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

THE GLOBAL PATIENT
Healthcare in Cambodia

ANAESTHESIA IN 2025
Projections for the future workforce

WELFARE OF ANAESTHETISTS
Substance abuse • Peer review groups • Dealing with catastrophes

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2013

NATIONAL SCIENTIFIC CONGRESS OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

Anaesthesia: Art and Science

The NSC 2013 organising committee headed by Drs Mark Skacel and Paul Burt have developed a program that will appeal to a wide audience and further explore how our understanding of the basic sciences improves clinical outcomes for our patients.

Special areas of interest will include neuroscience and consciousness, fluid therapy and outcomes for the high risk surgical patient.

Invited Speakers include

Professor Martin Smith
Queens Square, London

Professor Colin Mackenzie
University of Maryland, Baltimore

Professor Mike Grocott
University of Southampton

Professor Tony Quail
University of Newcastle, NSW

ASA
Australian Society of Anaesthetists

ASA NSC CANBERRA
ANAESTHESIA: ART AND SCIENCE
26-29 SEPTEMBER 2013

Anaesthesia Continuing Education Coordinating Committee (ACECC)

- ✓ Local and international anaesthesia-related events
- ✓ 17 special interest groups open to members
- ✓ Great resources to organise or promote anaesthesia-related events.

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Anaesthesia Continuing Education Coordinating Committee

AUSTRALIAN
Anaesthetist
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 the Editor:
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 Jiyan Mustafa at editor@asa.org.au to submit your letter or to contribute.

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Australian Society of Anaesthetists

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ASA EDITORIAL FROM THE PRESIDENT

DR RICHARD GRUTZNER, ASA PRESIDENT

As President of the Society I would like to welcome ASA members to the inaugural issue of *Australian Anaesthetist*. There are a number of interesting articles around the welfare of anaesthetists theme. The Health Workforce Australia report, HW2025, and its implications for Australian anaesthetists are discussed in some detail. This report will define the Government's approach to medical workforce issues over the medium term and beyond. There is also a point of view discussion on the Australian Defence Force outsourcing of medical services for active defence personnel to Medibank Health Solutions which will be of interest to members.

A colleague recently referred me to a skit from the Monty Python movie *Life of Bryan*. In this skit a group of citizens on the eastern edge of the Roman Empire are complaining about Rome. "What have the Romans ever done for us?" After some discussion lead by John Cleese the question is posed again. What have the Romans ever done for us apart from the aqueduct and fresh water, sanitation, roads, irrigation, education, wine, public baths, law and order and health?

In anaesthesia we could equally pose the question. What has the (insert ASA, ANZCA or AMA) ever done for us? What have the (insert ASA, ANZCA or AMA) ever done for us besides world class training, maintenance of standards for anaesthesia practice, anaesthesia research, continuing medical education, annual national scientific congresses, overseas aid, advocacy with Government, advocacy with health funds, workcare and transport accident commissions, peer-reviewed journal, assistance with professional issues in practice, library, museums, special interest groups, critical incident reporting system, representation of trainees, representation of staff specialists and on-the-ground assistance with industrial issues, provision of patient information material, Part 0 and Part 3 Courses? What have the Romans ever done for us besides that?

The specialty of anaesthesia has changed enormously over the last 30 years. We have seen significant improvements in anaesthesia safety to the point that anaesthesia is so safe that in the view of at least one public hospital CEO in Victoria, it can be performed by lesser qualified nurses. This is despite the fact that there is a significant shortage of nurses and a medical anaesthesia workforce which is in reasonable balance, not withstanding some maldistribution issues in rural areas. We are all aware of the situation in the east coast capital cities of young anaesthetists who are unable to secure suitable employment in the public or private sector. This situation has been exacerbated, particularly in Victoria, by a reduction in Commonwealth funding.

We have seen significant improvements in anaesthesia safety to the point that anaesthesia is so safe that in the view of at least one public hospital CEO in Victoria, it can be performed by lesser qualified nurses.

This is exactly the time at which our recent graduates would be posing the "what have the Romans ever done for us" question. It is at times like this that, in my opinion, membership of the ASA, ANZCA and the AMA are, almost paradoxically, so important. Each organisation plays a unique role in supporting the professional structure underpinning the practice of anaesthesia in Australia. ANZCA not only trains our younger colleagues but establishes and maintains the standards required to continue in practice. The ASA provides, amongst other things, the professional and economic advocacy by dealing with Government and funders of healthcare. The AMA has the resources to assist with Government advocacy and more importantly, on-the-ground industrial assistance.

By way of example, I am aware of a recent situation at a teaching hospital in a capital city where nurses were providing awake sedation for gastroenterological procedures under the supervision of a gastroenterologist. The nurses were using propofol and not surprisingly conscious sedation often became general anaesthesia. The nurses were uncomfortable with this situation and were being encouraged by the gastroenterologists to give more of "the white stuff" in response to patient movement and restlessness. The nurses, who considered themselves to be outside their comfort zone, approached an ASA member from the department of anaesthesia with their concerns. The ASA member then explained to the nurses that ANZCA has policies in this area, encapsulated in the Professional Standard 9 (Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures) a document produced with the cooperation of the Faculty of Pain Medicine of ANZCA, the Gastroenterological Society of Australia, the Royal Australasian College of Surgeons, the Australian College for Emergency Medicine, the College of Intensive Care Medicine, the Royal Australasian College of Dental Surgeons and the Royal Australasian College of Radiologists. Simply put, this collaborative document states that general anaesthesia is to be delivered by a registered medical practitioner with appropriate training and skills with suitable assistance for the task. This document is supported by ASA Position Statement 13 which also states that if propofol or other general anaesthetic agents are used then two medical practitioners are required, one to perform the procedure and the other to care for the patient.

The ASA member approached the gastroenterological department and pointed out that nurses delivering general anaesthesia under the supervision of a gastroenterologist is outside the standards espoused by ANZCA Professional Standard 9. The anaesthetist then asked the gastroenterologists as to whether they would be happy to be responsible for any adverse patient consequences arising from the use of nurses delivering general anaesthesia under their supervision. The answer to this question was a resounding 'no' and the gastroenterologists subsequently requested that the anaesthesia department provide anaesthetists to deliver general anaesthesia for these procedures. Anaesthetists themselves are often not helpful by way of trivialising the significance of what they do. How many times have we heard the expression "twilight sedation" or "just a quick whiff" to describe what is in fact a medically induced coma? This should be better described as general anaesthesia.
In this country the expectation of gastroenterologists, surgeons and their patients is that diagnostic procedures will be performed under general anaesthesia. To describe it as light sedation, deep sedation, twilight sedation or any other euphemism is disingenuous. Let us call it what it is and that is general anaesthesia. General anaesthesia in this country should be given by appropriately trained medical practitioners.

I have used this as just one example of the ways in which an ANZCA professional standard can be used by ASA members in everyday practice to support the standards which underpin our enviable safety record. Can we begin to imagine how much work went into creating such a standard, requiring agreement of eight different medical bodies and reviewing the document periodically to make sure it remains relevant? What have the Romans ever done for us? I encourage you to look at the vast number of professional standards on the ANZCA website and understand that these are tools that provide Australian anaesthetists with leverage to ensure that their patients continue to enjoy the safest anaesthesia in the world. So when a colleague next asks you "What have the Romans ever done for us?" you will be better able to answer that question.

Please enjoy the inaugural issue of *Australian Anaesthetist* and I hope you find the content informative.

RVG correction—Division V (printed version)

This is a reminder that the 15th Edition of the Relative Value Guide (RVG) contains a number of errors. On pages 91–104, there are a number of items which appear in both the the ASA RVG, and the Medicare Benefits Schedule (MBS), but which in the MBS do not have a unit allocation. Rather, they have a specific MBS Fee. The MBS Fees listed have not been updated to the November 2012 values. The Economics Advisory Committee apologises for any inconvenience caused.

The ASA would also like to take this opportunity to again encourage members to download the iPhone or Android RVG application, and to remind members that the complete and fully updated version of the RVG is available within the Members Section of the ASA website.

Should members have any questions regarding this matter, please do not hesitate to contact the ASA Policy Team on (02) 9302 2716 or alternatively via policy@asa.org.au.

Dr Mark Sinclair
Chair, Economics Advisory Committee

REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

The New Year usually brings with it a whole range of hopes and dreams, some of which are transformed into reality and some of which never seem to make it off the to do list. Looking ahead, I certainly hope that we can achieve most of our goals.

Already this year, the Society has hosted a most successful International Symposium on the History of Anaesthesia. Running from 22–25 January at the University of Sydney, the Symposium saw over 160 delegates share their passion and interest for the history of the profession. This event was supported by the History of Anaesthesia Exhibition, which is running from 23 January to 3 May, Level 2 Fisher Library at the University. This exhibition features a display of rare books and special items, which provide a valuable insight into the world of anaesthesia.

Not long after the Symposium concluded, Prime Minister Julia Gillard announced that we would be heading to the polls in September, making it the longest election campaign in the history of Australia. The impact of such an announcement is difficult determine. Does it mean that the Government will be looking to push ahead with initiatives or will everything come to a standstill? From the ASA's perspective, we certainly intend to remain active in areas that may have a direct impact on members. In recent times, President Dr Richard Grutzner has been called upon to comment in the media on the prospect of nurse-administered anaesthesia, as well as providing further comment on the issue of medical care for service personnel under the Medibank Health Solutions proposal. Comment on such issues is indeed timely as the Society is also looking to actively engage in the Health Workforce 2025 debate. Making comment and looking to engage in these debates is essential and I am sure that any further opportunities to express our views will be taken.

From the ASA's perspective, we certainly intend to remain active in areas that may have a direct impact on members

Not long after the election becomes part of history, the 2013 National Scientific Congress, running from 26–29 September, will provide the perfect opportunity for all members to meet in the national capital. Titled *Anaesthesia: Art and Science*, Convenor Dr Mark Skacel and his committee are putting together a first-rate program, featuring a range of top-quality international guests. I am sure that this meeting will be a highlight of the year.

Last year, I mentioned that the ASA was looking for a new home. While the current office in Edgecliff is adequate it is unlikely that it will meet the needs of the Society in the longer term. As such, there has been a great deal of effort put into finding a new office that meets both our present and future needs. I am pleased to say that a new home has been found at 121 Walker Street, North Sydney, with the arrangements finalised on 18 February. This is an exciting development and, while details concerning an actual move date are yet to be confirmed, this is certainly big news for the Society.

So I am pleased to say that some of our New Year hopes and dreams have already come to reality. I hope this continues throughout what promises to be a dynamic year for the Society.

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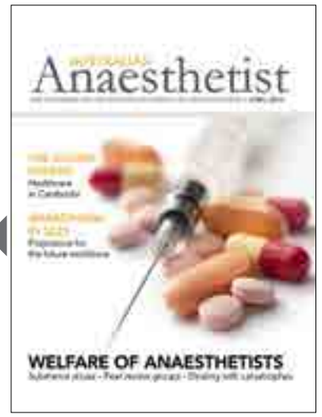
LETTERS TO THE EDITOR



FROM THE COMMUNICATIONS COMMITTEE CHAIR

Over the past year, the ASA's Communications Committee has been looking at how members identify with the ASA as a brand. The *ASA Newsletter* as it was known for many years, more recently the *ASA news*, is one of our main methods of communicating with members, it is also one of our key brand identifiers, so we decided to implement a change to the *ASA news* and turn it into more of a magazine with a new name: *Australian Anaesthetist*. This magazine underlines the ASA's position as one of the key stakeholders of anaesthetists in Australia. The ASA exists to promote and protect the status, independence and best interests of Australian anaesthetists and the name of our new magazine emphasises the Society's unique identity.

From a design point of view, the changes the Committee has implemented underline our transition from a four-page, black and white, A4 newsletter (as it was in the 1980s) to a full-blown magazine. We have established a style guide to ensure the colour used throughout the magazine ties back into the colours of the Society and the Society's logo, ensuring our new colours complement the old. Our images are representative of Australian anaesthetists—fresh, innovative and professional. Eye-catching headers and taglines serve to make the important issues featured in the magazine more engaging, while our use of white space, clean lines and aesthetically pleasing layouts give our new magazine a point of difference from other similar publications and highlight the Society's unique position within the anaesthetic community.

To all of this, we have added sections to ensure the magazine is easier to navigate; these currently include our 'regulars', 'features' and 'inside your Society' components. We'll also be adding some new, exciting sections throughout the year, so be sure to watch out for the August and December editions of *Australian Anaesthetist*.

Finally, I'd like to thank all those who contributed to the creation of *Australian Anaesthetist*: our Designer/Communications Officer Leah Blasset, Communications Manager Nicola Morgan and Magazine Coordinator Jiyan Mustafa; my fellow members of the Communications Committee Drs Sharon Tivey and Mark Suss, ASA President Dr Richard Grutzner and ASA CEO Mark Carmichael. This is the next phase of the development of the Society's communications and we'd love to know what you, our members, think of our new publication.

Dr Gregory J. Deacon
Chair, ASA Communications Committee

FROM THE MEDICAL EDITOR

Last year the Communications Committee agreed to move from the newsletter-style *ASA news*, which has served the membership of the ASA well for many years, to a magazine format which will allow a greater variety of articles to be presented. After several months of planning I am pleased to introduce you to this new publication.

The focus of *Australian Anaesthetist* is very much the ASA members. In addition to updates and reports from the various committees that perform the myriad functions of the ASA, this magazine will allow us to provide readers with indepth reviews of many topics of interest. For this first issue we have involved the Welfare of Anaesthetists Special Interest Group (one of 17 groups jointly administered by the ASA, the College and the New Zealand Society of Anaesthetists), and have brought you a number of interesting articles looking at various aspects of our wellbeing.

We have also introduced a 'Letters to the Editor' section so we can share your thoughts with our members. Please write and let us know what you think about the new magazine, about topics you'd like us to cover, or comment on any issues of concern to you in the world of anaesthesia.

Dr Sharon Tivey
Medical Editor, Australian Anaesthetist

WELFARE OF ANAESTHETISTS

The timing of the invitation from the ASA to the Welfare of Anaesthetists Special Interest Group (SIG)* to contribute several articles relating to welfare issues was fortuitous and welcome.

It is now nearly 18 years since the SIG was first formed and it has contributed significantly to improving awareness of the importance of doctors' health. The welfare of our colleagues has become a vital mainstream interest and there are new resource documents and initiatives (e.g. the proposal for 'welfare' officers in private and public practice settings).

Stresses impacting on safe practice occur in all anaesthesia environments: everyday stresses, dealing with life and death and the daily potential for disaster. Fewer resources and supports may be available in private practice. However, most anaesthetists have excellent coping strategies. For those who may not cope, those who may burn out, those who become distressed and those whose performance is affected by illness or crisis, we must ensure that their need is identified, that support is offered and that access to professional help is facilitated.

Substance abuse in anaesthesia is a rare, but tragic, condition: addiction medicine and psychiatry may not have kept up with emerging patterns of abuse (both intravenous and inhalational). Returning to work within a few weeks of being found abusing intravenous drugs or being allowed to return to private practice may not be the best that rehabilitation has to offer.

There are considerable difficulties in identifying and managing such doctors. Should we be establishing a database of substance abusers? Do we need a working party, involving ANZCA, the ASA, addiction medicine specialists, the Medical Board of Australia and the College of Psychiatrists, to better manage abusers?

Performance issues and the requirement for mandatory reporting can be extremely difficult to deal with and resolve—are colleagues able to access advice when concerned about a fellow practitioner? Are the external doctors' health organisations (i.e. the Doctors' Health Advisory Services, the Victorian Doctors' Health Program) filling that need? Should the College or the Society do more in these areas?

In founding the Welfare of Anaesthetists SIG we wanted to make a difference—are we keeping up with the challenges of the 21st century?

Dr Diana C. S. Khursandi, Co-Founder
Dr Prani Shrivastava, Chair
Welfare of Anaesthetists SIG

Note

* The SIG encourages the recognition of stressful situations in oneself and others, recommends strategies, avenues of support and professional help, and has an educational role convening sessions and workshops at regional, national and international CME meetings. It publishes Resource Documents (RD) with suggestions on ways to deal with many of the situations mentioned above, as well as others. The RDs are available on the ACECC website, www.acecc.org.au.

'OF SURGEONS BEARING GIFTS'—QUADRUPLE B-WARE

Much good work has been published in the anaesthetic literature on indices of perioperative risk, from Goldman to STOP-BANG. The best, like STOP-BANG, have a catchy acronym to offset the increasing POCD (postoperative cognitive dysfunction) of the clinician trying to apply them (while beset with ever more acronyms).

