been subject to a "cap" on the amount rebated under the EMSN (currently $114.10). However there is no cap (as yet) on anaesthesia items.

One specific account recently brought to the attention of the ASA involved a fee of many thousands of dollars for the anaesthesia time item for an outpatient cataract procedure. Again, this immediately resulted in the patient qualifying for the EMSN, and receiving a rebate of 80% of all surgical and anaesthesia fees. Such billing practices are not illegal. However, the medical profession has of late been receiving many harsh criticisms in the media regarding billing practices (see below), even where the medical fees are actually quite reasonable. The federal government is clearly committed to decreasing costs wherever possible, and a number of consumer and other organisations and institutes have come on board, again with harsh criticisms, and are receiving enthusiastic support from health and economics commentators. As members will be aware, some such criticism has actually come from medical bodies, such as the Royal Australasian College of Surgeons. In this environment, it is very hard to defend fees that are many multiples of the AMA fee.

ANAESTHETISTS IN THE MEDIA

In late April, The Australian published a series of articles, which were extremely critical of the medical profession, in particular on the issue of fees. The articles repeatedly stated that surgeons and anaesthetists are the two highest paid professions in the country, and accused the medical profession in general of overservicing and overcharging, to the detriment of Medicare and the private health insurance industry. There was no mention of the profitability of the for-profit health insurers (with a combined profit of over $1 billion last financial year), nor of the training required to become a specialist anaesthetist or surgeon, and the world class quality of our services.

At the time of writing, a response is still being planned. The reason for such a sudden flurry of media attention is uncertain, but members will be kept up to date with any developments.

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

PIAC Chair, Dr Antonio Grossi, provides the latest update on professionalism, in this issue of Australian Anaesthetist.

PROFESSIONALISM

Anaesthetists, and other medical specialists, have been criticised recently for their billings, income, tax arrangements, competence, contribution to the escalating healthcare costs and lack of professionalism. The ASA has been responding to many of these claims, which are factually incorrect. It is appropriate for us as anaesthetists to reflect on our own practice and ask why do these media reports resonate with public opinion?

I) COMPETENCE

A. What is the quality of anaesthesia care you deliver? Does your practice reflect evidence based medicine, peer reviewed guidelines, ANZCA professional documents and ASA position statements? Since February 2016, PIAC has revised the following position statements; PS03 Minimum Facilities for Pre-anaesthesia Consultations, PS05 The Provision of Anaesthesia Services to Rural Areas, PS06 Advice to members on Product Issues, PS07 Credentials and Clinical Privileges, PS13 Anaesthesia for GE procedures, PS14 Anaesthesia for Office-based surgery. Other position statements are being updated throughout 2016.

B. What precautions do you take to minimise adverse events in your practice? Recognising, reporting and analysing near misses and adverse events promotes a 'no blame', just culture improving quality and safety[1]. As in other high reliability industries, there are many human and system factors that contribute to adverse events[2,3]. These include fatigue, production pressure and normalisation of deviance[4]. This refers to accepting shortcuts such as cursory pre-anaesthesia assessment, failure to fully check the anaesthesia machine, mislabelling drugs, not participating in 'time out' or not being properly prepared with alternative management plans. NASA describes the Columbia space shuttle disaster as being due to a series of seemingly innocuous transgressions of protocols that were accepted as 'OK'[4]. It was not 'OK'. This normalisation of substandard practice resulted in a catastrophe.

II) REVALIDATION

A. Perhaps due to reports of recent medical disasters[5], the Medical Board of Australia has initiated the revalidation conversation[6]. The ASA believes that medical practitioners should be able to demonstrate that they are 'up to date', competent and 'fit to practice'[7]. Current comprehensive CPD programs[8] that include blended learning, multisource feedback, practice audits[9], combined with AHPRA's registration processes and compliance with national standards of clinical governance relating to accreditation of practitioners[10] commensurate with their scope of practice, already achieves these objectives. Revalidation seeks to identify undetected underperformance[11]. PIAC met with Dr Joanna Flynn of the MBA recently, who agreed that any revalidation model should be context sensitive, non-duplicative, build on current systems, practical, evidence based and cost effective. The ASA will provide feedback to a taskforce looking at a potential revalidation model for Australia that will deliver its findings later in 2016. The model is expected to be relevant for Australia unlike the complex and frustrating models seen in the UK or USA[9]. On the topic of sensible and practical CPD, McMahon[12] asks the question – 'What do I need to learn today?'

