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Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • SEPTEMBER 2016

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THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

The Australian Society of Anaesthetists (ASA) exists to promote and protect the status, independence and best interests of Australian anaesthetists.

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

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INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The December issue features of *Australian Anaesthetist* will focus on Regional Anaesthesia and the 2017 ASURA Meeting.
If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 6th October 2016.
- Final article is due no later than 17th October 2016.

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

ASA EDITORIAL FROM THE PRESIDENT

DR GUY CHRISTIE-TAYLOR
ASA PRESIDENT

This issue of *Australian Anaesthetist* contains a discussion-piece by Dr Jim Bradley on *Australia's Future Health Workforce - Anaesthesia* report from the Department of Health. The work by Dr Bradley puts the report into its historical context and is a very balanced summary and reasoned critique of the findings of the report.

The report is in the public domain and can be easily downloaded from http://bit.ly/anaesthesiareport.

With the modelling in the report extending out to 2030, the Executive Summary states "the results of the projections reveal a workforce that is in balance". So is it business as usual?

No.

In fact there are two provisos:

1. Trainee numbers must not increase.
2. The number of International Medical Graduates (IMGS) must decrease.

Why must the above provisos be met? They must be met to avoid a potential shift into oversupply.

The report indicates that even if a scenario of increased demand for anaesthetists were to arise then the workforce is in a position to implement various tactics to meet community needs. The workforce currently has the capacity to mobilise 52.5 FTE from underutilised segments.

The report is very particular that intake into the anaesthesia training program should not be driven by pressure or demand from medical graduates.

Intake must be attenuated to achieve a delicate balance between:

1. Business fiscal interests
2. Medical students vocational aspirations
3. Evolving community requirements

The report indicates a bottleneck of partially comparable IMGS who have not been able to obtain Fellowship. The report, in particular, indicates that there may need to be a more meticulous assessment of candidate's ability to complete the required examinations, before deeming the candidate as partially comparable.

The report indicates that the change to the ANZCA curriculum appears to have reduced the training bottlenecks that were previously problematic. In particular; rotations through neurology, paediatrics, cardiac and complex obstetrics.

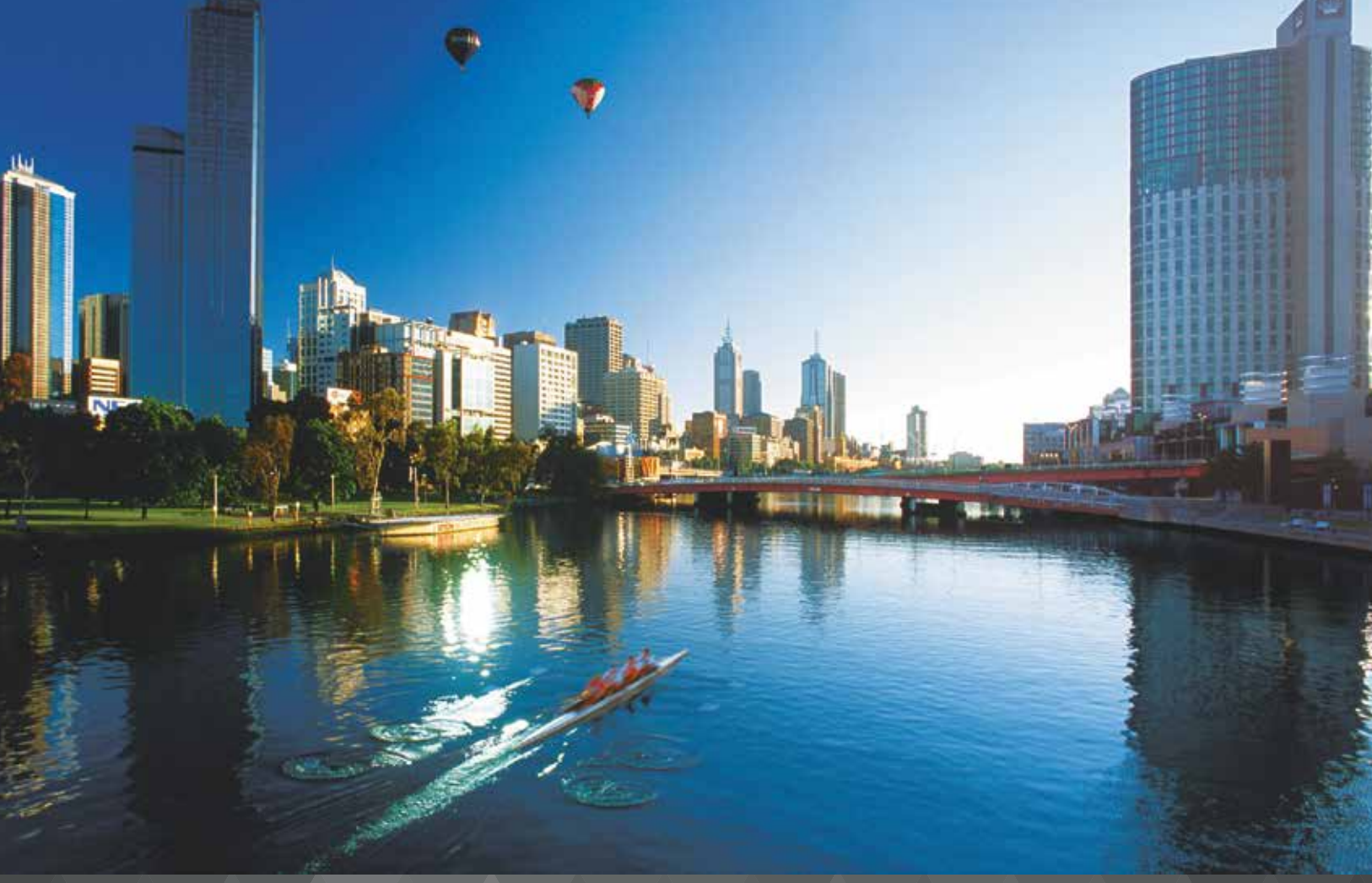
So what numbers are we discussing? Using the College Scenario Reduction to Migration on page 42 of the report it would indicate that once the current bottleneck of IMGS are dealt with and numbers decrease, the workforce will be 0.5% more than the required number of anaesthetists in 2030.

So noting we have 166 local New Fellows and 43 IMGS Fellows in 2016, the report projects the need for 166 local New Fellows and 51 IMGS Fellows in 2030. The implication of this is clear-in order to achieve balance in 2030 there must be no increase in locally trained Fellows for the next 14 years. The number required in any one year between 2016 and 2030 will only range between 152-166. Further, there are projected workforce surpluses of 3.6%, 3.7% and 2.6% in 2018, 2020 and 2025. There was an historic peak in total new Fellows in 2013 of 256. Clearly such numbers were not sustainable.

The report also deals with General Practitioners providing anaesthesia services. An examination of the MBS Items billed data would indicate that 6.3% of these services are delivered by a GP, with 57.6% of these GP delivered services provided by a workforce based in MM1 (that is, in capital cities and the largest non-capital cities), and the majority of services provided for upper and lower GI endoscopy.

Crucially the report makes the following key general points: updates to the workforce modelling results to determine future requirements must be made every two years; the report states there is a lack of coordination across the medical training pipeline. Between governments, universities, medical colleges and the various employers of doctors, there are hundreds of individuals making decisions on how many doctors and what types of doctors are trained in Australia. Ensuring these individual decisions are aligned to what Australia needs from doctors in the future is essential.

The speciality's response to the report cannot be one of business as usual; it demands a critical appraisal by the ASA and ANZCA, together with our additional survey data, to ensure that we are evolving our workforce in a coordinated fashion to align with Australia's needs now-and every two years to come!



2016 ASA ANNUAL GENERAL MEETING

Please join the election of Office Bearers, reports from key Committee Chairs, approving changes to the Constitution 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.

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ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

CONSTITUTION AMENDMENTS

Proposed amendments to the Constitution, which will put into effect changes regarding the governance reforms that the Board will propose to members at this year's AGM, are being finalised. As I have outlined in previous communications, the amendments to the Constitution are designed to put in place more contemporary, best practice governance.

The effective and efficient governance of the ASA provides the platform for achieving our strategic objectives, improving the performance of the ASA, increasing Member engagement and ultimately contributing to the sustainability of the organisation.

The Board has worked to align its governance structure with contemporary practice, including taking the following steps:

- A Strategic and Governance Workshop by Polaris Consulting in 2015
- A consideration by the Board of different governance structure options
- Discussion papers prepared by management and Board members examining varying approaches
- A Board adoption in March 2016 of a proposed reform.

What emerged from the review and subsequent discussion was that the current structure of the Board could be improved and that steps should be taken to create a new Board that would be responsible for the business management of the ASA whilst establishing a Council that would be responsible for the broader professional aspects of the ASA. At the same time this step will see the removal of the Executive. The Executive which has consisted of the elected Office Bearers has in fact operated as a 'Board within a Board', and in current governance thinking this is not ideal.

This represents the key change to the Constitution: establishing a smaller Board that will have the legal responsibility of Directors and will be responsible for 'running the business of the Society'. The 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 specific amendments to the Constitution that are being proposed, are available on the ASA website for members to peruse prior to the AGM.

Thank you to the 600 members who completed the recent Member Survey. The survey which focussed on service delivery and what you as members regard as valuable from your ASA membership will be used to shape how services are offered into the future. Within this issue there is an initial summary of the responses received and I am sure you will find this of interest.

August was a very busy month with both the annual Common Issues Group (CIG) meeting and the World Congress being held in Hong Kong. This year's CIG was staged immediately before the World Congress and was attended by representatives from the AAGBI, the Canadian, New Zealand, South African and US Societies. ASA was represented by Drs Guy Christie-Taylor, David Scott and Richard Grutzner, and myself. The topics discussed included workforce issues and welfare of anaesthetists.

This month is of course the National Scientific Congress being held in Melbourne. With registrations strong, I am sure this will prove to be another wonderful meeting. I would like to take this opportunity to thank Dr Simon Reilly, Professor Colin Royse and the members of the Committee for their generous contribution to this meeting and making it what I am sure will be a memorable event.

CONTACT

To contact Mark Carmichael, please forward all enquires or correspondence to Sue Donovan at: sdonovan@asa.org.au or phone the ASA office on 1800 806 654.

MELBOURNE 2016

AUSTRALIAN SOCIETY OF ANAESTHETISTS 75TH NATIONAL SCIENTIFIC CONGRESS

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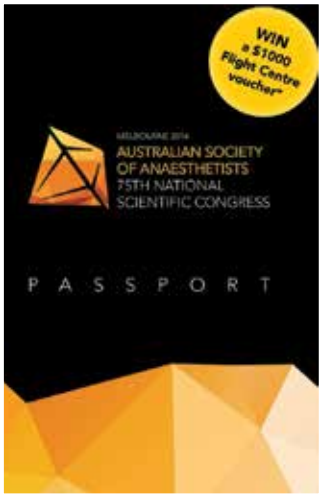

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REGULAR

LETTERS TO AUSTRALIAN ANAESTHETIST

I refer to the letter from Drs Duncan and Clarke (Australian Anaesthetist, June 2016), regarding point of care (POC) coagulation testing in the management of hamorrhage, and thank them for the list of references provided. Their points that the use of POC testing rather than 'uncontrolled' use of blood products is of benefit to patients, and could also result in cost savings, are well taken.

Drs Duncan and Clarke then go on to argue that current Medicare expenditure on item 22002 should be transferred to point of care testing. Unfortunately, this represents a fundamental misunderstanding of how the federal Department of Health (DoH) approaches the issues of updates and changes to the Medicare Benefits Schedule (MBS).

If the profession no longer supports the existence of a specific MBS item, and makes DoH aware of this (for example, via the current formal MBS Review), DoH will act swiftly and enthusiastically to abolish the item. We already have proof of this, with a series of such items already having been abolished following consideration by the MBS Review Taskforce. However, we can guarantee that, should item 22002 be abolished, there is zero probability that this funding will be shifted to a new item for POC testing simply because, in Drs Duncan's and Clarke's words, "…we believe that Medicare has the potential to save considerable sums of money with improved patient outcomes".

DoH has made the ASA well aware that the available pool of Medicare funds is not like a collection of bank accounts. Funds cannot be shifted from an old item to a new item, simply because the profession argues this would be worthwhile. As POC coagulation testing is currently unfunded, DoH would consider it to be a new technology (at least as far as the MBS is concerned). Therefore, there would have to be an application to the Medical Services Advisory Committee (MSAC) of DoH. After a detailed application is made, and MSAC has analysed the situation and asked various relevant questions of the applicant, MSAC would engage numerous medical and health economics experts, in order to assess whether the technology represents the 'prime directive' (my terminology) of MSAC, that is, to confine public funding to technologies and treatments which represent 'safe, effective and cost-effective' care.

The whole MSAC process can take several years, with no guarantee of success. Having read Drs Duncan's and Clarke's letter, I am confident that MSAC's requirements for "safe, effective" care would ultimately be satisfied. However, the question of "cost effectiveness" is much more difficult to answer to MSAC's satisfaction. MSAC has gone on the record to state that cost-effectiveness will be given more emphasis than clinical benefits. And of course, unless detailed health economic studies have been performed, the high level economic evidence required by MSAC will not exist. The application will therefore go the way of various others (including the use of ultrasound to guide invasive procedures performed by anaesthetists), in which saftey and effectiveness were proven, but no high level economic evidence could be presented, resulting in rejection of the application.

Furthermore, MSAC has clearly demonstrated several other philosophies which will almost certainly result in rejection of such funding. MSAC has a clear anti-fee for service agenda, and also a clear agenda to avoid multiple MBS items applying to the same episode of care. MSAC is also prepared to use anecdote and unsupported personal opinions in order to reject funding applications, while demanding high level evidence before supporting such applications. I will not go into details here, but referring to the final MSAC summary for ultrasound (recommending rejection) and the ASA's final critique of this rejection, will make all of this this quite obvious (available at asa.org.au, by following the links News/ASA_Submissions). MSAC makes a series of statements to justify rejection. Many of these have no supporting evidence, or even directly contradict the existing evidence, and the anti-fee for service and anti-multiple items agendas are clearly demonstrated. Our challenges to MSAC to justify their approach have gone unanswered.

Finally, I must take issue with the statement by Drs Duncan and Clarke regarding the 'simple' task of "hanging a bag of blood". At the very start of their letter, Drs Duncan and Clarke refer to the "adverse effects associated with the transfusion of blood and blood products", and later state that it "may be detrimental to the patient's welfare". These statements are quite true, as we all know. The transfusion of blood products most certainly adds to the clinical and administrative reponsibilities of the

anaesthetist, and a fee (and applicable Medicare rebate) are therefore justified. Drs Duncan and Clarke hint that the existence of the rebate may result in an incentive to administer blood when it may not actually be necessary – "lowering the threshold" is their term. I would suggest that the simplicity of POC coagulation testing, which is virtually risk free to the patient as opposed to a transfusion, would result in the same or even greater degree of incentive or 'lowering the threshold', should a Medicare item be introduced. In any case, the solution to the overuse or inappropriate use of Medicare items (unfortunately, a problem which has occurred across numerous specialties from time to time) is not simply abolishing the item, to the detriment of the patients of the vast majority of doctors who are strongly motivated to do the right thing. Rather, the correct approach is to educate the profession, in particular the small number of practitioners whose claim patterns are doubtful. This 'educational' approach could include reminding doctors that 'outliers' for certain claim patterns can easily be identified by Medicare and the private insurers, and that action could be taken against them.

The inappropriate administration of blood products is a serious matter, and the ASA's Professional Issues Advisory Committee (PIAC) would be glad to assist and offer initial advice, on a confidential basis, as to how to handle any individual instances identified.

Drs Clarke and Duncan, and the readers of Australian Anaethetist, may also be interested in the following data provided by Dr. Andrew Mulcahy, who has collated the raw data on item 22002, available on the Department of Human Services website: http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp.

In the 2002-03 financial year, there were 27,020 claims for item 22002, meaning that 1.80% of anaesthesia services in the private sector that year involved a blood transfusion. In the 2014-15 financial year, the number of claims was 21,777. This represented only 0.85% of private anaesthesia services. There has been a gradual decrease year by year; this is not a recent trend.

The incidence of claims for item 22002 has more than halved over the last decade or so. Perhaps Australian anaesthetists have already previously considered some of the concerns raised by Drs Duncan and Clarke. In any case, Medicare has already saved a significant sum of money as a result of our changing practices.

Dr Mark Sinclair
Chair, Economics Advisory Committee
Australian Society of Anaesthetists

BLACKHAWK ANNIVERSARY

The 12th of June 2016 marked 20 years since the Townsville Blackhawk Disaster where 18 defence force personnel died.

48 hours after the incident I was called up from the reserves from Lismore and found myself taking off from Ballina in the back of a C130 Hercules, with all the empty caskets, on route to Townsville. It was a sombre and sobering trip. In Townsville I was tasked with flying a ventilated paraplegic soldier with chest and pelvic injuries as well as extensive burns to Royal Perth Hospital. His name was Jerry Bampton and I have followed what happened to him closely over subsequent years.

It soon became clear to me that compensation for his injuries was inadequate – as per theage.com.au article of April 7th 2005: http://www.asa.org.au/UploadedDocuments/Publications/TheSurvivorJerryBampton.pdf – and so with the ASA's help, a number of medical specialists worked to improve death and disability compensation for all in the Australian Defence Force (ADF).

Anaesthetists were in an ideal place to advocate for improvement. Not only did we meet and look after these people when they were injured but also we were reservists with careers outside the military, so less was at stake if we spoke our truth honestly. With effectively no full time specialists then in the ADF, we were essential to go anywhere where there was a significant risk of injury or death to ADF members. The ADF needed us far more than we needed the ADF.

Initially I worked within the Chain of Command. Superiors within health services confidentially agreed that there was a major problem but found it difficult to resolve while maintaining their own career path within the military. When attempting to resolve this within the military proved fruitless, I enlisted the support of the ASA. Dr Rod Westhorpe, Dr Wally Thompson and Joe Dalzell all worked extensively and constructively to raise this issue at the highest political level. Eventually a Lismore journalist, Katherine Breen-Kurucsev, wrote 'No Specialist Treatment' for the *Bulletin* magazine with my assistance (http://www.asa.org.au/UploadedDocuments/Publications/TheBulletin_6Oct1995.pdf). This I think was a turning point and there was a general acceptance that things had to change. With time and through the necessity of a higher tempo of deployment, many of these issues are now addressed. It would have been nice if relationships between myself and senior military officers could have been preserved through this process but that has proved somewhat elusive.

It would be over a decade since I last read an article about an injured defence force member or their widow complaining about a lack of appropriate compensation.

The ASA was pivotal in resolving this issue. Only two medical officers have died on active duty since the Vietnam conflict and neither were anaesthetists. The ASA, particularly during Wally Thompson's time as President, has had a major role in improving death and disability compensation for all ADF members.

While this is a sensitive time for the families of those killed and injured twenty years ago, I just wanted to take this opportunity to say that I am proud to be a part of such an effective and altruistic organisation as the ASA.

Thank you for your support then and since.

Peter Cook
Anaesthetist and Intensivist

P.S. *The Age* article misspelt the SAS Corporal's name. It is Jerry Bampton not Brampton.

Ed Note:

We'd like to thank Peter Cook for his feedback and welcome letters such as this that reflect changes and improvements wrought by the hard work and dedication of members through the Society.

HAVE YOUR SAY

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

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

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

2016 MEMBER WORKFORCE SURVEY

Dr James Bradley, Specialty Affairs Advisor, summarises the 2016 Member Workforce Survey.

The 2016 ASA Member Workforce Survey was open for responses for four weeks from 31 May. As with the 2014 survey, it was targeted at ASA members in active specialist practice: registration as a Specialist Anaesthetist, Specialist Pain Medicine Physician and/or Specialist Intensive Care Physician were eligible to respond. A total of 900 members responded, with 125 also providing comments which have been collated and will be addressed elsewhere. The previous 2014 Workforce Survey was responded to by 961 members. This report provides an initial assessment of responses to the 2016 survey, and draws some comparisons with 2014.

In prefacing a consideration of the responses, validity is obviously contingent on the survey responders being representative of the national specialist anaesthetist workforce. The close alignment of the demographic findings with those of the *Australia's Future Health Workforce: Anaesthesia report*[1] confirms that this is so. Readers can access a presentation of the demographic and other immediate findings of the 2016 ASA survey via the following link http://bit.ly/asaworkforcesurvey2016.

Demographically, there were no appreciable differences from 2014 in relation to the age profile of the specialty, the gender split, location of practice, type of practice (public, private or both), years in practice and retirement intentions. Reassuringly, 90% enjoy practising anaesthesia and 90% practice anaesthesia exclusively (with the other 10% incorporating intensive care and/or pain management into their practice).

In relation to professional practice and workload, males on average worked about eight 'sessions' (equating to about four full days) per week, and females six (three full days), with the weekly sessional range extracted from sessions worked per month as shown in Figure 1. Sessional workload is however higher in non-metropolitan areas than in capital cities.

There was a slight increase in those wanting more public work from 2014 (from 11.5% to 15.7% – which could conceivably be significant) but in contrast, 37.7% wanted more private work.

Across the membership, half were happy with their existing workload, but the number of those wanting to increase their workload was double that of those seeking a decrease. Those in non-metropolitan areas were less likely to want more work than those in capital cities (Figure 2)

Across all members, more than three quarters reported being able to increase their current professional caseload without difficulty or with some difficulty. Rural

FEATURE

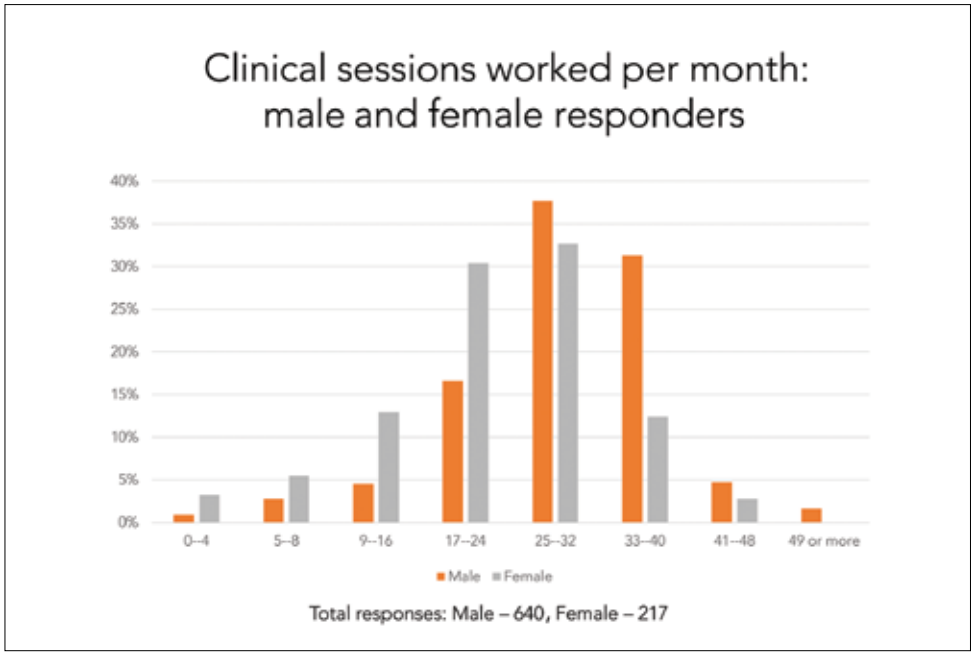


Figure 1: Clinical sessions worked per month: male and females responders

responders were twice as likely to be working at full capacity as their capital city peers (Figure 3).

New questions were asked in relation to nights and weekends on-call: these responses will be addressed at a later date. The most common annual workload in terms of weeks worked was 47-48 weeks. A sizeable majority (85%) felt that their case-mix and caseload was adequate for the purposes of maintaining clinical skills; conversely, 15% had felt obliged to work outside their 'comfort zones' due to economic pressures, and 25% due to workforce shortage or other professional pressures. Only 4% had moved to, or worked in, a rural region to obtain an adequate workload. Members in non-metropolitan areas did not report any more difficulty in obtaining professional or recreational leave than capital city members.

A new question was asked in relation to family income: of those members responding (94%), 95% of males reported being the major income earners in their families as opposed to 66% of females (20% of whom were not the major income earners in their families).

Further new questions were asked of younger specialists in relation to periods of unemployment or underemployment in the initial years since obtaining Fellowship. Unemployment was uncommon, but more than one third reported being underemployed for up to two years, with both limited case numbers and case-mix. These findings will be analysed further after the parallel ANZCA survey reports its findings.

As in 2014, across the entire membership, almost half felt that there were too many anaesthetists in Australia, with 40% feeling that the number was appropriate, and only 2% feeling that there was a shortage. This finding is exceeded by the response to the question dealing with vocational trainee numbers: 70% feel that there are too many vocational trainees. Further analysis of the responses of members in different geographical practice locations revealed differing opinions: members in non-metropolitan and rural areas were more likely to answer in a way that suggests a busier anaesthesia workforce in those locations, and a desire for an augmented workforce. While further analysis remains to be undertaken, 77% of capital city anaesthetists report that there are too many anaesthetists in their location, with 12% reporting an appropriate number, and 11% offering no opinion. 70% of responders believe that public hospitals should increase the availability of work for young specialists, and 80% believe that any increase in public workload should be met by the appointment of specialists rather than an increase in the number of vocational trainees.

In relation to a 'maldistribution' of anaesthetists in non-metropolitan areas, professional and social isolation was identified the most significant factor affecting recruitment and retention of anaesthetists in these areas. Early further analysis suggests that those practising in these areas may have different opinions: detailed future analysis may inform the ASA response to addressing any such 'maldistribution'.

Support for vocational training in the private sector is conditional: 60% support a limited exposure as opposed to 8% who support a substantial exposure. One-third believe that training should be restricted to public hospitals. A majority believe that productivity in the private sector would be diminished by the presence of vocational trainees.

A further new question addressed perceptions of the 'balance of power' in the professional milieu. Healthcare funders and health insurance funds were identified as the major beneficiaries of a shift in the 'balance of power'.

Almost 95% report understanding what is required in obtaining the 'informed consent' of a patient; 80% report understanding the concept of 'material risk'. In relation to the former, almost 10% obtain written consent from the patient, and although almost a further 60% document the attaining of consent

without requiring a signature, 30% do not document consent in any form.

'Revalidation' was canvassed, as in 2014. Two thirds believe that they understand the concept of revalidation.

Three-quarters of responders agreed that anaesthetists will incorporate an increasing component of 'perioperative medicine' into their practices. Conversely, only a third would like to incorporate more 'perioperative medicine' into their own practices.

In relation to obstetric anaesthesia practice in private hospitals, just over half report that the facilities with which they are most familiar have no difficulty in covering anaesthesia for epidural analgesia and caesarean section. Payment is made for participation in obstetric anaesthesia rosters in just under half of private facilities.