My regular vascular list, which the surgeon routinely describes as "the highlight of your week", recently offered a case which highlighted another potential risk index.

The patient in question was a 75-year-old man, booked for a **B**elow-knee amputation.

The surgeon was reassuring: "But don't worry—he breezed through Dr **B**loggs' anaesthetic two days ago", he said (which was '**B**ollocks', according to polite independent witnesses).

The patient's **B**MI was 38 which was, at least, greater than the **W**hite cell count of 30, which was greater than the **A**lbumin (28 g/dl), which was greater than the **R**enal function (eGFR 26 ml/minute), all of which were greater than the **E**jection fraction (25%).

Thus I offer '**Quadruple B-WARE**', a new acronym for others enjoying "the highlight of their week". I hope it may help in the daily struggle to gauge how much reassurance to draw from our surgical benefactors about the health of their patients.

Dr James Nielsen
Sydney, New South Wales

HAVE YOUR SAY

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 Jiyan Mustafa at editor@asa.org.au to submit your letter.

REGULAR | POINT OF VIEW

REGULAR: POINT OF VIEW

MEDICAL SERVICES FOR ADF PERSONNEL

DR RICHARD GRUTZNER, ASA PRESIDENT

The entire medical profession will no doubt be aware of the changes proposed to the funding of the healthcare of Australian Defence Force (ADF) personnel. In the view of representative organisations such as the ASA, the model proposed by Medibank Health Solutions (MHS) is flawed on a number of levels.

The agreement one must sign in order to become a "preferred provider" has been modified after groups such as the AMA and ASA pointed out its numerous flaws, but a number of concerns still remain. The issue of patient confidentiality has been dealt with to some extent, but MHS retains the right to vary the terms and conditions from time to time, as they see fit.

There is also the issue of the immediate 27% reduction in anaesthetists' fees (proposed RVG unit value $55, current value $75). It is not up to the medical profession to solve the Government's budgetary problems by accepting significant cuts to fees. We owe this and previous governments (from all sides of politics) nothing in this regard. The profession has already shown remarkable restraint over several decades, in the face of totally inadequate Medicare rebates, and inadequate annual indexation of both Medicare and private insurance rebates, despite the strength of the economy over most of these years. (There is also no guarantee of indexation included in the MHS agreement). We may well compassionately discount our fees to patients who are paying Medicare levies and private insurance premiums and are in need of our help. However, this history of generosity cannot continue to be taken advantage of by governments or private enterprise. Where a patient's costs are fully covered by an employer (e.g. ADF personnel) or an employer's insurer (e.g. Workers' Compensation), the AMA fee is nothing more than a fair and reasonable charge.

MHS and the Department of Defence continue to reassure everyone that healthcare services of excellent quality will continue to be provided. How this can be stated when it appears only (approximately) 10% of the medical profession has entered into the agreement is perplexing. Clearly, there is a significant risk that our serving ADF personnel, who deserve the full support of all Australians, will have their healthcare put at risk by this unsatisfactory proposal.

DR RODERICK BAIN, MEDICAL ADVISER, RSL EXECUTIVE

The specialist medical professions play a very significant role in the physical wellbeing of all Australian Defence Force personnel. Without this high standard of healthcare and its availability the three services cannot be deployed in peace time or in conflict in the sustainable manner expected of it by the people of this nation. Nor are they able to train and execute the necessary care to obtain the required above-average standard of results.

The overall exercise being currently undertaken by Joint Health Command at Defence is both necessary and overdue to improve both their records of individuals and their statistical health data and at the same time retain a cost benefit for Defence with the provision of specialist health services. These services very obviously include anaesthetists' expertise in many areas in the civilian world, as well as in aviation medicine and underwater/hyperbaric medicine.

However, as a specialist anaesthetist I believe I'm contracted to my patient and not to a further third party regardless of who is paying the account. To have the latter arbitrarily decide what my remuneration and responsibilities will be is unreasonable, unless the amount and professionalism are comparable to the assessable civilian equivalent.

The origins of the pay scale challenges now at the heart of renewing Defence Force contracts lie with one specific specialist group. They were not approached initially to renegotiate an agreed fee with Defence. The work was instead subcontracted out privately and an approach adopted whereby every specialist conformed within specific unconsulted boundaries and this has resulted in much subsequent disharmony.

The MHS subcontractor must continue to consult with the individual specialist societies to gain trust and mutually agreeable arrangements. MHS will also need to visit military bases and explain their procedures more clearly to the service staff involved, particularly with respect to aspects of legal liability and medical in confidence. In addition, Joint Health Command will require extensive support with personnel and expertise from the Department of Defence in order to bed down their own efficiency programs and be well prepared for the changes in train across all three services following our draw down from Afghanistan.

DR IAN BOYD, NATIONAL MEDICAL DIRECTOR, MEDIBANK HEALTH SOLUTIONS

There has been a great deal of public commentary regarding MHS' Garrison Health Service, yet much of it has misconstrued the nature and purpose of the contract and has, in some cases, ignored the facts. Some of the more common myths include:

Nature and purpose of the contract

Defence and MHS are committed to timely, high-quality and cost-effective healthcare services for all Defence personnel. Under the new arrangement there are no changes to entitlements for Defence personnel and MHS is not involved in determining their treatment—this remains the role of on-base medical officers. MHS' role is service administration and coordination—to contract with providers, book appointments and pay providers.

Consultation

While MHS was initially required to establish the provider fee structure in accordance with the tender process, it has subsequently held discussions with the ASA, other peak bodies and providers to restructure fees paid to anaesthetists. All contracted and non-contracted anaesthetists will be receiving communication confirming the 1 May 2013 transition to the single value RVG unit based model.

In addition, and based on feedback from medical peak bodies, clarification will also be provided regarding data privacy. Providers are only required to supply patient health information to Defence with patient consent.

Fees

Prior to MHS commencing the contract, fees charged to Defence by anaesthetists and other specialists were highly variable—ranging from being regularly below AMA recommended rates and often significantly above AMA rates.

Access to quality medical care is essential for Defence personnel. However, the Commonwealth on behalf of tax payers requires price certainty and effective governance when purchasing health services. Other payors standardise the rates that they pay medical specialists and Defence should be no exception.

MHS has worked with Defence to convert the original MHS anaesthetics pricing schedule to the RVG unit based model. The unit fee payable by MHS of $55.00 is materially above that of most other public and private payors. This is confirmed by the ASA's own analysis in November 2012*.

SENATOR THE HON DAVID JOHNSTON, SHADOW MINISTER FOR DEFENCE

It is my strong belief that Defence personnel, many of whom have put their lives on the line in Afghanistan and Iraq, have a fundamental right to timely access to the best medical treatment in Australia.

Because of the unique nature of service, the men and women of the military need to have ready access to the very best available health professionals so they can get back to the job of serving and protecting the nation.

I do not oppose the principal of reforming the health delivery service model to ADF personnel, but I am suspicious of this Government's motives.

Since MHS won the contract for health services to Defence, I have been contacted by countless medical specialists and their industry bodies telling me the some of the best doctors in Australia were no longer going to treat Defence patients because of the reduced rates offered.

When you are offering doctors significantly less money to treat Defence personnel than their private patients then it is nothing more than a cost-saving exercise for the Defence budget, the outcomes of which are both predictable and foreseeable.

That is to say, senior experienced medical professionals will understandably manage their valuable time to the exclusion of Defence patients.

Specialists in areas where there is a large contingent of Defence personnel such as Canberra, Townsville and Darwin that have historically treated Defence patients under the old system are now no longer prepared to do so and who could blame them.

I raised this issue in the Senate last October and was advised by Defence officials that it was up to MHS what rates they offered as it was now 'a commercial arrangement' and that deeply troubles me. Wouldn't that raise a red flag if you were the Minister? He is once again asleep at the wheel.

My office is already fielding calls from personnel sharing their experiences of trying to see a specialist and being rightly angry with the difficulties in obtaining the level of service they should always be entitled to.

* President's note: The ASA made no "analysis" of payors' rebates in November 2012. It simply provided members with publicly available information.

FEATURE

HW2025 AND THE FUTURE ANAESTHESIA WORKFORCE

The ASA has had an ongoing interest in the anaesthesia workforce for many years, writes ASA Professional Issues Advisory Committee Chair Dr James Bradley. Its regular member surveys have sought to explore the views of members in relation to hours of practice, workforce shortages (or oversupply), plans for retirement and other matters.

More recently, the state and federal governments and their agencies have addressed workforce from their own particular perspectives.

HW2025

Late 2012 saw the publication of the third in a series of volumes from Health Workforce Australia (HWA) titled 'The Medical Specialty Workforce to 2025'. These volumes, including two earlier reports which addressed the nursing and general medical workforce, constitute the report known as 'Health Workforce 2025' (HW2025). Volume 3 can be viewed at www.hwa.gov.au/sites/uploads/HW2025_V3_FinalReport20121109.pdf.

Health Workforce is a 'red hot' issue in the political arena at present, and the following article seeks to record the deliberations of the Society as it deals with 'workforce' on behalf of its members.

HWA states that HW2025 provides national workforce projections that will define the number of trainees required for the nursing and medical workforce. The report has been endorsed by the state and territory health ministers through the Standing Council on Health. The report identifies a range of policy considerations covering workforce reform, training, immigration and geographical distribution. It further states that the health ministers will "work together to ensure a more sustainable health workforce to meet the future needs of the Australian community" and that it is planned to "seek National agreement on the actions identified in HW2025".

The ASA, then, is in no doubt that HW2025 is the template that will be used to determine the structure of the future medical workforce.

Prior to HW2025, the ASA was involved in a study conducted by the National Health Workforce Taskforce which produced a draft report that was never finalised. Much of its information was subsumed by HW2025. Further, some years earlier, the ASA and ANZCA had co-funded a study which was interpreted quite differently in relation to the predicted workforce outcomes. The view of the College was that there could be a shortage of up to 2287 anaesthetists by 2027, a claim not at all supported by the HW2025 projections. The ASA felt that there was insufficient evidence to make, let alone support, this assertion.

HW2025, Volume 3, runs to 416 pages. Following an executive summary, an introduction leads to HWA's assessment of the medical specialty workforce, summarises the findings of the specialty workforce analyses, addresses the potential impacts of changes to how medical specialist services might be delivered ("service and workforce reforms" and "changes to immigration") and then addresses "imbalances" in the medical specialty workforce closing with a section on the "need for a coordinated training pathway". Pages 65–389 address each medical specialty. Anaesthesia is addressed in pages 69–76.

CURRENT FINDINGS

HW2025 finds that the overall supply of medical specialists is increasing towards a balance of supply and demand by 2025. Imbalances are said to currently exist and are projected to continue. These include a geographic maldistribution of the workforce in general practice and some specialties, with shortages in some regional and rural areas and oversupply in some metropolitan areas, with a maldistribution across medical specialties and imbalances between generalists and specialists/subspecialists. An ongoing reliance on overseas trained doctors to meet these deficiencies is predicted.

A number of specialties are identified as being in shortage: general practice, general medicine, medical oncology, psychiatry and radiation oncology.

Further specialties identified as having difficulties in filling positions, especially in non-urban areas, are: anaesthesia, dermatology, emergency medicine, obstetrics and gynaecology, ophthalmology, pathology, gerontology, nephrology, paediatrics, radiology and general surgery.

Anaesthesia is stated to have a replacement rate of minimal concern, an average practitioner age of modest concern, a dependence on overseas trained specialists and a training duration of some concern (page 34). No "significant" concerns were raised about the "workforce dynamics" of anaesthesia.

HW2025 then proposes that there are "three levers" which can be used to address the "workforce imbalances"

Specialties that are identified as having a sufficient current workforce include: intensive care, cardiology, gastroenterology, neurology, orthopaedics, ear, nose and throat, plastic surgery and some other surgical subspecialties including cardiothoracic surgery, neurosurgery, urology and vascular surgery.

HW2025 then proposes that there are "three levers" which can be used to address the "workforce imbalances" of "geographic distribution" across specialties and between generalists, specialist and subspecialists. The levers are training, funding and bonding (page 63). These "three levers" are summarised in the box below.

The next steps proposed by HW2025 are (pages 63–64):

- The establishment of a National Medical Training Advisory Network (NMTAM) which will advise on improved coordination of medical training to properly address the "current imbalances".
- The adoption of a "minimum efficient pathway" for clinical training at both entry and postgraduate levels.
- The development of National Training Plans to improve alignment between system requirements and training processes.
- An analysis of government and non-government industrial arrangements to identify barriers to workforce reform.
- An analysis of legislation to identify barriers to the ability of health professionals to work to their "full scope of practice".
- A review of the goal of "national self-sufficiency" in relation to the health workforce.
- A focus on the "national implementation of targeted workforce reform" once reform models are developed.

HWA'S DISCLAIMER

Noting the earlier proposals, HWA cautions that its projections rely on assumptions about future conditions and on the data used to calculate the projections. It states that workforce projections "become less accurate as the period of time over which they apply increases"; these inaccuracies being due to errors in projection methodology, changes in the nature of service delivery, changes in data and the assumptions used in the projections.

HWA summarises "the workforce projections are therefore not predictions of what will happen over the period to 2025—each provides an estimate of the likely outcome given a set of conditions on which it is based".

REFORMING THE MEDICAL SPECIALTY WORKFORCE

"Reform" to achieve "a sustainable affordable workforce" with "service and workforce reform" is then canvassed. The Medical Training Pathway is stated to be poorly coordinated with no mechanism to coordinate Commonwealth and state/territory training efforts. This is seen to contribute to the maldistribution between specialties, a lengthening of the time required to train specialists, a "lost opportunity" to better target distribution and the balance between generalists and specialists, "uncertainty" by graduates in relation to the specialty they might enter,

HW2025'S THREE LEVERS

1. **Training:** Suggests 'geographic outcomes' for specialties could be supported at all levels of the training system.
2. **Funding:** Includes funding support to attract and retain workforce in underserviced areas.
3. **Bonding:** Suggests the 'strengthening' of 'bonding' arrangements.

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FEATURE

and wastage in training in fields which may not match community needs.

It then proposes that a workforce that "sustainably and efficiently" meets community needs will require the addressing of:

- Barriers to reform (the report identifies regulatory frameworks, industrial agreements, funding arrangements and the institutional and professional cultures).
- Identified imbalances in the workforce.
- Poor coordination of training pathways (the report says there is no tangible mechanism to coordinate the training efforts of the states and territories—which are responsible for funding virtually all specialty training excluding general practice—with national workforce needs [numbers, distribution and generalist/specialist mix]).

The jurisdictions generally agreed that there were sufficient trainees to meet service demands. The distribution of the workforce was said to be the primary concern

The report states that the existing workforce position was determined "from expert opinion from jurisdictions, private employers and the profession, and an analysis of current vacancies and waiting times". While the ASA had earlier dealings with HWA in relation to its earlier workforce studies (which fed into this report), it was not consulted in relation to the draft version of Volume 3, although ANZCA was.

The report then states that to achieve its aims "a clear set of actions is required". These will "require national coordination and involve governments, professional bodies, colleges, regulatory training bodies, and the higher education system and training providers". The actions are to be a "targeted program" to replace unaccredited/"service" registrar posts (said to be extensively filled by international medical graduates), foreshadowing accredited posts filled by local graduates (including international medical students).

WORKFORCE PROJECTIONS

"Workforce projections" are a key component of the report and are obviously of great interest to all sections of the medical specialist workforce. The workforce projections were developed using five "planning scenarios":

- "Comparison scenario": current policy settings remain fixed—a 'no change' scenario.
- "Service and workforce reform scenario": demand for a particular specialty is reduced through reforms involving changed skill mix or technological or other reform. A rate of 1.4% per annum, with the report providing real world examples of reforms, could support this scenario.
- "Registrar work value scenario": the work contribution of senior registrars is included to indicate the relative reliance of different specialties on this component of the workforce.
- "Medium self-sufficiency scenario": the relative reliance of specialties on international medical graduates is modelled assuming a reduction in immigration of 50% by 2025.
- "Capped working hours": shows the impact of a reduction in maximum working hours to 50 hours per week.

The introductory table in the report displays the net difference between the projected number of specialists and the "expressed demand" for specialists for each medical specialty. A table summarising HW2025's projections for the anaesthesia workforce is below.