B. PIAC is also preparing a submission to the MBA on "Registration Standard for Specialist Registration".

III) PROFESSIONAL BEHAVIOUR

A number of member enquiries have highlighted poor professional behaviour.

A. Bullying and harassment

Mutual respect for our medical and non-medical colleagues requires anaesthetists to communicate effectively, compassionately and work collaboratively. Being clear about which behaviours are acceptable and which are not, is essential. Repetitive, unreasonable behaviour that abuses positions of power and causes

distress or humiliation in others constitutes bullying[13]. From a safety, productivity and legal[14] perspective, good 'Crew Resource Management'[3] cannot tolerate bullying behaviour. PIAC is preparing a submission on bullying and harassment for the Senate Community Affairs Reference Committee.

B. Billings & kickbacks

There have been reports of some surgeons requiring a financial reward for referring work to their anaesthetist. This is not consistent with RACS code of professional conduct[15]. It is important that anaesthetists remain independent advocates for their patients. Business 'arrangements', which threaten the anaesthetist's professional autonomy may compromise clinical decision-making. Members should contact the ASA if they feel they are being coerced into accepting substandard working conditions.

C. Third line forcing

PIAC has received reports of surgeon's being offered inducements or referrals to influence their choice of anaesthetists[16]. This qualifies as unsatisfactory professional conduct under section 139B section (f) of Health Practitioner Regulation National Law (NSW)[17] and may be illegal[16].

D. Random drug testing (RDT)

A member enquired if it were time for the anaesthesia profession to consider RDT as it occurs in other high reliability industries such as aviation, military, mining and the petrochemical sector[18]. While the ASA believes patients have the right to be treated by non-drug affected anaesthetists, and supports initiatives that will protect the community, it seems there are many aspects of random drug testing that need to be defined and clarified to make this a cost effective, scientifically valid and evidence based quality improvement initiative[18]. The ASA will keep members informed of developments in this space.

IV) ANAESTHESIA ACCESS FOR REGIONAL AND RURAL PATIENTS

A. While the oversupply of anaesthetists in metropolitan areas is reflected by available capacity[19], there continues to be a maldistribution of anaesthetists in regional and rural parts of Australia. The ASA continues to advocate for appropriate workforce planning through the revised workforce survey, meetings with NMTAN, the Minister for Health, the Prime Minister's Office and Senate Committee representations. It seems that a culturally and contextually appropriate solution needs to be developed for specific geographic areas. PIAC has formed a rural subcommittee to develop region specific solutions.

V) VALUE FOR MONEY

A. The 'fee for service' (FFS) model of payment for doctors has been criticised[20] with proposed alternatives including salaried or bundled payment options. FFS is blamed for the escalating costs of healthcare by producing provider induced demand. In Australia patients have a great deal of choice of primary carer. This drives demand for access to new services, technologies and treatments that may not necessarily be evidence based, but remain largely publically funded. Anaesthetists are well placed to provide common sense to a complex health system. As individual practitioners, we should question whether our own activities such as arterial and blood gas monitoring items are clinically justified.

B. As anaesthetists are we providing a 'good value', patient centric[21] service? If out of pocket costs are incurred, is the appropriate informed financial consent process being followed?

VI) CONCLUSION

A. Patients must trust their anaesthetist and have confidence in their expertise. As professionals, anaesthetists must be competent, up to date, practice according to a strict code of conduct[22], and display behaviours of altruism, compassion, diligence and care that engenders this trust[23].

B. The best way to neutralise unfounded media criticism may be to starve the journalist's fire of fuel.

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Study and Post Congress Tours

Three specialist post congress tours have been created to follow the World Congress of Anaesthesiologists in Hong Kong, 28 August – 2 September 2016.