A new question was asked in relation to 'bullying' during vocational training, with a fifth reporting being bullied, a quarter responding 'perhaps, depending on the definition of bullying', but more than half responding in the negative. In relation to 'bullying' during specialist practice, a quarter responded as being bullied, a further quarter 'perhaps', and half in the negative.

Medical indemnity cover for private patients is provided by AVANT, MDA National, MIGA and MIPS in decreasing order.

Finally, 240 responders expressed some interest in joining a State or Federal ASA committee.

As mentioned in the invitation to respond to the survey, completion of the survey greatly assists the ASA's ability to prosecute the views of the membership. Our thanks to those who contributed.

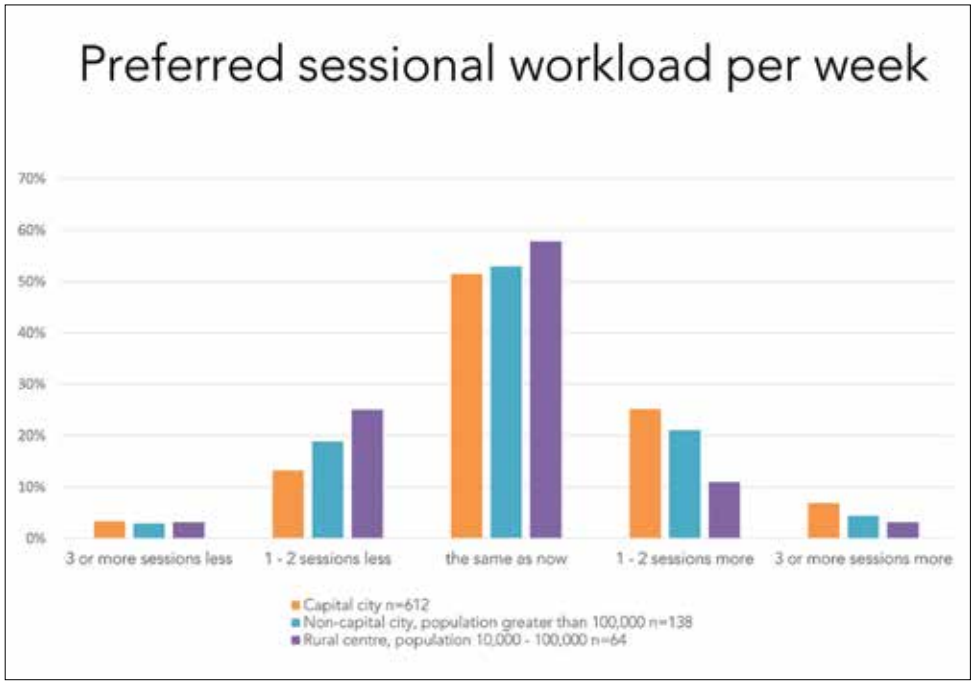


Figure 2: Preferred sessional workload per week

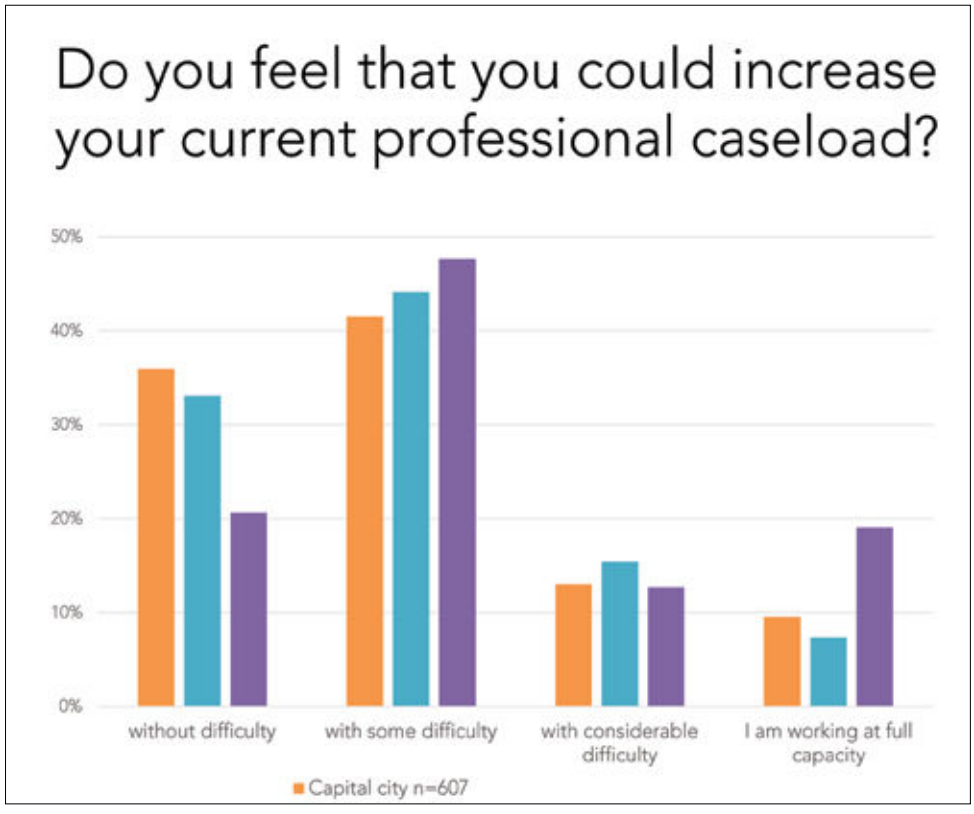


Figure 3: Do you feel that you could increase your current professional caseload?

Reference

1. Australia's Future Health Workforce – Anaesthesia. Department of Health April 2016. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/australias-future-health-workforce-anaesthesia-report

FEATURE

HISTORY OF ANAESTHESIA TIMELINE

HALMA Chair, Dr Reg Cammack, provides some background on his production of the ASA Timeline. The ASA would like to encourage members to check out the Timeline on the ASA website.

To state the obvious, the recording of historical events (historiography), be it by pictorial, oral or written record, is as old as history itself. But as mentioned in the foreword of the ASA's Timeline, this particular method of record keeping was first developed by a man whose work was of great relevance to anaesthesia, and obviously science in general, with his contributions towards the discovery of both oxygen and nitrous oxide – namely, Joseph Priestley FRS (1733-1804). This polymath was an English clergyman, theologian, chemist and teacher and is not to be confused with John Boynton (JB) Priestley (1894-1984), the author and social commentator.

According to Professor Leslie Woodcock, Chairman of the Priestley Society, Joseph Priestly, while teaching history at the Warrington Academy, produced his very popular 'A Chart of Biography' in 1765, which comprised 2000 famous names dating from 1200 BC to Priestley's then current year of 1765 AD and was organised into six categories: statesmen and warriors; diviners and metaphysicians; mathematicians and physicians; poets and artists; orators and critics; and lastly, historians and antiquarians. He produced a second version in 1769 called 'A New Chart of History'. Both editions apparently sold like hotcakes for several decades into the next century.

In my younger days, I personally had trouble appreciating the relevance of history, being simply caught up in the long hours of day-to-day work and establishing and running a practice. Over the years, however, I have come to understand just how fascinating and educational tracing the origins of our specialty really is. I decided to focus my interest by putting events into an orderly sequence – hence what is now the ASA's History of Anaesthesia Timeline.

Learning about our pioneering predecessors and their contributions to our daily practice (involving pharmacology, physiology, the myriad pieces of equipment and, yes, approach to complications) pulls the things we do each day into a much greater and a much more appreciated perspective. It makes one's daily use of our profession's substances, objects and methods so much more logical and understandable. It shows the benefits of deep thought and experimentation. It helps to answer 'why?'.

Apart from anything else, it also makes one realise that many of their discoveries

would not have been possible, or at least easily achieved, under the guidelines laid down for modern researchers. Truly pioneering spirits were often required, such as those of Baron von Bier with his personal experimentation with spinal anaesthesia, to name one of many – how could he have been certain that he or his assistant would not have been permanently paralysed?

Some things were discovered serendipitously, such as the reversal of curare-induced paralysis in 1900; others by the hard slog of scientific research, such as the development of sugammadex; and yet others by a combination of both, like the discovery and development of coumarin starting with 'sweet clover disease' and a farmer at his wits' end driving through a night-time blizzard to a laboratory.

Learning about what our pioneers achieved with the relatively limited resources that they had is simply inspiring. It helps to make one want to emulate their efforts (using modern techniques and equipment, of course) for both personal interest and the good of one's patients.

Joseph Priestly, 1733-1804.

By its very nature, a timeline cannot comprehensively address each item, otherwise a book would be written for each and every entry. Each entry, therefore, tends to be just a snippet of information that is designed to provide enough background to whet the reader's appetite and stimulate them to delve deeper into the particular subject with further reading and research.

The information in each entry of the ASA's Timeline usually does not come from a single source – it has invariably been checked and counter-checked from several sources. All of these sources are found in a combination of books, journal articles and lectures; most are available in their expanded form via the internet; many are available from the historical book collection in the Richard Bailey Library, which is now housed in the ASA head office in North Sydney. For the sake of producing a concise document without the distraction of a long list of references, the latter have not been included in the published Timeline. The aim is to generate interest and action on the part of the reader – who knows what more intriguing information they might unearth?

After three or four regular updates each year since its inception in 2011, there are now nearly 1000 entries in the Timeline, starting at 4500 BC (where you will find yourself in a Spanish 'bat cave') and ending at 2015 AD (with yet another brilliant Archie Brain innovation/development). The project is an on-going one because there is just so much more of interest to be found in the development and application of the specialty of anaesthesia – not just the nuts and bolts that provide us with daily practice matters, but those little sideshows like that involving Henry Hallett Dale and the 'brown dog affair'; the Pimlico murders; or even a murder of very recent times. (These last two murder subjects will be included in a forthcoming update.)

Several personalities have a little of their personal history detailed because of their prolific contributions to society as a whole or are associated with some fascinating tit-bit of information such as with Michael Servetus, Charles-Marie de La Condamine or Dominique Jean Larrey. Unfortunately, the occasional entry cannot do justice to the intriguing full life story of a particular person, such as in the case of Australia's first full-time Specialist Anaesthetist, Lieutenant Rupert Walter Hornabrook, with his daring exploits and experiences in the Boer War. But hopefully, the readers should be encouraged to take a further interest in such leading lights and discover a whole lot more about these characters for themselves.

With regard to the mechanics of the Timeline, many entries list cross-referenced dates to related entries. As well, there is the facility for key-word searching – a quick way to find related information.

For the reader's convenience, on each occasion that the Timeline is updated, the most recent entries, while also being included in the new complete version, are listed in a separate file on the ASA website until the next update is produced. Any pre-existing entries that are updated with expanded information in this separate file are presented with a yellow background to distinguish them from completely new material.

According to an old Chinese proverb, we should use today what we learn from the past to advantage the future. It is humbly hoped, therefore, that production of this Timeline will not only entertain and inform but possibly encourage readers to do likewise and explore for themselves our specialty's roots. A greater interest in our origins might very well stimulate greater efforts to improve the future clinical practice of our fascinating specialty.

FEATURE

WORLD ANAESTHESIA DAY 2016 – THE RENAISSANCE OF REGIONAL ANAESTHESIA

Vice President Assoc Prof David M. Scott, writes about the history of regional anaesthesia and the development of new technology and techniques.

Every year on 16 October the profession recognises World Anaesthesia Day (WAD), and this year the focus will be on regional anaesthesia (RA). RA is experiencing a revival in its fortunes due to a confluence of innovations in technology, pharmacology, our understanding of perioperative pain and a refreshed view of human anatomy. As an anaesthetist and RA enthusiast I have been fortunate to be practicing during this time of accelerated development.

Why has RA been singled out for WAD this year? I believe that RA is approaching the realms of accessibility for all anaesthetists due to new techniques and technology that was previously the reserve of a few experts. In the very early days of anaesthesia the whole process for the anaesthetist was likened to holding the patient over an open grave and hopefully snatching them back at the end of the case. RA offered an opportunity to be a little further from this open grave. Too often however, the use of RA was restricted to only those patients who were too sick for a GA and it was then often undertaken with a large degree of trepidation with an expectation of failure and surprise when it worked! The results of a successful block are always gratifying for both patient and anaesthetist, but failure bought the difficult question 'What do I do now?'

Today, with new technology and training we can now confidently recommend RA to patients for surgery and postoperative analgesia. We can rely on the results and the continuous catheters we place to provide a clear benefit to patients and improve outcomes for them. RA is now clearly a part of the ANZCA curriculum – not so long ago a trainee could complete their fellowship without performing a regional block (other then neuraxial). The specialty has come a long way, and still has further to go. The following is a look back

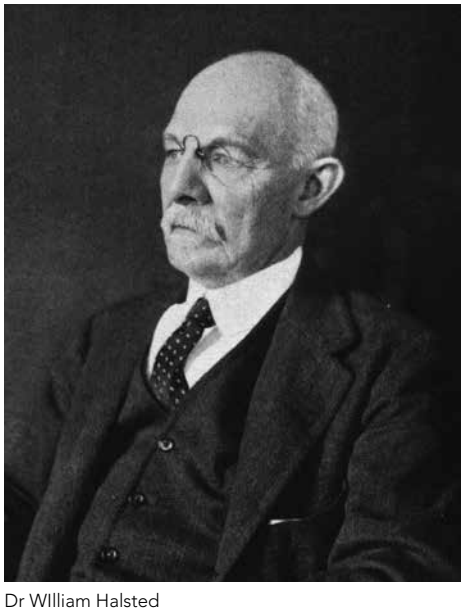
at the past, and to paraphrase Sir Isaac Newton we have arrived here by standing on the shoulders of giants.

It is also just over ten years since I established the Regional Anaesthesia Special Interest Group. This group has grown into one of the largest SIGs in the ACE stable and now has Dr Neil MacLennan from Auckland as its chair. Past Chair Dr Michael Barrington is a recognised world leader in RA and management of its complications.

The story of RA has been dependant on the development of necessary technologies and drugs over the centuries. These have been: drugs – cocaine to ropicacaine and beyond, syringes and hypodermic needles, nerve stimulators and insulated needles and now ultrasound and new technologies.

DRUGS

The earliest report[1] of the anaesthetic effect of the coca leaf was from Jesuit Bernabé Cobo in 1653, although nothing seemed to happen until 1860 when Niemann demonstrated numbness of the tongue from the same alkaloid. The Peruvian surgeon Thomas Moreno y Maïz experimented on animals in 1868,



Dr WIlliam Halsted

and in 1880 the Russian Basil von Anrep experimented on animals and himself, and recommended cocaine be used as a surgical anaesthetic. As we all know the German Dr Carl Koller took the final step in Vienna in 1884. Turns out Dr Koller was friends with Sigmund Freud[2], who had been busy experimenting with cocaine for its mind-altering effects. Koller astutely noticed the numbing effect it had on his tongue. He took this further experimenting on animals, his assistant and himself. His first surgical patient was for a glaucoma operation in September 1884. It was this case that formed the basis of a paper, which was reprinted in the *Lancet* in December of that year, and is what spread the news of cocaine as an anaesthetic to the English-speaking world.

In the USA Dr William Stewart Halsted (1852– 1922) became immediately interested in the use of cocaine[3] for RA and performed dental nerve blocks, and using infiltration dissected onto the brachial plexus in the axilla and performed an axillary block. Halsted is credited with inventing surgical gloves (to protect his mistress and theatre nurse) and also has the dubious honor of being an early recovered cocaine addict – which was successfully managed by the substitution of opium!

Dr August Bier (1861-1949) is considered the father of spinal anaesthesia[4]. In 1898 he famously performed a lumbar puncture on himself with his assistant, withdrawing some CSF, dissolving cocaine in the CSF and re-injecting it. They noted the anaesthetising effect – even hitting their legs with hammers to no ill effect – until the block receded! Dr Bier also developed the Bier block, or intravenous regional anaesthesia, after the introduction of procaine.

Dr August Bier (1861-1949) is considered the father of spinal anaesthesia[4]. In 1898 he famously performed a lumbar puncture on himself with his assistant, withdrawing some CSF, dissolving cocaine in the CSF and re-injecting it. They noted the anaesthetising effect – even hitting their legs with hammers to no ill effect – until the block receded!

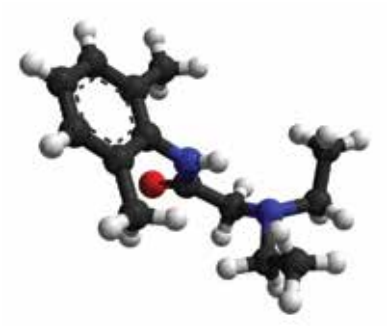
Dr Auguste Bier

The toxicity of cocaine was recognised and alternative drugs were sought. The German chemist Alfred Einhorn (1856–1917) made Novocaine (Procaine) in 1904. Prof Heinrich Braun used this agent and discovered adding adrenaline improved its effect. It became the standard in local anaesthesia (LA) drugs. Unfortunately, Procaine also had an unacceptably high allergy rate and limited efficacy.

In the early 1940s Nils Löfgren and Bengt Lundquist developed lidocaine (the first amide LA), and thereafter the whole family of amide LA agents. Sterio-isomeric and liposomal preparations have stemmed from here.

During my clinical practice I have seen the introduction of levo-bupivacaine and ropivacaine, which have proved to be much less toxic agents. Sadly the

FEATURE

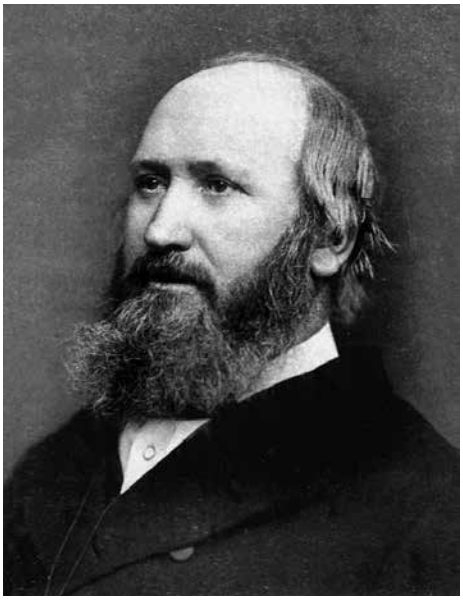


Lidocaine molecular structure

motor-sparing features have not been as spectacular as hoped! Liposomal bupivacaine is of interest but at this stage doesn't appear to be setting the local anaesthetic world on fire.

NEEDLES AND SYRINGES

At around the same time as cocaine was being rediscovered Scottish Dr Alexander Wood (1817-1884) developed the syringe and hypodermic needle. Since then syringes have developed through innovation in materials and manufacturing to the devices ubiquitous today. In the last decade devices have even been developed to accurately measure injection pressures to avoid high injection pressures – thought to indicate incorrect needle placement.



Dr Alexander Wood

ORIGINAL HYPODERMIC SYRINGE OF
DR. ALEXANDER WOOD
THE FIRST USED IN GREAT BRITAIN

Up until the 1980s RA required location of nerves using paraesthesia techniques. This meant a process of repeatedly needling a nerve until the patient reported a sensation in the distribution of the desired nerve to be blocked. With this unpleasant technique there was at best an 85% success rate. This meant RA was not particularly popular amongst anaesthetists or patients. The decade of the 1980s saw the development of the nerve stimulator and later, insulated needles for neurolocation. Raj wrote a review of the technique and its pitfalls in Regional Anaesthesia and Pain Management in 1985, which became the guide for anaesthetists wishing to improve success in their RA techniques. He stated[5] failure of nerve blocks using peripheral nerve stimulation is usually due to incorrect techniques of nerve stimulation. These techniques required a thorough understanding of surface anatomy and likely nerve anatomy, but with ultrasound in skilled hands success rates began to exceed 90%. Sadly Dr Raj recently passed away and the profession lost one of its founding fathers.

During this period I was completing my training and I recall our early innovative attempts at using electrolocation using a peripheral nerve stimulator alligator clipped to a long spinal needle attempting to locate the sciatic nerve with Dr Brian Horan. After completing my training I worked as an instructor in anaesthesia at Havard in the Beth Israel Hospital, Boston where they had the new insulated needles and dedicated nerve stimulators. I took the opportunity to develop my skills with these tools and soon had a reputation for RA in the department.

Returning to Australia in the early 1990s I was fortunate enough to work closely with Dr Eddie Loong who was well known as a proponent of RA in Lismore. This relationship was to further propel my practice into RA. The work done by Eddie in educating surgeons to the benefits in RA meant that in Lismore surgeons were more likely to ask "Why are you not using a regional technique?" than "Why are you taking so much time?"

An example of a nerve stimulator

It was during this time that continuous catheter techniques began to gain popularity. We had tried adding all sorts of things to our single shot blocks to make them last until the next morning, but were still getting phone calls in the middle of the night from distressed nurses dealing with distressed patients once their block had receded. At first we used epidural catheters through cannulas, and insulated needles, but our success rates for the catheter placement were disappointing. The first dedicated kits arrived with insulated needles and catheter systems and things improved, but there was still a failure rate – worse for some techniques like interscalene and sciatic block, whereas femoral and fascia iliaca block catheters were much more reliable. This we now

understand was due to the functional neural anatomy which was not as we had imagined – the nerve sheathes we considered reliable structures within which one could place a catheter just was not the case.

ULTRASOUND

In the late 1990s I attended the Military Anaesthesia Course run by Dr George Merridew in Launceston, and as part of that course we were introduced to the first generation of portable Sonosite ultrasound machines. I distinctly recalled asking the demonstrator if one could visualise neural structures using this device, thinking that this would be a useful adjunct to RA – only to be told that there was no way this could be done! If only the sonographer had a bit more imagination!

In 1994 Kapral[6] et al described the use of ultrasound in the performance of supraclavicular block, even demonstrating spread of local anaesthetic. Since then there has been an almost exponential development of ultrasound technology and needles, like the Mitchell needle (developed by our own Dr Chris Mitchell), to the point where we can now see structures in relatively high definition and even in 4D to facilitate our accurate placement of local anaesthetic drugs.

This has led to using ever-lower doses and concentrations of drugs to produce effective blocks and to the accurate and reliable placement of continuous catheters where we now perform the primary block via the catheter. Blocks that once we would routinely recommend the use of 40 ml of 0.75% (300mg) ropivacaine are now reliably being performed by 8ml of 0.2% (16mg) ropivacaine!

It has also led to the development of blocks that were once really only considered theoretical, as the accurate placement of local anaesthetic agents was almost random. The adductor canal block, TAP block and quadratus lumborum block are some of the techniques now becoming routine in our practice that were impossible without ultrasound. Continuous catheters are being placed in the rectus sheath and subcostal TAP planes allowing us to provide excellent anterior abdominal wall analgesia without having to perform neuraxial blocks – a real advantage in the setting of emergency surgery and concomitant anticoagulant and antiplatelet drugs. These blocks also avoid the unwanted sympathetic blockade associated with epidurals and so don't carry the requirement for higher acuity nursing care.

My first ultrasound-guided block was an infraclavicular block on a morbidly obese renal failure patient on aspirin for a revision of a non-functioning arteriovenous fistula. It was December 2005 and I called the sonographer and her machine up from radiology to assist me. It was a great success and was the first step in my path of developing and morphing my RA techniques from electro-location to ultrasound guidance. I have been running a RA anatomy course at the University of Queensland Anatomy Lab for the past 15 years and during that time we have seen the focus move from anatomy and electro-location to ultrasound. We have added neuraxial techniques and fresh frozen specimens and have adapted to keep pace with contemporary practice.

THE FUTURE

The search for the 'holy grail' of RA drugs continues, one day we may get a drug which just blocks pain nerves leaving motor nerves intact, and hopefully it will have a duration long enough to obviate the need for a continuous technique. The development of this will probably require a more detailed understanding of the neural sodium channel.

Needles should continue to develop, and in conjunction with imaging techniques we should see the advent of needle track prediction, automated identification of structures on ultrasound and possibly needles which transmit their tip location back to the sensor so the operator never loses sight.

The next generation of anaesthetists will be fully comfortable with using ultrasound in their clinical practice. They will think nothing of examining their patient's hearts routinely with echo instead of using their stethoscope. They will perform RA with ultrasound as an ordinary part of their anaesthetic technique and think nothing of it!

It is amazing to consider so many changes have occurred in the course of one anesthetist's practising career, the future certainly looks fascinating and challenging. Our role continues to be one of closely watching the developments, keeping pace with the professional challenges and guiding our trainees in development of new skills and technologies so they become the best anaesthetists they can be.

References

1. Calatayud J, González A, History of the Development and Evolution of Local Anesthesia Since the Coca Leaf, Anesthesiology 2003;98: 1503–1508.
2. Robinson DH, Toledo AH, Historical Development of Modern Anesthesia, Journal of Investigative Surgery, 2012;25;141–149.
3. Spirling LI, Daniels IR, Historical Perspectives on Health – William Stewart Halsted – Surgeon Extraordinaire: A story of 'drugs, gloves and romance'. J Royal Soc Prom Health, June 2002, 122-124.
4. Holmes CM, The history and development of intravenous regional anaesthesia, Acta Anaesth Scand, 1969:Sup XXXVI 11-18.
5. Pither CE, Raj PP, Ford, DJ, The Use of Peripheral Nerve Stimulators for Regional Anesthesia: A Review of Experimental Characteristics, Technique, and Clinical Applications. Regional Anesthesia and Pain Medicine April/May/June 1985:10; p49-99.
6. Marhofer P, Frickley N, Review article. Ultrasonographic guidance in pediatric regional anesthesia part 1: theoretical background. Pediatric Anesthesia 2006 16: 1008–1018.

FEATURE

OBESITY AND ANAESTHESIA: AN OPPORTUNITY FOR CHANGE?

Simon Macklin, Senior Specialist Anaesthetist at Royal Adelaide Hospital, writes about the healthcare challenges of our growing society.

You will all be aware of the multitude of challenges that face us when presented with the obese patient – vascular access, airway management, haemodynamic monitoring, regional anaesthesia issues, positioning and the additional equipment required – appropriately-sized blood pressure cuffs, appropriately weight-rated operating tables, beds, chairs, CT and MRI scanners and that is before you even consider the impact of comorbidities – diabetes, hypertension, dyslipidaemia, reflux disease, sleep apnoea (both central and obstructive), steatohepatitis, cancer burden (more of that later) not to mention the depression, loss of esteem and social isolation.

Can we realistically or logistically obtain sleep studies on all our obese patients who tick enough boxes on the STOPBANG score and can we get them treated with CPAP for their OSA in the time-course available to us in the preoperative period in our current, resource-stretched, high-demand, efficiency-driven healthcare system – and do we need to? How do we manage the OSA patient in the immediate post-operative setting? There are not enough high-dependency beds to go around to cater for all our OSA patients and there is a paucity of outcome data to drive best practice for post-operative management of these patients.[1]

For those who are lucky enough to work with a surgeon who has an interest in bariatric surgery, most of these questions will have been answered, surgery delayed and the insulin resistance, hypertension and sleep apnoea investigated and optimised. Some patients will have even been placed on a very low calorie diet (VLCD) in the immediate preoperative period to reduce their steatohepatitis prior to obesity surgery. The vast majority of our obese surgical patients are not worked up like this because they are presenting for their colectomy, hysterectomy, nephrectomy, cholecystectomy, TUR, cystectomy, mastectomy, joint arthroplasty or fracture fixation and are not viewed in the same way.