HWA'S ASSESSMENT OF THE ANAESTHESIA WORKFORCE

Pages 68–76 address the existing and projected anaesthesia workforce. In regards to the findings of the report in relation to the 2009 anaesthesia workforce supply, the specialty is "orange flagged" (page 30); this description reflecting "some perceived difficultly filling positions, either through maldistribution or insufficient workforce".

The "expert opinions" that determine this classification were described as "jurisdictional" and "the medical college". In some specialties, opinion was sought from "private employers" but this did not occur in anaesthesia and, as mentioned elsewhere, the view of the ASA was not sought prior to release of the report. As a consequence, it can be asserted that the views of the private sector in anaesthesia were not specifically canvassed.

The jurisdictions generally agreed that there were sufficient trainees to meet service demands. The distribution of the workforce was said to be the primary concern in that there were problems recruiting specialists in regional areas, and that regional areas were often reliant on private sector specialists and specialist international medical graduates; a secondary concern noted declining numbers of anaesthetists providing anaesthetic services to children, impacting service delivery and hospitals not dedicated to children (i.e. regional hospitals). The medical college (i.e. ANZCA) is reported as highlighting a number of considerations that may influence the interpretation of the workforce projections, including a trend for early retirement, an expanded training capacity through the greater availability of private sector training places and an effect of increasing in the training time through a limitation of access to the primary examination in that it would be restricted to those on accredited training places.

Summary projections of HW2025 for the anaesthesia workforce through to 2025

Scenario	Summary projections
No change	Net surplus of 130 in a workforce of 5460
Service and workforce reform	Net surplus of 861 in a workforce of 5460
Registrar work value	Net surplus of 316 in a workforce of 5460
Medium self-sufficiency	Net deficit of 316 in a workforce of 5259
Capped working hours	Net surplus of 85 in a workforce of 5415

It is apparent on considering the report that the actual outcome for the specialist anaesthesia workforce will depend on the interplay of any or all of these scenarios, and perhaps on scenarios that have not been considered or even identified. Having said that, it is apparent that if nothing is done between now and 2025, HW2025 projects that the specialist anaesthesia workforce will be adequate except for a rural maldistribution. The two reform scenarios that would generate an effective increase in the specialist anaesthesia workforce are "service and workforce reform" and the inclusion of the work contribution of senior registrars (which could be seen as a "workforce reform"). Further, noting the various provisos and disclaimers, the consequence could be a specialist anaesthesia workforce which is 20% larger than the "expressed demand".

WHERE TO NOW FOR THE ASA?

The ASA's Professional Issues Advisory Committee is working on the premise that HW2025 sets the ground rules for dialogue with government and its agencies in the area of anaesthesia workforce for the next few years. HWA will use information obtained from the Australian Health Practitioner Regulation Agency through the annual medical registration and reregistration process to update its information and predictions in relation to the anaesthesia workforce. The ASA will likewise use this information, and it is unlikely to be of benefit to burden members by revisiting this information in future ASA surveys. What ASA surveys can do is explore qualitative and quantitative aspects that the Australian Health Practitioner Regulation Agency is unable to discover. To this end members were surveyed early this year, following on from the two e-surveys conducted in 2012. A high response rate to ASA surveys underwrites our credibility in attempting to influence future initiatives.

CONCLUSION

The ASA will promote its views on the workforce projection results and advise also on the issues raised regarding the specialty by HW2025, with its position reflecting the views of the membership. The areas for discussion include (perhaps in order of importance):

- The need for input to HWA by employers as well as the jurisdictions and medical colleges, as there was with other specialties.
- Whether there is an insufficiency in the anaesthesia workforce beyond rural and remote areas or in jurisdictions where there are funding and/or industrial aspects (i.e. the distribution of the anaesthesia workforce.
- The capacity for training in the private sector and whether it can have any significant effect on the future workforce.
- "Service and workforce reform".
- The "bonding" of trainees, incentives or other mechanisms used to geographically locate or relocate the specialty.
- Assertions in relation to retirement age.
- The need for overseas trained specialists in anaesthesia.
- Hours of work.

The ASA has a long-established view on the ethics of recruitment of overseas trained specialist anaesthetists and will not be commenting on the ANZCA training program except to say that it fully endorses it. The ASA will have a view on the "bonding" of trainees, "incentives" or other mechanisms used to geographically locate or relocate the specialty. It will comment on "service and workforce reform", noting that the federal government has other processes in train in relation to funding of services and how and where they might be provided (including the Independent Hospital Pricing Authority, Local Health and Hospital Networks and the National Health Performance Authority).

The ASA has long been aware that procedural services requiring anaesthesia are funded and delivered quite differently in countries that we know very well: New Zealand, Canada, the USA and UK. All systems have their strengths and weaknesses. Generally, the ASA believes that healthcare is well delivered in this country, with the exception of some known difficulties in the public system, and in rural and remote areas. The private system attracts some unfavourable comment in relation to equity in access and to non-recoverable expenses.

The ASA will promote its views on the workforce projection results and advise also on the issues raised regarding the specialty by HW2025

In noting the "common considerations for future workforce", as expressed by jurisdictions and medical colleges (HW2025, page 36), maldistribution, subspecialisation and workforce feminisation are mentioned. The ASA does not at this time see any significant consequences of the above to anaesthesia given the current workforce dynamics.

As a member-based organisation, one of the ASA's greatest concerns is that specialists should have access to professional practice that maintains their skills to the best advantage of patients and the community. An oversupply of anaesthetists will surely lead to problems as great as an undersupply. Australia does sit awkwardly between the UK and the North American countries in that Australia (like the UK) employs trainees to meet in part the workforce requirements of Medicare-funded services in public hospitals, in addition to training them to be specialists, unlike the USA and Canada, where the system is such that trainees (as opposed to Fellows) are less essential to service provision. To rephrase this, while "service and workforce reform" is often understood to mean expanding or limiting the scopes of practice of various health professionals, in anaesthesia (and in other disciplines for that matter) it might mean that more work in Australian public hospitals could be more efficiently delivered by trained specialists rather than non-specialists (i.e. trainees).

FEATURE

THIOPENTONE TIVA: TRULY INNOVATIVE OR VERY ARCHAIC?

It was with great excitement that Dr Jennifer Plummer (FANZCA) answered the call for an anaesthetist to support a Royal Hobart Hospital/University of Tasmania conjoint general surgical mission to Siem Reap, Cambodia in July 2012. This is her story.

Our Surgeon Prof Turner was in contact with the local general surgeons via email and had visited Siem Reap previously without anaesthetic support. He'd introduced laparoscopic surgical techniques and further general surgery was planned. We also had a nurse educator who undertook epidemiological research.

Cambodia's medical services were decimated in more recent times by an oppressive regime, when many educated people were executed or fled the country. Despite this horrific history, Cambodia has re-established a medical school and subspecialty training is a work in progress. Medical French is still widely used, especially amongst older physicians and nurses, but the University in Phnom Penh training is now in English.

Dr Haydn Perndt put me in touch with Dr Suzi Nou, a Cambodian anaesthetist working in Darwin. Suzi forwarded me an information pack supplied by Angkor Children's Hospital which contained lots of useful information including Medical Khmer phrases and suggested reading materials on Cambodian history and culture. It was clear that the Children's Hospital had a much more organised approach to the overseas aid worker than the Provincial Hospital. In addition, once on the ground, Suzi gave me tips to counter my anxiety about providing an anaesthetic in an austere environment.

My first day, I admit to being completely horrified. The Provincial Hospital has no working anaesthetic machines and there are no volatile agents available. I managed to find a halothane vapouriser (but no halothane) and an empty isoflurane container (but no vapouriser.) So anaesthesia consisted of bolus thiopentone.

The anaesthetic technicians spoke Khmer and just a few words of English, so communication was interesting! Observation and miming played a huge role in teaching (e.g. how to use a bougie instead of going straight to tracheostomy in the case of failed intubation). I found that Laryngeal Mask Airways were not used at all. In future visits, Laryngeal Mask Airway use for the failed airway could be a focus, but I didn't want to overwhelm them and wanted the changes suggested to be ones they might actually continue with.

The anaesthetic technicians were very grateful to receive the Lifebox pulse oximeter donated by the Royal Hobart Hospital, but it took a while to get them to understand that it was for them to keep and use.

Patients were induced with thiopentone—a standard dose of 250 or 500 mg depending on wellness. All patients received suxamethonium at induction, but cricoid was not used, and then vecuronium for maintenance relaxation. Maintenance anaesthesia was limited to bolus dose every 15 minutes or whenever the patient moved and tried to leap off the table—whichever came first. Blood pressure was never an issue, although it was invariably high (probably due to awareness). By lunchtime on the first day I was wondering what I had gotten into.

In terms of analgesics, fentanyl is the mainstay—they have morphine and ketamine, although both are limited and expensive. Tramadol, paracetamol and diclofenac were on the ward, although not widely used. There were no local anaesthetics except for bupivicaine (heavy) for spinals. Appendicectomy was routinely performed under spinal with 4 ml of 0.5% bupivicaine as the standard dose given. Adjuvants for spinals aren't used and despite the high dose they often wore off towards the end of the surgery. I was told it was due to the local being out of date or just within.

I managed to find a French syringe pump that I could get to work and I trialled a low dose infusion of thiopentone for a lap chole instead of bolus thiopentone. As the case was short the infusion didn't seem to prolong the wake-up phase and worked well. Dosing was anyone's guess. There is no literature to support the use of thiopentone in this fashion. I started with the upper end of the range for intensive care unit status epilepticus protocol and titrated to response.

I had one case where the patient presented with propofol for her operation. This was the mother-in-law of one of the hospital doctors who could afford the expensive propofol which was otherwise never used. She came with four bottles of 20 ml propofol for her lap chole operation! Amazingly, we managed to make it last the distance.

As a general rule, patients are charged for all consumables and the technicians have to keep a record so that the patient is billed for the correct items. It was quite confronting to witness patients who needed emergency surgery and couldn't afford it, so made the decision not to pursue treatment.

Another patient had significant complications from a previous laparoscopic procedure prior to our arrival. She continued to have ongoing bile leak and peritonitis. A five-hour laparotomy was performed in order to try to fix her bile duct and a Roux-en-Y anastomosis was performed. We kept her asleep with a low dose infusion of thiopentone after an initial induction bolus. It was hard to know how to titrate the infusion to prevent the prolonged duration of action of the thiopentone. Infusion kinetics clearly state that accumulation is a problem, but how much to give and what to give was very unclear to me. As a result her recovery was very prolonged. She didn't wake for eight hours and was ventilated in recovery post procedure. They have the facility to do this and the staff to do so but no formal intensive care unit.

At times, the technicians shook their heads at my 'strange' ideas. Pre-oxygenation with a facemask rather than nasal prongs for rapid sequence was a novel idea for them. Oxygen is a precious resource and the cylinder ran out during theatre on at least one occasion, resulting in a mad dash for a concentrator to fill the void while a new cylinder was found.

Laparotomy was routinely performed on 200 µg of fentanyl with only paracetamol and tramadol postop. The logistics and infrastructure just couldn't support many of the analgesia/anaesthesia options that we take for granted (such as epidural and other peripheral nerve catheters). Having said this, the patients complain very little about anything—they seem to have an altered experience of pain. They mostly appeared grateful to be alive and their outlook was entirely positive.

I think this is an area we can improve in the future, but I had to be reminded that the cost to the patient should be considered. Our multi-modal ideas are expensive, and we would need to ask the patient whether they would prefer to experience pain or pay for more analgesia. You might be surprised by the responses. When the average income is less than US$3 a day, the cost of medicine is significant. I believe all people have a right to analgesia and anaesthesia, but places in the developing world have additional constraints on what is achievable given the limited resources and finances.

I'd really like to be able to say that we made a huge difference, but I'm not sure I can. I think we made a difference to the experience of the patients we treated and hopefully we added to the experience and knowledge of the local health professionals. I know we have a working list of things to focus on for the future. I'd like to believe that in the near future access to safe surgery and anaesthesia will be available to all Cambodian people and not just those who can afford it.

ADDENDUM

We returned in January 2013 to find that a young, enthusiastic Khmer doctor anaesthetist had joined the ranks. Anaesthesia remains much the same, but I have hope that small changes and improvements will be made by Dr Kimhean. Although young and inexperienced, he is very keen to seek advice, improve his skills and teach the technicians some newer ideas. As I said to him: "one little step at a time".

For a full account of Dr Plummer's experiences as well as accounts from other surgeons and medical students who have visited Siem Reap, please visit the University of Tasmania website: http://bit.ly/YemppO.

FEATURE

EMERGING PATTERNS IN SUBSTANCE ABUSE

Substance abuse has plagued medical practice since doctors began using neurologically active substances. Here, Dr Robert Fry (FANZCA) discusses substance abuse by medical practitioners and the patterns that have emerged.

It can be defined as the overindulgence in or dependence on a drug or other chemical, leading to effects that are detrimental to the individual's physical and mental health or to the welfare of others. The step between abuse and addiction relates to compulsion: in addiction, control of drug use is lost and it becomes the most important activity in that doctor's life.

The study of abuse and addiction is an inexact science and incidence remains uncertain. It has been estimated that about 14% of the approximately 800,000 physicians in the USA abuse substances including alcohol; about 112,000 doctors[1]. Historically, anaesthetists have been over-represented in substance abuse statistics, with anaesthesia residents making up almost 34% of those in treatment programs in the late 1980s[2].

There is no evidence that Australasian anaesthetists have similar figures for substance abuse, but anaesthetists are three times more likely to be in treatment for abuse than surgeons. The apparent over-representation is possibly because major opioids have frequently been the 'drug of choice' for anaesthetists and abuse of these drugs usually requires admission to treatment facilities. Heightened awareness of the problem and self-regulation are also features of our profession.

The most recent Australian incidence estimation was 1.17/1000 consultant anaesthetist years of observation (1.37/1000 for registrars) or one anaesthetist every 20 years in a department with 50 anaesthetists[3].

Most drugs of abuse are chosen by anaesthetists because of familiarity and availability. Doctors who abuse drugs can be those who possess an ill-conceived sense of security or confidence that they can successfully manage their drug use[4].

Historically, addicted physicians were accepted by society until the 1920s. Horace Wells, the pioneer of nitrous oxide anaesthesia, abused chloroform and died under its influence; Crawford Long openly used ether recreationally; and early regionalists Halsted and Hall developed opium addictions while perfecting regional blocks. In general, anaesthetic agents of abuse have followed their development and introduction into practice.

Despite the ubiquitous nature of alcohol abuse, which may take years to identify and which is particularly prevalent in older anaesthetists, opioids have traditionally been the drugs of choice. Ninety-four percent of physicians reporting fentanyl as their drug of abuse were anaesthetists or surgeons[5]. Cocaine and benzodiazepines are used less commonly by anaesthetists, but are usually chosen for their easy use—via transnasal, sublingual, oral or rectal routes.

As opiates became more carefully controlled, ketamine emerged as a drug of choice for anaesthetists due to its ease of access, rapid onset and offset and the short time frame available for identification through drug testing[6].

Propofol use escalated early this century for similar reasons and because of its lack of side-effects. Its narrow safety margin makes it a very dangerous agent and mortality rates of up to 40% are reported. Like most drugs of abuse dosage escalation is common, with some individuals taking up to four grams per day while continuing to work[7,8].

Inhalational agent abuse has become popular once again with the introduction of sevoflurane, a relatively uncontrolled medication; its use has one of the highest mortality rates recorded, especially amongst trainees. It is also associated with the highest failure rate for rehabilitation and thus failure to successfully re-enter anaesthesia as a career[9].

Substance abuse is a chronic illness with a genetic predisposition; it is often associated with childhood problems and mental health instability. The treatment compliance for asthma or hypertension is about 30% and substance abuse is no different. Addicted colleagues need to be monitored and treated for the duration of their lives if they wish to re-enter anaesthesia.

The highest risk of drug-related death occurs within the first five years of leaving medical school. Relapse is 2.3 times more common after treatment if there is a family history of abuse, and 13 times more likely with a concurrent psychiatric diagnosis and a previous history of substance abuse[10]. In general, doctors have better outcomes following substance abuse than other middle class patients, although only 20–45% of those returning to anaesthesia remained in the profession in the long-term[3,11].

Regular drug testing is now commonplace within the mining and construction industries (as a safety procedure before workers enter the workplace and commence work), resulting in improved accident rates[12]. Similar random drug testing within the medical profession has been recently suggested to optimise patient safety[5]. Cost constraints and the complexity of testing for some of the commonly used substances make this an unlikely scenario, but an extremely robust and rigorous national system for physician rehabilitation and care would be essential prior to its introduction.