The tours can be taken following the Congress or joined independently from Australia and New Zealand.

Anaesthesia in China
3 – 11 September 2016

This tour gives fascinating insight into China examining anaesthesia and pain management, alongside an examination of its culture. A repeat of the highly successful China tour in 2014, the tour is led by anaesthetist Dr John Crowhurst.

South West China and Tibet
3 – 11 September 2016

Travel from remote south west China, an area of incredible cultural diversity, and cross the mountains into Tibet – a land that is, above all, uplifting, both spiritually and physically. The tour is led by experienced tour leader, Jamie Veitch.

Vietnam
3 – 13 September 2016

This tour travels through Vietnam and includes a number of specialist visits and talks that provide insight into Vietnam's military and medical history. The tour is led by anaesthetist and search and rescue specialist Dr Paul Luckin. Optional Cambodia extension.

For further information on the tours and any flights required contact Jon Baines Tours:

Tel: 03 9343 6367
Email: info@jonbainestours.com.au

www.jonbainestours.com http://wca2016.com/post-congress-tours.htm

Jon Baines tours

INSIDE YOUR SOCIETY

GROUP OF ASA CLINICAL TRAINEES UPDATE

The common theme of the state reports for this quarter was the combined ANZCA/ASA Part Zero courses which were held in February, writes Scott Popham GASACT Chair.

The 2013 Queensland Part Zero course which I attended in my Introductory Training was my first introduction to the ASA and I recall finding it a very valuable networking experience. Coming from an ED followed by mainly ICU background in my junior doctor years, I was curious to know how other fledgling anaesthetic registrars were getting on in other local hospitals, and how their experiences compared to mine.

I was also keen to pick up any information that would enable me to have the best possible start to my training, and listening to the speakers giving out pearls of wisdom was invaluable in my first few months of training.

I was glad to see that, certainly in Queensland and from verbal reports in other states as well, that the spirit of the ASA and the Part Zero course in giving trainees that 'extra edge' at a key time in their careers has been preserved.

NSW

Welcome to Brenton Sanderson who steps in as Senior Trainee representative for the state. Adam Hill (previous NSW Senior Rep) attended the state's Part Zero and feedback was positive. Thanks also to Adam for his hard work as NSW rep.

TAS

Tasmania held their Combined ANZCA/ASA ASM from 20-22 February with the trainee's day being well attended. There was a talk from Thoracic Anaesthesia doyen Professor Peter Slinger which was a highlight of the trainee event.

VIC

Welcome to Kellie Brick as Senior rep and Liam Twycross Junior rep and thanks to previous reps Debra Leung and Greg Bulman.

Medical Viva Boot camps in Victoria organised by trainee reps appear to be very successful events and useful in the extreme – passing the Med Viva gives you an invitation to the Anaesthesia Viva and considering each of the two 18 minute vivas represent 6% it is very good 'value for money' to do well in them.

SA

Welcome to Cheryl Chooi who is taking on the role of SA/NT junior rep with Nicole Diakomichalis stepping into the senior rep role.

All the best to Brigid Brown who has done a fantastic job over the past year as senior rep.

QLD

There was a Primary Examination Practice Viva night at the Gold Coast University Hospital on the 12th of April which received funding from both the ASA and ANZCA. It was well attended and feedback was very positive.

On a similar vein there is a Final Examination Practice Viva morning at Nambour Hospital which, again receiving funding from both the ASA and ANZCA, will be held on the 14th of May.

The Part Three Course which will be organised later this year will be based on trainee feedback conducted in February to make it as relevant as possible for senior trainee members.

WA

The WA reps continue to organise successful networking events. They have two excellent projects in the pipeline; namely a state based resource manual for anaesthesia training in WA plus a mentor training program to supplement the WA Trainee Committee buddy system.

For more information, please contact:

Committees Assistant – Maxine Wade mwade@asa.org.au or phone 1800 806 654.