EXERCISE

Elective surgical waiting time should be spent productively by preparing for the surgical episode – ensuring that patients present in optimum physical, mental and nutritional states. For many, surgery presents a life-changing event and as such should be treated as a 'teachable moment' that can be used to trigger lifestyle changes to improve outcomes and reduce mortality.

There is growing evidence of the value of exercise in chemotherapy regimens and the benefits of being 'fit for surgery'. Myers et al demonstrated that exercise capacity is a more powerful predictor of cardiovascular mortality than other established risk factors[2] and Kokkinos demonstrated a 15% reduction in mortality rates for every 1 MET increase above 4 METs.[3] Nevertheless, we need to gather more evidence on the effects of exercise capacity improvements on surgical outcomes and the most cost effective method of measuring exercise capacity improvements.

The UK has embraced Cardiopulmonary Exercise Testing and there is now a PeriOperative Exercise Testing & Training Society, POETTS. This will hopefully help to elucidate some of these questions such that evidence-based change can be introduced. In the meantime, however, we should take the opportunity as medical professionals to advocate for change.

The following table is taken from the Academy of Medical Royal Colleges' paper 'Exercise: The miracle cure and the role of the doctor in promoting it'.[4] The report makes compelling reading.

OBESITY

According to the WHO more people die as a result of obesity than die from malnutrition.

According to the Australian Bureau of Statistics, 11.2 million Australians are overweight or obese. (This equates to 63.4% of our adult patients aged 18-64 years and over one in four (27.4%) of children aged 5-17).[5] Of course, this is not just an Australian problem. The Global BMI Mortality Collaboration was published in the Lancet online in July 2016.[6] The study looked at 239 studies in 32 countries involving 10.6 million patients. Their conclusion was that overweight and obesity (BMI >25kg/m^2) were associated with increased all-cause mortality with a strong and positive association in every global region – with the exception of south-east Asia.

We are all well aware of the rising tide of obesity in our community and nowhere is this more explicitly represented than on the Centre for Disease Communication website where a powerpoint presentation about obesity rates makes for salutary watching. Notwithstanding changes made in the Behavioural Risk Factor Surveillance System (BRFSS) that were made in 2011, I would urge you to look at the flood of self-reported obesity in the USA from 1985 to 2010 and (after the changes in methodology) from 2011 to 2014.[7] In 2014, 44 states had a prevalence of self-reported obesity of greater than 25% (where obesity is defined as a BMI of >30 kg/m^2).

There are medical, environmental and societal costs associated with obesity. Again, data from the US estimates that in 2008 the medical costs of obesity were $147 billion. Additionally, the economic costs of obesity and related conditions cost somewhere between $3,38 and $6.38 billion.

Obesity and its associated health problems have a significant economic impact on the US health care system. Medical costs associated with overweight and obesity may involve direct and indirect costs. Direct medical costs may include preventive, diagnostic and treatment services related to obesity. Indirect costs relate to morbidity and mortality costs including productivity. Productivity measures include 'absenteeism' (costs due to employees being absent from work for obesity-related health reasons) and

Condition	UK lifetime Risk of a condition	The reduction (%) in a person's chance of developing each condition by doing the recommended level of exercise
All-cause mortality		30%
Heart disease	33%	40%
High blood pressure	70%	40%
Type 2 diabetes	10%	50%
Obesity	25%	10%
Cancer	23%	Unclear
Breast cancer	13%	25%
Bowel cancer	6%	45%
Depression	33%	30%
Dementia	13%	30%
Low back pain	65%	40%
Osteoarthritis	14%	50%
Osteoporosis	50%	40%
Falls in the elderly	50%	40%
Major fractures	35%	50%

FEATURE

'presenteeism' (decreased productivity of employees while at work) as well as premature mortality and disability.

What is more, obesity is second only to tobacco as a cause for cancer[8]. Worldwide it is estimated that 45 million surgical procedures will be needed for cancer by 2030.[9]

So why do we not spend as much time, money and effort on preventing obesity as we do on tobacco use? Cigarette advertising has been banned on television, billboards and films; we have plain packaging adorned with gruesome pictures of the adverse effects of smoking; ciggies are locked behind the counter in supermarkets. Yet we do nothing about the cheap, calorie-rich, fast food that we see being consumed in our streets. What about fast food wrappers adorned with pictures of colon cancer? Why not package our soft fizzy drinks in plain aluminium cans with pictures of intra abdominal adipose tissue? Where is the education program that proselytises healthy eating and exercise but demonises unhealthy eating and a sedentary lifestyle?

The fundamental cause of obesity and being overweight is an energy imbalance between calories consumed and calories expended.[10] Changes in dietary and physical activity patterns are often the result of environmental and societal changes associated with development of or the lack of supportive policies in sectors such as health, agriculture, transport, urban planning, environment, food processing, distribution, marketing and education. We in anaesthesia have a role to play at both an individual level and collectively, as part of the medical profession, at a societal level to push for some of these changes.

When one considers the impact of obesity on disease burden and the impact of exercise on reducing non-communicable disease risk, it is astounding that more effort is not made to address these two.

ANAESTHESIA

Anaesthesia is on the cusp of a revolutionary change in the anaesthetist's involvement in patient care. There is an international groundswell of opinion that anaesthetists should be more than simply the administrators of 'that blessed chloroform'. The First Annual Perioperative Surgical Home Summit was held in California in 2014. In early 2015 the Royal College of Anaesthetists joined the fray with 'Perioperative medicine: The Pathway to Better Surgical Care'.[11] Both these put anaesthesia firmly at the hub of the 'perioperative wheel' with our ability to co-ordinate the care delivered by the various medical specialities to ensure the surgical patient arrives in the operating theatre in the best possible condition with a post-operative plan that is designed to proactively manage the recognised and optimised co-morbidities for enhanced recovery from surgery.

This presents us with many challenges. Possibly the two hardest are behaviour change and funding change. Behaviour change needs to occur in anaesthetic, surgical and patient populations. As anaesthetists, we need to broaden our horizons and our sphere of influence to be more involved in the whole peri-operative period – not focussed solely on pre and per-op. We need to engage our surgical colleagues to redesign the pathway to surgery such that all aspects of the surgical patient's physiology are taken into consideration at the initial surgical consultation and that referral to the 'optimisation' clinic is well in advance of the date of surgery.

Our patients have to be educated that they have a responsibility as well as a right and their health plays a significant role in the healthcare expended on them. The healthcare care cheque is one written by society and not the individual. Therefore improved levels of fitness and body mass reduction are essential lifestyle choices that reduce healthcare expenditure. The funding model currently in place is arranged in well-demarcated silos. Innovation that requires expenditure by one silo that has cost benefits for another struggles to get sufficient oxygen to thrive. The result is progress paralysis and the squeeze of existing healthcare systems. We have to move on from the mantra of efficiency improvements that pervades the public sector. A wise man said this of liposuction "It works as long as there is fat left to suck". I see 'efficiency improvements' in a similar light. There are savings to be made but this requires a more holistic approach to the surgical process and requires 'buy-in' from all groups involved in the surgical pathway. Henrik Kehlet and his 'Enhanced Recovery after Surgery' (ERAS) group have been hugely successful in making efficiency savings following colorectal surgery. Instituting a consistent approach and measuring outcomes enables information to be gathered that can further improve patient care and reduce healthcare costs. This is not the same as the current drive to do more at less cost without a clinical structure supporting it, but will achieve a similar outcome. We have been slow to expand the ERAS program beyond colorectal surgery.

It would be disappointing if such an ERAS expansion concentrated on the 'After Surgery' component of ERAS without emphasising the healthcare benefits of increased exercise and weight reduction. When one considers that in 2010-11, there were 2.4 million admissions to hospital that involved both elective (88%) and emergency (12%) surgery in both public and private hospitals in Australia, the potential savings in healthcare expenditure by a co-ordinated approach, such as ERAS, are huge.[12]

CHANGE

We have better drugs, work-stations, integrated monitoring, ultrasound, echocardiography, CT, MRI and PET; clearer understanding of team dynamics and crisis management. Now, I believe we are fast approaching a cross-roads and

the direction we choose will be crucial to the long-term sustainability of our speciality. Do we continue to do what we have done before or do we embrace change that broadens our remit in peri-operative patient management and grasp the opportunity that dangles tantalisingly in front of us? If you only do what you have already done, you will only know what you already knew.

The seven deadly sins originated in the sands of the Scetes desert of Egypt around the third century AD. In the context of this article, two of these sins, sloth and gluttony (which is the greater evil - another topic for debate) combine to produce the opportunity for lifestyle change where anaesthetists can play a major role in driving debate on holistic co-ordinated patient care through the model of the preoperative surgical home by targeting sloth and gluttony through advice on exercise, smoking and weight loss prior to the surgical admission. Reducing healthcare costs by proactive strategies that attack the deadly sins of sloth, gluttony and smoking. Now, there's an idea…

References

1. Anesthesiology. 2014 Feb;120 (2):268-86
2. Myers et al. NEJM 346 (11) 793-801
3. Kokkinos et al. Circulation 2008; 117 (5): 614-622
4. http://www.aomrc.org.uk/wp-content/uploads/2016/05/Exercise_the_Miracle_Cure_0215.pdf
5. Australian Bureau of Statistics: National Health Survey 2014-15 http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/CDA852A349B4CEE6CA257F150009FC53/$File/national%20health%20survey%20first%20results,%202014-15.pdf
6. Body-mass index and all-cause mortality: individual- participant-data meta-analysis of 239 prospective studies in four continents. http://dx.doi.org/10.1016/S0140-6736(16)30175-1
7. https://www.cdc.gov/obesity/data/prevalence-maps.html
8. http://www.cancercouncil.com.au/918/cancer-prevention/diet-exercise/nutrition-diet/other-foods-nutrients/obesity-and-cancer-prevention/
9. The Lancet Oncology Commission Global cancer surgery: delivering safe, affordable, and timely cancer surgery Lancet Volume 16, No. 11, p1193–1224, September 2015.
10. http://www.who.int/features/factfiles/obesity/en/
11. http://www.rcoa.ac.uk/perioperativemedicine
12. http://www.aihw.gov.au/hospitals/surgery-2010-11/

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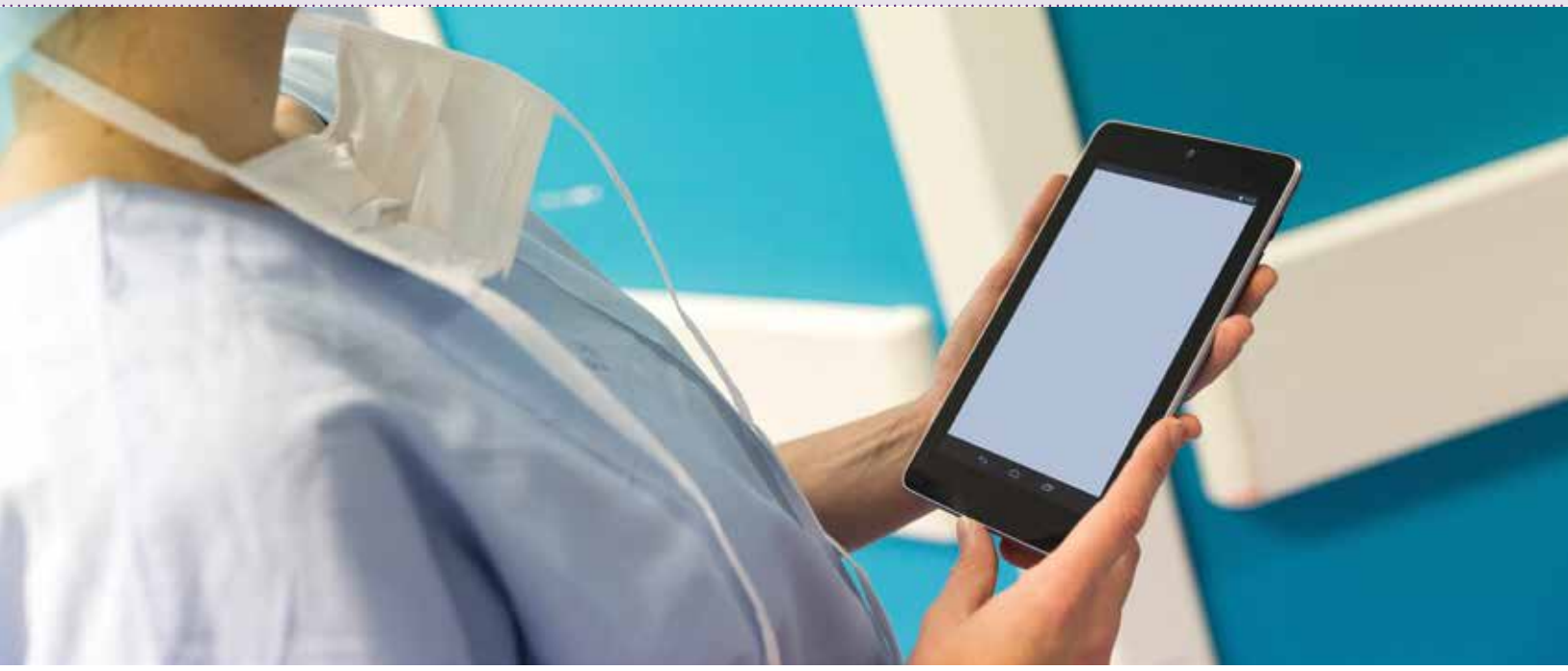

SOCIAL MEDIA IN ANAESTHESIA AND CRITICAL CARE: SORTING THE GRAIN FROM THE CHAFF

Dr Ben Piper, Staff Specialist Anaesthetist at Royal Darwin Hospital, considers the emergence of social media in the medical information sphere.

We practice in an internet rich world saturated with data yet paradoxically we can also suffer from a famine of usable knowledge. The exponential increase in medical literature is a dazzling beast, fed by the emergence of online publishing globally. So, should we consider the emergence of social medial in the medical information and education sphere to be friend or foe? Is it just another distraction?

Social media can loosely be described as an electronic platform through which user generated content is shared by an online community. The diversity of platforms is enormous, however, the dominating power of Twitter, Facebook, YouTube and LinkedIn account for the lion's share of the social media pie. It's a pretty big pie with 2.3 billion (one-third) of the world's population active on social media, growing at 10% per year. It is often demonised for being the harbinger of doom for the next generation, robbing them of real social interaction to the dismay of their parents! There are, however, other aspects to this phenomenon that allow the (almost) universal presence of social media in our lives to offer opportunity and improve our ability to interact as professionals in a time poor, information rich 21st century.

EDUCATION: THE PHENOMENA OF FOAM AND SMACC

Social media has been able to break down the traditional geographical and economic barriers to medical education. It permits anyone with an internet connection to access the latest information and real-time peer opinion. Something that was not possible in the 20th century. The FOAM (Free Open Access Medical education) and SMACC (Social Media and Critical Care) movements illustrate the power of social media to organise, share and collaborate on a global scale never seen before. The ability to educate via social media is best illustrated by the

FOAM movement. Coined over a pint of Guinness in 2012 by Mike Cadgoan (also the founding editor of Lifeinthefastlane.com). FOAM is an open online community that shares a rich variety of resources reviewed in real time. While FOAM is a fairly generic medical construct it has developed an anaesthesia specific community (#FOAMgas) and another for critical care (#FOAMcc).

So what can you use FOAM for? The FOAM community shares journal articles, take home messages from conference presentations (in real-time), podcasts on topical evidence based reviews, links to YouTube videos on regional techniques, to name but a few. Alternative social media platforms such as LinkedIn offer open and closed groups that can share files or ask opinion about "hypothetical cases" to a group of like-minded but geographically disparate colleagues.

So is this all about screen gazing, is there no real interaction between peers anymore? Enter the SMACC conference. Like all good things, also had its beginnings in Sydney Australia in 2013. Without any College, Society or Institutional backing attracted 700 delegates. The following year this doubled to 1400 at smaccGOLD (Gold Coast) and 2015 saw Chicago SMACC attract over 2000 delegates from 60 countries. This year the registrants were capped at 2000 for SMACC Dublin and it sold out in minutes. There would be few of the traditional conference conveners that wouldn't salivate at that thought. The conference format falls in-line with the social media theme being short talks (10-15 minutes) given in a TEDx style format. All content is of course streamed and available online free creating more 'FOAM'.

LIMITATIONS OF SOCIAL MEDIA

There are well placed concerns about the quality and quantity of social media sourced information. With regard to quality the open access platforms may lead to the content being unreliable. There is a counter argument that peer review (in the form of the communities response to a post) is a partial solution, however, it is not by any means editorial grade peer review. Interestingly it does open the world of "post-publication review", that allows readers to post their own opinions after an article goes to print, visible to all future readers. The role of administrators on social media platforms does not extend itself to editorial standards and thus as a primary source of information perhaps should not be relied on. Social media is, however, an excellent tool for propagating of primary sources such as traditional media (e.g. Journals, Societies, Texts, and Colleges etc).

The quantity of content can also be problematic. The brevity of some social media platforms such as Twitter (<140 characters) may reduce the complexity of a nuanced task or technique so much so as to be dangerous in the wrong hands. The alternate and preferred approach is to link to a blog, video, journal that gives this nuanced view to the audience of the Tweet.

Privacy, defamation and unprofessional conduct are also a major concern given that the forum is often open (although not always). The ease of translating images, documents or comments on a mobile device heralds a world of potential danger. Educators and curriculum developers in medicine would be ill advised not to start considering this emerging elephant in the room. The AMA has a position statement for doctors in the social media environment - well worth reading for anyone with a social media account. Challenges for institutions are also real and include balancing real-time interaction with legal and strategic consequences of unintended posts or tweets.

WHERE TO FROM HERE?

Can we opt out? In my opinion no, it is not a viable option. The rise of social media as a major and significant method of communication between peers is already with us. As a Society and a profession having a social media presence allows us to be relevant to the current membership. There is also the tangible cost of being left behind. There is observational data suggesting that anaesthetic journals not managing active Twitter accounts suffered a fall in impact factor (and other publishing metrics). The journals that do manage an active Twitter account saw metrics improving in-line with Twitter use. One such journal, The Canadian Journal of Anaesthesia, has gone as far as publishing an Editorial listing the author as 'Skeptical Scalpel' – one of the most world's influential anonymous medical bloggers. This acknowledgement from traditional media of the opportunity that social media presents is a significant step forward.

Social media may not be able to replace the quality of tried and proven peer reviewed literature however it is certainly an overtly popular and effective manner to propagate it! So the question begs, how should traditional media interact with social media? Are there opportunities for traditional media sources to screen social media feeds and give opinion on reliability and utility of certain social media movements (similar to the manner in which Journals review traditional media such as books)? Should authors be compelled to engineer article summaries in under 140 characters? Would time spent engaging in education online that was sourced via social media be considered for CPD credits?

The challenge of engaging professionally, efficiently and with confidence in the social media space has arrived. Guidelines and education on how we as professionals and institutions should interact in the social media space are necessary. How we negotiate this emerging and exciting landscape of global and instant possibilities is up to us. Like any new technology it will be in using it wisely and knowing its limitations that will

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provide the best results. I suggest giving it a go…

TWITTER LANGUAGE FOR THE UNINITIATED…

@ denotes an entity (person or organisation) e.g. @ASA_Australia is the ASAs official account name. To mention the ASA in a tweet one would type "@ASA_Australia".

# denotes a "hashtag" or searchable field (similar to MeSH terms or "key words" used in literature searches). Placing it after a tweet allows anyone searching for that term to find it. Clicking on a hashtag shows all tweets that have used the tag. It allows you to follow a story or topic.

A PRACTICAL EXAMPLE:

A registrar is presenting a case states that they would target a urine output of 2mL/kg as per ye old textbook. Knowing this not to be what the current literature suggested I gently objected.

On reflection that evening (and a moment of self-doubt), I undertook a traditional PubMed search (via my institutional login) and identified a selection of reviews. After filtering the results and looking at a few abstracts available to my subscription I settled on a trusted source, a review in the BJA Dec 2015. Fortunately there in was a succinct summary supporting my suggestion that perhaps oliguria had no effect on renal function and targeting euvolaemia via dynamic measures was wiser council (phew). Time taken 20 minutes.

The next afternoon while compiling this very article I challenged myself to see what answer social media might bring. Via Twitter I searched #oliguria and the second tweet from @Dal_Anaesthesia (Dalhousie University Canada) was a link to a full text review in Anaesthesia and Analgesia Jan 2016 which had concluded the same thing (double phew). Time taken 25 seconds.

References

https://ama.com.au/article/social-media-and-medical-profession

C.Duffy. Br. J. Anaesth. (2015) 115 (6): 940-941.

CULTURE AS THE CAUSE AND CURE?

In his final article as President Dr Guy Christie-Taylor challenges us to consider the concept of 'culture' and how it impacts our organisation and our professional lives.

"All eyes are on culture as the cause and the cure."[1]

"Bullying is endemic in surgery; common in training and the surgical workplace; and central to the culture of surgery."[2] This powerful generalisation about the 'culture' of surgery is made by the Expert Advisory Group on discrimination, bullying and sexual harassment advising RACS, in its report to RACS.[2]

RACS has therefore logically committed itself to working to make changes in three key areas; the first of which is 'Cultural change and leadership'.[3]

The report[2] also made reference to a 'Culture of fear and reprisal' and made it clear that its authors support the notion put forward by Major General David Morrison to his personnel that 'everyone is responsible for culture.'

It is somewhat ironic that a culture of competition and perfection could have given rise to a culture of 'bullying'.[2]

So where else has 'culture' been invoked as the cause of harm and chaos? Was it a culture of 'every dollar counts' at BP that lead to the Deepwater Horizon disaster[4] and the US's worst ever oil spill, or 'lapses in character and culture' that lead to the 2014 Veterans Administration scandal in which clinical delays were alleged to have caused scores of deaths as well as the 2008 Mid-Staffordshire scandal which showed pervasive clinical lapses and gaming of the system to meet targets[5], or was it a 'club culture' as described in the Kennedy Report[6] that lead to the Bristol Children's Heart Surgery scandal, or was our Prime Minister correct to invoke 'big cultural issues' as being central to the recent behaviour of the banks in which ''Some, regrettably, as we know have taken advantage of fellow Australians and the savings they've spent a lifetime accumulating"?[7]

So if the above examples are true then it seems reasonable that the Australian Institute of Company Directors should intend over 2016 to focus on boardroom culture by continuing to work with governance leaders to 'drive performance through culture.' The AICD continues to believe that directors creating and nurturing the 'right culture' or setting the right tone from the top are crucial to organisations success.[8]

Greg Medcraft, Chairman of the Australian Securities and Investment Commission upped the ante recently when he issued a veiled threat that the watchdog might move to extend the laws to enforce corporate culture if certain companies fail to lift their standards.[9]

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As far back as 1997, an issue of quality in health care was devoted to considerations of organisational change in health care calling it the 'key to quality improvement.' In discussing how such change can be managed one of the authors asserted that 'cultural change' needs to be wrought alongside structural reorganisation and systems reforms to bring about ' a culture in which excellence can flourish.'[10]

The Labour Government elected in 1997 in the UK made quality the central reform issue in the NHS.[10] Its strategy aimed to:

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

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

In articulating the strategy needed to deliver this new care official documents stressed the interlinking of three different strands: clinical governance, life-long learning, and professional self-regulation. Underpinning and binding each of these was the notion of 'cultural transformation as a primary driver to deliver improved quality of care.' Specifically "…achieving meaningful and sustainable quality improvements in the NHS requires a fundamental shift in culture, to focus effort where it is needed and to enable and empower those who work in the NHS to improve quality locally."[10]

Some of the desired 'cultural changes' are listed in the table below:[10]

And accompanying this was a desire for a 'new moral fabric' (see table on next page).[10]

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

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

It is interesting to note the comments made by John Traphagan in his recent article in the Harvard Business Review (HBR) entitled 'Why Company Culture is a Misleading term':[11]

"Today, the idea that organizations have cultures is rarely questioned by the media, by corporate executives, or by the consultants who make a living helping organizations improve their 'cultures'. Organizational culture is assumed to be important to making sure that employees are happy and productivity is good. At the same time, the concept, meaning, and function of culture rarely garners much thought. When I ask business people to define culture – or even when I ask students in my class on organizational culture to do so – it turns out to be difficult. I either get a simple definition,

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

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

such as 'the values of a group' or I get 'interesting question' and something of a blank look as a response. The problem here is that while we use the term 'culture' constantly, most of us give very little thought to what that term means and how its use influences behavior and thought within organizations."

He goes on in more detail to explain: "In fact, anthropologists – the group of academics who first used the term in an analytical sense – have never really agreed on what exactly culture means. In the 19th Century, E. B. Tylor defined culture as 'that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.' Most of the definitions of culture used in books about organisational culture and values follow the Tylorian definition. Culture is the values, practices, beliefs, etc. of a group of people. In other words, culture is everything; which basically means it's nothing from an analytical perspective. The only really useful aspect of this definition is that culture involves groups (society) and that those groups share something. Otherwise, it's pretty vague."[11]

In a paper in the HBR[12] in May 2013 Michael Watkins wrote:

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

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

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

"Culture is how organizations do things, in large part; culture is a product of compensation; organizational culture defines a jointly shared description of an organization from within; organizational culture is the sum of values and rituals which serve as 'glue' to integrate the members of the organization; organizational culture is civilization in the workplace; culture is the organization's immune system; organizational culture [is shaped by] the main culture of the society we live in, albeit with greater emphasis on particular parts of it; it over simplifies the situation in large organizations to assume there is only one culture… and it's risky for new leaders to ignore the sub-cultures; an organisation [is] a living culture… that can adapt to the reality as fast as possible."[12]

At the core of a modernist approach is the view that organisational phenomena (including cultures, structures and performance) are concrete entities, which can be systematically described and explained. If, as this approach suggests, culture is something that an organisation has, then it may be possible to create, change and manage culture in the pursuit of wider organisational objectives. It is clear looking at the examples sited above and in reading the management literature that this is all based on the (possibly false?) assumption that cultures are an attribute of an organisation and are open to manipulation.