There is a recognised lack of addiction specialists in Australasia, particularly those with a specific knowledge of anaesthesia-related substance abuse. This problem is compounded by the general lack of valid data available. The incidence, changing pattern of substance abuse and outcome statistics for anaesthetists in Australasia is at best completely inaccurate[13].

A confidential de-identified database has previously been suggested, as it would be an inexpensive method of monitoring this information more accurately, but the question of who would hold this database is an important one.

In the meantime, we need to improve our vigilance and earlier detection, and develop a consistent program for the treatment of abuse.

REFERENCES

1 Bright RP, Krahn L. Impaired physicians: how to recognize, when to report, and where to refer. Curr Psychiatry 2010; 9:11-20.
2 Bryson EO, Silverstein JH. Addiction and substance abuse in anesthesiology. Anesthesiology 2008; 109:905-917.
3 Fry R. Substance abuse by anaesthetists in Australia and New Zealand. Anaesth Intensive Care 2005; 33:248-255.
4 Bennett J, O'Donovan D. Substance misuse by doctors, nurses and other healthcare workers. Curr Opin Psychiatry 2001; 14:159-199.
5 Garcia-Guasch R, Roigé J, Padrós J. Substance abuse in anesthetists. Curr Opin Anaesthesiol 2012; 25:204-208.
6 Moore M, Bostwich J. Ketamine dependence in anesthesia providers. Psychosomatics 1999; 40:356-359.
7 Wischmeyer P, Johnson B, Wilson J, Dingmann C, Bachman H, Roller E et al. A survey of propofol abuse in academic anesthesia programs. Anesth Analg 2007; 105:1066-1071.
8 Bonnet U, Scherbaum N. Craving dominates propofol addiction of an affected physician. J Psychoactive Drugs 2012; 44:186-190.
9 Wilson J, Kiselanova N, Stevens Q, Lutz J, Mandler T, Tran Z et al. A survey of inhalational anaesthetic abuse in anaesthesia training programmes. Anaesthesia 2008: 63:616-620.
10 Domino K, Hornbein T, Polissa NL, Renner G, Johnson J, Alberti S et al. Risk factors for relapse in health care professionals with substance use disorders. JAMA 2005; 293:1453-1460.
11 Collins B, McAllister M, Jensen M, Gooden T. Chemical dependency treatment outcomes of residents in anaesthesiology: results of a survey. Anesth Analg 2005; 101:1457-1462.
12 Gerber JK, Yacoubian GS. An assessment of drug testing within the construction industry. J Drug Educ 2002; 32:53-68.
13 Anaesthesia Continuing Education Coordinating Committee. Welfare of Anaesthetists Special Interest Group Resource Document 20. From http://www.acecc.org.au/Welfare.aspx. Accessed January 2013.

FEATURE

WELLNESS: A PROFESSIONAL OBLIGATION

Anaesthetists make critical decisions when patients are at some of the most vulnerable times in their lives, writes Dr Marion Andrew (FANZCA).

This is a huge part of the anaesthetist's role and patients, professional bodies and medical indemnity companies expect that we do this and expect us to be fit to make those decisions. But do we take this responsibility as seriously as we should?

The ASA and the Medical Board of Australia (MBA) endorse wellness as a professional goal. In the MBA's *Good Medical Practice: A Code of Conduct for Doctors in Australia* there is "the requirement for self-reflection and self-awareness of our relationships with patients and colleagues, and our own health and wellbeing"[1]. This clearly implies a professional duty to effective self-management and personal wellness.

In 2006, the World Health Organization defined wellness as "an optimal state of health of individuals and groups with two focal concerns—the realization of the fullest potential of an individual physically, psychologically, socially, spiritually and economically and the fulfillment of roles and expectations—in family, community, place of worship, workplace and other settings"[2].

WHAT IS THE REALITY?

There is an expectation that doctors are a group with specialist healthcare knowledge, therefore will be more than capable of looking after their own health needs. However, current evidence suggests that doctors engage in skillful denial, deflection and minimisation of symptoms[3]. With themselves as the expert, many self-investigate, diagnose and medicate.

A Doctors' Health Advisory Service study found that one in four doctors neglected a condition warranting medical attention. A 2007 survey of South Australian doctors, triggered by a series of suicides, unexpected departures from clinical practice and the appearance of "ill doctors" before the South Australian Medical Board for unprofessional conduct, found that 40% lacked their own general practitioner and 25% identified multiple barriers to seeing a doctor[4]. Major barriers included confidentiality and fear of notification; many admitted to self-investigation, diagnosis and treatment.

Mental health issues are frequently accompanied by a fear of admitting such vulnerability. Doctors accessing the Doctors' Health Advisory Service[5] do so mostly in relation to stress, mental illness, drug and alcohol problems and personal and financial difficulties.

When individuals become isolated or marginalised in their peer groups or experience interpersonal conflict in private or personal life, significant stress and distress can emerge and manifest in the workplace as loss of motivation, disengagement, disruptive behaviour and self-harm.

Sadly, doctors have the highest rates of suicide of any profession, with female doctors 146% more likely to commit suicide than other females[6]. Suicide in anaesthetists is higher than other specialties. Less extreme solutions to mental distress and depression include abuse of alcohol and drugs.

The practice of anaesthesia inevitably contains periods of stress due to high workload, exposure to acute events and death and pressure to perform. McDonnells' Mental Health of Anaesthetists survey 2012 found that 25% consulted their general practitioner for mental health issues; 50% of those were diagnosed with mental illness and 15% reported suicidal ideation[7].

FINDING SOLUTIONS

The extent of the problem has highlighted the need for welfare support and resources and for education in personal wellness and self-management.

In recognition of the problems of maintaining wellness in doctors, external doctors' health programs began in 1982, when the Doctors' Health Advisory Service was launched, providing a 24-hour helpline in Australia and New Zealand. In 2011, South Australia launched a doctors' health program (Doctors' Health SA) which operates dedicated weeknight and weekend general practitioner clinics and pursues research in doctors' health.

The Welfare of Anaesthetists Special Interest Group (SIG) works to educate anaesthetists in wellness, encouraging care of personal and psychological health, fostering openness and providing valuable guidelines and resources[8].

The recent evidence of the vulnerability of trainees to stress, illness and suicide has initiated the establishment of state-based trainee welfare support systems in Western Australia, South Australia and New Zealand. The system offers an 'open door' to finding confidential, unbiased support in seeking solutions and healthcare resources.

Much of our social interaction and friendships develop at work and evidence of the significance of good social interaction in improving performance is emerging[9]. Negative behaviours in a social or work context often flag colleagues in need of non-judgemental support and guidance. Listening and looking out for colleagues is the frontline of peer support.

SELF-AWARENESS AND SELF-REFLECTION ON RELATIONSHIPS WITH PATIENTS AND COLLEAGUES

The Welfare of Anaesthetists SIG strongly endorses wellness by providing continuing medical education activities, which allow anaesthetists to focus on lifestyle, mental health, relationships, stress management and personal development. Such education harnesses input from life and leadership coaches, pilots, psychologists and financial planners. Mindfulness training offers skills in focusing attention purposefully, and accepting the present moment as a worthwhile place to be[10]. A stressful, busy life often results in sacrificing good diet, exercise, sleep and personal interests. Awareness of the importance of these simple measures is worthwhile, as they underpin optimal functioning, lift our spirits and motivate us.

In complaints about doctors, poor communication is frequently a major component (indeed, it is often the cause of the complaint itself). Learning new communication skills raises self-awareness and encourages self-reflection in our dealings with others. Language is a powerful tool that we can hone to help us cooperate with others and motivate them. Skills in breaking bad news, debriefing and open disclosure can be learnt; these skills ease distress and can protect us from litigation. Operating theatres are stressful environments with high workload, time pressures, conflicting priorities and goals. How we interact with others and function under pressure is a fundamental issue in human factors training[11]. The Process Communication Model workshops and stress management sessions offer new frameworks for understanding and managing teamwork. Self-management in stressful situations is of paramount importance in a safety-critical industry.

With the impending launch of the ASA's continuing professional development system, it could be time to consider a continuing professional health system. Such a system would support self-directed, regular health checks, enhance skills in communication and self management, set personal priorities, monitor motivation and promote recreational activities.

Wellness is one of the foundation stones of our professionalism—it is the patient's right and our obligation.

REFERENCES

1 Medical Board of Australia. Good Medical Practice: A Code of conduct for Doctors in Australia. From www.medicalboard.gov.au. Accessed January 2013.
2 Smith BJ, Nutbeam D, Tang KC. WHO Health Promotion Glossary: new terms. Health Promotion International 2006; 21:340-345.
3 Clode D. The conspiracy of silence: emotional health among medical practitioners. Royal College of General Practitioners, South Melbourne 2004.
4 Gardiner M. South Australian Doctors Health Survey (2007). From www.doctorshealthsa.com.au. Accessed January 2013.
5 Doctors' Advisory Service. From www.dhas.org.au. Accessed January 2013.
6 Hawton K, Malmberg A, Simkin S. Suicide in doctors: a psychological autopsy study. J Psychosomatic Research 2004; 57:1-4.
7 McDonnell NJ, Kaye RM, Hood S, Shrivastava P, Khursandi DS. Mental health and welfare in Australian anaesthetists: results of a national survey (manuscript not yet published).
8 Anaesthesia Continuing Education Coordinating Committee. Welfare of Anaesthetists Special Interest Group Resource Documents. From http://www.acecc.org.au/page.aspx?A=2428. Accessed January 2013.
9 Khawanja MA, Chen F, Marcus N. Analysis of collaborative communication for linguistic cues of cognitive load. Hum Factors 2012; 54:518-529.
10 Baer R. Mindfulness training as a clinical intervention: a conceptual and empirical review. Clinical Psycholology: Science and Practice 2003; 2:4.
11 Bromley M. Clinical Human Factors Group UK. From www.chfg.org. Accessed January 2013.

FEATURE

THE ROLE OF THE WELFARE OFFICER

As an executive member, co-founder, and past chair of the Welfare of Anaesthetists Special Interest Group (SIG), Dr Diana C. S. Khursandi (FRCA, FANZCA) has dedicated much of her career to promoting the welfare of her fellow practitioners. Here, she discusses the role of the welfare officer.

The Welfare of Anaesthetists SIG was formed in 1995 and the current chair of the SIG is Dr Prani Shrivastava from Western Australia. One of the recommendations of the group is that each department or group of anaesthetists identify someone who is willing to act as a 'welfare officer'.

In many organisations this has occurred and in others the role has been assumed unofficially. Such persons are not appointees of the College, the ASA or the New Zealand Society of Anaesthetists.

It is extremely important that the welfare officer does not take on a duty of care to any anaesthetist, but refers him or her to an appropriate provider of the relevant professional service or suggests such referral.

Members of the SIG executive have been contacted for advice in many different situations. The founders of the SIG, myself and Dr Genevieve Goulding, have fielded phone calls on a regular basis from colleagues concerned about others. Issues range from the suicidal trainee to significant performance concerns in senior anaesthetists.

If a group or department appoints a welfare officer, that person should not hold any official role with respect to trainees and should be someone who junior staff and colleagues will feel comfortable approaching. He or she will frequently be chosen as a mentor by others. Characteristics such as a sympathetic ear, a non-judgmental attitude and a guarantee of confidentiality are paramount.

Other skills may include an interest in doctors' health, in medical education and knowledge of local resources. In public hospitals it is often appropriate to offer access to a psychologist via an employee assistance program. Psychologists are a valuable source of help to any doctor in distress. Knowledge of methods of 'de-stressing' will also be useful. Dealing with colleagues in distress or performance issues may require a team approach, with discretion and confidentiality by all members of the team being essential. Common issues which have come to our attention are briefly discussed here.

PERFORMANCE ISSUES

Welfare officers may be called upon in situations where an anaesthetist's performance has been called into question. He or she will know the importance of accurate documentation of the relevant issues and may be asked to discuss the appropriate process with those in authority in the department or group.

If the person is a trainee, then the College has a Professional Document to outline the process to be followed: TE18. If performance issues are impacting on patient safety, then the College Trainee Performance Review process may be considered and/or the trainee may be asked to cease work temporarily. The welfare officer must be aware of the existence of these processes and also be aware of the criteria for mandatory reporting to the relevant medical board or council.

Where the person is a specialist, the actions suggested are more complex and problematic, especially if the anaesthetist is exclusively in private practice. Garnering and documenting evidence must be suggested to the enquirer—often easier said than done. Evidence must be documented before any approach is made to the clinical privileges committee, the employer, or the medical board or council. Mandatory reporting conditions apply if the practice of an individual is significantly jeopardising patient safety (potential 'substantial harm') or significantly departs from standard practice.

PSYCHIATRIC ILLNESS

The welfare officer must be sensitive to the problems of others and be able to recognise (or be alerted to) those in distress. Sometimes the commencement interview raises flags that an anaesthetist may struggle in the future or is currently struggling. A sympathetic talk may bring out problems that the distressed doctor has not revealed to anyone else at work. Often the offer of a chat will have to be made a few times before the doctor will agree to it.

THE DIFFICULT CONVERSATION

It is recommended that those who seek to fill (officially or unofficially) the role of a welfare officer read *Difficult Conversations—How to Discuss what Matters Most* by Stone, Patton and Heen. As a Director of Clinical Training at my hospital, I have difficult conversations every week with my junior doctors and this book has been an enormous help to me.

CRITICAL INCIDENTS AND COMMUNICATION

Both junior and senior doctors can be involved in critical incidents; dealing with the fall-out of an adverse outcome can be very stressful, especially if litigation may result (see RD5).

Communication skills are of supreme importance to anyone who has to deal with personal and professional issues. *The Handbook of Communication in Anaesthesia and Intensive Care* is an essential read.

SUBSTANCE ABUSE

Tragically some anaesthetists feel the need to have recourse to intravenous recreational drugs— perhaps more often than we realise. Recognition of, and conducting interventions in, these cases are crucial to successful handling of such doctors. Rob Fry has written about this condition in another article in this magazine (and see RD20).

VIOLATIONS

If a welfare officer becomes aware of deliberate or serious violations of the Code of Conduct, or any criminal activity, the doctor concerned will immediately be the subject of a mandatory report to the relevant medical board or council, as well as to the head of the department or group and the employer.

CONCLUSION

Looking after ourselves and our colleagues is an essential activity in ensuring patient safety and is a responsibility which must be taken seriously.

Those whose interest is in this area should join the SIG (for instructions on how to join visit www.acecc.org.au), read the Resource Documents, and consider acting as a mentor and/or an official or unofficial welfare officer.

RECOMMENDED READING

- Welfare of Anaesthetists Special Interest Group Resource Document 3: Depression and Anxiety 2011. From http://www.acecc.org.au/Welfare.aspx.
- Welfare of Anaesthetists Special Interest Group Resource Document 5: Critical Incident Support 2011. From http://www.acecc.org.au/Welfare.aspx.
- Welfare of Anaesthetists Special Interest Group Resource Document 16: Welfare Issues in the Anaesthetic Department. From http://www.acecc.org.au/Welfare.aspx.
- Welfare of Anaesthetists Special Interest Group Resource Document 20: Substance Abuse 2011. From http://www.acecc.org.au/Welfare.aspx.
- Welfare of Anaesthetists Special Interest Group Resource Document 24: Mandatory Reporting 2011. From http://www.acecc.org.au/Welfare.aspx.
- Australian and New Zealand College of Anaesthetists Training and Educational Document 18: Policy for Assisting Trainees in Difficulty. From http://www.anzca.edu.au/resources/professional-documents/documents/training-and-educational/training-and-educational-18.html.
- Stone D, Patton B, Heen S, Fisher R. Difficult Conversations—How to Discuss What Matters Most. New York, USA: Penguin 1999.
- Cyna A, Andrew M, Tan SGM, Smith AF (eds). Handbook of Communication in Anaesthesia and Intensive Care. Melbourne, Victoria: Oxford University Press 2011.

FEATURE

DEALING WITH CATASTROPHES

According to Drs Jane McDonald (FANZCA) and Ken Harrison (FANZCA), a catastrophe in the workplace can take many forms. It may be an anaesthetic mishap causing death or injury to the patient, serious injury or sudden death of a colleague in the workplace, suicide of a coworker, an event where the victim is known to the staff, multiple trauma victims (particularly children) or coping with a large-scale disaster.