AUSTRALIAN Anaesthetist

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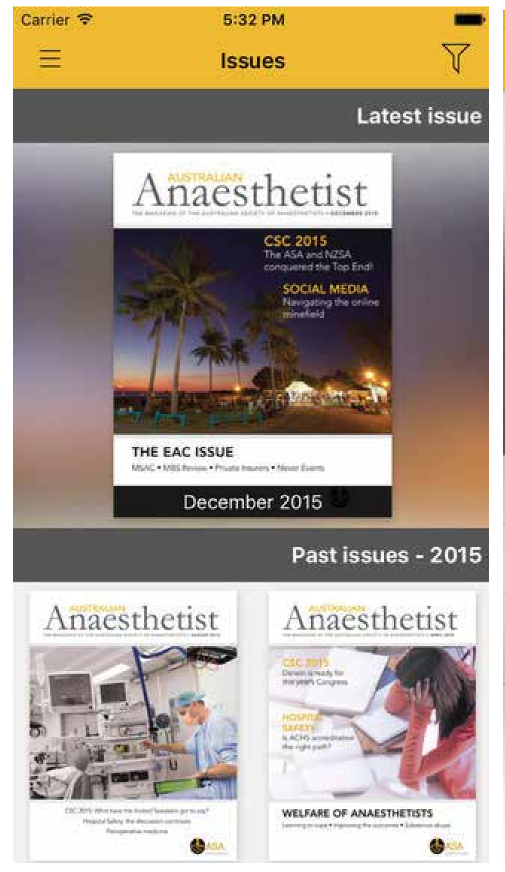

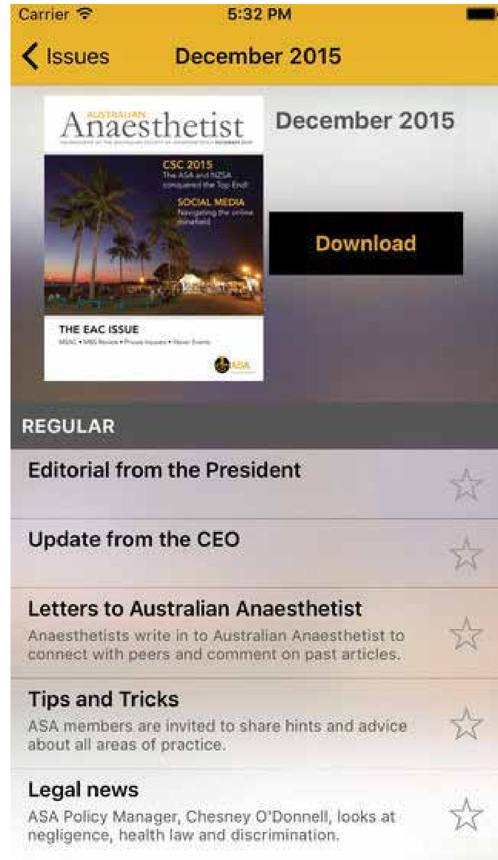

To download the App search for 'Australian Anaesthetist' in your App store and look for the following icon...

The App can be accessed using your standard ASA member login details. Please contact membership@asa.org.au if you have misplaced these.

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

'BLACK MAGIC' AT THE HARRY DALY MUSEUM

Book in your appointment to visit the Harry Daly Museum and enjoy the most recent addition to the exhibition titled "Black Magic… Agents from the New World". Here, we explore the discovery of the anaesthetic properties of curare, a medicine which had once been treated with suspicion by the western world. Early accounts from explorers referred to the "flying death" as the curare tipped darts shot from blowpipes would kill within a minute of contact. The exhibition includes the display of one such curare blowpipe donated to the collection in 1949.

Since the first report of poisoned weapons from the New World reached the western hemisphere in the early 16th Century, the research and discoveries of many explorers and scientists have led to a greater understanding of the foreign poison. In Australia, this culminated in 1945 with the country's first use of curare in the form of intocostrin. Sydney anaesthetist and our museum's namesake Dr Harry Daly convinced oral surgeon Dr Frank Carberry to allow a patient with a fractured mandible to be anaesthetised with the intocostrin. The surgery was a great success and Daly's pioneering use of curare was praised as a significant advancement in anaesthesia.