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

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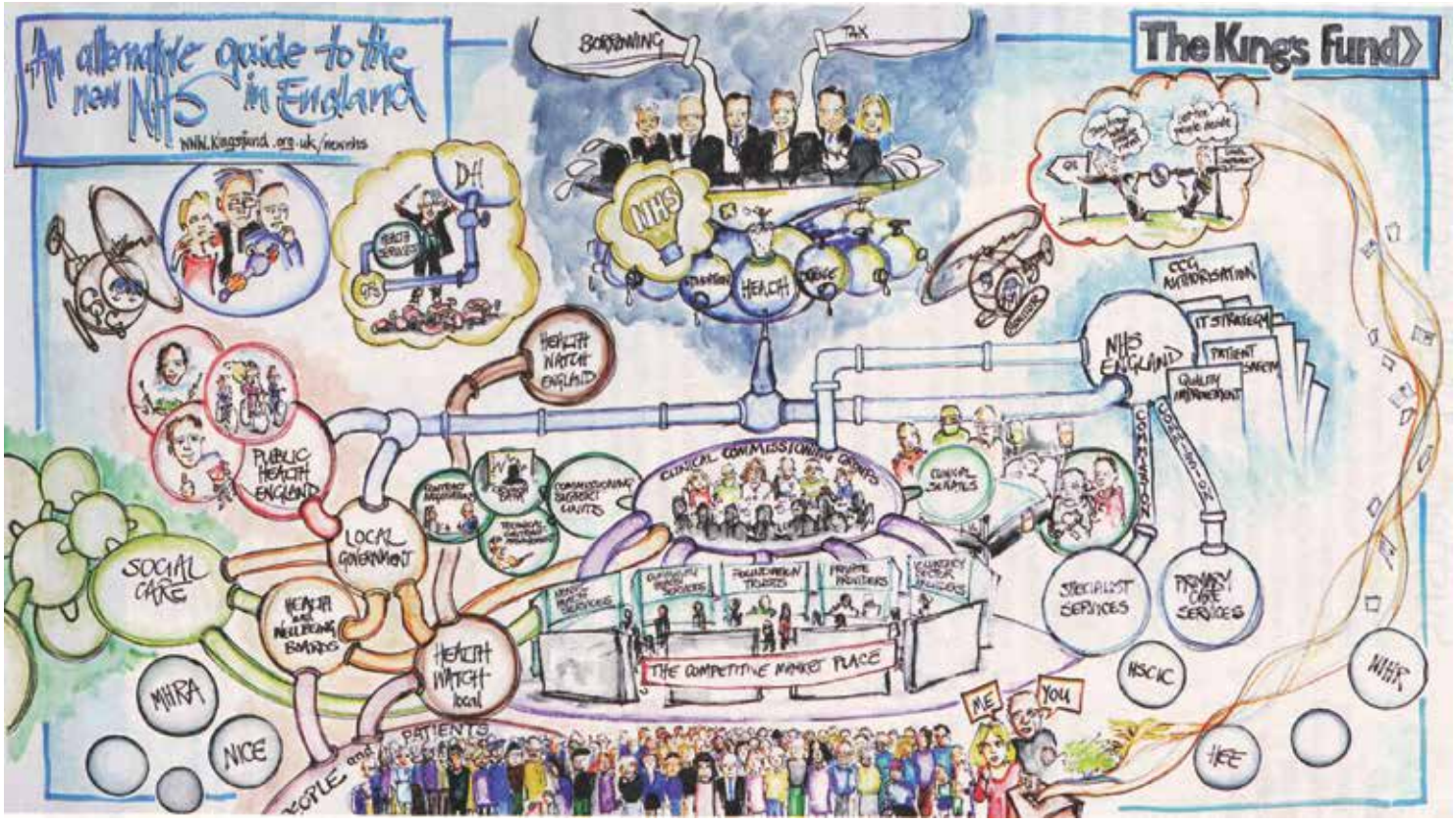


Image courtesy of The King's Fund, London. http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

marginalised from such discussions.[10]

A recent discussion in the HBR written by Jay Lorsch and Emily McTague[1] suggests that there is an emerging opinion, particularly amongst CEOs who have lead major transformations within their organisations that culture in not something that you fix. Rather, in their experience cultural change is what you get after you've put new processes or structures in place to tackle tough business challenges like reworking an outdated strategy or business model. They all show in a range of settings that culture isn't a final destination but that it morphs right along with the company's competitive environment and objectives.

John Traphagan[11] suggests:

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

And he goes on:

"So I think we need to stop using the term 'culture' to talk about what's going on in our organizations. By using the culture concept, we tend to artificially ossify the diverse, complex, and constantly changing social environment that is any organization. As a result, it becomes easy to misinterpret or misunderstand the nature and influence of power, conflict, cooperation, and change in relation to both individual and group behaviors. Corporations and other organizations do not have cultures; they have philosophies and ideologies that form a process in which there is a constant discourse about the nature and expression of values, beliefs, practices, ideas, and goals. This discourse happens in sales meetings, interactions with customers, board meetings, and in conversations around the water cooler. It's a constantly moving target."[11]

If defining and understanding our conceptualisation of organisational culture is hard enough then it is even more sobering to consider how complex the problem in health is when you attempt to explain the NHS (or our own health system) with a simple sketch.[13]

From the above it can be readily appreciated that the culture within an organisation may be far from uniform or coherent and that looking for commonality might be less rewarding than an examination of differences. Some cultural attributes may be seen across an organisation others may be prominent only in some sections of that organisation. Thus different cultures may emerge within different occupational or professional groups. Hence we have the emergence of subcultures. Some of these might be malleable and others resistant-giving rise to the so-called 'counter culture'.[10]

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

For all the influence in defining and assessing organisational cultures the crucial generic question of whether and how organisational culture impacts on organisational success or performance remains empirically poorly explored.[10]

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

In the concluding remarks to their paper[10] Hu Davies et al say: "In the UK the Governments quality strategy emphasizes the importance of cultural transformation. If such an approach is to bear fruit a number of assumptions that are implicit in the approach must be verified as having some substance. Firstly there must be such a thing as organizational culture; secondly, the nature of this culture must have some bearing on clinical performance and health care quality; thirdly it should be possible to identify particular cultural attributes that are facilitative of performance and finally there must be some hope that interventions and management strategies can have a predictable impact on cultural attributes as a precursor to bringing about performance improvements."

At the very least this paper[10] demonstrates that these assumptions are far from trivial or self-evident. Indeed empirical thinking illuminates contention rather than consensus.

This in turn suggests that a more sober assessment of the task of cultural transformation in health care is warranted.[10]

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

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

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

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

What we cannot do is fall into the category of 'risk-averse' culture (HBR May 2016)[14], which is likely to be an obstacle to innovation.

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

As a final word I would ask you to consider the words of Dr Harold Griffiths written in tribute to Dr F.H. McMehan: "Friendliness was the keynote of all his activities. He built up the foundation of cooperation, enthusiasm and friendship, which is present more strongly in the specialty of anesthesiology than in any other medical group."

Maybe a simple 'culture of friendliness'?

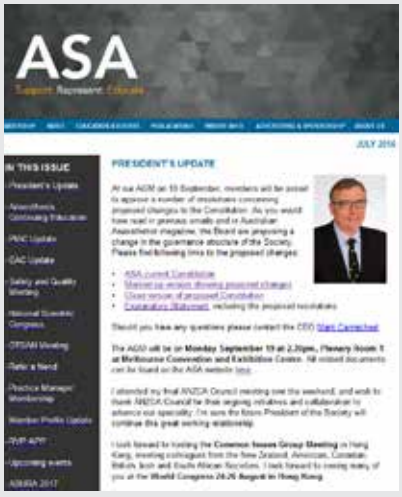
References

1. Jay W. Lorsch and Emily McTague. Culture is not the Culprit. HBR. April 2016 97-105.
2. https://www.surgeons.org/media/22045685/EAG-Report-to-RACS-Draft-08-Sept-2015.pdf
3. https://www.surgeons.org/media/22260415/RACS-Action-Plan_Bullying-Harassment_F-Low-Res_FINAL.pdf
4. https://www.theguardian.com/environment/2013/feb/26/deepwater-oil-spill-trial-bp-failure
5. Bloche M G Scandal as a sentinel event-recognising hidden cost-quality trade offs. N Engl J Med 374; 11 March 17, 2016.
6. http://webarchive.nationalarchives.gov.uk/20090811143745/http:/www.bristol-inquiry.org.uk/final_report/the_report.pdf
7. http://www.afr.com/news/politics/malcolm-turnbull-slams-banks-saying-they-have-not-always-treated-customers-right-20160405-gnzcm3
8. Brogden J Setting the right tone. Company Director Volume 32/Issue 05/June 2016
9. http://asic.gov.au/about-asic/media-centre/speeches/the-importance-of-corporate-culture-in-improving-governance-and-compliance/
10. Davies H Nutley S and Mannion R Organisational culture and quality in health care. Quality in Health Care 2000;9:111-119.
11. https://hbr.org/2015/04/why-company-culture-is-a-misleading-term
12. https://hbr.org/2013/05/what-is-organizational-culture10)
13. http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england
14. https://hbr.org/2016/05/increase-your-return-on-failure

KEY FINDINGS 2016 MEMBER SURVEY

TOP TWO COMMUNICATION CHANNELS

70% of survey participants read the President's enews



Australian Anaesthetist Magazine

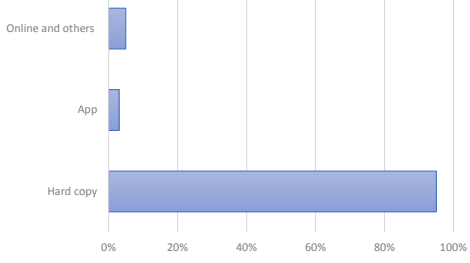
98% recognise the ASA logo

ASA
Australian Society of Anaesthetists

70% feel it accurately represents the ASA

PREFERRED FORMAT FOR PUBLICATIONS

AA



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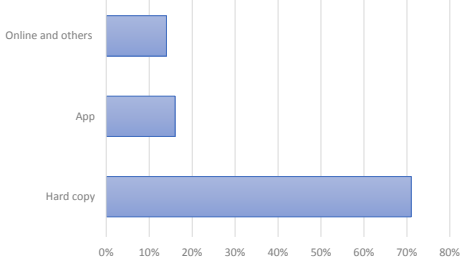
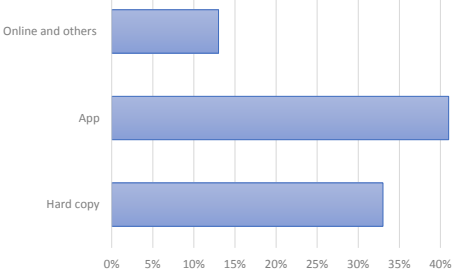


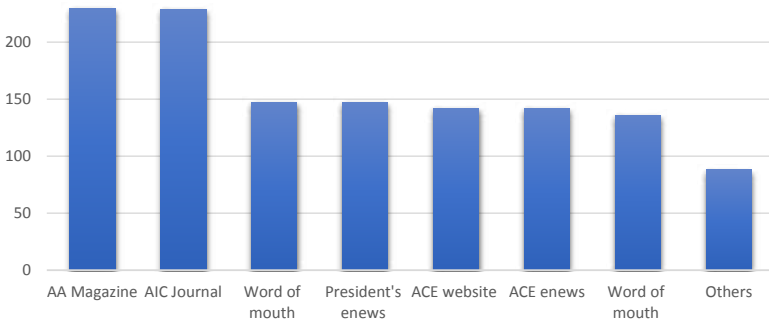
RVG



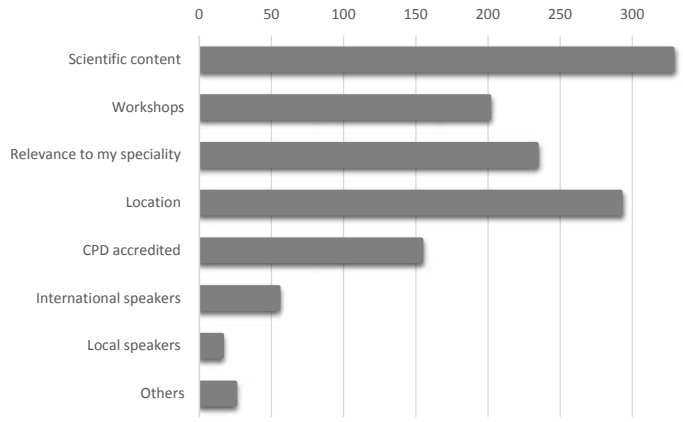
58% of members use the RVG at least once a week

602 TOTAL SURVEY RESPONSES

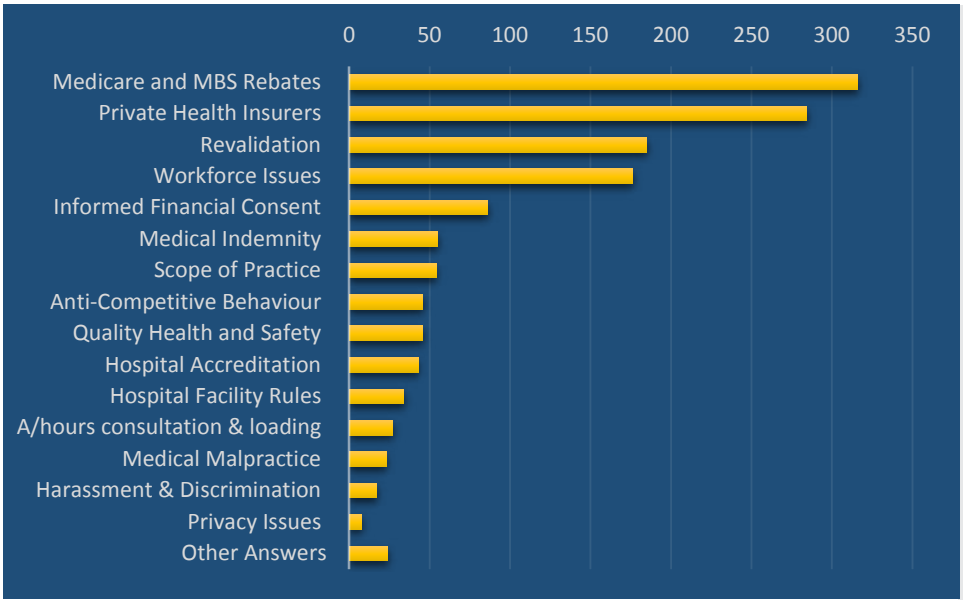
HOW DO YOU FIND OUT ABOUT EVENTS



TOP THINGS TO CONSIDER FOR ATTENDING EVENTS



THREE BIGGEST CONCERNS REGARDING YOUR SPECIALTY...



87% attended a NSC or CSC

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82% would recommend joining the society to a colleague

THANK YOU FOR YOUR FEEDBACK!

FEATURE

THE 2016 AMA NATIONAL CONFERENCE

Drs Guy Christie-Taylor, David M. Scott and Mark Sinclair report on the 2016 AMA National Conference.

The 2016 AMA National Conference was held in Canberra, from Friday 27th to Sunday 29th May. Each medical specialty, (as well as other groups such as doctors-in-training), is allocated a number of delegate positions, this number depending on the percentage of AMA members practising in that specialty. Anaesthesia is allocated three delegate positions, which are usually filled by the ASA President, Vice President, and the President of ANZCA. Any AMA member may attend the National Conference as an observer, but only delegates have voting rights at the AGM and for the election of AMA office bearers. This year, our three delegates were ASA President Dr Guy Christie-Taylor, ASA Vice President Assoc Prof David M. Scott and the Immediate Past President of ANZCA, Dr Genevieve Goulding. Economics Advisory Committee Chair, Dr Mark Sinclair, attended as an observer on behalf of the ASA.

This year was an election year for the federal government, as well as an election year for the senior AMA office bearers. This combination, when it does occur in the same year, results in a lively and interesting series of talks and debates. The conference is certainly popular with journalists at such a time, and literally dozens were in attendance at various sessions.

As we all now know, the Turnbull government has been returned to office, albeit with a much-reduced majority. There have also been a number of cross-benchers elected to the Senate, and it is still uncertain how this will affect the Turnbull government's agendas. However at the time of the AMA conference, while this might have been the outcome expected by some, it was by no means certain which way the electorate would vote.

Prof. Brian Owler opened the conference, and gave an address summarising his two years in office. He highlighted a number of important areas in which the AMA had been involved:

- The AMA's successful opposition to the GP Medicare co-payment plan in 2014
- The extension of the Medicare freeze to 2020 (and the lack of consultation with the medical profession on this and other matters prior to policy announcements, despite repeated promises to have the AMA kept in the loop).
- The concerns about the current MBS review; in particular a lack of reassurance that cost savings are not the aim
- Concerns that the private health insurance industry is pursuing a 'managed care' agenda
- An admission that he would have liked to have given more time to issues such as domestic violence, child abuse and road safety

- A response to criticisms that the AMA should not be involved in political discussions on issues such as asylum seekers and children in detention. His position is that the AMA focuses on the relevant health issues, and that this is entirely appropriate.
- That the AMA is a powerful health lobby group, probably the best of all, and that the AMA has immediate access to politicians without donating a cent to the various political parties.

Ms Catherine King (ALP), Shadow Minister for Health, then addressed the meeting. Her two chief policies were that the ALP would remove the Medicare freeze if elected, and that the new government would establish a permanent Australian Healthcare Reform Commission. This body would consult widely with clinicians, and provide advice to federal and state governments and to the Council of Australian Governments. The overall aim was to decrease health expenditure while maintaining health outcomes, preserving universal access, and removing inequities. The new body would assume the roles of other bodies downgraded or abolished by the Abbott/Turnbull governments, such as Health Workforce Australia, and also of existing bodies such as the Australian Commission on Safety and Quality in Health Care. Savings realised by the MBS review could have been put towards any "new models". Of course, with the ALP having failed to win government, none of this will now happen, but they could form the basis of policies at future elections.

Senator Richard di Natale (Australian Greens leader) spoke next, and outlined the Greens' policies for health. These included allocating $4.3 billion over four years to chronic illness, not only for primary care but also for allied health and public hospital system care. Savings from changing the current negative gearing arrangements, taxation arrangements for superannuation, and removing 'tax cuts for the rich' would be used to reinvest into the health system.

Health Minister Ms Sussan Ley did not attend this session, but spoke at the Gala Dinner on the Saturday night. The Minister was critical of Labor's planned Reform Commission, highlighting this as a "typical example" of Labor overspending on bureaucracy. She also criticised the Greens' policies, emphasising the extremely large amounts of money involved, and the fact that as the Greens have no realistic hope of ever forming government, they can make "reckless promises" which will never have to be implemented. The Minister strongly emphasised her belief that only the Coalition has the "fiscal discipline" to be able to afford its promises. A key focus would be to lower the barriers patients face, by reducing fragmentation across the health system and improving the co-ordination of care, not just "throwing more money" at the system.

But the AMA Conference is not just about politics and elections. A number of interesting policy sessions were held. The first of these was titled 'Assisted dying – Exploring members' perspectives'. Tony Jones from the ABC program Q&A was the moderator, and panelists both for and against voluntary euthanasia gave their views, as well as members of the audience. Some take-home points were that doctors' awareness of the relevant laws is poor, and that where pain relief or sedation are required to alleviate the suffering of a terminally ill patient, but the so-called 'double effect' is to hasten death, there is no legal risk to the doctor. The intent of the doctor is the important factor here – intent to hasten death is of course illegal.

The first policy session on the Saturday morning was titled 'Medical self-regulation – diagnosis, prognosis and treatment'. The Chair was Dr Susan Neuhaus (surgeon), The panelists were Dr Joanna Flynn AM (Chair, Medical Board of Australia), and Assoc. Prof. Matthew Thomas (Chair of Council, Australian Patient Safety Foundation). It was noted that there has been a "slow but steady erosion of trust" in the medical profession, which is "not held in the same esteem it was a few decades ago". Reasons for this were discussed, including the media attention given to "outliers" in the profession. The issue of underperforming doctors was discussed. It was emphasised that standing by and watching an underperforming doctor, or witnessing poor behaviour without taking action, is inappropriate. However 'soft' data (eg. simply that "Dr X is no good") is insufficient.

Doctor-rating websites were also discussed. Dr Flynn appears to be quite supportive of the idea, stating that patients are quite capable of assessing doctors' interactions and behaviours. Dr Neuhaus did however highlight the negatives, such as these websites being open to deliberate manipulation.

The issue of "outliers" for medical fees was also discussed. Dr Flynn applauds the RACS for its stance, stating that "unreasonable" fees are "unprofessional".

Anaesthetists at the AMA National Conference. L to R: Dr John Murray, Dr Ross Kerridge, Assoc Prof David M Scott, Dr Mark Sinclair, Dr Liz Feeney, Dr Guy Christie-Taylor, Dr Genevieve Goulding, Dr Andrew Miller, Dr Margie Cowling

Dr Neuhaus agreed that such cases, although rare, do not reflect well on the profession. Disclosure of information about fees is the key, and there was concern that regulation could be inevitable if practices do not change.

The next policy session was titled 'Health Policy in an Election Year' and was moderated by well-known journalist Mr Paul Buongiorno. On the panel were journalists Ms Sue Dunlevy, Mr Malcolm Farr, Mr Andrew Probyn and Ms Laura Tingle.

There was general agreement among the journalists that the Coalition was likely to win the upcoming election, but with a greatly reduced majority. As we know, this prediction proved to be accurate. The likelihood of another hostile Senate (again, possibly quite an accurate prediction) was discussed, as were issues such as the now abandoned GP co-payment, pathology and radiology billing, and out-of-pocket expenses. Ms Dunlevy was quite forthright on the last of these, saying that she herself has recommended family members go public rather than private due to the "ridiculous" costs. Mark Sinclair was able to address the panel from the floor, pointing out that the main problem is the paucity of the available rebates, and the ongoing freeze. He also mentioned the recent flurry of articles demonising doctors for the problem, with little or no attention given to the rebates issue, or the >$1 billion profits of the health insurers. Her answer was not particularly satisfactory, her opinion being that Medicare and private insurers cannot afford higher rebates, while nevertheless agreeing that poor rebates contribute to the problem.

On Saturday afternoon the policy session was 'The role of private insurance in the Australian healthcare system'. The speakers were Prof John Horvath AO (Strategic Medical Adviser, Ramsay Health Care) and Dr Linda Swan (Chief Medical Officer, Medibank Private). As expected, the discussions covered the rising demand for and cost of health care, and its affordability for patients, hospitals and insurers, as well as the rising expectations of health care consumers. Dr Swan was questioned directly on the extremely large profits generated by the for-profit health insurers in recent times. She replied that the main reason for profits generated specifically by Medibank was a lower than expected hospital utilisation by its customers (14% less than expected). The reasons for this are uncertain but could relate to 'consumer doubts', possibly driven by the publicity being given to the MBS review, and negative influences such as the program on the ABC's Four Corners earlier in the year, which generated much debate about quality of care, 'unnecessary' procedures and 'waste'.

AMA Gala Dinner (Old Parliament House), from L to R: Andrew Mulcahy, Mark Sinclair and Guy Christie-Taylor

Policy Session 5 was titled 'The Medical Profession's Role in Closing the Gap'. Some sobering statistics on indigenous health, including life expectancy and the incidence of "diseases of poverty" such as rheumatic fever, were presented by Prof. Owler. The main speaker for the session was Ms Brooke Boney, political reporter for SBS World News. She is an indigenous Australian, but admits her appearance and accent would lead most people to think she is simply a "well tanned" person of European background. She believes the fact that she is not usually immediately recognised as indigenous has given her a unique insight into the issues. Ms Boney gave an impassioned plea to the medical profession to do better, highlighting the fact that she can probably expect her mother, aunt and grandparents to die at least 10 years younger than non-indigenous Australians (and more like 20 years in some regions).

The final policy session was 'Bullying and Harassment – Changing Culture'. The speakers were Dr Ruth Mitchell (Chair, RACS Trainees Association and neurosurgical registrar at the Royal Melbourne Hospital), Mr Chris Ronalds AM (Sydney-based barrister specialising in discrimination and employment law, and Dr Philip Truskett AM (senior staff surgeon, Prince of Wales Hospital, Sydney). Surveys indicate that up to 63% of trainees have experienced bullying at work, and 30% of all females have experienced sexual harassment. 71% of hospitals have had to deal with poorly behaving surgeons. However, it was emphasised that bullying and harassment are not just surgical, female, or trainee issues, but whole-of-profession issues. Again, the issue of witnessing such behaviour but not acting was discussed.

Apart from policy sessions, the usual annual meetings were held. This year, there was an election for the positions of federal President and Vice President. As is now well known, Dr Michael Gannon (obstetrician, WA) was elected to the position of President, and Dr Anthony Bartone (GP, Victoria) to the position of Vice President. As an aside, we congratulate ASA Treasurer Dr Andrew Miller for being elected to the position of President of AMA WA, replacing Dr Gannon in this role.

Concerns were expressed during the meeting about the decline in membership of the AMA and in particular the decline in membership among doctors in training. An urgency motion to form a new AMA Commission to specifically examine the problem of declining membership was defeated. It was felt that the issue is already well and truly a focus for the organisation and is already allocated the appropriate resources. Whether a different style or approach by the new leadership team will significantly impact membership numbers, remains to be seen.

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

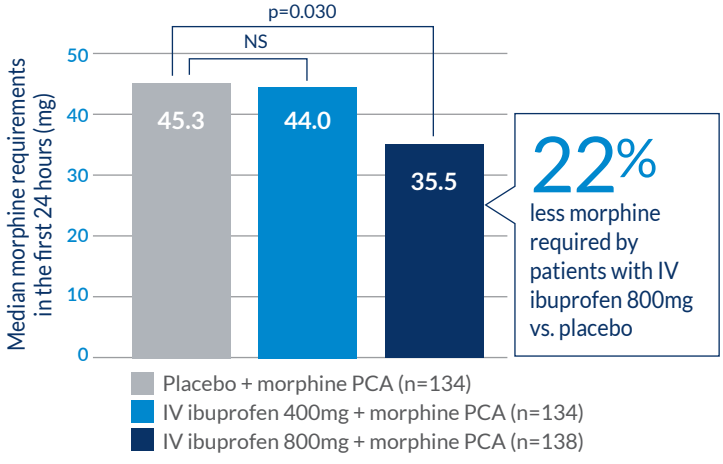
The primary objectives of post-operative pain management are to provide analgesia, facilitate return of function, reduce the incidence of chronic pain, reduce the risk of opioid dependency, minimise side effects, and provide patient satisfaction.[1-4] The sooner pain relief is provided the better the 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% less post-operative pain at rest†

26% less post-operative pain with movement†

31% 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]

REFERENCES: 1. Schug SA *et al.* APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine 2015, Acute Pain Management: Scientific Evidence (4th Edition), ANZCA & FPM, Melbourne. **2.** Macintyre PE & Schug SA. Acute Pain Management: A practical guide 4th Edition 2015, CRC Press. **3.** Gronow, D. Multimodal Management of Acute Pain: Does the Current Approach to Peri-Operative Analgesia Need to Change? ASA Scientific Congress; 2015: Darwin. **4.** Sajewski, D. Multimodal Management of Acute Pain: Does the Current Approach to Peri-Operative Analgesia Need to Change? ASA Scientific Congress; 2015: Darwin. **5.** Southworth S *et al. Clinical Therapeutics* 2009; 31: 1922–35. **6.** Caldolor® Approved Product Information, May 2015. **7.** Singla N *et al. Pain Medicine* 2010; 11: 1284–93.

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FEATURE

THE ASA TIMOR-LESTE FELLOWSHIP

Dr Sam Rigg, talks about the ASA Timor-Leste Fellowship and the time he spent working in Dili.

The ASA Timor-Leste Fellowship was created in December 2015. It is a three month, full-time, non-salaried position based at the Hospital Nacional Guido Valadares (HNGV) in Dili, the main hospital for the whole of Timor-Leste.