All of these can cause powerful emotional reactions in those exposed to these events. Most anaesthetists are fairly resilient, but incidents have the potential to cause symptoms of stress such as flashbacks, nightmares, difficulty sleeping, numbness, anger or depression. There may also be physical symptoms such as sweating, palpitations, tearfulness or fatigue.

It is likely that most anaesthetists will experience such events and symptoms at some stage in their career.

In most of us these natural symptoms of stress gradually decrease over the weeks after the event. Persistence of symptoms over a period of months can occur and is described as post-traumatic stress disorder.

Post-traumatic stress disorder occurs in less than 5% of people and such individuals need extra support and possibly referral for ongoing professional help. How an individual copes is a result of both environmental and genetic factors and it is important to have strategies in place to deal with events.

Critical incident stress management is a comprehensive, systematic and multi-component approach to the management of traumatic stress in personal and work settings. It provides both individual and wider strategies for implementation and is widely used in the management of emergency services personnel.

Critical incident stress management comprises strategies in three different time epochs: before, immediately after and some time after the incident.

Before the event, the general management of your own welfare is important. The Welfare of Anaesthetists Special Interest Group has produced Resource Document (RD) 1: Personal Health Strategies, which addresses issues of self-care and provides advice such as:

- Monitor your mental health regularly.
- Have a mentor, develop personal and professional networks, and avoid professional isolation.
- Recognise times of high stress, such as examinations, and plan appropriately. Diet, exercise and time for relaxation are important. Participation in activities that help to diminish stress such as hobbies or exercise plays a part. Attention should be paid to work–life balance, avoiding overwork and keeping the home front organised.
- If one area of life is causing high stress, try to minimise stress in other areas.

Identification of any underlying symptoms of background depression or anxiety is important as such issues affect your ability to respond in a crisis. Professional help should be sought when necessary.

Critical incident stress management is a comprehensive, systematic and multi-component approach to the management of traumatic stress in personal and work settings.

Some organisations provide formalised general stress management education and mental preparedness training, and this is particularly important for those involved with frontline trauma management. Groups involved in large-scale emergencies and disaster response are also trained so they can provide basic psychological care (first aid) in the aftermath of a traumatic event that may overwhelm any existing mental health response resources.

Immediately after the incident, individual crisis support needs to be provided on-scene as soon as practical. The Welfare of Anaesthetists Special Interest Group RD5: Critical Incident Support and RD11: After a Major Mishap, deal with practical steps to be put in place at the time of a catastrophe. In particular, it is important to document events accurately and soon after the event, notify the coroner if required and deal with any medicolegal issues.

The possible psychological impact of such events on the anaesthetist should be recognised. If there is a background of other stress-related problems, there is the potential for a sudden acute psychological crisis. This can place the individual at risk of self-harm. The anaesthetist should be relieved from further clinical work. Support should be provided according to individual need and counselling should be offered to all staff involved, with an 'open door' policy for those who decline. There should also be an initial defusing of the situation, followed by debriefing within 72 hours.

The third time epoch is later on, but this can vary from a few days to years. Critical incident stress debriefing should be offered to all involved in the incident, but never made compulsory. When done, it is provided by an appropriately trained individual and should occur in a timely fashion. The debriefing focuses on the impact of the event on the participants, rather than the facts of the event. It is hoped that such a debriefing will mitigate symptoms of anxiety, depression and traumatic stress symptoms later; however the evidence for its effectiveness is not conclusive.

The anaesthetist may choose to talk to a trusted colleague or mentor, or simply to a friend. Talking to someone who wasn't there means support can be provided by reflective listening. Ongoing support may need to be provided for several weeks and, where symptoms persist, referral may be required for additional professional support services.

Wider support to deal with the impact of stress needs to be provided by the workplace as well as by the family and community. It is important that there is a commitment within the organisation to provide support and manage stress.

Finally, the individual involved in the disaster may well benefit from a short break from clinical duties and the workplace until she or he has recovered from some of the emotional impact of the disaster.

A helpful mnemonic to remember is **STOW AWAY**:

- **S**TOP—whatever is happening clinically needs to be managed by someone else, for your sake and the patient's.
- **T**ALK to someone—ensure it's someone who wasn't there.
- **O**BSERVE your emotions—don't feel you 'should' be OK or you 'should' be affected; anything can and may happen and your emotions may change rapidly, but watch yourself.
- **W**RITE something down—the factual account, your own feelings etc.
- Get **AWAY**—organise something you like doing in the near future

Also be aware, that like a stowaway, you have jumped on a ship, it is going somewhere, and it may well be a bumpy ride for a while.

FEATURE

PEER REVIEW GROUPS IN PRACTICE

Drs Prani Shrivastava (FANZCA) and Tracey Tay (FANZCA) discuss the concept of peer review groups and the enhanced learning opportunities these groups can offer.

Once you become a fellow, you have fewer opportunities to learn from others. Fellows infrequently anaesthetise with colleagues present, so are rarely observed. No one prompts us to use alternative techniques or make a different decision; so how can we get feedback from our colleagues? While anaesthetists have access to a number of avenues of continuing medical education, each of these has strengths and weaknesses and appeals to individuals to varying degrees.

A possible addition to the choices available is that of peer review groups, a process introduced by the Royal Australian and New Zealand College of Psychiatry (RANZCP) to psychiatric practice in the early 1990s. It has since spread to become the most widely practised RANZCP continuing professional development activity across Australia and New Zealand.

CURRENT OPTIONS AVAILABLE TO ANAESTHETISTS

There are a variety of ways in which we learn from our colleagues including lectures, workshops, problem-based learning discussions, case presentations and reading. Retaining information from these sources can be difficult. A point relevant to your practice can be swamped by other facts.

Higher impact learning may come from medical board/council and medical defence organisation publications, morbidity and mortality meetings, the websites of the Society and College and coronial findings. These filtered sources enable us to learn indirectly from the adverse experiences of our peers. These powerful learning experiences may be condensed to a rule or paradigm (i.e. "you should always/never ...").

We've all participated in tea room conversations. Why is it that the information gleaned here can be retained and used in clinical practice, while other information is forgotten? Salient points from these discussions can be more vividly recalled than facts from a lecture or workshop. Could a colleague's flawed decision-making influence and inform our practice? Detractors might point to the risks of learning from anecdotes rather than turning to somewhat higher levels of evidence.

Most of us seek to measure our practice against others: am I out of date? Am I conservative in my practice or way out there? Our peers may be the best judges of that.

PEER REVIEW—ANOTHER OPTION IN OUR CPD TOOLKIT?

Three years after the introduction of peer review groups, psychiatrists in Australia responded that it was a tool that had value "in maintaining and improving skills, sharing ideas and methods, receiving constructive criticism and feedback, of educational benefit and an important source of professional accountability. Group participants perceived it as a professional growth forum … providing critical review of treatment, continuing education and a sense of collegiality. Boundaries of accepted practice were accepted and defined"[1].

Peer review groups offer a forum without a hierarchy—unlike departmental morbidity and mortality meetings.

Peer review in psychiatrists' practice consists of a small, self-selected group of fellows that meet at regular intervals outside work. In this confidential forum, a fellow presents a challenging case, seeking reflections and feedback from other group members. Relying on honesty and trust within the group, it offers a method to challenge our thinking and established boundaries.

Unlike a journal club, peer review group meetings are case based: a fellow's thought processes and decision-making in the management of a particular patient are reflected upon by the fellow and the group. In psychiatry, the ongoing therapeutic relationship allows the next interaction with this patient to be influenced by the group's feedback and expert opinions. As practised by psychiatrists across Australia and Ireland, highly functioning peer review groups can enhance collegiality. Both RANZCP and the College of Psychiatry in Ireland have recommendations about how to form and sustain a healthy group.

In anaesthesia, knowledge of a colleague's case may positively influence our responses when a similar situation arises in our practice. Our colleagues cannot be present during an anaesthetist–patient encounter, but can help us reflect upon and learn from the experience afterwards.

Peer review groups offer a forum without a hierarchy—unlike departmental morbidity and mortality meetings. If only peers are present, freely expressed opinions and constructive criticism may be less intimidating and less damaging to a colleague than a potentially hostile morbidity and mortality meeting.

Following an unexpected death on the operating table, a review with peers who understand the complexity our practice (e.g. anaesthesia for neonatal surgery) might defuse some tensions prior to presenting to a hierarchical audience at a morbidity and mortality meeting. This is not the same as discussing it with mates. It's not for sympathy—it's to elicit others' insights into your own practice and judgement.

The Medical Board of Australia has implemented mandatory reporting, so there is an explicit obligation for us to be practising 'within accepted standards'. In a peer review group, we could be challenged in a safe setting (as opposed to a coroner's court or a court of law). However mandatory reporting obligations remain applicable.

Many anaesthetists face isolation in their practice: e.g. the rural or solo practice anaesthetist, a manager, someone facing the media, the coroner's court or the relevant regulatory body. An established peer review group would be well-equipped to provide support in such circumstances.

For the isolated anaesthetist, it may present an opportunity to meet with colleagues, perhaps once every three months, to discuss difficult cases. International medical graduates could gain exposure to Australian practice and pick up implicit cultural cues. The group or departmental director/manager or supervisor of training might feel unburdened by attending a peer review group, and at the same time learn from other managers at other institutions.

Peer review groups offer us an opportunity to reflect on our practice, to hear frankly what others think of our practice and offer a new opportunity to learn from colleagues' cases.

REFERENCE

1 Balla M, Knothe B, Lancaster J, Prager S, Beatson J. Group peer review in psychiatry: the relationship to quality improvement and quality care. Aust N Z J Psychiatry 1996; 30:653-659.

Peer review falls under category 3, level 1 and is worth two continuing professional development points per hour. The College requires a record of the peer review group meeting to be kept so that individuals have evidence of participation. Any additional information can be found in the College's CPD Handbook, available from www.anzca.edu.au.

FEATURE

THE CHALLENGE OF RETURNING TO WORK AFTER ILLNESS

Dr Cath Purdy is a Provisional Fellow who was diagnosed with cancer in 2010. She is currently in remission and is working full-time at Auckland City Hospital. Here, Cath discusses some of the challenges she faced when returning to work.

I am writing this as a doctor who is living in remission from cancer. I was incredibly fortunate to work in an institution with a supportive clinical director, who helped me organise my time off and arranged a slow part-time return to work when I was in remission. My time off work was measured in months rather than weeks and presented me with challenges in navigating a return to work. I would like to share a little of my experience here.

In both Australia and New Zealand, the Australian Health Practitioner Regulation Agency and the Medical Council of New Zealand require, along with registration, the notification of conditions that may cause impairment. In my case I notified the Council, as I was having daily radiotherapy and weekly chemotherapy causing significant fatigue. This notification carries no sanctions and should not be seen in a negative context. It is part of our responsibility to our patients and colleagues as we leave and then reintegrate back into the workforce.

Guidelines on determining fitness to practice are available through the Medical Council of New Zealand and the Australian Health Practitioner Regulation Agency. The Australian and New Zealand College of Anaesthetists has two relevant professional standards (PS), PS49: Guidelines on the Health of Specialists and Trainees and PS50: Recommendations on Practice Re-Entry for a Specialist Anaesthetist. They provide good guidelines on the practicalities of getting back to work.

Returning to work can be daunting and getting back to 100% of your previous capacity can take time. You may be confronted with side-effects of treatment, ongoing physical disabilities, fatigue[1] and the psychological challenge of treating patients with similar illnesses to your own. A degree of emotional fragility may be normal.

I started back working for two half-days the first week, then three the next, working up to six half-days a week for six months. I would not have been ready either physically or psychologically to return to full-time work any faster. Recognising this allowed me to justify the slow return to myself; and to others who may have thought I should have returned earlier or later.

People did openly question my decision to study for exams while I was on sick leave. For me, it kept my mind active and eased my return to work. The majority of people were overwhelmingly supportive of my return to work, although some did question it.

There was only one instance where I truly questioned my own return. I was doing a preoperative assessment on a patient with terminal cancer and, when I went to see him, he was in the room where much of my treatment had occurred. I froze and couldn't go in. My colleagues were completely understanding of this feeling and arranged for another registrar to perform the assessment. I was more afraid of their opinion of what I felt was a failing than I should have been. Again, communication allowed a solution to be quickly and easily arranged.

Negotiating a gradual, initially mentored return to work will benefit the department, your patients and yourself. Part-time options and on-call duties require separate consideration. If work is overwhelming or simply physically exhausting, being in a supernumerary capacity initially allows a more flexible plan and can accommodate short notice changes. Maintaining an open dialogue with your department about your changing abilities will help match both parties' needs and expectations. Human resources departments can help with access to a broader knowledge base of the resources and supports available.

Departments will have continued to operate in your absence and while in smaller departments or private practice there may not be the same flexibility as there is in a larger group, it is important to acknowledge early that a full-time return to work may not be possible immediately. Short notice leave should be used for follow-up appointments.

Having a good exercise program, a general practitioner you trust and a psychologist are all important strategies, as are strong personal relationships with a partner, friends and family.

Being faced with an illness that may potentially impact your working career in the medium to long-term is a daunting prospect. While I diligently arranged income protection when I started as a junior house officer, I neglected to update it as I became a senior registrar. Having the added income was of huge benefit, but had it been in line with my current income there would have been less pressure financially.

Returning to work can be daunting and getting back to 100% of your previous capacity can take time.

Know what your leave allowances are and their limitations. If you choose to take out income protection insurance know what it currently covers, what your stand down period will be and what impact it would have on your current life, in comparison to when you took it out (e.g. you now may have a bigger mortgage, children etc).

In New Zealand, there are several pathways for accessing free psychology appointments, including through Employee Assistance Programs and some medical defence organisations. There should be no stigma involved in accessing this service; rather, it should be encouraged as part of a wider health strategy.

Lastly, the elusive work–life balance is never more closely examined than when confronted with personal health concerns. Having been told that "time off is great when you have the money and the health to enjoy it", I have actively sought to achieve a better balance between work and leisure since returning to our profession.

REFERENCE

1 Taskila T, Lindbohm ML. Factors affecting cancer survivors' employment and work ability. Acta Oncologica 2007; 46:446-451.

FEATURE

RETURNING TO WORK AFTER MATERNITY LEAVE

Returning to work after maternity leave can be challenging, writes mother of two Dr Kushlani S. K. Stevenson (FANZCA).

There are many reasons why anaesthetists may spend significant periods away from their normal working environment; those taking maternity leave form the largest group and most expect to return to normal practice within a short period of time.

I returned to work following brief periods of maternity leave after the arrival of my children. I planned meticulously beforehand, but tremendous upheaval follows the arrival of your child and any plans may not remain intact. It is best to keep plans flexible so they can be adapted to your child and your individual circumstances. In this article I have included suggestions to facilitate a smooth return to work and links to resources to help with planning.

It is hard to know when to resume working. Finances, your stage of training (or experience as a specialist) and the demands of balancing your private and public work may influence your return. An early return to work (less than six months after birth) impacts less upon self-confidence in clinical practice, although balancing the demands of breastfeeding, sleep deprivation and on-call commitments can be challenging. Returning to work later (more than six months after birth) means that breastfeeding is not as much of a drain as it may have been earlier and your baby is more likely to be settled and sleeping well. However, with a later return to work there may be issues with separation anxiety in your child and confidence in your clinical competence.

For trainees, rotations may determine the timing of any interruptions and variations to your training. These need to be coordinated prospectively with ANZCA through the Director of Professional Affairs (assessor). If you take more than one year off from training, subsequent training must include at least one continuous year of supervised training. If you are a specialist who has been absent from practising clinical anaesthesia for more than 12 months, ANZCA recommends participation in their Practice Re-entry Program.

Childcare is a significant factor influencing when and how to return to work. Your workplace may provide long daycare facilities, but there may be a long waiting list. As a trainee you may not even know where you will be working in several months' time. Childcare facilities close to work will enable you to drop off and pick up your child closer to your own start and finish times. However, for most of us this means a very long and tiring day for both parent and child.

A nanny may be a better option, especially if you have more than one child. Nannies can fit in with your schedule and there is no rush to get the children up and out by a certain time. However, it can be hard to find the best person for you and your family. You will not be eligible for the childcare rebate with a nanny (unless it is through certain nanny agencies), so it would be a significant drain on your finances, especially if you are a trainee.

Family and friends can be helpful and leaving your child with someone you know and trust is a huge help with the transition back to work, but it is not an option available to everyone.