Contact us to arrange a visit to the the Museum. We are open by appointment Thursdays and Fridays. Please phone the ASA head office on 1800 806 654 or email asa@asa.org.au.

Julianne Kiely

Curator, Harry Daly Museum

View of the Harry Daly Museum's new addition "Black Magic… Agents from the New World"

Organizer:

Host Organizer:

16th World Congress of Anaesthesiologists

28 August – 2 September 2016
Hong Kong Convention and Exhibition Centre

SAVE THE DATE

Take the opportunity to represent your country at the 16th World Congress of Anaesthesiologists being held in the vibrant city of Hong Kong from 28 August to 2 September, 2016.

WCA 2016 will again prove to be a truly international event that covers the varied fields in anaesthesiology and its sub-specialities. The congress will once again:

- Showcase the latest research and findings in anaesthesia, pain medicine and intensive care
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- Provide many opportunities to meet and discuss hot topics with the experts
- Encourage you to make new friends and learn from each other

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Circulation
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Pain
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Professional Practice
Regional
Research and Publication
Respiration and Airway
Safety and Quality
Technology

www.WCA2016.com

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

QUEENSLAND

Dr Jim Troup, Chair

First up, congratulations to Dr Scott Popham on his election as national GASACT Chair. Scott has been a fantastic GASACT representative on the Queensland Committee. I'm sure he will do well as the national trainee leader.

Professional

Thank you to Drs Jim Bradley (Specialty Affairs) and Guy Christie-Taylor for substantially fleshing out the ASA's response to the Queensland Chief Health Officer's Queensland Medical Workforce Survey. This was submitted after some refinements from the Queensland Committee of Management.

In Queensland members have raised an issue with the introduction of electronic medical records (EMRs) in some private hospitals. Where this is occurring the old paper charts, which may contain valuable information, are sometimes not available. This has obvious safety implications if a previous anaesthetic issue has been documented but the current treating anaesthetist is not able to access this information. Discussion within the Committee has highlighted that this is sometimes the case in hospitals that do not yet have EMRs. We are about to approach hospitals about correcting this.

The Committee will also be approaching the private hospitals to ask them to make the Anaesthesia Crisis Manual available in each anaesthetising location.

Events

In February the Part Zero course was run – Scott Popham attended for the whole day, whilst I attended in the afternoon to present. We followed up with drinks at a small social event. The day was a success in terms of signing up 13 new trainee members. It was good to meet cheerful and interested trainees or soon-to-be trainees.

The combined Queensland ANZCA-ASA meeting will be held in Brisbane on June 25th. The theme will be Perioperative Care of the Injured Patient.

The Queensland Committee are in the process of organising a social event for members which can also act as a membership recruitment activity. No firm date yet but October or early November are firming as the favourite time.

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin, Chair

Our first CME meeting of the year was yet another successful event and I thank the organising committee for their efforts to provide an interesting program for 2016. Following on from the meeting in March 'Anaesthesia and Recreational Drugs' with 64 attendees, we look forward to June 22nd when Assistant Professor Kingsley Storer will present on a topic that is of keen interest to many of us: 'Mind the Gap': How systems neuroscience can help explain what we still don't know about unconciousness under anaesthesia". This event will be at the usual venue: Queen Victoria Lecture Theatre, Women's and Children's Hospital, at 7.30pm. As usual, light refreshments will be available.

Remember that you can register on the ACE website www.acecc.org.au. Please note that this has been rebadged to be 'Anaesthesia Continuing Education' and comes with a new logo. This should be your 'go to' site for anaesthesia related CME events. I look forward to seeing you all there!

SANT COM AGM

We are pleased to announce the AGM will take place immediately prior to the 22 June CME.