Timor-Leste is one of the poorest nations in Asia-Pacific – according to the Asian Development Bank 49.9% of the population live below the poverty line – although being only around an hour's flight from Darwin it is a close neighbour of one of the world's richest. Despite being recently re-classified as a lower middle-income country by the World Bank due to petro-dollars, much of the population still relies on subsistence farming, and many challenges remain in delivering health care. Table 1 shows how health indicators have improved in Timor since gaining independence in 2002 (with Australian figures for comparison).

Timor-Leste has a population of over 1.2 million people, and HNGV performs 85% of the country's surgical work. It has three operating theatres, a minor procedures area and a recovery unit in its operating block. The hospital also has busy emergency, paediatric, medical, obstetric and intensive care units.

The aim of the Fellowship was to provide medical education and to support the Timor-Leste Post Graduate Diploma of Anaesthesia training program under the Universidade Nacional de Timor Lororsa'e (UNTL).

The anaesthesia department at HNGV consists of four specialist anaesthetists, four Diploma of Anaesthesia trainees and six nurse anaesthetists. A number of

Table 1

	Timor-Leste (2002)	Timor-Leste (2014)	Australia
Life expectance at birth (years)	61	68	83
Maternal mortality (per 100,000 live births)	601	231	4
Under 5 mortality (per 1000 live births)	99	55	6
Health Expenditure per capita ($US)	$21	$107	$6031

different languages are spoken at HNGV including Spanish, Mandarin, Tetun and Portuguese, although English is the language used in the operating theatre and for teaching.

During this fellowship, I was directly supervised by the Royal Australian College of Surgeons ATLASS II Specialist Anaesthetist Dr Eric Vreede, who has been in the country for 12 years where he has trained all the anaesthesia providers and Dr Flavio Brandao, head of department at HNGV. Dr Brandao is Timor's first Specialist Anaesthetist having undertaken the Diploma in Anaesthesia under Dr Vreede before completing his Masters in Anaesthesia at the University of Fiji. ANZCA Fellow Dr Dan Holmes from the Royal Darwin Hospital provided remote supervision.

The normal working day started at 8am, helping to run two elective theatres and an emergency theatre. A Timorese registrar was assigned to each theatre with level 2 supervision provided by the local Specialist anaesthetists and myself.

The caseload was an interesting mix of both elective and emergency work. General surgery, ENT, obstetrics and gynecology, paediatrics (including neonatal surgery), thoracic surgery, neurosurgery and burns were all represented. The resources available in Dili are vastly different to those in Australia, providing a unique challenge to this fellowship.

The anaesthetic machines were similar to those in Australia, although the variable availability of capnography and end tidal gas monitoring presented challenges at times. This fellowship provided a great opportunity to become familiar and comfortable with using ketamine and halothane for the maintenance of anaesthesia. There was also plenty of opportunity to become familiar and competent in the use of drawover vaporisers.

One memorable case was the evacuation of a pericardial effusion, caused by tuberculosis, in a paediatric patient performed solely under ketamine and a Hudson mask. This is just one example of the wide range of pathologies seen in Dili but rarely seen in Australia.

The afternoon was dedicated to classroom based teaching of subjects ranging from basic sciences, physiology, and pharmacology to more clinical specialty topics adapted to the clinical environment at HNGV. A number of specialists kindly donated their time to visit from the Royal Darwin Hospital to help teach topics requested by the local anaesthetists, including simulation teaching on basic and advanced life support and an introduction to managing emergencies in anaesthesia. These proved to be very successful and were enjoyed by all the trainees. These days also provided a pathway to progressing emergency management algorithms specific to the environment at HNGV, and further courses are being planned for the future.

Introducing the trainees to quality improvement projects was another aim of this fellowship. One group audited the use of the Surgical Safety Checklist at HNGV whilst another examined the rates of PONV in the Timorese population, which had never been studied before. After education and intervention, the re-audit of the use of the Surgical Safety Checklist showed a greatly improved completion rate from 5% in the initial audit to 95%

Dr Eric Vreede teaching Dr Fernanda da Silva

The trainees, Sam Rigg and Eric Vreede, the RACS anaesthetist

Dr Flavio, Head of Department at HNGV and first Timorese specialist and graduate of University of Fiji

Dr Eric Vreede helping Dr Jonatas Madeira dos Reis during simulation teaching

Tropical storm over theatres

Dr Helena da Silva undertaking a paediatric case

Dr Eric Vreede teaching Dr Maria Piedade

in the re-audit in June. Both audits have lead to changes in practice and hopefully increased patient safety and satisfaction.

Life outside the hospital was enjoyable with plenty to see and do both in Dili and the rest of Timor-Leste. Dili is a vibrant capital city overlooking the sea and is a great base from which to explore the rest of the country. Aside from the plentiful bars and restaurants there is great mountain biking, trekking, scuba diving and deserted beaches all within easy reach.

This Fellowship is only in its infancy and there is huge scope for its development by future Fellows. The development of a Masters in Anaesthesia program is currently being discussed, the success of which will require the involvement of Provisional Fellows of ANZCA in the future.

In conclusion, I would highly recommend this Fellowship to anyone with a passion for teaching and medical education who wishes to broaden their experience and push the boundaries of their comfort zone.

Finally a big thank you to the ASA Overseas Development and Education committee for funding me on this Fellowship and RACS Global Health for all the logistical support.

Anyone interested in this Fellowship should contact

- Dr Brian Spain, Director of Anaesthesia. Royal Darwin Hospital. Email: brian.spain@nt.gov.au or
- Dr Dan Holmes, Specialist Anaesthetist, Royal Darwin Hospital. Email: Daniel.holmes@nt.gov.au

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FEATURE

PARENTAL LEAVE – RIGHTS AND RESPONSIBILITIES

Dr Kara Allen at Royal Melbourne & St Vincent's Hospital Melbourne and Clinical Lecturer at the University of Melbourne, writes about the difficulty faced by anaesthetists to take parental leave and when to return to work.

Having a child is a joyous if tumultuous experience which many Australian anaesthetists experience, especially during the training and early consultant years. There is no published data on when or how much parental leave is taken by Australian doctors. Anecdotally in anaesthesia parental leave is commonly taken between the primary and fellowship examinations, and following the fellowship exam whether as a senior registrar or as a consultant. There are competing interests at all stages, with administrative and professional concerns at the forefront for a department, while the need to balance work and life may predominate in the minds of parents, especially in the first few years.

Despite the availability of unpaid parental leave to both men and women, very few countries outside of Scandinavia have substantial paid parental leave (PPL) for fathers (>3 weeks). The result is only 2% of new fathers in Australia take more than 3 weeks parental leave compared with 40% of new fathers in Scandinavia. Therefore, women take the bulk of parental leave in Australia, both paid (PPL) and unpaid (UPL). This gender divide is reflected in anaesthesia and perioperative specialities, with potential negative effects for both men and women. Access to leave as the primary carer may be limited for men, with potential implications for training (see text box).

Access to PPL and UPL varies enormously around the world. The United States of America makes no provision for dedicated maternity or paternity leave for employees. According to the Harvard School of Public Health this may correlate with poor mental health and reduced life expectancy.[1] Our American colleagues may perceive a short absence from work with minimal impact on the workplace as normal and may be unaware of the possible long term effects of these policies. In terms of social policy, this puts the USA below Rwanda, Somalia and Tanzania, who have maternity leave policies in line with most of Africa (12 weeks paid leave). Thankfully Australia has not chosen to emulate this and instead recognises the significant health benefits of longer periods of maternity leave[2] adopting a means tested federal paid parental leave program of 18 weeks, in addition to employer or award mandated parental leave. Federal provision exists for parents to split 52 weeks of unpaid leave, with job security. This however has been an issue for some trainees who complete a contract with a health service during a period of parental leave, and find themselves unable to return to the job they left.

Leave allowances during ANZCA training:

- Minimum two years consecutive training must be completed
- Must complete 22 weeks before sitting primary exam
- Three weeks during introductory training (six months)
- 16 weeks during basic training (24 months)
- 16 weeks during advanced training (24 months)
- 12 weeks during provisional fellowship (12 months)
- 52 weeks of interrupted training may be approved by DPA however will need to do the next 52 weeks (PT or FT) continuously

A number of private organisations (HSBC, Edith Cowan University, Alcoa, National Australia Bank) have developed generous parental leave policies which include superannuation benefits, no qualification period, flexible working hours and longer than average paid periods (up to 24 weeks full pay). Helen Ormond, Head of Organisation Capability at NAB acknowledges "While this is a substantial investment in our people, we have done sufficient cost analysis to reap the dividends in terms of employee productivity, job satisfaction and staff retention." Medicine lags behind business with respect to flexibility, working whilst pregnant and returning from parental leave. Sheryl Sandberg successfully lobbied Google for changes to parking arrangements, meeting times and flexible hours which as CFO she could directly link to productivity and organisational success whilst improving job satisfaction for men and women raising families. From an economic perspective, adequately resourced parental leave has proven beneficial to keeping women engaged with the workplace in the long term, and may reduce the economic disadvantage that women usually bear along with the children.

DISCRIMINATION

Nearly 50% of women report discrimination in the workplace during pregnancy, maternity leave or when returning to work, although less than 10% make a formal report (FairWork National Review). In anaesthesia, this may manifest as changes to in hours vs on-call ratios, less exposure to desirable lists, and direct or indirect discriminatory comments. For departments this can create a significant gender imbalance which does not reflect the increasing number of female trainees or women admitted to fellowship. Additionally, this may become a self perpetuating cycle if women lack role models or mentors who have successfully balanced a varied and interesting career with family commitments. This is often met with an argument of meritocracy, simply put, that those who are more willing to forgo involvement in family life to pursue career progression make better anaesthetists. This dismisses the value of women and men in the life of a family, their desire to contribute to both family and the workplace, and may result in policies which are discriminatory to same sex families. Moreover, there is strong evidence that meritocracy is essentially sexism and racism masquerading as non biased assessment of competence[3]. Conversely, increasing numbers of men wish to invest time in their family, or seek a more balanced approach to work, but find themselves on the end of discriminatory policies which prioritise 'maternity leave' over 'primary carer leave', which disadvantages not only male primary carers, but also same sex couples and parents of adopted children. When men do work part time or take extended parental leave, they may experience similar discrimination-as one male anaesthetist stated "There's this thing of, you stepped back, you've lost interest, you're not really committed to [a career in] anaesthesia."

Therefore, whilst it is easy to say 'Have your family when it suits you and no one else' the reality for many women, and increasingly for men who wish to take a greater involvement in raising children, this needs to be a carefully considered career break with an understanding of the risks involved.

"The dilemma for a working mother is a very precise one — she should work as if she does not have children, and raise her children as if she does not have a job." – Annabel Crabb

RIGHTS AND RESPONSIBILITIES

For some women, changes to work practice may need to occur during pregnancy. Many women are able to work through pregnancy side effects, from morning sickness to pre-eclampsia, but occasionally modifications to duties are required. Most departments see this as accommodating an anaesthetist who needs modified duties for a short period of time due to physical restrictions (e.g. broken wrist, postoperative recovery), but this can be a source of discrimination, which may discourage women from pursuing modified duties, even when required. Instead, she may take sick leave or early maternity leave.

The International Atomic Energy Agency recommends that pregnant women limit exposure to radiation as much as is practicable throughout pregnancy, but particularly in the first trimester. Night shift work, particularly rotating shift work, is associated with a clinically significant increased risk of miscarriage[4]. Bonde et al recommend that women, especially if the pregnancy is high risk, consider ways to mitigate this increased risk. Understandably this can prove difficult, especially for senior trainees in small departments. Generally trainees and consultants accept that there will be

FEATURE

an after hours component to the work, however some departmental flexibility around timing and regularity is highly valued by pregnant employees.

In order to access PPL, contracts for public hospital doctors usually specify a period of notice (up to ten weeks), with six weeks' notice required if changes occur. There may be restrictions in some states around how early maternity leave can be accessed, although in most cases earlier access would be a result of medical necessity. Doctors planning to take parental leave should bear in mind that department administration usually prefer clear communication as early as is practicable around when the leave will be taken and when the doctor plans to return.

Employees are entitled to 12 months parental leave and to return to the job s/he previously held. This is problematic for many trainees who may be on six or 12 month contracts. Duration of PPL varies, with doctors in Victoria entitled to ten weeks maternity or primary carer (adoption) leave provided they have 12 months continuous service, through to the generous provisions in the Northern Territory of 18 weeks followed by up to three years unpaid after five continuous years of service. Additionally, some states make provisions for doctors who had finished contracts to take parental leave to allow continuity of service over parental leave in the absence of a contract and retention of entitlements. In addition to ANZCA requirements, AHPRA requires doctors who have taken more than 52 weeks of parental leave to complete a period of supervision before returning to practice.

Dr Susan Voss, an anaesthetist at Westmead Hospital (Sydney) has taken administrative responsibility for rotational allocations for over 20 years. "The earlier the better," she says, when it comes to notification about leave. This allows the department to plan to fill gaps, allows for accommodation of work preferences (to reduce exposure to radiation for example) and interview to replace the practitioner for a long period of leave. "Understandably most people want to wait until all the testing is done," says Dr Jade Radnor, now a consultant anaesthetist, provides a trainee perspective on having children during training.

With many medical schools moving towards post-graduate courses, it is reasonable to expect that the average age of trainees will increase and many trainees may well have already begun – or completed – their families. This applies to trainees of both sexes and with growing trends in men sharing parenting duties, there exists a need for training networks and programs to adapt to these changing demographics of trainees and their requirements.

Coupled with the well known risks of increasing age being associated with infertility and obstetric complications, female trainees often find themselves in real personal and professional predicament.

There are always going to be challenges no matter when trainees choose to have a child during their training. Many wait until they have completed their primary examinations but for some this may not be an option – whether by choice or otherwise. To quote a fellow medical mum "children are out to disrupt even your best laid plans from the moment they are conceived"! It is unclear whether males choosing to be the 'stay at home dad' are entitled to the same length of time away from training as women who have children early in the careers-comment was sought from ANZCA on this issue but this is not confirmed.

The ANZCA training fees continue to increase each year and thanks to the inspiring hard work of Dr Amanda Dalton and past CEO Dr Lindy Roberts, fees are now charged pro-rata. Prior to 2015 if a female trainee went on maternity leave they were still required to pay the full year's training fee despite not being able to utilise training resources. Consequently some female colleagues who took maternity leave prior to 2015 paid close to 40% more in training fees despite completing exactly the same number of weeks training time as their male colleagues.

Taking parental leave then returning to work and study with a young family in tow is demanding both professionally and personally. However, trainees should not be disadvantaged, for example by no longer rotating to a hospital or sub-speciality area allocated prior to interrupted-training, simply because they have chosen to start a family. Sadly work-place harassment of trainees does occur, whether explicit or implicit. Mentor relationships can help to navigate some of the more difficult issues that may come up in the process of taking parental leave, and provide the trainee with departmental advocates.

Parental leave during training has numerous advantages for the individual and the broader community. Trainees are able to begin a family when biologically favourable and most importantly at a time that is right for them. Upon returning to work they have the advantage of supervision, depending on their stage of training. Such measures are important in ensuring the high standards of patient safety and care that our profession prides itself on. Particularly if the trainee is returning to a department where few doctors have taken parental leave, a return-to-work plan is paramount in setting expectations for return. Parental leave takes planning, organisation and tremendous hard work but it is, undoubtedly, highly rewarding and should not be discouraged.

Voss, acknowledging that for some women this can continue until 18 weeks gestation. Westmead has had many opportunities to navigate these issues, with 11 pregnancies announced in one memorable year. She points out that it is crucial that the roster coordinator operates with discretion, and acknowledges the burden that timing of children can place on trainees. "When you hear someone say they are going [to have a baby] between the written and the viva, you think 'Oh wow!' but people do it successfully."

There are common factors that maintain a good working relationship between the doctor and the department. Notification of intention as early as possible is helpful, as is a realistic assessment of time off. "I encourage them to take as much time as they need," says Dr Voss, a sentiment echoed by other Directors. For trainees, working around the academic year will often dictate a return, whilst consultants have more flexibility. It is crucial to have reliable childcare arranged prior to returning to work, and ideally this will cover study time as well. This may be a significant cost to some families, as in-home childcare can easily cost $25-35 per hour after tax, once insurances, superannuation, holiday and sick pay are considered.

In preparation for return, issues such as sleep deprivation and breastfeeding need to be considered, as most departments have limited flexibility in the call roster. In the research done around the CRASH course (see below), returning to after hours work has varied from two days to six weeks for trainees. This is a source of significant anxiety for doctors who may have taken lengthy periods away from work. In this respect there may be an advantage to leave taken early in training as these trainees felt well supported after hours, compared to some consultants who delayed their return to after hours work as there was less support.

PREPARING FOR A RETURN TO WORK

The Royal College of Anaesthetists has a position paper on the process of returning to work, including a pre-leave questionnaire that addresses what the doctor is planning to do with regards to continuing professional development, use of the mandated, paid Keep In Touch (KIT) days, and opportunities for specific retraining. ANZCA PSD 50 covers returning to work as a specialist anaesthetist, whilst regulation 37 covers trainees. PS50 outlines a four stage process for anaesthetists returning to work after 12 months or more away from clinical anaesthesia, and this process can be adapted for shorted periods of leave.

There is also a specific course available to meet some of these requirements and provide practical solutions to the anxieties and challenges faced on returning to work. The CRASH course is run by a group of critical care specialists who have experience in handling these issues personally and professionally. Over 85% of participants felt that the course significantly improved the process of returning to work, including improving patient safety, reducing anxiety and refreshing knowledge.

CONCLUSION

With increasing numbers of women entering the anaesthetic training program, and increasing numbers of post graduate medical students, it is likely that parental leave will be an issue for all anaesthesia departments. Working together with the trainee or consultant to optimise safe work practices during pregnancy and orchestrate a return to work which suits both parties is the best possible outcome for a department and the individual doctor. Ideally expectations for length of leave, continuing professional development activities during leave and return from leave should be discussed well in advance. Evidence from the business community suggests that investing in work life balance reaps dividends in terms of morale, productivity and staff retention. Whilst medicine lags behind in provisions for paid parental leave for both men and women, the community of anaesthetists have an opportunity to demonstrate leadership in returning critical care specialists safely to the work environment. Ultimately this benefits all members of our craft group, and the wider community.

Resources

[1] http://www.hsph.harvard.edu/news/features/maternity-leave-and-mental-health/ Accessed on 14th April, 2016

[2] Staehelin et al, Int J Public Health, 2007

[3] The Meritocracy Myth by Stephen J McNamee and Robert K Miller Jr ISBN 978-1442219823

[4] Bonde, JPE et al. Risk of miscarriage and occupational activity: a systematic review and meta analysis regarding shift work, working hours, lifting, standing and physical workload. Scand J Work Environ Health, 2013 Jul 1: 39(4): 325-334.

The CRASH course

The CRASH course has been designed by critical care specialists to form part of a structured return to work after extended leave. It is run twice a year in Melbourne, facilitated by a dedicated faculty. CRASH meets the ANZCA requirements for Major Haemorrhage and Cardiac Arrest Emergency Response accreditation, as well as providing exposure to case based discussion, airway management, simulated clinical scenarios and anaesthetic emergencies. Feedback from participants includes:

"This course should be mandatory for all anaesthetists returning to work."

"Excellent course – I felt reassured that my previous skills and knowledge were available to me, and got a very efficient refresher on some less frequently used skills and information."

See more at http://www.anaesthesia.mh.org.au/the-crash-course/w1/i1016166/

FEATURE

FOLLOWING PROTOCOLS VS TAILORING CARE BASED ONLY ON EXPERIENCE – WHY NEITHER IS BEST

Michael C. Reade, Defence Professor of Military Medicine and Surgery, University of Queensland and Vice President David M. Scott discuss the use of evidence-based medicine.

The adoption of business principles to medicine and patient care has been an attractive concept for policy makers. Developing cost-effective policies, setting compliance targets, auditing results and rectifying deviations are fundamental tools of professional management. This makes sense when dealing with organisational issues such as appropriate staff rostering or equipment maintenance. Implementing 'evidence-based medicine' appears superficially synonymous with this type of compliance-directed policy-making. Unfortunately, few appreciate the fundamental differences. Doctors, trained to tailor care to individuals rather than apply a set of universal rules, can feel their clinical expertise usurped by mandated 'evidence based' protocols. Some have responded by rejecting entirely 'evidence-based care'.[1] When it comes to translating the results of clinical trials into practice, neither the 'protocolisers' nor the 'individualists' are entirely correct – and here we explain why.

Protagonists of protocolised clinical care argue that hospitals complying with evidence-based guidelines have better results. Many studies in acute care show this is true.[2,3,4] However, association does not necessarily equate to causation. It is likely that hospitals adhering best to protocols do so for various reasons, all of which plausibly affect patient outcomes to a greater degree than protocol adherence itself. For example, lower risk patients, such as those without comorbidities, are less likely both to die and to have contraindications to protocolised care. Academic (vs community) hospitals might have better outcomes because they have more staff or enhanced peer-review rather their greater implementation of protocols. Some studies control for observed

confounders, but statistical adjustment can never be complete.

Detractors of protocolised care easily find examples of non-evidence-based performance metrics that should be associated with better outcomes whereas the converse is true. For example, a delay of >4hrs in undergoing a CT after significant head injury logically sounds bad, but in fact is associated with a lower mortality.[5] The problem is confounding by severity of illness, for which few process quality metrics adjust. Defining 'good care' by such indices creates perverse incentives for clinicians. However, truly 'evidence-based' medicine recognises this, requiring validation of any metrics before adoption, although this is more easily said than done.

Implementation of 'Early goal directed therapy' for severe sepsis is an archetypal example of the way in which evidence-based medicine can be misused. A single-centre trial with limited external validity demonstrated reduced mortality in patients randomised to receive a multi-faceted intervention aimed at normalising central venous oxygen saturation,[6] and several before-and-after studies found reduced mortality after introduction of a similar protocol.[7] However, when the protocol was tested in three multicentre randomised trials, no benefit was observed.[8] By this time, the US National Quality Forum had recommended funding be tied to measures of compliance with this and other, now discredited, Surviving Sepsis Guideline recommendations. Over-interpreting limited evidence to define performance targets is not implementing evidence-based medicine.

It is tempting to regard misguided protocols as reasons to reject the notion of evidence-based medicine. However, this is incorrect. There are two types of clinical trial:

- 'efficacy' trials involving small numbers of narrowly-selected patients who receive strictly protocolised care, often with surrogate outcomes and analysed by 'treatment received'; and
- 'effectiveness' trials, enrolling large patient numbers meeting loose criteria who ideally receive the treatment intended, but who might deviate from the protocol for any number of reasons. Outcomes are patient- or cost-effectiveness centred, analysed by intention-to-treat.

Evidence-based medicine relies on effectiveness trials with broad generalisability and meaningful outcomes, not on efficacy trials. Effectiveness trials are not so much testing a drug or protocol as the policy of trying to implement an intervention, accepting that some patients should be excluded, or have their allocated treatment discontinued if it becomes apparent that they are not responding. If a policy of trying to implement an intervention, with these caveats, is found effective then evidence-based medicine rightly recommends its broad adoption. However, it is never intended that the intervention should be applied unthinkingly to every patient. Thoughtful clinicians must tailor care to individual patients, just as they did in the effectiveness trial. An important consequence is that, for most evidence-based interventions, it is illogical to aim for 100% compliance. Simplistically, the ideal compliance rate should be similar to that in the underlying trials. In practice this will vary according to hospital, patient population and other factors.

The alternative is to return to the principles of experience-based medicine. Unfortunately, clinical decisions are unduly influenced by first or most recent experiences (the primacy and recency effects) along with a long list of other biases.[9] Thinking that protocols might help the majority but that one's own greater-than-average expertise reduces their applicability is countered by the observation that physicians' self-rating of performance correlates poorly with reality,[10] and also the Dunning-Kruger effect, in which less skilled individuals systematically overestimate their abilities while the reverse is true for the most skilled.[11]

Expecting 100% compliance with any clinical protocol is dangerous, as is abandoning protocolised care. The appropriate course lies somewhere in between – and in the absence of evidence identifying exactly where, medical judgment remains essential.

References

1. Porta M. Is there life after evidence-based medicine? J Eval Clin Pract 2004;10:147-52.
2. Shafi S, Barnes SA, Rayan N, et al. Compliance with recommended care at trauma centers: association with patient outcomes. J Am Coll Surg 2014;219:189-98.
3. Cnossen MC, Scholten AC, Lingsma H, et al. Adherence to guidelines in adult patients with traumatic brain injury: A living systematic review. J Neurotrauma 2015.
4. Rice TW, Morris S, Tortella BJ, Wheeler AP, Christensen MC. Deviations from evidence-based clinical management guidelines increase mortality in critically injured trauma patients*. Crit Care Med 2012;40:778-86.
5. Glance LG, Dick AW, Mukamel DB, Osler TM. Association between trauma quality indicators and outcomes for injured patients. Arch Surg 2012;147:308-15.
6. Rivers E, Nguyen B, Havstad S, et al. Early goal-directed therapy in the treatment of severe sepsis and septic shock. N Engl J Med 2001;345:1368-77.
7. Damiani E, Donati A, Serafini G, et al. Effect of performance improvement programs on compliance with sepsis bundles and mortality: a systematic review and meta-analysis of observational studies. PLoS One 2015;10:e0125827.
8. Angus DC, Barnato AE, Bell D, et al. A systematic review and meta-analysis of early goal-directed therapy for septic shock: the ARISE, ProCESS and ProMISe Investigators. Intensive Care Med 2015;41:1549-60.
9. Croskerry P. Achieving quality in clinical decision making: cognitive strategies and detection of bias. Acad Emerg Med 2002;9:1184-204.
10. Davis DA, Mazmanian PE, Fordis M, Van Harrison R, Thorpe KE, Perrier L. Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. JAMA 2006;296:1094-102.
11. Simons DJ. Unskilled and optimistic: overconfident predictions despite calibrated knowledge of relative skill. Psychon Bull Rev 2013;20:601-7.

FEATURE

'AUSTRALIA'S FUTURE HEALTH WORKFORCE: ANAESTHESIA' – AN ASSESSMENT

Dr James Bradley considers the Federal Department of Health and Ageing's assessment on the anaesthesia workforce.

The Federal Department of Health and Ageing released the report *Australia's Future Health Workforce: Anaesthesia* on 1 August 2016. This is the second detailed investigation of a medical specialty, psychiatry having been already addressed, and it was developed for the Department by its National Medical Training Advisory Network (NMTAN). The anaesthesia report[1] can be accessed online through the Department's website.

As addressed in the June 2016 issue of *Australian Anaesthetist*[2], the report is directed by the 'agreed guiding principles' outlined in the *Australia's Future Health Workforce – Doctors* report[3], which has superseded HW2025[4] previously addressed in *Australian Anaesthetist*[5].

The 'guiding principles' are to support:

- the training of the medical workforce to match community requirements in both specialties and location
- the matching of supply and demand for training against various trends and advances
- the provision of cost-effective and efficient medical training
- the provision of information about future service needs
- the prioritisation of Australian trained medical graduates, with Overseas Trained Doctors (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".