If you are breastfeeding, and intend to continue after your return to work, then you need to prepare for expressing milk and ensure your baby will take a bottle. Returning to work part-time helps with maintaining your supply as there is not as much pressure to produce an adequate amount of milk while you are away from your baby.

I recommend an electric breast pump, as well as getting your baby used to taking a bottle early. It is not always easy to express breastmilk and it helps if you are not stressed. You need to practise at home first and find somewhere private at work where you feel comfortable. It would help if you can visit the workplace and make a plan for this before you start work. If your baby is on-site, you may be able to visit the childcare facility for feeds. If you have a nanny or family member caring for your child, your child may be able to be brought in to you. The Australian Breastfeeding Association provides some excellent resources about breastfeeding and work.

Private practice has its own challenges. It is hard to find someone who is not only able and available to cover your lists for you, but someone who can also be relied upon to return those lists to you at the end of your maternity leave. This leads to many of us returning to our private lists earlier than our public lists or giving up the private work entirely. It helps to have an understanding surgeon and also to return to a morning or afternoon session as opposed to a full day. That way factors such as expressing at multiple locations will be less of a concern.

A supportive family is invaluable for a successful return to work. Discuss your plans well ahead of your start date and ensure that you divide up household responsibilities early to minimise stress.

Finally, ask your colleagues what they did—what worked for them and what would they not do again? You may feel you are inconveniencing them when you first return to work, but most of them have been through it themselves, either personally or through their spouse; in return they will get a motivated, organised and happy colleague with a raft of valuable skills to share.

My main message is to do what is right for you and your family—that way you get to enjoy your job and your child, and be an asset to your employer and colleagues.

ACKNOWLEDGEMENTS

I would like to acknowledge my friends and colleagues who have been great resources for me—for helping me with my return to work from maternity leave and for their input into this article.

USEFUL RESOURCES

- Australian and New Zealand College of Anaesthetists. Professional Standard 50: Recommendations on Practice Re-Entry for a Specialist Anaesthetist. From http://www.anzca.edu.au/resources/professional-documents/documents/professional-standards/professional-standards-50.html.
- Australian and New Zealand College of Anaesthetists. Special Requests. From http://www.anzca.edu.au/training/2004-training-program/special-requests.
- Raising Children Network. Returning to Work: A Guide. From http://raisingchildren.net.au/articles/returning_to_work.html.
- Australian Government Fair Work Ombudsman. Returning to Work. From http://www.fairwork.gov.au/leave/parental-leave/pages/returning-to-work.aspx.
- Australian Breastfeeding Association. Breastfeeding and Work. From http://www.breastfeeding.asn.au/bf-info/breastfeeding-and-work.
- Hill E. So you want to be a medical mum? London, UK: Oxford University Press 2008.
- Royal College of Anaesthetists. Returning to work after a period of absence. From http://www.rcoa.ac.uk/node/771.
- Royal College of Anaesthetists. A structured return to work—who, when and why? From http://www.rcoa.ac.uk/system/files/CSQ-Bulletin76.pdf.

FEATURE

TRANSITION TO RETIREMENT

Since 1970, the percentage of the population below 14 has dropped over 30%, while the percentage of the population between the ages of 65 and 85 has increased by 50%, writes Clin Assoc Prof David Sainsbury (FANZCA).

In Victoria, almost one in six registered medical practitioners are over 60 years of age[1].

The Global Financial Crisis and subsequent collapse of superannuation funds have delayed our plans for retirement. This has provided a convenient excuse to postpone that uncomfortable retirement day—that day we contemplate with trepidation—when we give up the purpose and social circle provided by the most rewarding career we could have imagined.

But our cognitive clocks are ticking. How can we be sure that we do not outstay our welcome? To answer this question we need to know how cognitive function and performance change with age. We should consider our responsibilities to our patients, our colleagues and the law. Then we will be better placed to incorporate age-related changes into our own life plans.

Only one of the ten broad stratum cognitive abilities improves with age. It is referred to as 'crystallised intelligence' and encompasses verbal skills, long-term memory and the implicit memory necessary for intuitive or expert problem-solving.

Four mental abilities decrease with age. They are fluid intelligence, processing speed, short-term memory and its related working memory[2]. Their loss affects planning, abstraction and cognitive flexibility. This leads to a tendency to rigid and concrete thinking. There is also a decreased ability to react quickly in unfamiliar circumstances or emergencies. This is made significantly worse when our reserve is diminished by the HALTS factors: Hungry, Angry, Lonely, Tired and Stressed. Fatigue can be compounded by the decrease in sleep efficiency with age.

The challenge is to find a balance between reducing hours and maintaining standards. Strategies include avoiding night shifts (alone and tired) and avoiding weekend shifts (alone). There are opportunities to expand interests that benefit from 'crystallised intelligence': administration, research or teaching.

Senior doctors may exercise the wisdom of time and experience in support of their profession through their colleges or broader medical organisations such as medical unions and associations. The Welfare of Anaesthetists Special Interest Group provides a useful document on retirement and late career options for the older professional[3].

The overwhelming majority of doctors self-determine the end of their career before their practice is compromised. For those who continue to work, memory failure is often the first sign that alerts the individual, their family or colleagues that it is time to go.

The Australian Health Practitioner Regulation Agency mandates the disclosure of any impairment or restriction of practice rights resulting from health, conduct or performance issues. Patient complaints may also lead to a doctor's referral to a medical board or council for assessment of health and performance. These institutions are primarily for the protection of the public, although they do provide a point of contact with potentially impaired doctors.

What do medical boards uncover? Between 2000 and 2006, there were 70 notifications to the health committee of the New South Wales Medical Board concerning doctors over the age 60. Forty-one of these doctors were determined to have impairment affecting their capacity to practice as defined by the Act. As in younger groups, the three Ds of depression, drugs and drink were found in the majority of cases. This older group added the fourth D of dementia, with 21 (54%) demonstrating mild cognitive impairment. Five doctors (12%) were still practising with frank dementia[4].

A smooth transition to retirement requires more than simply setting a date and obtaining sound financial advice: it requires intentional planning of future life goals and roles. Successful transition will also include the development of broader interests outside medicine. Strategies that include cognitive, physical and social activities may slow cognitive decline. It is important to control vascular risk factors, in particular through diet. Finally, every doctor should have a general practitioner skilled in looking after doctors. This independent practitioner is more likely to recognise and treat depression, which can enter by stealth or in times of change and mimic or worsen cognitive decline.

Retirement should provide the opportunity to engage Erikson's eighth stage of development, 'Late Adulthood', with integrity rather than despair. This involves reflecting on a world that has meaning and on our contribution through career and family[5]. Then our perspective may broaden and attachments may loosen their grip as we prepare for the next transition[5].

REFERENCES

1 Adler RG, Constantinou C. Knowing—or not knowing—when to stop: cognitive decline in ageing doctors. Med J Aust 2008; 189:622-624.

2 Christensen H. What cognitive changes can be expected with normal ageing? ANZ J Psychiatry 2001; 35:768-775.

3 Anaesthesia Continuing Education Coordinating Committee. Welfare of Anaesthetists Special Interest Group Resource Document 4: Retirement and Late Career Options for the Older Professional. From http://www.acecc.org.au/Welfare.aspx. Accessed January 2013.

4 Peisah C, Wilhelm K. Physician don't heal thyself: a descriptive study of impaired older doctors. Int Psychogeriatr 2007; 19:974-84.

5 Erikson EH. The Life Cycle Completed. Extended Version with New Chapters on the Ninth Stage of Development by Joan M. Erikson. New York, USA: W. W. Norton 1997.

2013 AWARDS, PRIZES & RESEARCH GRANTS

PRE-NSC ADJUDICATED

ASA PhD Support Grant

Description
Applicants submit a proposal to carry out research to advance the safety, delivery or efficacy of anaesthesia while having a favourable impact on society as a whole.

Eligibility
Application is open to ASA members only.

Award
The grant comprises a certificate and financial support up to $10,000 per recipient (the grant may be used to purchase or lease equipment, facilities or material; fund administrative or scientific support; offset research and other expenses or fund travel and accommodation). Up to two Grants may be awarded annually.

Kevin McCaul Prize

Description
Applicants submit a written paper, critical review or essay on any aspect of anaesthesia, pain relief, physiology or pharmacology, with particular reference to the female reproductive system.

Eligibility
ASA members who are registrars in training or junior specialists within two years of obtaining a higher qualification in anaesthesia.

Award
The prize comprises of a certificate and $10,000.

Jackson Rees Research Grant

Description
Applicants should submit a proposal outlining how the grant, if awarded, will assist in research projects in anaesthesia or related disciplines such as resuscitation, intensive care or pain medicine. Recipients will provide an annual progress report of the research project and will make a final report as a presentation during the scientific program of the subsequent National Scientific Congress (NSC).

Eligibility
Application is open to ASA members only.

Award
The prize consists of a certificate and $25,000.

PRE-NSC ADJUDICATED CONTINUED

Jeanne Collison Prize

Description
The Jeanne Collison Prize is awarded for outstanding research in the fields of anaesthesia and pain management and recognises excellence in original research within Australia in these fields. Applicants should submit a proposal outlining plans for original research within Australia in the fields of anaesthesia and pain management.

Eligibility
Applicants must be a member of the ASA with an interest in or sub-specialising in pain management or intending to enter this subspecialty.

Award
The prize consists of a certificate and $10,000.

NSC PRESENTATION AWARDS

Gilbert Troup ASA Prize

Description
The Gilbert Troup ASA Prize commemorates the contribution to Australian anaesthesia by Dr Gilbert Troup of Perth, Western Australia. Applicants should submit an abstract via the online submission process for papers to the annual NSC once the 'Call for Papers' is issued. This submission page is found by following the 'Application' link for the Award on the NSC website. All papers submitted are reviewed by the committee as to their eligibility and suitability prior to acceptance. Those accepted for presentation at the NSC will deliver a ten-minute oral presentation illustrated by AV support discussing the aims, methods and results of their research. This will be followed by a five-minute question period. Those papers not accepted may be offered a poster format—either in a Smiths Medical/ASA Best Poster Prize session or as a static poster display.

Eligibility
Application is open to ASA members only. Applications must be based on original research, (the majority of which has been performed in Australia). The principal content of the paper must not have previously been presented at a national meeting in Australia. The presenter must be one of the authors of the paper. Once a paper has been accepted for inclusion in the Gilbert Troup ASA Prize session, it will no longer be eligible for other NSC-judged awards.

Award
The prize includes a medal, known as the Gilbert Troup Medal, and $7500.
The award will be presented during the NSC, usually prior to the ASA's Annual General Meeting. Please refer to the ASA Bylaws (which can be found on the ASA website) for more detailed information regarding this award.

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NSC PRESENTATION AWARDS CONTINUED

Smiths Medical/ASA Best Poster Prize

Description

Applicants should submit an abstract via the online submission process for papers to the annual NSC once the 'Call for Papers' is issued. This submission page is found by following the 'Application' link for the Award on the NSC website. All papers submitted are reviewed by the committee as to their eligibility and suitability prior to acceptance. Those accepted for presentation at the NSC will deliver a three-minute oral presentation discussing the aims, methods, results and conclusions of their research. This will be followed by a seven-minute question period. The precise presentation requirements for each NSC will be sent out prior to the NSC.

Eligibility

Application is open to ASA members only. Applications must be based on original research, (the majority of which has been performed in Australia). The presenter must be one of the authors of the paper.

Award

Three prizes will be awarded comprising a certificate and $4000, $2500 and $1500 respectively for recipients judged first, second and third by the adjudicating panel. The awards will be presented during the NSC, usually prior to the ASA's Annual General Meeting.
Please refer to the ASA Bylaws (which can be found on the ASA website) for more detailed information regarding this award.

2013 AWARDS, PRIZES & RESEARCH GRANTS

NSC PRESENTATION AWARDS CONTINUED

Smiths Medical/GASACT Best Poster Prize

Description

The Smiths Medical/GASACT Poster Prize was introduced in 2011 and is only open to GASACT members who present a poster at the NSC. Applicants should submit an abstract via the online submission process for papers to the annual NSC once the 'Call for Papers' is issued. This submission page is found by following the 'Application' link for the Award on the NSC website. All papers submitted are reviewed by the Committee as to their eligibility and suitability prior to acceptance. Those accepted for presentation at the NSC will deliver a three-minute oral presentation discussing the aims, methods, results and conclusions of their research. This will be followed by a seven-minute question period. The precise presentation requirements for each NSC will be sent out prior to the NSC.

Eligibility

Applicants must be GASACT members. The majority of the research must have been performed in Australia (or as determined by the Committee). The principal content of the poster must not have been previously presented at a national meeting in Australia.

Award

The prize consists of a certificate and $500. The award will be presented during the NSC, usually prior to the ASA's Annual General Meeting. Please refer to the ASA Bylaws (which can be found on the ASA website) for more detailed information regarding this award.

smiths medical
bringing technology to life

FOR APPLICATION DATES OR TO APPLY, VISIT THE 2013 NSC WEBSITE WWW.ASA2013.COM.AU

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ASA
Australian Society of Anaesthetists

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Getting your head in the cloud

Streamlining anaesthetic billing.

As more and more medical practice software moves into the 'cloud', one pressing question is this: should anaesthetists have to adapt to new technologies, or should the software be designed to accommodate the habits and needs of practitioners? Developers at Cutting Edge Software and PaperAct Solutions believe that only by working in the space and listening closely to the needs of end users can great services be created. Their respective applications aim to meet the needs of a mix of doctors, ranging from gadget fiends to those who currently use only paper.

Applications that talk to each other

A good example of this easy-to-use, practitioner-focused product development is the recently announced integration of **PaperAct's AnaestheticCard** with the well-established electronic claiming suite from **Cutting Edge Software.** Anaesthetic Card is an iPad application enabling anaesthetists to collect patient and procedure data offline in theatre with inbuilt optical character recognition (OCR). The Anaesthetic Card can then be sent to both the PaperAct Electronic Filing Cabinet (EFC) system and to Cutting Edge Software's web-based billing application. This not only dramatically reduces errors that occur when staff re-enter information but also improves productivity, accuracy and visibility of the billing process.

Streamlining your billing

Both Anaesthetic Card and Cutting Edge have been conceived with streamlined flow of data in mind. In theatre you can capture patient and billing information for transmission back to your practice staff, or **send directly to health funds with Cutting Edge**. By minimising data handling and delays, the average turnaround time is reduced from 2-6 weeks to less than 48 hours for Bulk Bill and DVA claims.

ECLIPSE claims to private health funds are generally accepted within 0-2 days and will then be paid on the fund's next pay run, typically within the week.

Tracking your claims

With PaperAct, anaesthetists are able to log into their own EFC account to securely view all the cards in their own filing cabinet. Users can access PaperAct EFC using any device (mobile or PC). Administrative staff who are responsible for processing the cards are able to log into PaperAct EFC from their PC using a browser. They can view all anaesthetists' EFC accounts and associated filing cabinets and process them accordingly.
The status of all outstanding electronic claims claims submitted through Cutting Edge is updated daily. When payment is reported by the funds, Cutting Edge automatically records the details in the appropriate invoices. Rejected claims are flagged for easy follow up.

Through cooperation such as these, anaesthetists and their staff can devote less time on billing. Regain control of your time!

Dr Tony Stewart
Director, Cutting Edge Software

Gil Hidas
Managing Director, PaperAct Solutions

Learn more about AnaestheticCard at:

www.anaestheticcard.com.au
assist@paperact.com
03 9018 5400

Learn more about Cutting Edge Software's online billing platform:

www.cesoft.com.au
enquiries@cesoft.com.au
1300 237 638

REGULAR | CAREERS IN ANAESTHESIA

REGULAR

CAREERS IN ANAESTHESIA
PAEDIATRICS

Assoc Prof Andrew Davidson (MBBS, MD, FANZCA) is currently ANZCA's Lennard Travers Professor. He practises paediatric anaesthesia at the Royal Children's Hospital in Melbourne, Victoria, where he is also Director of Clinical Research.

Assoc Prof Davidson spoke to ASA Publications Assistant Jiyan Mustafa about his work as a paediatric anaesthetist.

WHY DID YOU CHOOSE PAEDIATRIC ANAESTHESIA AS A CAREER?

For a number of reasons. Firstly, it seemed very challenging because you're dealing with a child, which just technically seems harder than with an adult. And I guess because you're dealing with something that often seems more vulnerable and precious. It's also more challenging because you're dealing with everything from tiny little babies that are about 500 g to adults, or essentially adult teenagers, who are 100 kg.