Nomination forms will be distributed in the near future so keep an eye out for them in your email inbox. Your attendance will be much appreciated. If you are interested in being part of this committee, please contact me samnjo@mac.com or 0419 543 820.

e-Newsletter

I hope you enjoyed the inaugural SANT ASA eNewsletter. I am not sure whether you were driven by curiosity but it has attracted a 73% opening rate. I hope you found the contents interesting and of some value. If you have any specific comments to make or feedback to give – positive or negative – I look forward to hearing from you.

Membership

We continue to make progress with our local membership numbers, having seen a modest 4% growth since June last year

INSIDE YOUR SOCIETY

(better than CPI). Thank you to all our members who continue to support the ASA, which allows the ASA to continue to support, represent and educate our members.

Remember also the role played in your hospitals by your welfare officers, or the 'Doctors Health SA' program – http://www.doctorshealthsa.com.au – if you want to discuss issues that need to be outside of the immediate workplace.

Philanthropy

If you have always felt that you would like to volunteer for overseas aid work but somehow it has never quite worked out for you because of family commitments, work opportunities, health and safety issues when away or just uncertainty, then all is not lost. For a day in May you can join the 'Twice the Doctor' Foundation and donate you one day's earnings to support Unicef or the Fred Hollows Foundation to pay the wages for a Doctor in Sierra Leone or Ethiopia for a month (approx. $1000) or a nurse for 5 months (at $200 per month). If this is of interest to you, have a look at this slideshare http://www.slideshare.net/centralcoastrestaurant/twice-the-doctor-foundation or visit http://twicethedoctor.org.au/projects/sierra-leone/

Unfortunately, we missed the April edition of Australian Anaesthetist for this article. Although the day for donation was nominated as Friday 20th May, this was a marketing strategy so that you could be 'Twice the Doctor for a Day in May' – it has a 'ring' to it. This date is not obligatory and you are free to choose any day of the year!"

AUSTRALIAN CAPITAL TERRITORY

Dr Mark Skacel, Chair

On April 14 the ACT anaesthesia trainees led by Dr Jennifer Hartley and Dr Chris Mumme organised an excellent dinner meeting. The invited speaker Assoc Prof Alicia Dennis covered the topics of eclampsia and obstetric emergencies. Consultants and trainees thank her for taking time out from her busy schedule to lecture in Canberra. I would like to thank the ASA and ANZCA for sponsoring this meeting.

The Art of Anaesthesia meeting is to be held 15-16 October 2016 and will coincide with Floriade flower festival. The co-convenors for this event are Dr Carmel McInerney and Dr Girish Palnitkar and they will be finalising the programme in the next few weeks. The theme for the meeting is 'Back to the Future' and the Saturday program will consist of presentations on the modern management of some old chestnuts such as coagulation, illicit drugs and pulmonary embolism to name a few. The Sunday program will be focused on the following workshops, CICO, Anaphylaxis and Fibreoptic Bronchoscopy. The meeting is to be held at the John Curtin School of Medical Research, Australian National University.

Dr Ross Peake from the ACT has organised an excellent Regional Ultrasound Scanning Workshop in Thredbo from 14–17 July 2016.

The VMO dispute has moved to arbitration and of note, ACT Health has requested, firstly, indexation be set at 0% over the terms of the three and five year contracts and, secondly, a cut in Fee for Service payments of around 15%.

WESTERN AUSTRALIA COMMITTEE

Dr David Borshoff, Chair

Western Australia continues to deal with the economic downturn.

The opening of the new children's hospital has been delayed again but the Fiona Stanley has been relatively quiet on the newsfront. There was surprise at the resignation of the head of the new Childrens Hospital and our Premier is convinced the hospital will open 'sometime later in the year'.

There is still a hold on any new public hospital appointments until the end of the financial year, but the recent state budget, although predominately structured to create a surplus by 2020 and predicting a $40b state debt in two years time, perhaps surprisingly for some included an $8.6b spend on health – up 5%.

The Autumn Scientific Meeting was once again a great success with an excellent standard of presentations by guest lecturers, and a wonderful meander through her own working history in both Scotland and outback Australia, given by Aileen Donaghy in the Bunny Wilson Memorial Lecture.