As noted previously[2], the Department commenced an assessment of the

anaesthesia workforce in 2015 following a representation by ASA, ANZCA and AMA, with ASA subsequently meeting formally with the Department (through its NMTAN personnel) on two occasions. These meetings were well supported by the findings of the 2014 ASA member workforce study[6].

"Results of the projections reveal a workforce that is in balance, with the potential to shift into oversupply if trainee numbers are increased or if there is not a decrease in International Medical Graduates".

The draft reports seen by the ASA focused on the existing anaesthesia workforce, both specialist and non-specialist, the 'training pipeline', the desirability of providing and maintaining a well skilled and appropriately utilised anaesthesia workforce, the matching of supply and demand, and the 'maldistribution' of the workforce.

The 'Australia's Future Health Workforce: Anaesthesia' report as released[1] makes the following headline findings, detailed in its Executive Summary key findings:

SUPPLY AND DEMAND PROJECTIONS:

- The anaesthesia workforce is in balance "with the potential to shift into oversupply if trainee numbers are increased or if there is not a decrease in International Medical Graduates".
- "Should a scenario of increased demand for anaesthetists rise, various tactics could be implemented to meet community needs" given that it is suggested that components of the current workforce "may be currently underutilised". Further, those anaesthetists practising in a second specialty could also increase their anaesthesia workload.

TRAINING PROGRAM:

- Anaesthesia is identified as a popular specialty for vocational training, with the number of medical graduates (421) indicating intention to train in anaesthesia double the current annual intake (just over 200).
- Intake into vocational training in anaesthesia should not be driven by pressure or demand from medical graduates, "rather intake should be attenuated with the aim of achieving a delicate balance between business fiscal interests, medical students' vocational aspirations and evolving community requirements".

CAPACITY AND DISTRIBUTION FOR VOCATIONAL TRAINING:

- Previous 'bottlenecks' in some subspecialty areas seem to have eased with the introduction of the current ANZCA curriculum.

THE RECOMMENDATIONS OF THE REPORT, GIVEN THE FINDINGS ABOVE, ARE TO:

- closely monitor supply and demand projections updating every two years;
- monitor vocational training numbers and transition rates;
- monitor the progression of IMGs to Fellowship.

The report is yet to be formally considered by the ASA Board. However, the initial assessment of the Professional Issues Advisory Committee is that the report is very much 'a work in progress'. To that extent, it seems, in relation to the 'guiding principles' above:

- That in relation to training the medical workforce to match community requirements in both specialties and location, there are now concessions about 'the maldistribution' ("it is important to note that due to the collaborative nature of the anaesthetic field, the distribution or maldistribution of anaesthetists is inextricably tied to the distribution of other medical specialists") which suggests that there is an emerging understanding that simply "pump priming the specialist workforce" will not in itself address distribution of the medical specialties.

"Should a scenario of increased demand for anaesthetists arise, the workforce is in a position to implement various tactics to meet the community needs".

- That although supply and demand have been modelled, they have not been comprehensively modelled against trends and advances (in fact, the number of scenarios modelled has been reduced from HW2025, and the productivity improvements canvassed in the *Australia's Future Health Workforce – Doctors* report[3] have not been incorporated).
- The cost-effectiveness of medical training has not been addressed – though its efficiency has been partly addressed: 'bottlenecks' have been diminished. There is no expressed desire for shortening of vocational training, and the ASA's observation that "overtime by trainees should not be unreasonably restricted" has been published in the report: the ASA's position being that vocational training numbers should not be dictated by State budgetary aspirations.
- Future service needs have been addressed by combining data which represents services delivered in both the public and private sectors, taking into account population growth and the consequences of the ageing of the population on utilisation of services.
- The use of OTDs to fill workforce gaps

FEATURE

has been replaced by the proposal that components of the current anaesthesia workforce be used – along with a warning of the potential for the workforce to shift into oversupply if there is not a decrease in International Medical Graduate numbers.

- In relation to the need to recognise the balance between service delivery demands and training needs, and the adjusting of the training system "in relation to career opportunities, choices and expectations of doctors at all levels", there are throughout the report references to the need to balance the aspirations of would-be vocational trainees against ultimate community needs, but no answers.

"…it is important to note that due to the collaborative nature of the anaesthetic field, the distribution or maldistribution of anaesthetists is inextricably tied to the distribution of other medical specialists."

WHERE NEXT:

As mentioned in the introduction, anaesthesia is the second medical specialty (following psychiatry) to undergo detailed assessment by NMTAN. The findings of the two reports provide an interesting contrast, with psychiatry facing an undersupply not shared by anaesthesia.

Both reports however highlight the difficulties in satisfying the Government's 'guiding principles', it being obvious that 'one size fits all' solutions cannot be applied to the differing problems seen across the various specialties.

Over the last few years, there has been no evidence that there is an undersupply of anaesthetists, except in relation to the filling of salaried positions in non-metropolitan public hospitals. The ASA surveys over the last three years have provided solid data in this area.

The report states that the "anaesthesia workforce is in balance", though it would be the view of the ASA (based again on survey findings) that there is some underutilisation, a finding also made by the report.

NMTAN has made well nuanced findings in relation to a capacity for an increased workload based on the reported professional hours worked by the specialty, evidenced for example by the finding (page 5 of the report) that "the current workforce may be underutilised. An additional reserve of 52.5 FTE could be mobilised if specialist anaesthetists aged 45 to 50 years worked one extra session per week".

With the workforce 'in balance' and the training program meeting (or more than meeting, over the next few years) supply requirements, other findings of the report can be debated: for example, is any need for training in the private sector, do Commonwealth STP (Specialist Training Program) monies need to be directed to anaesthesia, and what role do non-specialist anaesthetists have in metropolitan (MMM1 and MMM2) areas as opposed to other areas (where there is genuine need for rural generalist with anaesthesia capabilities).

Accordingly, the ASA will continue to survey its members in relation to their views about the anaesthesia workforce, with the surveys providing a unique database for the specialty and able to inform others, particularly NMTAN.

NMTAN's data is principally drawn from the registration and reregistration processes of the Medical Board of Australia and AHPRA, and while comprehensive and 'whole of specialty', has some limitations (for example, there is an absence of any questions which gauge the preferred workload of the anaesthesia workforce or its desire to work more or work less). This is data which the ASA has provided to NMTAN, and which could be surveyed against all specialties by future MBA Annual Workforce surveys.

Finally, the 'guiding principles' of the *Australia's Future Health Workforce – Doctors* do require the training of the workforce to match community requirements in both specialties and locations, and to recognise the balance between service delivery demands and training needs (meeting the expectations of doctors at all levels).

Addressing these principles requires that the hard questions continue to be asked: how do we in fact match anaesthesia vocational trainee numbers to community needs, and how do we meet the expectations of both would-be vocational trainees and practising specialists?

The ASA will remain very active in this area on behalf of its members, noting that the report is due to be updated in two years.

References:

1. Australia's Future Health Workforce – Anaesthesia. Department of Health, April 2016. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/australias-future-health-workforce-anaesthesia-report
2. Beyond HW2025: Australia's Future Health Workforce report. Australian Anaesthetist, June 2016, 32-35.
3. Australia's Future Health Workforce – Doctors. Department of Health, August 2014. Accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/F3F2910B39DF55FDCA257D94007862F9/$File/AFHW%20-%20Doctors%20report.pdf
4. HW2025 "Health Workforce 2025: Doctors, Nurses and Midwives". Accessed at http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-review-australian-government-health-workforce-programs-toc~appendices~appendix-ii-health-workforce-2025-summary
5. HW2025 and the future anaesthesia workforce. Australian Anaesthetist, April 2013, 14-17.
6. 2014 Workforce Survey Report. Australian Anaesthetist, December 2014, 46-49.

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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.

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Research suggests you can slash your investment fees by almost one quarter of this amount (i.e. $70,000 using the above example) whilst at the same time giving yourself a 96% chance of getting a higher investment return.

THEY NEED TO SELL YOU THIS STORY... BUT IT IS NOTHING BUT SLICK MARKETING!

Everyone likes an 'insider's tip' don't they? Something that gives them the edge over everyone else. So if I told you that I have this awesome investment methodology that allows me to make money in the stock market and it can't fail, you might be interested, right? Most people would be and this is how the financial services industry has successfully marketed itself for many decades. I mean it is a great story to tell isn't it; 'pay me a fee and I'll make you lots of money. I am the expert so that's why you have to pay me fees. I can invest your money better than you can.'

However, this story is nothing more than a marketing tactic. Let me tell you why.

Generally, there are two ways to invest money being active and passive. Active funds management is probably what you are familiar with. Active fund managers try to beat the market by deciding what stocks to invest in. They typically take two approaches being value and/or growth. A value approach means that they will buy stock that they think are undervalued in the hope that the market will eventually value them correctly (in their opinion anyway). A growth approach involves investing in companies which, in the investment manager's opinion, have great growth prospects and they hope that will reflect in their future share price growth. Active fund managers typically charge in the range of 1% and 2.5% p.a. in fees.

The second type of management is called passive (or index). This approach is based on the philosophy that you can't beat the market (because the participants are highly skilled and the market is efficient). Instead, you should invest in an index such as the ASX200 (being the top 200 companies on the ASX) for example. An index fund such as an ASX200 fund for example, will invest in the top 200 companies weighted by their market capitalisation. For example, CBA makes up 9.68% of the index so 9.68% of your money is invested in CBA. Index funds charge in the range of 0.20% and 0.60% p.a. in fees.

> *"Most advisors, however, are far better at generating high fees than they are at generating high returns. In truth, their core competence is salesmanship".*
> Warren Buffett
> – 2013 letter to shareholders

THESE TWO METHODOLOGIES HEAD TO HEAD

So how have active fund managers performed compared to passive? The short answer is; poorly! There is a huge body of research evidence that demonstrates that active fund managers cannot outperform the market in the long run. Even recent research by Vanguard proved that only one third of active fund managers beat the index over the last five years ended December 2015 – this is during a time where the market has moved sideways – surely it's an easier environment to trade shares for profit? Evidently not! So the question becomes; firstly, how do you know which fund managers will outperform this year? Secondly, when you do pick a winner, when do you know to jump off the wagon (i.e. before they underperform the market)? This is the 'marketing story' that many financial planners' business models rely upon i.e. that the financial planner has some sort of crystal ball and knows which

fund managers will perform well this year. They don't. Virtually no one does.

I am not saying that no one can beat the market. There are a select few fund managers that have actually beat the market over the long term (Warren Buffett, Ray Dailo, David Swensen to name a few) – but they are the top 0.0001% investors in the world. We don't have a chance when we invest in the same market as these guys. Actively investing in the share market is like playing poker against the World Series of Poker champion… you stand a very slim chance.

"The goal of the nonprofessional should not be to pick winners – neither he nor his "helpers" can do that – but should rather be to own a cross section of businesses that in aggregate are bound to do well. A low-cost S&P 500 index fund will achieve this goal."
Warren Buffett
– 2013 letter to shareholders

THERE SOME ADDITIONAL BENEFITS OF PASSIVE INVESTING

In addition to higher longer term investment returns there are some additional benefits passive management provides compared to active management being:

- Less tax – one of the issues with buying and selling shares or switching between managed funds is that it gives rise to income and/or capital gains tax. Each time you buy and sell, if you make a profit, you'll have to pay tax meaning you have less to reinvest.
- Lower fees – arguably you do not need to pay your financial advisor high fees when you invest in passive funds because it eliminates the fund manager risk (i.e. you don't need to pay for advice about which fund manager you should invest with). Also, when your fund manager buys and sells shares you pay brokerage. When you sell out of a managed fund there are exit costs (called the buy-sell premium). Lower turnover results in lower fees.

It is inefficient to turnover your investments because of the tax and fee consequences. There is far less turnover in a passive fund because the managers don't buy and sell stocks based on their 'opinion'. An index fund buys the stocks that represent the index and the only time they buy and sell is when a stock enters or leaves the index (which is typically immaterial) or to rebalance. There are also 'optimised' index fund manager alternatives which reduce turnover even further. The fact is that there's significantly lower tax and fees as a result of lower turnover in passively managed investments.

INVESTING IN INDEX FUNDS ELIMINATES THE ANXIETY CREATED BY TRYING TO WORK OUT WHICH MANAGED FUNDS OR STOCKS TO INVEST IN. AND MORE INVESTORS ARE WORKING THIS OUT…

About 30 years ago you had to go to a financial advisor or stock broker to learn about various investment strategies and their benefits. Not today. There's an enormous amount of information just one Google search away. This has helped more and more people 'wise onto' the marketing tricks that the financial services industry has relied upon to generate huge profits. As such, there has been an enormous amount of money shift out of active investments into passive investments driven by both individual investors and large institutions.

The Wall Street Journal recently reported "clients yanked $207.3 billion in 2015 from US-based managed funds that hand pick their positions (read actively managed) while pouring $413.8 billion into funds that mimic broad indexes for a fraction of the cost (read passive funds), according to new data from research firm Morningstar Inc.". In my opinion, this trend will continue because most people have worked out that 'stock pickers' just are not worth the fees they charge.

CASE STUDY: $860K MORE SUPER: THE COST OF HIGH FEES AND LOWER PERFORMANCE

John is 40 years of age. His superannuation balance is $220,000. His super is currently invested with AMP in an actively managed 'growth' investment option. His fund charges an investment fee of 1.80% p.a. John's employer contributes 9.5% of his salary which equates to $14,000 p.a. John is considering switching his super into a low cost fund and investing it into passively managed investments.

I have compared two options. Firstly, John could stay with AMP and pay 1.80% p.a. in fees and earn a return of 6% p.a. Alternatively, John could switch to a lower cost alternative and pay just 0.20% p.a. in investment fees. Given its passively managed and based on the research, I have assumed that the return is 2% higher compared to AMP (being 1% extra to account for passive versus active management investment returns plus a further 1% to account for lower tax and transaction fees and no advisor fees).

I have projected that if John stays with AMP his super balance by age 65 will be $1.175 million after he has paid $260k in fees. However, if John switches to a low cost passively managed super fund per the assumptions above, his super balance at age 65 is projected to be $2.04 million – some $860k or 74% higher.

Of course I cannot guarantee that if you invest in a low-cost passive fund that your super fund's after tax and fees return will be 2% p.a. higher than any active fund. I don't have a crystal ball. No one does. However, the research suggests that it will be higher and this is a simple case study to demonstrate that a small change in fees, taxes and returns altogether make a massive difference.

REGULAR

GET ADVICE BEFORE YOU TAKE ACTION

Of course the information in this article is general in nature and I cannot take into account each reader's individual circumstances. Therefore, you must seek independent personal advice before you consider switching your super or any other investments as there are many things to consider. It is best to seek advice from someone that is not invested in the answer (i.e. have an investment to sell you) – excuse the pun.

Stuart Wemyss is an independent and licensed chartered accountant, financial planner and mortgage broker with over 18 years' experience in financial services. He founded ProSolution Private Clients in 2002. Send any questions or comments to swemyss@prosolution.com.au

WEBAIRS NEWS

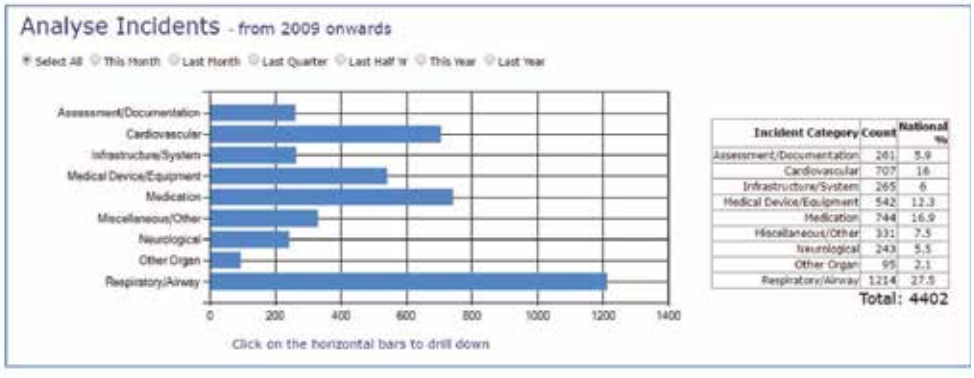
Dr Martin Culwick provides the latest update on WebAIRS.

In May 2016, Prof. Michael Cousins AO retired from full-time practice. Prof. Cousins has initiated many valuable and important contributions to anaesthesia, pain medicine and patient safety. In the latter context, Prof. Cousins instigated the formation of the ANZCA Safety and Quality Committee and the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC). In 2004 Prof. Cousins set up a number of working groups including the Quality and Safety Taskforce and the Data Taskforce. From the findings of these taskforces, the ANZCA Quality and Safety Committee and the ANZTADC were formed in 2006. These two committees are now regularly creating resources to improve patient safety, with ANZTADC's webAIRS initiative providing an enduring repository of patient safety information.

WebAIRS has now collected over 4000 incident reports. 127 sites report data and, in addition, there are many individuals who are independently registered. For the local administrators of sites there are some new analysis features in webAIRS. Accessed via the Administration tab on the homepage, 'Incident Charts' gives the opportunity to view local statistics in specified date ranges. The chart below gives a snapshot of bi-national figures as at 27 June 2016.

There is ongoing analysis of webAIRS data with articles detailing findings and themes featuring in the publications of the parent organisations and peer reviewed journals. Scientific meetings also provide opportunity for shared learning. The upcoming ASA NSC in Melbourne features the webAIRS presentations listed on the right.

For those who are not yet registered for webAIRS, the process has never been simpler. Streamlined registration involves a tick box approval of site terms and conditions. Anaesthetists can choose to link with an already registered site, set up a new site or enter incidents as an individual. Reports can be submitted completely anonymously and CPD points are earned with every incident that is logged in the database. Ultimately, contributing to this important safety and quality initiative leads to unique learning opportunities and practice improvement.



Incident Category	Count	National %
Assessment/Documentation	261	5.9
Cardiovascular	707	16
Infrastructure/System	265	6
Medical Device/Equipment	542	12.3
Medication	744	16.9
Miscellaneous/Other	331	7.5
Neurological	243	5.5
Other Organ	95	2.1
Respiratory/Airway	1214	27.5

Total: 4402

TUESDAY 20 SEPTEMBER 11AM-1PM

Chair: Dr Gregory Deacon

Session: Error Reduction Strategies – how you can improve your practice

- The Bowtie Diagram – a concept that incorporates causal analysis and event management *Dr Daniel Clarke*
- Are all human errors also system errors? *Prof Neville Gibbs*
- What do you do when the unexpected happens? *A/Prof Kersi Taraporewalla*
- Show us the evidence! An analysis of webAIRS data. *Dr Martin Culwick*

For more information:

Follow the links on www.anztadc.net to download an information brochure and register online, or contact ANZTADC at anztadc@anzca.edu.au

INSIDE YOUR SOCIETY

POLICY UPDATE

ASA Policy Manger Chesney O'Donnell and Policy Officer Elaine Tieu give an overview of the role of the policy team

WHAT DOES THE ASA MEAN BY POLICY?

Policy at the ASA involves our Economics Advisory Committee (EAC), the Professional Issues Advisory Committee (PIAC) and the soon to be re-activated Public Practice Advisory Committee (PPAC) working in unison with our internal policy team. Chairs Dr Mark Sinclair (EAC) and Dr Antonio Grossi (PIAC) lead these committees which combined have over 30 working anaesthetists who assist in providing individual advice to our members. We also have the added advantage of past President Dr James Bradley who is our Specialty Affairs Adviser and workforce survey specialist.

HOW DOES OUR POLICY TEAM WORK?

The policy team assists with the management of three committees. Each committee is designed with a specific focus.

The Economics Advisory Committee established in 1991 and now comprising of 20 members is responsible for overseeing issues of economic importance to the speciality as well as assisting members in the financial aspects of practice. One of the main foci of the EAC is providing assistance to members in relation to:

- Medicare billing requirements,
- Interpretation and use of correct item numbers,
- Dealing with private health insurers.

The EAC liaises with relevant bodies including:

- The Australian Medical Association,
- The Federal Department of Health (DoH),
- The Department of Human Services,
- The Department of Veterans' Affairs,
- The Australian Competition and Consumer Commission,
- Workers compensation insurers,
- Traffic accident insurers and
- Private Health Insurers.

Over the years, we have had input into DoH policy formulation, via regular submissions and face-to-face meetings. The EAC has been able to achieve numerous improvements to the Medicare Benefits Schedule, as surgical and anaesthesia practices have developed and changed. This has benefitted both anaesthetists and patients. The EAC puts strong emphasis in providing sound advice on Informed Financial Consent.

The Professional Issues Advisory Committee was formed in 2004 with the emergence of significant and ongoing issues related to the professional aspect of the anaesthetist. The PIAC is comprised of 19 members and provides advice to the Board and members on professional issues which include:

- Clinical practice and standards
- Position statements
- Credentialing and privileging
- Broad industrial disputes
- Professional indemnity insurance
- Continuing Professional Development
- Professionalism
- Personal health and welfare
- Workforce.

Workforce issues include:

- Addressing the distribution of anaesthetists (specialist and non-specialist) necessary to satisfy national and regional demand
- Determining the reasons for any maldistribution
- Suggesting strategies to address any maldistribution
- Conducting member surveys.

The Public Practice Advisory Committee is in the process of reinvigoration. The Board is establishing a committee which will comprise of staff specialists from a range of ages, cultural and ethnical backgrounds, and representing different geographical locations. The PPAC will strive to provide support and guidance to members working primarily in the public sector, including current awards and conditions for staff specialists and visiting medical officers applicable in each state and territory. As public practice anaesthetists carry the greatest load in training and shaping future anaesthetists, it is important for us to actively support this group.

HOW DOES THE POLICY TEAM SUPPORT MEMBERS?

The team is the first port of contact for members who have queries relating to economic and professional issues. Internally we provide assistance to the above committees from secretariat support, help with surveys, researching policy and drafting legislative opinions and briefs which encompasses all areas of healthcare issues. Additionally we provide feedback from primary health and allied

health conferences. We attend seminars and forums including the fundamentals of healthcare macroeconomics and budget governance, introduction to health economics and the employment and life of doctors as surveyed by the Melbourne Institute of Applied Economics and Social Research.

MEMBER QUERIES HANDLED

Annually the team receives over 200 queries from members covering a variety of issues. Currently we review these queries and categorise them as an economics matter and/or a professional issue, for consideration by the relevant committee. The relevant committee members contribute their ideas, feedback and advice to solve the concerns of the member. The team then compiles these comments into a final cohesive response for the member.

Approximately 75% of queries are of an economics nature, and as the name suggests, are handled by EAC. The majority of these queries are in regards to:

- Private health providers, how their payments and no-gap schemes operate.
- Billing item numbers for services such as epidurals, blood transfusions and after-hours consultations.
- Understanding the descriptors applicable for each item number under the Medicare Benefits Schedule.

In relation to billing queries, the EAC releases an annual Relative Value Guide which provides guidance as to how and what items to bill as a truer reflection for the remuneration of services. Often questions about the billing process spark new ideas for the RVG and are included in the annual revision of the RVG. Such examples include the addition of transabdominal plane blocks and laparoscopic hysterectomies.

Should members share common queries in regards to problems in the workplace such as contracts, VMOs and other professional issues, the PIAC will examine these matters more closely. However, specific individual matters require the service of your Medical Defence Organisation as the ASA does not provide individual legal, accounting or financial advice. Over time we have been receiving more queries in relation to issues such as:

- Alleged unfair contractual agreements between doctors and their employers
- Mandatory on-call rostering
- Alleged anti-competitive behaviours.

Most of these issues may have arisen due

Third International Primary Health Care Reform Conference 2016

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to oversupply and/or maldistribution of specialists in capital and rural/remote regional areas. As mentioned earlier, the team along with EAC and PIAC advocate on these new issues by drafting new policy ideas and submissions to bring to the attention of relevant stakeholders and government bodies through meetings or written submissions. Recent submissions include those to the Medical Board of Australia, National Medical Training Advisory Network and Skilled Occupations List.

SOME EXAMPLES OF THE ASA POLICY TEAM'S WORK

With every notable meeting comes before it preparation and research undertaken by the team to help prepare them to better advocate on behalf of members and the speciality. Here are some examples of areas we have been involved in:

- Senate Standing Committee on Community Affairs & Out-Of-Pocket Costs in July 2014, where our President, Chair of EAC and Policy Manager attended to discuss the impact of costs and affordable healthcare and the sustainability of Medicare as well as informed financial consent and other forms of co-payments.
- Meeting with the Minister for Health the Hon. Sussan Ley in November 2015 where our President, Vice-President, Chair of EAC, Chair of PIAC, Specialty Affairs Adviser and CEO attended to discuss anaesthesia fees, Medicare & private health insurance rebates, Medicare Benefits Schedule Review, Medical Services Advisory Committee transparency and full evidence-based analysis.
- Assisting and participating in a meeting at the Prime Minister's Office in April 2016 where our President, Vice-President, CEO and Policy Manager attended to discuss medical workforce issues and maldistribution, improving locum schemes for Temporary Rural Specialists as well as the Medicare Benefits Schedule Review, MSAC Reforms, medical schools and Skilled Occupation List.
- Preparing for the meeting with Dr Joanna Flynn Chair of the Medical Board of Australia and Australian Health Practitioner Regulation Agency in April 2016 where our PIAC Chair and CEO attended to discuss the introduction of revalidation of Australian doctors, its structure and limitations in light of the UK's NHS.
- Participation at the Australian Competition and Consumer Commission Private Health Insurance Forum in June 2016 where our EAC Chair and Policy Manager attended to discuss the need for more transparency when insurers change their policies for patients so as to prevent 'bill shock'.

THE FUTURE OF POLICY

Strategically, issues relating to the MBS, workforce maldistribution and oversupply appear to becoming more prominent concerns to the anaesthesia speciality as shown by our workforce surveys and member queries. We already have a strategy in place with regards to ensuring we are getting targeted meetings and discussions with the relevant parties and stakeholders. This is an ongoing process and we welcome any feedback from our members. The ASA Policy Team aims to advocate for outcomes that are best for the speciality.

CONTACT US

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

Email: policy@asa.org.au

Phone: 1800 806 654.

4th MABEL Research Forum 2016

Drs David M. Scott and Guy Christie-Taylor, Vice-President and President of the ASA, and Mark Carmichael, CEO of ASA at Parliament House for the Prime Minister's Office meeting

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ECONOMICS ADVISORY COMMITTEE

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

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

As a result of the meetings of the first group of clinical committees formed to review individual sections of the MBS, 24 Medicare items have been deleted from the MBS, and two have been restricted to patients under the age of 16. It is estimated that this will result in a $6.8 million decrease in Medicare expenditure. The specialties involved were diagnostic imaging, ENT, thoracic medicine, gastroenterology, and obstetrics. The list of deleted and modified items is available on the MBS Online website at: mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home

The only two items of any relevance to anaesthesia were items 18246 for glossopharyngeal nerve block (which was almost exclusively claimed in relation to ENT surgeons' services, not anaesthetists' services) and 11500 for bronchospirometry, which was subject to a only a small number of anaesthesia-related claims.