Secondly, the people who are involved in caring for children seem to be different to those who care for adults. There's much more of a esprit de corps and people tend to come to work because they want to, not because they have to. People who work at a children's hospital don't do it just for the money, they do it because they want to look after children and there's more of a teamwork approach to everything.

I also think children can be great fun, well it's good fun working with adults too—you can obviously have a lot more detailed conversations with adults than you can with children—but working with kids is fun. They're all different and unpredictable. You have to be flexible. You don't have to be all gooey about children to be a paediatric anaesthetist. But the more you do it the more you do like children. However, having your own children can make it harder, especially if you're looking after a particularly sick child who is the same age as your own children.

IS IT WHAT YOU EXPECTED?

No. In fact at university I found paediatrics a bit daunting, so I didn't really ever expect to do paediatric anaesthesia. As soon as I started doing it I found I loved it. I thought it was great. It just grows on you and many of the anaesthetists who come through here as registrars think it's fantastic too.

HOW DID YOU GET INTO PAEDIATRIC ANAESTHESIA?

In Victoria at that stage all the registrars went through the Royal Children's Hospital. So I rotated through. It's a fantastic place to work. It is probably one of the best hospitals in Australia. It just has this great feeling of everybody working for a common purpose and it has a fantastic international reputation. When you work at the Royal Children's Hospital you meet lots of inspiring people—other anaesthetists, paediatricians, surgeons—and you just feel as if you're amongst the best. As I said before, they're not interested in making money. They don't really care how many hours they work. They come here because they want to work here and there's enormous competition to work here. They're the hardest programs to get into. The anaesthetic department here is a fantastic department. It has a long-established tradition of being one of the best departments in the world, with people like Kester Brown, Rod Westhorpe and Rob Eyres who all have tremendous reputations overseas.

So when you work in the department here you feel as if you're part of this world community of paediatric anaesthesia and you feel like you're very privileged. I once worked at Boston Children's Hospital and from there went on a mission to do cleft lip surgery in Ecuador. I met several paediatric anaesthetists and none of them knew any of the famous anaesthetists in Boston, but they all knew Kester Brown from Melbourne. They were far more excited by the fact that I'd worked as a registrar at the Royal Children's Hospital than that I came from the Boston Children's Hospital. That's the sort of place it was with both Kester and with Rod Westhorpe, and then more recently with Rob Eyres.

DOES IT TAKE A PARTICULAR TYPE OF PERSON TO BECOME A PAEDIATRIC ANAESTHETIST?

With paediatric anaesthetists, it's often said they need to be flexible and a little bold, perhaps, because with children things don't always go to plan. Whether it's because they've got some disease and nobody really knows what's wrong with them or when you're taking the child to go off to sleep and they suddenly decide they don't want to, you've got to change your plan to meet what the child wants. So you've got to be flexible as a paediatric anaesthetist. And also you're often dealing with a lot of unknowns, so you need to be a bit bold and brave.

IS THERE A BEST PART TO PAEDIATRIC ANAESTHESIA?

I think the best part is that the children, they get better. They get sick very quickly, but the vast majority of them get better. You're caring for someone that you know is going to go on and be productive and contribute to the community. There's a feeling of sort of hope about it. You're not just dealing with someone who's probably going to die anyway or is towards the end of their life. You're dealing with people who are at the beginning of their lives. The reward of doing that is, I think, the best part of paediatric anaesthesia.

DO YOU THINK THERE IS A WORST PART TO PAEDIATRIC ANAESTHESIA?

I haven't found one yet! I think that probably the most challenging part is looking after children who are very sick. But that's challenging rather than bad.

IS IT HARDER TO BUILD A RAPPORT WITH A CHILD?

Doing paediatric anaesthesia you've got to build a rapport with the family as well. It's not just building a rapport with the child; you've got the parents as well, so you're not just getting to know one person, you've got to get to know three or more people. That makes it hard. And you're anaesthetising the child not the parents. Just because you're spending a lot of time with unconscious children, doesn't mean you don't build rapports with the families.

WHAT HAPPENS IF THE PARENTS DON'T AGREE WITH YOU ABOUT A METHOD OF TREATMENT?

People worry about that, but it's very unusual. Most of the time it's just about spending the time and communicating effectively with the parents and coherently with the child. It's very unusual for parents not to have the best interests of their child at heart. I've never been in that situation.

YOU'VE MOVED FROM FULL-TIME PAEDIATRIC ANAESTHESIA TO A CAREER IN RESEARCH, IS THAT CORRECT?

Yes, I'm Director of Clinical Research at the Children's Hospital.

HOW DID THIS TRANSITION OCCUR?

Our anaesthesia department has a strong tradition of supporting research and the hospital has a strong tradition of supporting research. I'd always wanted to do research and when I went to Boston I spent the year doing a research fellowship there, both in the lab and clinically. So when I came back the anaesthetic department was very supportive of me starting a research career, so I was very lucky. I've also been well mentored by Kate Leslie and people like Paul Myles, who have helped me in my research career. And then the more research I did the more I just enjoyed it. The atmosphere of doing research, the way it makes you think and you get the freedom to do your own thing. Most research these days is very collaborative. It's not just one person doing their own thing, it's groups of people. Doing research here means that you know psychologists, statisticians, paediatricians and even surgeons. So you rapidly become collaborative and that eventually leads to not just doing anaesthesia research. Some of the research I look after now actually has very little to do with paediatric anaesthesia, so I guess my research career has just grown out of paediatric anaesthesia into a naturally more collaborative and then more administrative role in the hospital.

I still do anaesthesia though. Most paediatric anaesthesia I do now is neuroanaesthesia.

DO YOU HAVE ANY ADVICE TO SOMEONE WHO IS THINKING ABOUT PAEDIATRIC ANAESTHESIA?

Do it. Everybody says it's very competitive and you'll never get in, but if you really want to do it, you'll get to do it. If you're enthusiastic about doing paediatric anaesthesia and you want to do it, then don't give up. Just keep persevering and eventually you'll get there. I had to do two or three years of fellowships here and elsewhere around the world waiting for a position to come up and eventually a position did come up, so here I am as a paediatric anaesthetist. So if you want to do it, don't give up and you'll eventually do it. Then you'll be in one of the best anaesthetic jobs you can have.

REGULAR | ANAESTHETISTS IN TRAINING

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ANAESTHETISTS IN TRAINING
PRACTICALITIES OF BILLING

At the GASACT Part 3 Course each year, the biggest concern facing those about to become fellows of the College is the practicality of billing, writes Simon Zidar (FANZCA).

Everyone requires some background to using item numbers to create an account for services rendered. You may be providing an account for department billing on private patients in public hospitals or generating accounts for private income. In any case, a basic outline of things relating to this is touched on and follows.

A PROVIDER NUMBER

A provider number is used by Medicare and health funds to identify the services you provide to patients.

You have a provider number for each campus you work at from internship (restricted to radiology and pathology referrals for patients) which is then 'upgraded' to specialist when you have qualified for your FANZCA. The upgrade is something that requires a form from Medicare to identify specialist recognition. The provider numbers are then associated with all item billing numbers you may use for services you provide to patients.

Each item number comes with a billing address and it is possible to link all services to a single number associated with one address. This process is a 'provider number group link'. The point of this is to enable you to link all of the services you provide to one provider number (the group link number) to allow for simplified billing of patients and payment of income. This becomes convenient when working in multiple hospitals, where all mailing and billing receipts can go to your specified single bank account or address for that group link number.

However, if you are a staff specialist and have the department bill in your name, this hospital provider number needs to be separated from the 'group link'. Otherwise the department billing will end up in your account and you will need to pay this back when you or your boss finds out! This is a trap for young players and the longer it goes on the more expensive it gets.

GAP, NO GAP OR KNOWN GAP?

The Medicare Benefits Schedule (MBS) outlines government figures for services medical practitioners provide. MBS items particularly relevant to anaesthetists are the ones in section ten. The MBS sets out the item numbers in this section as a relative value guide (RVG) with a unit value structure for services reflecting weighting for procedural/service difficulty. Over many years, the ASA has influenced the look of the MBS RVG, which has a very similar look to the ASA RVG (produced in hard copy and electronically and updated at the end of each year).

Five components make up the fee for anaesthetic services: consultation times, the basic unit value based on difficulty of procedure, a unit for total time, modifying units, and associated therapeutic/diagnostic specified services.

The MBS or 'schedule fee' is a list fee for which the government, via Medicare, will reimburse patients for 75% of the value for inpatient services and 85% of the value for outpatient services.

Health funds only cover the 15–25% difference up to the total 100% schedule fee. In terms of unit value, the schedule fee is approximately $19 per unit (75% schedule fee is approximately $15 per unit, with $4 per unit for health funds to add to complete the schedule fee).

By entering into arrangements with certain health funds, practitioners can ensure patients are reimbursed ('no gap') to approximately $29–31 in total by agreeing with the health fund in question not to charge more than the 'agreed no gap' unit rate/value.

Some health funds are willing to allow practitioners to charge a fee beyond the 'no gap' fee in certain circumstances (as specified in their contracts) and still remunerate the patient to the higher than schedule fee 'no gap' level. This is a 'known gap' arrangement with those selected health funds. While the patient still receives a 'known gap', this is smaller than a gap they would accrue without the arrangement charging the higher fee. Thus, in numbers above the schedule fee without this arrangement a patient only gets $19 per unit for a service back, while the known gap allows up to $31 per unit. Again, you need to understand the arrangement with the individual funds in question.

The ASA and AMA both publish an RVG. They both reflect the ASA position that, on evidence base and with the nature of practice, alternate and other item numbers should be made available to practising clinicians. While the health funds require MBS RVG derived item numbers for patient billing, private services involving WorkCover and insurance-based remuneration recognise and permit the use of the ASA RVG item numbers. A maximum unit value is recommended based on true costs of practice to practitioners and at present sits at $75 per unit. While the ASA lobbies government to adopt the ASA RVG in totality, items for bispectral index, ultrasound and other procedures still remain outside the MBS RVG. In the meantime, these and other ASA RVG items may still be used for accounts. Only WorkCover or insurance-covered patients will be reimbursed completely. Other patients will receive out-of-pocket or non-reimbursable expenses for those ASA items not in the MBS schedule.

A gap exists because the MBS has shifted little since inception in 1985. Substantial increases in average weekly earnings, consumer price index, movements and costs of practice with indemnity, professional fees and payments to staff have all occurred without the MBS schedule keeping pace and it is important for you to value the service you provide to patients and account for those costs when considering how you will set your fees.

INFORMED FINANCIAL CONSENT

Whenever billing is a topic, informed financial consent (IFC) becomes critically important. It is not something natural to us or taught in our training or practice. It is not part of the ANZCA curriculum, but is just as important a skill for maintaining rapports with patients, particularly in private practice and particularly in cases where things go wrong.

Wherever possible, this process needs to occur pre-procedure; ideally at a time of general consent to surgery. This can be achieved at a pre-anaesthetic assessment before the day of surgery or as a drafted quote available to patients in a surgeon's rooms or made via patient contact over the phone prior to surgery. In emergencies, this can still be done at the earliest appropriate time post-procedure. Just as in any consent process, you need a competent patient who is able to provide volition and understanding.

CONCLUSION

Here have been some basics to discussions on the topic of billing. Ultimately all new consultants need the fundamentals above and an intimate encounter with schedules of items and billing for accounts. Professionalism in your practice is not just the clinical aspects but also involves billing. It need not be the daunting experience it feels like when crossing to consultancy with good advice from colleagues and from the ASA.

REGULAR | WEBAIRS NEWS

REGULAR

WEBAIRS NEWS

WebAIRS (Web-based Anaesthetic Incident Reporting System) is the WebApp developed by the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) for members of the ASA, fellows and trainees of the College and members of the New Zealand Society of Anaesthetists (NZSA). Nineteen sites in New Zealand and 34 sites in Australia have registered so far. Adj Prof Martin Culwick (FANZCA) explains.

At the ANZTADC meeting in February 2013, the Committee discussed the objectives for the coming year. It was agreed that the highest priority was to increase the engagement of registered hospitals. Various ways of encouraging reporting were discussed. It was decided to implement the following initiatives:

- Improve feedback.
- Continue producing publications and presentations.
- Provide tools to enable WebAIRS to facilitate and inform departmental morbidity and mortality meetings.
- Create a risk register of the most common and most serious incidents types with key safety messages.

ENCOURAGING INCIDENT REPORTING

ANZTADC has received 1311 incident reports via WebAIRS since the system was released in October 2010. This is a good start but the actual rate at which critical incidents occur is probably much higher. An initiative at one of the registered sites is to log all instances where there has been a call for help in the operating theatre. Remember that nothing bad has to happen to log a report. We encourage reporting near misses in line with other safety-conscious organisations such as the airline industry. A near miss reported might prevent serious harm in the future.

IMPROVING FEEDBACK

At present ANZTADC provides feedback by traditional sources such as presentations at scientific meetings and printed articles. The disadvantage of these methods is that they are a bit slow in providing feedback and are generalised in their focus. As an additional and new initiative we intend to provide some of this content on the WebAIRS website. In this way, members who haven't read the articles or didn't see the presentation, or those who simply wish to refresh their memory, will be able to view these items online. (Continuing professional development points will be applicable).

PUBLICATIONS AND PRESENTATIONS

The incidents are analysed and summaries are published three times a year with key messages. The focus is on improving patient safety. These summaries appear in *Australian Anaesthetist*, the ANZCA Bulletin and the newsletter of the NZSA. The main content of the article is the same in the publications of each organisation with some small recent updates, as well as some customisation for each issue. In the future articles will also be submitted for publication in peer reviewed journals.

ANZTADC has decided to pilot an online risk register that can initially be used by the local administrator and might be used (for instance) in conjunction with quality assurance meetings

Results are also presented at annual meetings of the parent organisations. Last year presentations were made at the ASA National Scientific Congress in Hobart, the ANZCA Annual Scientific Meeting in Perth and the NZSA combined meeting with the International Congress of Cardiothoracic and Vascular Anesthesia in Auckland. In addition there was a presentation at Mission Beach at a regional meeting and at site visits to various hospitals. If you would like a presentation at your hospital we will try to provide this when in your area. This approach works well in sites near major towns and cities.

RISK REGISTER

This was suggested by one of the registered sites as a novel and effective method to provide feedback on critical incidents. ANZTADC has decided to pilot an online risk register that can initially be used by the local administrator and might be used (for instance) in conjunction with quality assurance meetings. If successful, access will be enabled for all registered users. The aim of the risk register will be to display the description of risks identified by high numbers of incident reports, the risk score and control measures. There will be a development phase when the risk register is available to selected sites for Beta testing and then later this year it is hoped that the tool will be available for quality assurance meetings at all registered sites.

MORBIDITY AND MORTALITY MEETING TOOL

This tool has been released and can be used to display incidents at the morbidity and mortality meetings at registered sites. It is a web-based tool, it is provided free and WebAIRS can also be used to provide a means of recording incidents in your department instead of using paper forms. The software includes a tool for subsequently presenting incidents from your department at your local morbidity and mortality meetings while maintaining anonymity at a national level. The data is protected by Qualified Privilege in Australia and New Zealand. If your hospital has an e-Health compliant anaesthetic recording system then data can be shared electronically with ANZTADC. You are able to receive Category 3 continuing professional development credits if you report incident data to ANZTADC. WebAIRS allows you to print out a certificate to confirm the credits or the confirmation can be sent by email. Registered sites are encouraged to send feedback to allow continuous improvement of this software.

For more information, please contact:

Adjunct Professor Martin Culwick, Medical Director, ANZTADC

E: mculwick@bigpond.net.au

Administration Support

E: anztadc@anzca.edu.au

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

Demo can be viewed at: www.anztadc.net/demo.

INSIDE YOUR SOCIETY | ECONOMICS ADVISORY COMMITTEE

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

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

MEDICAL SERVICES ADVISORY COMMITTEE APPLICATIONS

The application for the introduction of Medicare Benefits Schedule (MBS) items into the Relative Value Guide (RVG) to fund ultrasound guidance for local anaesthetic nerve block and major vascular access procedures continues. At the time of writing the ASA is still awaiting the final Decision Analytic Protocol (DAP) from the Medical Services Advisory Committee (MSAC). Members will recall that the DAP is a document purporting to summarise the clinical aspects of the use of ultrasound in anaesthesia practice, and poses a number of questions to the applicant. It will be used to guide the next stage of the process, which is to assess the scientific and economic evidence behind the proposal. Unfortunately the first two drafts of the document contained numerous errors and misconceptions, and it was clear the authors knew very little about the practice of anaesthesia in general, let alone more specialised topics such as ultrasound. The ASA has suggested a number of changes, which will hopefully be reflected in the final document. However the release of the final DAP has been delayed, creating further uncertainty as to how long the entire MSAC process will actually take.