The first quarter morbidity and mortality meeting held in association with the SJGHC group, was the most popular to date with over 110 anaesthetists enjoying some excellent food and drink courtesy of MSD and some really interesting cases.

On a more sombre note we farewell Dr Terry McAuliffe. A gentleman and a well-known mentor to generations of anaesthetists he will be fondly remembered by all who knew him.

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from March to May 2016.

TRAINEE MEMBERS

Dr Blagoja Alampieski	NSW
Dr Chun Wah Chui	SA
Dr Christopher Cummerford	QLD
Dr Mustansir Farooq	QLD
Dr Nikolai Fraser	SA
Dr James Edward Nevin Gardiner	QLD
Dr Emily Anne Hamilton	WA
Dr Allan Hurley	QLD
Dr David John	VIC
Dr Clement Lee	NSW
Dr Victoria Elizabeth Lingard	QLD
Dr Stuart McKnown	ACT
Dr Daniel Morcombe	SA
Dr Craig Morrison	SA
Dr Tyrone Paikin	QLD
Dr Alicia May Paterson	SA
Dr Caydee Pollock	QLD
Dr Courtney Maree Roche	QLD
Dr Catherine Rudinski	NSW
Dr Mark David Sharples	WA
Dr Carmel Toms	SA
Dr Aaron Victor	NSW
Dr Matthew Kyle Wagner	QLD
Dr Samuel Walker	QLD
Dr Samuel Jeremy Whitehouse	SA
Dr Nicole Whitlock	QLD
Dr Maysana Allaf	VIC
Dr Hamish Bradley	TAS
Dr Adam Cammerman	VIC
Dr Tejas Chikkerur	NSW
Dr Benjamin Dal Cortivo	NSW
Dr Chloe Heath	WA
Dr Kate Elizabeth Howson	NSW
Dr Kent Lavery	VIC
Dr Samuel Lewis	ACT
Dr Ainsley Lorych	VIC
Dr Harry Idris Marsh	VIC
Dr Clare McCann	VIC
Dr Vaughan McCulloch	VIC
Dr Alice Louisa Moore	VIC
Dr Mark O'Donnell	VIC
Dr Chad William Oughton	VIC
Dr Liam George Twycross	VIC
Dr Mitchell Allan Warren	NSW
Dr Stewart Anderson	SA
Dr Armin Baghini	SA
Dr Stephanie Cruice	QLD
Dr Sean Davies	VIC
Dr Alice Goldsmith	NT
Dr Harry Laughlin	TAS
Dr Peter Michael Simmons	NSW

ORDINARY MEMBERS

Dr Dennis Gokcay	NSW
Dr Emad Samir Hanna	VIC
Dr Christine Anne Huxtable	SA
Dr Mathieu Guy Ickeringill	WA
Dr Gurvinder Kaur	SA
Dr Miles Ma	QLD
Dr Jun Dennis Parker	VIC
Dr Timothy Zien Tay	WA
Prof Krishna Boddu	WA
Dr Michael Charles Lumsden-Steel	TAS
Dr Mahsa Adabi	VIC
Dr Andrea Jane Bowyer	VIC
Dr Anthony John Klobas	WA
Dr Don McLachlan	NSW
Dr Ravindran Samuel Nathan	SA
Dr Ruta Nerlekar	VIC
Dr Vaughn Oerder	ACT
Dr Dana Pakrou	QLD
Dr Juluri Rao	QLD
Dr Ross Dominic Scott-Weekly	WA

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Colin Hopper McCulloch (NSW) and Dr Norris Harvey Green (QLD).

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

INSIDE YOUR SOCIETY

UPCOMING EVENTS

JUNE 2016

NSW Regional Conference

Date: 18 June 2016

Venue: Hilton Sydney

Contact: nswevents@anzca.edu.au
02 9966 9085

JULY 2016

37th Annual ANZCA/ASA Combined CME Meeting

Date: 30 July 2016

Venue: Sofitel Melbourne on Collins

Contact: vic@anzca.edu.au

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