A number of other committees have commenced meetings. The specialties involved are cardiac services, dermatology, allergy and immunology, endocrinology, intensive care, emergency medicine, oncology, and renal medicine. The members of each committee were listed in the MBS Review Taskforce's April newsletter, available at: health.gov.au/internet/main/publishing.nsf/content/MBSR-newsletters.

No further information is available at the time of writing, but members will be informed as soon as this second group of committees releases its recommendations. There will be an opportunity for feedback from the medical profession before the final recommendations are made to the federal Minister for Health.

At the time of writing we have no further information on when to expect the review of anaesthesia items to occur, or on who will be asked to join the review committee. The ASA has repeatedly requested a say in who will be involved, and this appears to have been received sympathetically, but members will be informed when any further developments occur.

PRIVATE HEALTH INSURANCE

Representatives of the ASA and ANZCA met with representatives of Medibank Private (MBP) at the MBP head office in Melbourne in May. This was a follow up to a meeting held at the ASA offices in Sydney in March (reported on in the June issue of *Australian Anaesthetist*), and is also part of the wider aim of MBP to meet with all of the medical representative groups, to discuss MBP's views on the future of private healthcare and its funding.

It is clear that MBP wishes to make substantial changes. Its stated aim is to focus on "improving the health outcomes of patients, improving patient experiences, and improving efficiencies in the health system". Exactly how MBP plans to do this is uncertain at this stage, but members will recall there has already been much controversy generated by its approach to the funding of complications of surgery, as just one example.

In order to further its stated aims, MBP collects highly detailed statistics on funding and outcomes, and has already shared some of these with the Royal Australasian College of Surgeons (RACS). This resulted in the release of a co-branded publication by RACS and MBP, titled 'Surgical Variance Report – General Surgery'. Similar reports have since been released, covering certain ENT and urological procedures. These reports can be found on the RACS website www.surgeons.org, and searching for the term 'surgical variance report'.

The Surgical Variance Reports analyse the statistics for a number of specific surgical procedures performed on patients insured with MBP. As MBP is the largest individual health insurance company, the numbers of patients are very large, and in fact represent 25% of all private hospital separations for the year in question (2014). Statistics on unexpected overnight stay, readmission to hospital

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within 30 days, and the rates of hospital acquired complications, were some of the data analysed. Individual surgeons (de-identified) who were 'outliers' for any of these statistics can be seen in the various graphs. Out-of-pocket costs to patients were also analysed, and again, outliers can be seen.

MBP has also analysed statistics on anaesthesia services, and again has identified individual practitioners who are outliers for certain MBS item claiming patterns. One individual anaesthetist charged for anaesthesia times which were significantly greater than the operating time, in all cases, across all surgical specialties and at all hospitals serviced. In another case, again across all surgical specialties and all hospitals, 100% of patients were charged time items 23021, 23031, 23041, 23051, and so on, with no patients at all billed for the 'middle' or 'last' item in each time category (eg 23022 or 23023). Of course, these claim patterns are very rare, but it is clear MBP can and does analyse such statistics in detail, and may request an explanation from the individual practitioners involved. Members are reminded that the Department of Health also analyses Medicare statistics in detail, as part of the ongoing Medicare National Compliance Programme, and has already audited the billing patterns of a number of anaesthetists, as well as other doctors. No cases of ASA members being referred on for further action have been reported to us at this stage, but there are certainly cases where other doctors have been subject to disciplinary action for incorrect billing.

At this stage, outcomes data for anaesthesia has not been assessed in detail, but this is certainly planned by MBP, and is something they wish to discuss with us and ANZCA. Further meetings will be held, and the ASA will continue to gauge exactly how MBP wishes to pursue its agenda. Members will be updated as soon as more information comes to hand.

AUSTRALIAN COMPETITION AND CONSUMER COMMISSION (ACCC)

As members will recall, the ASA has regularly made submissions to the ACCC, in relation to its annual report to the Australian Senate on the practices of health insurance companies. We have repeatedly highlighted the issue of a lack of information being made available to patients by insurance companies, resulting in unexpected out-of-pocket costs to patients, or in occasional cases, cancellation of elective procedures. The ACCC has now commenced a formal review of the issue. As part of this, various stakeholders (including representatives of the ASA) met at the ACCC headquarters in Canberra, in June. This was of course only the beginning of the process, but there was general agreement, including from insurance company representatives, that more needs to be done. It is clear however that the insurers and their representative bodies will constantly highlight the issue of informed financial consent (IFC) for medical fees, and continue to attempt to divert attention onto our practices here. Members are again reminded to adopt best possible IFC processes, and to contact the ASA for any assistance they require.

Again, members will be kept informed on the ACCC process via the ASA's regular electronic and printed updates, as further information becomes available.

The ACCC has commenced legal action against Medibank Private, for allegedly misleading consumers regarding its limitations on the funding of pathology and radiology services. This resulted in a number of patients facing unexpected out-of-pocket expenses. The ACCC alleges that MBP deliberately withheld this information, for fear its reputation and business could suffer. Interestingly, the organisation Private Healthcare Australia, which represents the interests of health insurance companies (we should not be misled into thinking it has anything to do with the provision of care. It was previously known as the Australian Health Insurance Association) immediately attempted to shift the focus onto the medical profession. Its Chief Executive, Dr. Rachel David, was quoted in the media as being very supportive of all necessary information being provided to patients, but immediately went on to state: "The ideal situation is that the provider gives the patient a quote which outlines all possible costs, including what the funds should cover, what Medicare will cover and all out of pockets well in advance of the surgical procedure. That doesn't take place as they are being wheeled into surgery." Exactly how providers are supposed to provide such a quote, when the insurer does not reveal new limitations on its cover, was not addressed.

MEDICAL SERVICES ADVISORY COMMITTEE (MSAC)

MSAC application 1308, for the introduction of new Medicare items to cover all local anaesthetic nerve blockade (LANB) procedures performed for post-operative analgesia, (rather than the limited range of LANB covered by items 22040-22050) is progressing through the system.

MSAC approval relies on unfunded treatments and technologies being found to be safe, effective and cost-effective. As expected, MSAC is satisfied that LANB is safe and effective. However, the case for cost-effectiveness was found to be wanting. The economic analysis does however have a number of flaws. Proven benefits, such as a faster recovery and discharge from hospital, a lower incidence of post-operative chronic pain syndromes, and possibly a lower incidence of cancer recurrence, were not assessed. The ASA has submitted a critique of the MSAC analysis, which can be downloaded from the ASA website along with the actual MSAC report. (under News/ASA_ Submissions).

JOURNALISTS AND LOBBYISTS

As mentioned in a previous edition of *Australian Anaesthetist*, there have been a number of very strongly worded articles in the media in recent months, regarding the supposedly 'unsustainable' level of expenditure on Medicare, and blaming the supposedly self-interested medical profession for this. Terms such as 'villains' were used to describe doctors, and there were allegations of 'rampant overservicing'. The AMA has previously released statistics showing that the Commonwealth Government's expenditure on health has in fact decreased slightly in recent years, as a percentage of overall expenditure, but this seems to have been ignored. Additionally, many of the articles appeared to treat the health insurance industry quite favourably.

At the same time, several lobbyists and think-tanks have released papers highly critical of the fee-for-service system, and lauding the US-style managed care system. Much of the 'evidence' they quote is nothing more than 'expert' opinion. The known problems with the managed care system do not appear to rate mentioning. The concern that a fee-for-service system will result in extra services being provided and billed for by self-interested doctors is repeatedly mentioned, but there is no discussion of the fact that a managed care system can be manipulated by profit-motivated insurance companies.

There is certainly a mood for significant change at government level, as well. Minister Ley is supportive of the idea of a single 'bundled' payment for each episode of care, in order to prevent patients receiving multiple medical accounts. And as reported several times in recent years, the Department of Health's Medical Services Advisory Committee (MSAC), which makes recommendations for or against Medicare funding, has demonstrated a lack of support for the fee-for-service model, and for the fact that numerous medical services involve simultaneous claims for more than one Medicare item.

It is clear that insurers, some government bodies and certain commentators and lobbyists have a certain vision for the future of healthcare funding. The medical profession must continue to ensure that our opinions, particularly on patient management and access to services, remain at the forefront of the debate. The alternative is to leave the decisions to those whose primary role is not patient care, and who are motivated by political beliefs, or financial agendas.

Members will recall that ASA representatives met with both the Minister and Shadow Minister in 2015. The ASA will continue to engage with them, and with other members of parliament where necessary, including meeting person-to-person where possible.

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PROFESSIONAL ISSUES ADVISORY COMMITTEE

Feedback from around the country has identified the following issues affecting anaesthetists' professional practice, writes Dr Antonio Grossi.

SUSTAINED ANTI-MEDICAL MEDIA CAMPAIGN

There have been a number of media reports this year regarding doctor's fees, salaries, professional conduct and the impact on patient's access to health services. Many of these claims are factually incorrect but truth seems to be a disposable commodity in this campaign. Medibank Private for example has specifically misrepresented some data to promote their agenda.[1] The government is facing increased cost containment pressure with increased per capita utilisation of health services[2], an ageing population, increased prevalence of chronic disease, and increasing costs of investigations and treatments. The moral hazard[3] of a fee for service provider payment system combined with universal access, are said to be contributing to these escalating costs. The value proposition for patients, particularly in the private sector, has been questioned and attributed to medical out of pocket costs. Evidence from the private health insurance ombudsman[4] reflects that private health insurance fund exclusions, excess payments and hospital gap payments are the largest source of patient concerns with the vast majority of medical services billed directly to funds. The private health insurance industry extracted $1.1 billion in profits and $1.8 billion in management fees in the previous financial year[5] from the healthcare sector. Little wonder doctors are being targeted as scapegoats. Erosion of trust in the doctor-patient relationship provides more opportunities for corporate exploitation. The recent promotion of the 'Whitecoat'[6] website provides a populist forum but may not reflect complexity of caseload and other informed quality indicators.

There have been many reports in recent times calling for healthcare reform[1] and rationing of services.[7] This includes channelling more resources from existing MBS services into primary care, health prevention and population health initiatives.[8,9,10] There is no guarantee that these initiatives will translate to immediate decreased hospital utilisation[11,12] yet funding to public hospitals may be threatened. It is important that people scrutinise the research of 'think tanks' that make these recommendations and consider their vested interests. A financially compromised think tank is little more than an undisclosed lobbyist.

Coupling health expenditure with that which the community is prepared to pay[2] for health requires politicians to have frank and transparent conversations with affected communities. Collaborative and inclusive innovative solutions require engagement with stakeholders. The ASA remains active in this space. Blaming doctors is a populist and simplistic approach that will not solve the problems of sustainability, fragmentation and universal access to health.

WORKFORCE

The ASA's latest workforce survey and *Australia's future health workforce-Anaesthesia report*[13] have been discussed earlier in *Australian Anaesthetist*. Importantly, many fellows in public and private practice throughout Australia are finding themselves chronically underemployed. This is generating significant stress amongst anaesthetists. There are concerns about maintaining and consolidating clinical skills and disquiet regarding financial security. These workforce conditions are creating the 'perfect storm' for the government and the private health insurance industry to consider alternative provider payment systems to replace the MBS fee for service arrangements and task substitution by alternative providers.[14]

RURAL

An oversupply of anaesthetists in metropolitan areas has not fixed the more complex issues of access to anaesthesia services in rural areas. The ASA is working on State and regional context specific solutions including use of locums, access of provider numbers and attracting quality practitioners to areas of need.

PROFESSIONAL AUTONOMY THREATENED

Members in public and private practice are facing increased pressure to comply with onerous accreditation processes and increasingly demanding contracts requiring provision of on-call services beyond one's usual scope of practice. Issues of fatigue[15] and patient safety need to be considered.

Unfortunately, some referrers are

demanding financial kickbacks in exchange for anaesthesia work. This is immoral, unprofessional and illegal. Providing quality anaesthesia services and acting as an advocate for the patient requires anaesthetists to maintain their professional independence and integrity.

REVALIDATION

The process of revalidation is continuing and the ASA will keep you informed of it's progress and development. Controversial outstanding issues relate to proposed risk based approaches targeting particular health practitioners and which CPD activities will be recognised.

BROADENING THE AGENDA

The Committee have been working through these strategically related issues. Our primary concern is patient safety and the provision of quality anaesthesia care. Maintaining working conditions is a prerequisite for this. Healthcare challenges of sustainability, fragmentation, equity and access do need to be addressed. Anaesthetists are well placed to make positive contributions to improving our universal healthcare system. Scarcity means allocation of resources based on values and setting priorities. Managing 'end of life care' well for example, provides an opportunity for anaesthetists to contribute maturely and meaningfully to the 'bigger picture'. Considerations for dealing with the social determinants of disease[16] may provide new opportunities for anaesthetists.

References:

1. Australian Private Hospital Association. Medibank time travels to find data to suit their cause. APHA Media Release 8th August 2016. [Internet] available at: http://www.apha.org.au/wp-content/uploads/2016/08/08082016_medibankdatafraud_FINAL.pdf (accessed 12/08/16)
2. Stoelwinder, J. Sustaining universal healthcare in Australia: Introducing dynamic efficiency. Chapter One pp19-30 in Healthcare: Reform or ration. April 2013. Melbourne. Committee for Economic Development of Australia. [Internet] available at: http://adminpanel.ceda.com.au/FOLDERS/Service/Files/Documents/15366~healthcarefinal1.pdf (accessed 08/08/16)
3. Delkeskamp-Hayes C. Morality at the Expense of Others: Equality, Solidarity, Taxes, and Debts in European Public Health Care. J Med Philos 2015; 40(2): 121-136.
4. Gravel, S. Private Health Insurance Ombudsman Annual Report 2013-2014. Sydney. Australian Government. 2014. [Internet] available at: http://www.ombudsman.gov.au/__data/assets/pdf_file/0027/29295/PHIO-Annual-Report-2014.pdf (accessed 11/08/16)
5. Australian Prudential Regulation Authority. Private health insurance industry overview. Australian Government. APRA Insight Issue One 2016. [Internet] available at: http://www.apra.gov.au/Insight/Pages/insight-issue1-2016.html (accessed 25/07/16)
6. Whitecoat. 2016 [Internet] available at: https://www.whitecoat.com.au/ (accessed 11/08/16)
7. Donaldson, C., Bate, A., Brambleby, P., Waldner, H. Moving forward on rationing: an economic view. British Medical Journal 2008; 337, 903-906
8. Duckett, S. Perils of place. Melbourne. Grattan Institute. 2016 July. [Internet] available at: http://grattan.edu.au/wp-content/uploads/2016/07/874-Perils-of-Place.pdf (accessed 09/08/16)
9. Hableton, S. Primary Health Care Advisory Group. Better outcomes for people with chronic and complex health conditions. Canberra. Commonwealth of Australia as represented by the Department of Health. 2016. Pages 1-77. Publications approval number 11412 [Internet] available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/76B2BDC12AE54540CA257F72001102B9/$File/Primary-Health-Care-Advisory-Group_Final-Report.pdf (accessed 08/08/16)
10. Swerissen, H., Duckett, S. and Wright, J. Chronic failure in primary care. Grattan Institute. 2016. [Internet] available at: http://grattan.edu.au/wp-content/uploads/2016/03/936-chronic-failure-in-primary-care.pdf (accessed 08/08/16)
11. Purdy, S., Paranjothy, S., Huntley, A., Thomas, R., Mann, M., Huws, D., Brindle, P., and Elwyn, G. Interventions to reduce unplanned hospital admission: a series of systematic reviews. National Institute for health and Research. Bristol. 2012 June. [Internet] available at: http://www.bristol.ac.uk/media-library/sites/primaryhealthcare/migrated/documents/unplannedadmissions.pdf (accessed 09/08/16)
12. Jackson, G.L., Powers, B.J., Chatterjee, R., Bettger, J.P., Kemper, A.R., Hasselblad, V., Dolor, R.J., Irvine, R.J., Heidenfelder, B.L., Kendrick, A.S., Gray, R., and Williams, J.W. Improving patient care. The patient centred medical home. A systematic review. Annals of Internal Medicine. 2013 Feb; 158(3): 169-178.
13. National Medical Training Advisory Network. Australia's Future Health Workforce- Anaesthesia. Department of Health. 2016 April [Internet] available at: www.health.gov.au/internet/main/...nsf/.../Anaesthesia%20Report.docx (accessed 11/08/16)
14. Productivity Commission. Efficiency in Health. Productivity Commission research paper. Canberra Commonwealth Government 2015 [Internet] available at: http://www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf (accessed 09/08/16)
15. ANZCA. PS 43 Statement on fatigue and the anaesthetist. ANZCA 2007. [Internet] available at: http://www.anzca.edu.au/documents/ps43-2007-statement-on-fatigue-and-the-anaesthetis.pdf (accessed 09/08/16)
16. Marmot M. Universal coverage and social determinants of health. Lancet. 2013; 382: 1227-8.

GET IN TOUCH

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

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

INSIDE YOUR SOCIETY

ASA TRAINEE MEMBERS UPDATE

There are various matters of interest to ASA Trainee Members this quarter.

STATE EVENTS

At a state level, it has been great to see several extremely successful educational and networking events organised by our state representatives. I'd specifically like to congratulate Chris Mumme and Jennifer Hartley (ACT) who organised, along with ANZCA, a Pre-eclampsia and Obstetric Emergency evening in April which was well attended and well received; Kellie Brick and Liam Twycross (VIC) who organized a New Fellows forum and a cocktail function for successful exam candidates in May and June respectively; and James Anderson and Tom Ryan (WA) who organised a cocktail networking event with positive feedback from attendees. I note as well that Chris Mumme is moving back to NSW and his role with the ASA will be taken up by Martin Dempsey. Thanks to Chris for all his hard work and participation, and welcome to Martin.

NAME CHANGE

At a national level, there has been a change in name of our group. Trainees who were formally referred to as GASACT members will now be known as ASA Trainee Members (a more descriptive and recognisable name). Please note that the contact email for Trainee Members has been changed to trainees@asa.org.au.

RESEARCH

Over the past few years, in various countries and specialties, the concept of Trainee-led Research Networks is in various stages of development. The idea is that trainees in different institutions collaborate, forming a network, which can then be used to gather data to be used in research. This can be overseen by an experienced consultant mentor. The concept harnesses the enthusiasm that many trainees have for participating in research whilst addressing the fact that opportunities for such activity may be limited.

The network of trainees across the country represents such a potential tool for anaesthesia research. As a result, please keep an eye on updates from the Trainee Group and your state representatives about any upcoming projects. More information about the concept, and what our anaesthetic colleagues are doing in the UK can be found by searching 'RAFT Trainees' in your search engine.

MELBOURNE NSC

I'm looking forward to the NSC, having our state representative face-to-face meeting on the Friday, and catching up with other trainee members from around the country. If you have paid your full Advanced Trainee ASA membership, you are eligible for reimbursement of the registration fee. Once you have registered, please contact membership@asa.org.au for further assistance and instructions.

REFLECTIVE PRACTICE

Having completed the Part 2 ANZCA exam earlier this year, I'm enjoying the transition towards increasingly independent theatre practice. I've always enjoyed managing cases independently and, in my facility at least, the part 2 exam marks a milestone where consultants are usually happy to hand over the reigns of the whole list and be on standby when needed.

However with this transition comes insight into certain other dynamics, which I believe one is shielded from to some degree as a registrar with a consultant who is supervising in a level 1 or 2 capacity.

I was called to cardiac cath-lab one recent evening to oversee anaesthesia of an intubated & ventilated patient who had come via ED following a VF arrest. During the transfer of care from the ED registrar to myself, I was distracted by the cardiologist arriving and being very vocal and disruptive to attempts by the ED registrar to do a verbal handover, whilst patient and monitoring transfer was occurring from trolley to procedure table. It resulted in an unsatisfactory (in my view) transmission of information and also meant that a malfunctioning piece of monitoring (NIBP) was missed and needed to be troubleshot later in the case once drapes were on.

I've noticed similar examples, usually out of hours where the proceduralist has interfered with pre-operative processes that would normally occur.

Throughout my training I have prided myself on my approach to my various surgical colleagues, the majority of the time I have a very amiable relationship with them, consultant and registrar. Perhaps though when dealing with surgeons as a registrar you are protected from the difficult interactions by your consultant. When conducting lists alone, the consultant buffer is no longer there.

It has highlighted to me that in the complex machine of the theatre suite,

an important role of the anaesthetist (aside from ensuring the comfort and safety of the patient) is a facilitatory one. Smoothing the interactions of the various specialties and disciplines involved in the patient's care is another skill to master along with cannulation, intubation, nerve blocks etc.

This isn't something that is taught (although difficult colleagues do crop up in the examinations). However we are faced with a wealth of experience, which gives us fodder to reflect on our own practice and how we can optimise it in the future. A debrief with colleagues can and does help deal with the immediate feelings of frustration which can surround these experiences. A structured approach to these scenarios is what is needed in order to change future behaviors.

In the UK it is a requirement of trainees to keep a reflective log as part of their 'e-portfolio'. Similarly, although optional rather than mandatory, there is a Reflective Learning box available for each case in the ANZCA TPS.

The Situation	The Reaction	The Response
This should be kept brief (as above) answering Who, When, Where, What, Why?	Inspection of your feelings during the interaction, and why these feelings were evoked.	How did you actually respond during the scenario? VS How would you have preferred to respond? What would be the best way to respond? Why do you suppose the other person involved behaved in such a manner? How would you deal with this scenario in the future?

There are various suggestions about how to analyse the event, it may usually boil down to three headings:

I have applied this approach to my cath-lab scenario to beneficial and constructive effect, and believe that when faced with a similar scenario I will be prepared to defend a safe transfer process more rigorously without being confrontational or rude.

Anaesthetists tend to be highly motivated individuals, with high expectations of themselves and others. Realistically, we are faced with 'suboptimal' interactions on a frequent basis, so it makes sense to have a straightforward and structured way of analysing and attempting to remedy them.

The above framework can be applied to interations with patients, other anaesthetists and doctors from other specialities, and ultimately should be able to assist us foster inter and intra-professional relationships.

References

i BMJ 2008;336:827
ii https://www.abdn.ac.uk/iahs/documents/Reflective_practice_handout.docx

Are you receiving all the latest information from the ASA?

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

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

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

ASA
Australian Society of Anaesthetists

"Thank you, for the convenience of Zofran Zydis wafers"*[1]

Zofran Zydis pack and wafer not shown to scale.

- Dissolves on tongue within 3 seconds[1]
- No water required[1]
- Strawberry flavoured[2]

For prevention of post-operative nausea and vomiting (PONV) in adults, the recommended oral dose is 16mg given 1 hour prior to anaesthesia[2]

Zofran® Zydis®
ondansetron wafers

*Not an actual patient quote.

Before prescribing please review Product Information available via www.aspenpharma.com.au/products or call 1300 659 646

Zofran® Injection, Tablets, Syrup, Suppositories and Zofran Zydis Wafers (ondansetron) – Minimum Product Information. INDICATIONS: Prevention and treatment of nausea and vomiting induced by cytotoxic therapy and radiotherapy. Ondansetron (injection) is also indicated for the prevention and treatment of post-operative nausea and vomiting. **CONTRAINDICATIONS:** Hypersensitivity to any component of the preparation; concomitant use with apomorphine. See full PI. **PRECAUTIONS:** Hypersensitivity reactions; dose-dependent QT interval prolongation so caution in those who have or may develop prolongation of QTc; avoid in congenital long QT syndrome; correct hypokalaemia and hypomagnesaemia prior to use; concomitant treatment with ondansetron and other serotonergic drugs due to the possibility of serotonin syndrome; monitor those with subacute intestinal obstruction as ondansetron increases large bowel transit time; caution in patients with phenylketonuria (wafers); paediatric patients; pregnancy (Cat B1); lactation. See full PI. **INTERACTIONS:** co-administration with drugs that prolong QT interval and/or cause electrolyte abnormalities; apomorphine; potent inducers of CYP3A4 (i.e. phenytoin, carbamazepine, and rifampicin); concomitant use with other serotonergic drugs including SSRIs and SNRIs; tramadol; others (see full PI). **ADVERSE EFFECTS:** headache; sensation of warmth or flushing; constipation; xerostomia; local anal/rectal burning sensation following insertion of suppositories; asymptomatic increases in liver function tests with cisplatin; local I.V. injection site reactions; others (see full PI). **DOSAGE AND ADMINISTRATION:** Use lowest effective dose. Place wafers on top of tongue where it dissolves within seconds, and is swallowed. **Post-operative nausea and vomiting: Adults:** *Injection:* give 4mg by I.M. or slow I.V. injection for prevention. Up to 8mg if required for treatment. *Oral:* 16mg given 1 hour before anaesthesia for prevention. **Children:** 2 to 12 years: slow I.V. injection at 0.1mg/kg up to 4mg. **Hepatic impairment:** Maximum total daily dose of 8 mg in moderate or severe dysfunction. See full PI. (PI last amended 11 Sep 2015). **References: 1.** TK Giri, et al. International Journal of Pharmacy and Pharmaceutical Sciences Vol 2, Suppl 3, 2010. **2.** Zofran Product Information v5 15 Oct 2013 | The person depicted herein is a model shown for illustrative purposes only. | **All sales and marketing requests to:** Aspen Pharmacare Australia Pty Ltd, 34-36 Chandos Street, St Leonards NSW 2065 | Tel. +61 2 8436 8300 | aspen@aspenpharmacare.com.au | www.aspenpharma.com.au | Prepared: Jul 2016 FD16805 ASP01099

PBS Information: Zofran Zydis wafer. Zofran Zydis is not listed on the PBS for postoperative nausea and vomiting.

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WORLD ANAESTHESIA DAY – A DAY TO CELEBRATE

Next month on October 16th we celebrate World Anaesthesia Day to commemorate the first successful public display of ether anaesthesia. It was on this day in 1846 that William Morton administered ether to a patient with a tumour in the neck at Massachusetts General Hospital. The world took notice as pain free surgery was demonstrated.

The vast improvements made in anaesthetic practice since this event is evident when perusing the objects on display in the Harry Daly Museum. From a replica of Morton's ether inhaler, to the Boyle's anaesthetic machine and beyond, medical advances have seen anaesthesia evolve as a safer practice for both patient and doctor.

However, it was not that long ago that, following in the footsteps of Morton, items such as the metal mask combined with cloth and open drop ether bottles were still in use.

Dr Reg Cammack recalls his experience with open drop ether anaesthesia as a young man at Old Penrith Governor Phillip hospital:

"I was anaesthetised by open drop ether using a Schimmelbusch mask. It felt like they were choking me, making me cough and burning my throat out. While struggling and crying with fear during what did seem to be a relatively brief induction, I looked backwards over the head of the table to see a Jersey cow grazing about two feet from the open theatre door. This was the last thing I remembered about the actual procedure."

Today, open drop anaesthesia has been replaced with more precise methods leaving the Schimmelbusch mask and dropper bottle in the museum cabinet as a record of the not so distant past. The celebration of World Anaesthesia Day acts as a catalyst for looking back on the development of the anaesthetic profession and admiring the countless hours of work conducted across the globe that have resulted in our practice today. So, no matter where you are on Sunday 16th October, I encourage you to take a moment to reminisce, explore or marvel at the advancements of anaesthesia and pain management since that fateful day 170 years ago when William Morton inspired the world.

Julianne Kiely
Curator, Harry Daly Museum

Above: Replica of Morton's ether inhaler from the Harry Daly Museum

Left: Schimmelbusch face mask with anaesthetic cloth and dropper bottle from the Harry Daly Museum

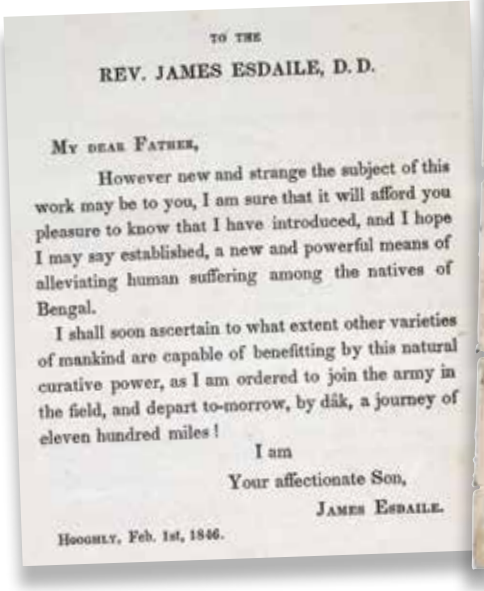
INSIDE YOUR SOCIETY

RICHARD BAILEY LIBRARY MUSINGS

It is surprising what turns up when one pokes about books – no matter if they are your own or books in a library. A library is the place to seek ideas of others. The atmosphere of well-being pervading a library stimulates your own ideas. Unlike the internet where information is skimmed and about as satisfying as a take-away meal, the information in a library is enriching and scholarly. It is akin to the slow, savouring, gustatory experience of dining at a hatted chef's establishment.

At home recently I found the delightfully titled *He Knew He Was Right.* It was, of course, one of Anthony Trollope's 47 novels – he who wrote *The Chronicles of Barsetshire,* six novels richly dramatised by the BBC. Trollope worked for 33 years for the British Post Office and is notable for having suggested letters bearing stamps posted in special boxes. The first post box, circa 1851, was on Jersey and was painted sage green to blend with the landscape. The first boxes were on posts and then turned into pillars to hold more letters. (The saying from pillar to post goes the opposite way; is the etymology from pillory to (whipping) post or from the fifteenth century court tennis or from post haste? – there's library research for another day.)

The real reason why *He Knew He Was Right* caught my attention was when I flipped through the pages I found there were characters in the story called Stanbury and one of them, Jemima, lived in Exeter. My name and my birthplace!



TO THE

REV. JAMES ESDAILE, D. D.

My dear Father,

However new and strange the subject of this work may be to you, I am sure that it will afford you pleasure to know that I have introduced, and I hope I may say established, a new and powerful means of alleviating human suffering among the natives of Bengal.

I shall soon ascertain to what extent other varieties of mankind are capable of benefitting by this natural curative power, as I am ordered to join the army in the field, and depart to-morrow, by dâk, a journey of eleven hundred miles!

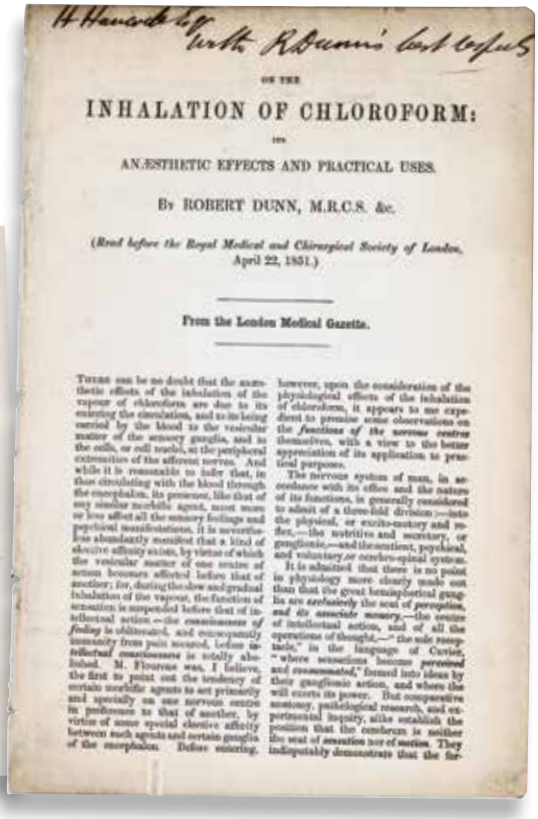
I am

Your affectionate Son,

James Esdaile.

Hoogly, Feb. 1st, 1846.

Esdaile's dedication of his work in India to his father, first printed in 1846



H Hancock Esq with Robert Dunn's best respects

ON THE

INHALATION OF CHLOROFORM:

ITS

ANÆSTHETIC EFFECTS AND PRACTICAL USES.

By ROBERT DUNN, M.R.C.S. &c.

(*Read before the Royal Medical and Chirurgical Society of London, April 22, 1851.*)

From the London Medical Gazette.

With the Author's compliments (to H Hancock?), a paper presented by Robert Dunn in 1851

I went into a reverie back into time and realised that 1951 was not only the centenary of the pillar box (now virtually extinct, in spite of having changed colour from green to eye-catching red) but also of my migration to Australia.

So then I thought, "Hmm, 1851, I wonder what books there are in the Richard Bailey Library dated 1851, just five years after Morton's discovery of modern anaesthesia".

When I looked on the ASA's website at our Library's catalogue eHive I found there was an interesting selection, roughly grouped into mesmerism or allied subjects and anaesthesia.

The Richard Bailey Library has a significant collection of mesmerism and 1851 was one of its fruitful years. For example, we have Capern, Thomas, *The Mighty Curative Powers of Mesmerism: Proved in Upwards of One Hundred and Fifty Cases of Various Diseases.* London: H. Baillière. This is a handbook of curative animal magnetism describing treatment of many conditions. Animal Magnetism is just another name for Mesmerism, thus called after Franz Anton Mesmer, who popularised the technique in the late 1770s. Hypnotism derives from it.

That mesmerism was difficult for many contemporaries to accept is shown by the publication of another book that year, *An History of Magic, Witchcraft and Animal Magnetism* in two volumes by John Campbell Colquhoun. He strove to convince people that animal magnetism was a fit and proper scientific practice and not one based on magic and popular superstition.

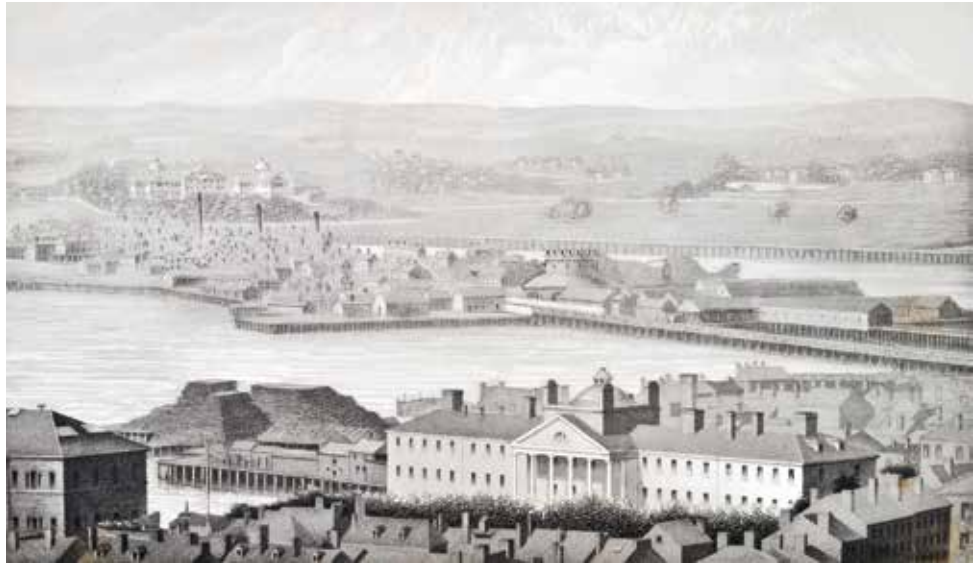
One of the best evidenced-based

practices of mesmerism was that of James Esdaile. His book, *Mesmerism in India and Its Practical Application in Surgery and Medicine*, was first published in 1846 and reprinted in 1851. Esdaile was able to carry out painless surgical operations including the removal of tumours weighing 80 pounds, amputations and cataract procedures when patients were under a mesmeric trance. His work was convincing but the publication of practical anaesthesia in the same year as his first edition resulted in the slow decline of mesmerism and magnetism in medical practice. Hypnotism just survives today being used by some anaesthetists to help adults overcome problems like needle phobia. It appears that to be a successful hypnotist or magnetiser one must be a forceful personality and the patient a true believer.

The Richard Bailey Library has a paper read before the Royal Medical and Chirurgical Society of London on 22 April 1851, a paper by Robert Dunn *On the inhalation of Chloroform its Anaesthetic Effects and Practical Uses*. It is signed by the author with his best wishes, an extraordinary survival of just eight pages. It deals with the physiological effects of chloroform, the degrees of consciousness and the precautions and observational techniques required of the administrator. He states that in ordinary and normal labour, anaesthesia is uncalled for, but concludes that it is a 'valuable boon' in difficult cases.

From the London Medical Gazette for 1851 the Library possesses John Snow's *Narcotism by the Inhalation of Vapours*, in which he discusses chloroform and ether (in facsimile admittedly, but including all his earlier and later papers too, a valuable historical account).

Also published in 1851 is *A History of the Massachusetts General Hospital* by N. J. Bowditch and printed by John Wilson of Boston. The title page clearly states in upper case, NOT PUBLISHED, which I take to mean the monograph of 442 pages was of limited circulation. Nevertheless this book gives a compelling contemporary account of the tussle between Morton and Jackson for the primacy of the discovery of anaesthesia.



A view of Massachusetts General Hospital from Bowditch's History, 1851

A glimpse of the almost Wild West era then prevailing is given by Chauncey D. Leake in his comprehensive and fascinating *Cadenced Story of Anaesthesia* (1947) –

Young Morton was ambitious: he had married.
He pushed to puff his reputation as
a dentist, sought an easy painless way
to pull a tooth, and snatched at any hint
which came from Jackson. One, to put
some ether on the aching tooth, he tried,
and then he thought to give enough
by inhalation to prevent
whatever pain might be,
however long the operation.

Experimenting feverishly on animals at home,
on patients in his office, he
soon learned the dose to use.

He wangled Collins Warren for
an invitation to appear before
the Boston surgeons in the same
old amphitheater where Wells had failed,
and there to try to demonstrate
his new invention which could blunt,
he thought, the biting edge of pain.

To conclude, it is well worth visiting the Richard Bailey Library. Your library is a significant asset of the Society, a meeting place, an atmospheric discovery mine that teaches the history of the past and stimulates future research. And a question for you:

Has a date or fact recently stimulated you to follow a train of thought or research?

Whatever your answer, please visit our Library, or the Harry Daly Museum, you will find a warm welcome and a meeting of minds.

Peter Stanbury OAM
Richard Bailey Librarian

CONTACT US

Contact us to arrange a visit to browse or for research. We are open by appointment Monday to Friday, 9am to 5pm. Please phone ASA head office (1800 806 654).

INSIDE YOUR SOCIETY

MEET YOUR NEW ASA STATE CHAIRS

VICTORIA COMMITTEE

Dr Jenny King

I have been an active member of the ASA committee for several years.

I have been a consultant anaesthetist for 25 years and have a mix of public, private and regional practice. I have enjoyed catching up with members from Melbourne and further afield, and liaising with our junior members.

The Victorian ASA has an active committee with good balance of males and females, and wide variance of ages, and are there to represent our members and offer support. We are always happy to be contacted.

We have recently held two social functions: 'New Fellows Forum', and a 'Celebratory Cocktail Evening' for all members and welcoming our successful exam candidates into the fold. We hope to have some more functions in the future.

The Victorian Committee has very busy ramping up for the September Melbourne NSC, putting together the polishing touches for an exciting, vibrant and highly educational meeting, with the added bonus of fun social functions to celebrate in style our 75th anniversary.

On a personal note I have three children in their early 20s, and my husband is a business analyst. In my spare time I play hockey for MCC and do spin classes, enjoy playing clarinet in a church band, and escape to Inverloch for breaks.

SOUTH AUSTRALIA COMMITTEE

Dr Josh Hayes

I come into the role of state chair with a degree of trepidation – our outgoing chair Dr Simon Macklin approached the job with boundless enthusiasm and led a committee that achieved much during his tenure.

Hoping that I will grow into the job, I'm looking forward to working with the state committee that contains old faces with enormous corporate knowledge and new faces to hopefully bring new ideas.

Professionally, I work in both public practice at the Royal Adelaide Hospital (and looking forward to seeing what the new RAH brings!) and in private practice as an associate with Stace Anaesthetists in Adelaide. I enjoy a varied casemix, including ENT, head and neck surgery, plastics, hepatobiliary and general surgery and vascular surgery.

Personally, I have a young family that I adore spending time with, along with pursuing obligatory anaesthetic extracurricular activities such as cycling (road and cyclocross) and ski conferences.

I'm looking forward to the next year as state chair and hope to continue to build on the growth in the ASA's profile and membership in SA that has been achieved thus far.

NEW SOUTH WALES COMMITTEE

Dr Ammar Ali Beck

I have been living in Sydney since 1998. After gaining my fellowship in 2005, I took on the challenge of becoming staff Specialist at Nepean Hospital for two years before moving on to a VMO position in a hope of gaining a better work - life balance. My current practice is divided between the private and public around 60/40.

My clinical interests in anaesthesia have evolved around neurosurgery, bariatric, colorectal, and obstetric. Despite my limited involvement in research, I was able to involve the Nepean anaesthetic department in a multi-centre trial for the first time of the department history. I have a keen interest in teaching, and enjoyed spending two years as supervisor of training.

In Sydney's Western Suburbs, where most of my practice is based, the large population growth has brought new challenges and made me more aware of the effects of government policies on patient outcomes.

As the government adopts new funding models, I believe, the coming few years will bring a lot of change to the way we practice medicine. As a representative body the ASA is well placed to negotiate the new order on behalf of the profession. It is exciting to be part of the NSW committee, and I feel privileged to be part of a great team.

Outside work, I love to spend time with my wife, Gail, and our three children who continue to keep us busy. My best holidays have been when taking long road trips exploring the amazing countryside of Australia, or taking the opportunity to ride my bicycle on short trips. History and geopolitics are dear to my heart and I am looking forward to a time when I have the opportunity take up a formal study in one of these subjects, hopefully, in the not too distant future.

INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

NATIONAL

Dr Donald Maxwell

The Retired Anaesthetists Group is in a very healthy position. It is active in all states and is a popular forum for our retired members to meet and socialise and at times to attend educational talks arranged for some of the meetings. The popularity of the lunches with members is a testament to the value of the group. Attendance varies according to States but usually from about 20 to 30 .

The annual number of members now totals 446 and have been increasing annually.

The breakdown is :

State	No.	State RAG Chairs
NSW	148	Dr Donald C Maxwell
SA & NT	79	Dr John Crowhurst
QLD	68	Dr Colin Busby
VIC	67	Dr Rod Westhorpe
WA	63	Dr Walter Thompson
TAS	10	Dr Michael Hodgson

In addition to having regular State meetings, there are luncheons and meetings at all our annual meetings and it is very pleasing that the ANZCA also, in cooperation with the ASA includes a RAG lunch at its' annual meetings.

SOUTH AUSTRALIA

Dr John Crowhurst

The SA group meets on the second Monday of every odd month. The guest speaker at our May luncheon meeting this year, at the Kensington Hotel, was Prof. Ian Symonds, Dean of Medicine and Head, School of Medicine, University of Adelaide; Visiting Medical Specialist, Women's and Children's Hospital, Adelaide; Conjoint Professor of Obstetrics and Gynaecology, University of Newcastle, NSW; Adjunct Professor, University of New England, NSW, and Editor in Chief, Journal of Obstetrics and Gynaecology.

Prof. Symonds presented his views on 'Contemporary Concepts of teaching Medical Undergraduates', a topic in which he is a world authority. Such teaching methods today are vastly different from the Science-based curriculum which all of us endured many decades ago. After lunch, all 36 of us present appreciated a vigorous and interesting discussion.

Ian's father, Prof. Malcolm Symonds a former Reader in OB/GYN in Adelaide in the 1970s, and Foundation Professor at Nottingham University from 1973, was also present. We invited several other retired OB/GYN colleagues to join us. They included: Drs Graham Andersen; Alan Down; Eric Green; Graham Hamdorf; Prof. Alastair MacLennan; Assoc. Prof. David Morris, and Psychiatrist, Dr Ken O'Brien.

We extend our sincere thanks to Prof. Symonds and our guests for a most enlightening and memorable meeting.

Prof. Warren Jones, PhD, FRCOG, FRANZCOG, AO

Our July meeting was attended by 26 members, including 'first-timers' Drs Margie Cowling and Tony Laver. Dr Ken O'Brien consultant psychiatrist and husband of Dr Glenys Miller also attended.

Our guest speaker was Prof. Warren Jones AO, former professor of Obstetrics and Gynaecology at the Flinders Medical Centre and a World Health Organisation OB/GYN consultant. Prof. Jones is a widely respected critic of the SA Government's 'Transforming Health Program' which is in the process of radically changing public health and rehabilitation systems in the State. Prof. Jones outlined some of the major specialities' major criticisms and raised many questions regarding possible solutions.

Dr Michael Tingay proposed a vote of thanks to Prof. Jones and presented him with a commemorative John Snow coffee mug.

L to R: Drs John Foote; Ashim Sen; Tony Kaines; John McEwin; Bill Fuller; Rob Lenthall; John Hughes.

Prof. Ian Symonds, our guest speaker

Our next meeting will be on Monday the 12th of September at the Kensington Hotel. Any visiting colleagues from interstate or abroad are welcome to attend.

Please RSVP by 9th September to: Alison Cook, Events Coordinator SA & NT, ANZCA, T: +61 8 8239 2822. E: acook@anzca.edu.au

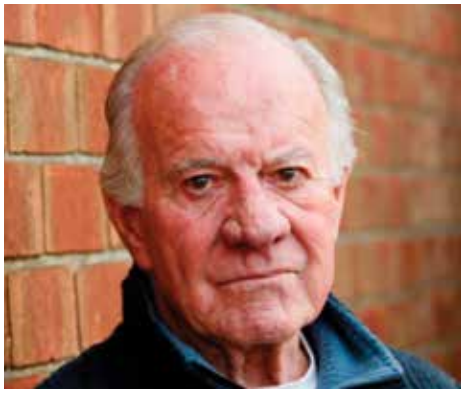
GET IN TOUCH

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

Or you can call the ASA offices on: 1800 806 654.

INSIDE YOUR SOCIETY

DR OWEN FRANCIS JAMES AM MS FANZCA FCICM 1936–2016



The ASA was saddened to hear of the passing of Dr Owen James on 1 June, 2016.

Owen Francis James was an achiever for medicine and his community. He oversaw the development of the anaesthesia department of Royal Newcastle Hospital from a mainly service-provision unit to a teaching-hospital standard postgraduate training unit for specialists in anaesthesia. In addition, he established an intensive care unit of the highest standard, and later as an administrator, initiated improvements to health care in the Hunter region, most notably in securing approval and finance for a new teaching hospital, the John Hunter Hospital, and then overseeing the planning, building and commissioning of that hospital.

Following graduation from the University of Sydney Owen took up a three year position as a resident medical officer at Royal Newcastle Hospital in January 1959. He went on to become a registrar in anaesthetics and furthered his experience in the United Kingdom and the United States, acquiring Fellowship of the Faculty of Anaesthetics of three Royal Colleges in the process.

Owen returned to Newcastle in 1968 as a Staff Specialist Anaesthetist and shortly after was appointed Director of Anaesthetics. He immediately began the task of improving registrar training. He created more specialist appointments and increased their diversity by creating visiting positions. He also arranged and found resources for distinguished anaesthetists from overseas to visit his department on a regular basis. As a result, the department was transformed from a predominately service-provision role with only the occasional registrar completing their training and gaining their Fellowship in Anaesthetics to one in which completion of training and success in the fellowship became the norm. Increased staffing at both specialist and registrar level also contributed to Owen's objective of building up a first class intensive care unit at Royal Newcastle Hospital. Other factors were securing from the hospital budget the resources to equip the unit with contemporary technology and train medical and nursing staff, but the most important factors were Owen's expertise, enthusiasm and hard work. Royal Newcastle Hospital was the only major hospital between Sydney and the Queensland border, and in the 1970s, before seat belts, random breath tests and expressways, it received a high number of road casualties including many serious chest injuries. The intensive care unit, as a result of this, rapidly built experience and expertise in the management of major trauma. The unit had a good system of record keeping and Owen regularly audited these records and later analysed them to write a thesis on the management of life threatening trauma for which he was awarded the degree of Master of Surgery by the University of Sydney, a degree rarely awarded, even to surgeons.

In the 1980s Owen began to turn his mind to broader health issues in the Hunter, and in particular the relatively out-dated facilities of the Royal Newcastle Hospital and the overall need for more beds in the region which had been recognised in the Olsen report. In 1984 Owen was appointed to a Department of Health position with administrative responsibility for all the hospitals and community health services in the Hunter.

A meeting was arranged between Owen and community representatives and the then Premier Neville Wran which led to finance being approved for the building of a new hospital in the Hunter for $250 million. The Premier directed the money be found from within the health department's existing budget which did not win Owen and the Hunter many friends in the Department of Health. Planning and building commenced with the support of then minister for health, Peter Collins, who suggested the name John Hunter for the new hospital.

The hospital was completed within budget and on time and received its first patients in January 1991. However, in the

first year of operation of the new hospital the Hunter Area Health Service exceeded its budget. Consequently, Owen faced a number of professional challenges. He was later appointed Director of Anaesthetics to Tweed Heads Hospital. Following retirement he returned to Newcastle. He was diagnosed with lymphoma in 2011 and died peacefully in the Mater hospice on 1 June 2016.

He was made a Member of the Order of Australia by the Governor General for service to the community. Few would be willing to risk career and livelihood for the community they serve. Owen was one of those few. When asked in an interview a few months before he died "would he do it all again considering the consequences?" he replied "Yes". When asked why, he answered "Because it was needed". He was also asked how he viewed his life he replied to the effect that he thought of it as a success professionally but achieved at great personal cost. Owen deserved better.

N. Potter

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from June to August 2016.

TRAINEE MEMBERS

Dr James Atkins	SA
Dr Adriana Mira Bibbo	VIC
Dr Simon Peter Bradbeer	WA
Dr Hanna Burton	QLD
Dr Joshua Chew	VIC
Dr Leonard Conrad	NSW
Dr Ali Jilani Coowar	VIC
Dr John-Paul Favero	NSW
Dr Pitipanage Kisholi Antoinette Fernando	NSW
Dr Karina Gotjamanos	WA
Dr Andrew James Iliov	VIC
Dr Dilan Kamalasena	NSW
Dr Alison Kearsley	WA
Dr Melissa Li-Ping Lim	VIC
Dr Sarah Maguire	QLD
Dr Anneliese McBride	ACT
Dr Nagaraj Narayana Swamy	NSW
Dr Michael Lyons Nash	WA
Dr Lachlan Nave	NSW
Dr Andrew Nikola	NSW
Dr Kasia Nowak	NSW
Dr Dominic Peter Ormston	QLD
Dr John Stephen Pieterse	SA
Dr James Preuss	WA
Dr Bernard Roach	NSW
Dr Victoria Sabbouh	NSW
Dr David Michael Samson	NSW
Dr Antony Scanlan	QLD
Dr Claire Heather Stewart	NSW
Dr Adam Sutton	VIC
Dr Patrick Chee Fei Tan	VIC
Dr Christine Vien	VIC

ORDINARY MEMBERS

Dr David Robert Alcock	VIC
Dr Andrea Colette Binks	NSW
Dr Craig Dennis French	QLD
Dr Grace Gunasegaram	VIC
Dr Sean Stephen Hearn	VIC
Dr Katarzyna Ibrahim	VIC
Dr Robert Lattik	QLD
Dr Benin O'Donohoe	NSW
Dr Linda Partridge	SA
Dr Anand Keshavchandra Rajbhoj	SA
Dr Alister Ramachandran	NSW
Dr Lone Rasmussen	NT
Dr Anne Rasmussen	NSW
Dr Kavitha Shetty	NSW
Dr Bradley Smith	QLD
Dr Paul James Suter	NSW
Dr Deborah Tooley	TAS
Mrs Lekha Dilrukshi Walallawita	WA
Dr Neil Raymond Warwick	NSW
Dr Paul Christopher Williams	NSW

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Elaine Kluver (Qld), Dr Terence McAuliffe (WA), Dr Owen James (NSW), Professor Garry D. Phillips (SA), Dr Lachlan Dickson (SA) and Dr Bruce Jones (VIC).

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

SEPTEMBER 2016

National Scientific Congress

Date: 16-20 September 2016

Venue: Melbourne Convention and Exhibition Centre

Contact: Denyse Roberson, ASA, events@asa.org.au

ANZCA/ASA SA and NT CME Committee Annual Dinner Meeting

Date: 27 September 2016

Venue: The Lion Hotel, North Adelaide, SA

Contact: Alison Cook, ANZCA, acook@anzca.edu.au

OCTOBER 2016

Combined ANZCA/ASA ACT CME

Date: 15 & 16 October 2016

Venue: John Curtin School of Medical Research, Acton ACT

Contact: act@anzca.edu.au

Practice Managers Conference

Date: 21 October 2016

Venue: Stamford Plaza Melbourne

Contact: Samantha Pascoe, ASA, events@asa.org.au

Contact: events@asa.org.au

NOVEMBER 2016

Part 3 Courses

Queensland
Date: 5th November 2016
Venue: AMA Qld Hunstanton Building

Victoria
Date: 12th November 2016
Venue: Kooyong Tennis Club

Western Australia
Date: 12th November 2016
Venue: The Cottesloe Beach Hotel

New South Wales
Date: 19th November 2016
Venue: Parkroyal, Darling Harbour

South Australia/Northern Territory
Date: 26th November 2016
Venue: AMA (SA), North Adelaide

To register: www.asa.org.au or email: events@asa.org.au

FEBRUARY 2017

Final Exam Preparation Boot Camp

Date: 4 & 5 February 2017

Venue: John James Theaterette, John James Medical Centre

Contact: Vida Viliunas
vidav@goape.com.au

Australian Symposium on Ultrasound & Regional Anaesthesia

Date: 23-26 February 2017

Venue: Peppers Noosa Resort & Villas, Noosa Heads

Contact: events@asa.org.au

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