In the meantime, members are reminded that MBS item 55054 for the use of ultrasound will be rejected if claimed in association with anaesthesia services. The same restriction applies to item 55026 (used where the ultrasound equipment is more than ten years old).

The MSAC applications for improved pain medicine attendance items, and items to cover local anaesthetic nerve blocks for postoperative analgesia, have received confirmation of their 'eligibility' for consideration. This determination was delayed while the MSAC sought justification of the reasons for submissions of the application, given that, in their words, the services are "already accommodated in the RVG for anaesthesia". This lack of understanding of the basic premise behind the applications (most nerve blocks cannot be claimed in association with anaesthesia items and therefore are certainly not "accommodated within the RVG", and the rebates for pain medicine attendance items are very poor for prolonged, complex attendances) again undermines our confidence in the process and the time it will take to progress.

REVIEW OF MBS ITEMS

The Department of Health and Ageing (DHA) has advised that the MSAC is about to start the process of assessment of RVG items related to cardiopulmonary bypass procedures. Members will recall that a number of specific MBS items are under review by the MSAC as part of the "Comprehensive Management Framework". This Federal Government initiative has the stated aim "to systematically review MBS items to ensure that they reflect contemporary evidence, improve health outcomes for patients, and represent value for money". From the dealings of the ASA with the DHA, it is clear that cost savings, via removal of MBS items wherever possible, is the overriding priority.

Besides cardiovascular perfusion, items related to knee arthroscopy, inguinal hernia repair and wrist ganglion repair are under review, amongst others. Further information can be obtained online at www.msac.gov.au/internet/msac/publishing.nsf/Content/reviews-lp.

A call has been made for nominations to the committee to be formed to assess the perfusion items. Our gratitude goes to Dr Nigel Symons (New South Wales) for agreeing to represent the ASA. Dr Symons also represented the ASA on the committee that assessed MBS items relating to pulmonary artery catheters (PAC). No changes to the existing PAC items were made as a result of that review.

The Cardiothoracic, Vascular and Perfusion Special Interest Group, and the National Association of Medical Perfusionists of Australia (NAMPA), will also be represented.

MEDICARE NATIONAL COMPLIANCE PROGRAM 2013

The Department of Human Services (DHS), responsible for administering Medicare, Centrelink and the Family Assistance Office, has reaffirmed its intention to increase its focus on compliance and auditing. As far as the Medicare system is concerned, members will recall that anaesthesia has already been identified as an area of 'concern', particularly in regards to consultation items, anaesthesia time items, correct application of base anaesthesia items, and the appropriate use of emergency modifier items.

ASA representatives again met with representatives of the DHS in December. The DHS again emphasised its belief that the vast majority of anaesthesia-related claims are entirely appropriate, and that the uncommon situations in which erroneous claims have been made were usually the result of a lack of knowledge, rather than deliberate acts. The DHS has also reaffirmed its aim to provide an educative and supportive approach, rather than punitive. Nevertheless, as previously reported, there have already been five situations in which anaesthesia time items were incorrectly claimed and funds have had to be repaid to Medicare by the anaesthetists involved. The DHS accepted that these cases were due to inadvertent errors and no further action will be taken.

It is obviously essential that all Medicare claims are correct and appropriate. The ASA strongly advises members to carefully note the requirements in the descriptors for consultation items, and to ensure that correct basic anaesthesia items are applied. As far as anaesthesia time units are concerned, it is essential that the start and finish times accurately represent the time spent providing exclusive care to a patient and that there is no 'overlapping' of recorded times. The RVG book can be of much assistance here, but members are most welcome to send any queries to EAC via policy@asa.org.au. Again, we emphasise that it is far better to send queries to the ASA, rather than directly to Medicare. Members of EAC and the ASA's in house staff are experienced at handling such queries (typically far more so than DHS clerical staff) and can, in the majority of cases, provide accurate advice very quickly. Should there be any doubt, EAC will contact the appropriate staff within DHS on members' behalf.

As a result of the increasing focus on compliance, it is likely that a number of anaesthetists will receive a letter from the DHS regarding their claim patterns. We have strongly emphasised to the DHS that so-called 'outliers' for particular items are usually easily explained by the specific clinical interests of the practitioners involved (e.g. a large number of higher-level time items by those with an interest in cardiothoracic or neurosurgical anaesthesia, or a high number of hours billed per week by a rural anaesthetist with a heavy on-call commitment). The DHS accepts this reality but nevertheless intends to write to anaesthetists whose claim patterns have significant 'outlier' status. The DHS has advised that this 'initial' letter will not require a reply, but will simply contain a request for the anaesthetist to review their records to ensure the clinical services and Medicare claims are correctly matched. The ASA strongly advises members receiving any such material to contact EAC immediately at policy@asa.org.au or on 1800 806 654. This is particularly important should there in fact be a request for a reply.

AUSTRALIAN DEFENCE FORCE PERSONNEL

Representatives of the ASA met for a second time with personnel from Medibank Health Solutions (MHS) in late October. The system initially proposed, with a variable RVG unit value, has been altered. MHS have suggested a unit value of $55, to be applied across the whole RVG. This compares to the Australian Medical Association (AMA) fee of $75 per unit. ASA President Dr Richard Grutzner has written to MHS to again express our disappointment with this offer. Also, while the contract proposed by MHS contains some improvements from the point of view of patient privacy and confidentiality, it is still heavily weighted towards the interests of MHS rather than doctors and patients. For example, there is no provision for regular indexation and the terms of the agreement can still be varied unilaterally by MHS from time to time.

Both the ASA and the AMA have warned that this proposed system places the timely delivery of healthcare to this most deserving group of Australians in jeopardy. The AMA has noted that less than 10% of doctors approached to become MHS "preferred providers" have signed an agreement, and this figure appears to be even lower in communities with a busy Australian Defence Force (ADF) patient workload.

At the time of writing, MHS has not released a final decision. Doctors who have not signed an agreement are still able to bill MHS for their 'usual fee' in the meantime. EAC is aware that a number of accounts for members' services, billed at $75 per unit, have been paid, but reports are by no means consistent. Difficulties or delays in obtaining payment appear to have been due to administrative rather than policy issues. However, members are reminded that they are under no obligation to provide elective services in the private sector if they are unhappy with any aspect of the remuneration arrangement. This issue is discussed further in our 'Point of View' section on page 12.

RVG 15TH EDITION 2013

EAC was recently made aware of a number of errors in the hard copy of the RVG. The MBS Fees for a number of items in the therapeutic and diagnostic section (particularly specific nerve blocks) are incorrect, being the November 2011 values rather than the November 2012 values. EAC apologises for this error. A correction was emailed to members in February 2013 and the electronic versions available in the member section of the ASA website are all up to date.

INSIDE YOUR SOCIETY | PROFESSIONAL ISSUES ADVISORY COMMITTEE

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

On 3 February 2013 the Professional Issues Advisory Committee (PIAC) held its annual face-to-face meeting at the Edgecliff office in Sydney. During a very productive day many important issues were dealt with, writes Chair Dr James Bradley.

The most significant issue that PIAC will be involved with in 2013 revolves around the Health Workforce Australia Report (HW2025) into the medical specialities, and the ramifications of the recommendations of this report.

HEALTH WORKFORCE AUSTRALIA REPORT

An article addressing HW2025 in considerable detail appears on page 14 of this magazine. A survey in relation to how the Society deals with HW2025 has been conducted. The contribution of those who responded is greatly appreciated. A high response rate certainly enhances our ability to advocate on behalf of our members and the specialty.

The ASA has long been aware that procedural services requiring anaesthesia are funded and delivered quite differently in countries that we know very well: New Zealand, Canada, the USA and UK. All systems have their strengths and weaknesses. Generally, the ASA believes that healthcare is well delivered in this country, with the exception of some known difficulties in the state delivered public system, and in rural and remote areas. The private system attracts some unfavourable comment in relation to equity in access and to non-recoverable expenses.

PIAC's assessment of HW2025 and the specialty of anaesthesia in 2012 as predicted for 2025 at the time of compilation of this report is:

- HW2025 raises no serious or significant concerns about the workforce dynamics of anaesthesia for 2012.
- HW2025 indicates that, as of 2012, anaesthesia has a practitioner replacement rate of minimal concern, an average practitioner age of modest concern and a dependence on overseas trained specialists and a training duration of some concern.
- HW2025 predicts a 'slippage' of all dynamics for 2025, but no indicators reach the level of significant concern.
- HW2025 identifies problems in recruiting specialists to regional areas.

PIAC has suggested to ASA Council that the following areas need to be explored with Health Workforce Australia (HWA) (perhaps in this order of importance):

- The ASA believes HWA needs to hear from the 'organised profession', not just the 'jurisdictions' and 'medical colleges'. There was broader consultation with other specialties.
- The ASA is unaware of any insufficiency in the specialist anaesthesia workforce anywhere except in rural and remote areas or in jurisdictions where there are funding and/or industrial difficulties.
- The ASA suggests that the rural and remote demographic is such that the provision of specialist anaesthetists in these areas will have no effect on the delivery of medical services without the addressing of the clearly identified deficiencies in the general surgical workforce.

> Generally, the ASA believes that healthcare is well delivered in this country, with the exception of some known difficulties in the state delivered public system, and in rural and remote areas. The private system attracts some unfavourable comment in relation to equity in access and to non-recoverable expenses

- The ASA suggests that the capacity for training in the so-called private sector may be limited, and that it has never been fully canvassed with the relevant stakeholders (that is, private facilities and specialist anaesthetists practising within them) and that training in the private sector will have deleterious effects on productivity.
- The ASA considers that the "service and workforce reform" scenario modelled by HWA should include an assessment of how the workforce in publicly funded facilities is best used. In making this comment, it is noted that virtually all anaesthesia services in teaching hospitals in North America are provided by specialists, with trainees largely supernumerary in terms of service provision (i.e. they are there to be taught, not to provide direct patient care as non-specialists). In other words, an indepth exploration of the "service and workforce reform" scenario would explore the specialist/non-specialist mix in teaching hospitals. To rephrase this, while "service and workforce" reform is often understood to mean expanding or limiting the scopes of practice of various health professionals, it might mean in anaesthesia (and in other disciplines for that matter) that more work in public hospitals could be more efficiently delivered by trained specialists rather than non-specialists (i.e. trainees).
- The ASA will stress that an oversupply of anaesthetists will surely lead to problems, as will an undersupply. Specialists should have access to professional practice that maintains their skills to the best advantage of patients and the community.

The ASA also questions:

- Whether the 'bonding' of trainees, and 'incentives' or other mechanisms used to geographically locate or relocate the specialty, could have unintended effects on the future anaesthesia workforce.
- Whether assertions that an earlier retirement age might be expected have any veracity.
- Whether in fact there is a need for overseas trained specialists in anaesthesia given our knowledge in relation to the intractability of provision of anaesthesia in rural and remote areas.
- Whether caveats on 'hours of work' would be realistic outside employee practice.

The ASA will be commenting on the ANZCA training program to say that it fully endorses it.

PRIVATE HOSPITAL PRACTICE

It has been mentioned in previous reports that some members are reporting difficulties with the administrations of the private hospitals in which they practice. These include disciplinary and accreditation/reaccreditation matters. Partly pre-emptively but also partly in response, the Society had produced a position statement (PS) dealing with anaesthesia governance in private facilities (ASA PS16). Members are urged to read this document, which can be found on the ASA website. It does provide an overview of the collective thinking of the Society in this area. It would be disingenuous to think that hospitals feel bound by its content but it is proving useful in dealing with some issues. A related document (ASA PS7) deals with credentials and scope of practice. Other bodies, including ANZCA and the Australian Commission on Safety and Quality in Health Care (ACSQHC) address this area, but only the ASA considers the industrial implications of the difficulties.

> Members are reminded that where propofol is used to produce "deep sedation" to facilitate diagnostic or interventional procedures, general anaesthesia may be the outcome, intended or otherwise

The ASA is very willing to address member concerns in these matters. Often a great deal of information is required in effecting results. It also needs to be noted that membership of the AMA also enables further, often critical, support to be given, with the AMA possessing particular expertise at the level of its state branches. Dual membership of both organisations may be regarded by some as expensive, but its value is frequently observed by members of PIAC, especially when serious challenges to the stability of one's professional practice are posed.

OTHER BUSINESS

PIAC is very busy responding to the publications and reports of the bodies that have been established by government at state and federal levels in recent years (HWA and ACSQHC being just two examples).

Anaesthesia and You

Minor modifications to the Society's patient information brochure, *Anaesthesia and You*, have been made and will be included in the next print run.

Non-anaesthetist administration of propofol (NAAP)

This is the latest acronym for an area that remains under intense scrutiny.

NAAP has been discussed at some length. PIAC's view is that the multi-party ANZCA Professional Standard 9 (which addresses "sedation and/or analgesia") aligns reasonably with the views of the ASA and that it should be the benchmark document regarding the appropriate use of propofol in this limited context. Members are reminded that where propofol is used to produce "deep sedation" to facilitate diagnostic or interventional procedures, general anaesthesia may be the outcome, intended or otherwise, and that the recommendations of ANZCA Professional Standard 55 (which addresses "anaesthesia") need to be considered.

Vale and welcome

At this time I would like to take the opportunity to thank two of our departing PIAC members: Dr Nigel Symons (New South Wales), who has previously chaired the Committee and in particular provided guidance during the 'medical indemnity meltdown' and the subsequent reforms to medical indemnity insurance, and Dr Peter Devonish (South Australia), who is a past GASACT Chair. Their contributions are greatly appreciated. I would like to welcome Dr Michelle Horne (Victoria) and Dr Simon Macklin (South Australia) who have agreed to join PIAC. We look forward to their valuable insights in the coming months.

INSIDE YOUR SOCIETY

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

The ASA's Overseas Development and Education Committee (ODEC) offers a range of educational opportunities in conjunction with volunteer work. Here, Committee Chair Dr Rob McDougall reports on recent activities.

LIFEBOX

In just over one year, ASA members have raised more than $71,000 for Lifebox. Our oximeters have been distributed to many Pacific nations, including Samoa, Tonga, Fiji and the Solomon Islands, with more oximeters to be sent to East Timor and Mongolia very shortly. The oximeters going to East Timor and Mongolia are the result of an ASA/ODEC supported fundraiser held late last year, which was held at the Malvern Bowling Club in Melbourne, Victoria.

The event was a 'Barefoot Lawn Bowls and Argentinean BBQ' organised by three event management students at Holmesglen TAFE and supported by the ASA. A silent auction with donations from a number of local businesses was held. Entertainment consisted of a wandering guitarist and a demonstration of Argentinean Tango by one of the silent auction donors. The bowling green was used by only a small number of guests due to wet weather. During the course of the evening each guest received a demonstration of a Lifebox pulse oximeter, speeches were given by ASA President Dr Richard Grutzner and myself, and Lifebox's *Make it Zero* video was shown.

This event was successful and feedback from attendees was very positive. The practical demonstration of the Lifebox on each guest appeared to be a very powerful tool for non-medical people to better understand the project. More than $9000 was raised and thanks must go to the three organisers, Damien, Megan and Shelagh. This money will be used to provide Lifebox pulse oximeters (with training) to medical facilities in East Timor and Mongolia.

UPCOMING EVENTS

ODEC supports many events that take place all over Australia and around the world.

In just over one year, ASA members have raised more than $71,000 for Lifebox.

The always popular Real World Anaesthesia Course is coming around again, with this year's course to be held at the Frankston Hospital Department of Anaesthesia in Melbourne from 28 October to 1 November. Places are limited, so go to www.asa.org.au/events/future_events for more information or to find the registration form.

From 21–25 February 2014, the combined meeting of the 14th Asian Australasian Congress of Anaesthesiologists (AACA) and the 4th Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA) will take place in Auckland, New Zealand. The AACA is the major regional meeting of the World Federation of Societies of Anaesthesiologists and is held every four years, so put it in your diary! More information can be found on the AACA website, www.aaca2014.com.

Preceding this congress is the Pacific Super Meeting, which will take place in Auckland from 20–21 February 2014. The aim of this meeting is to get Papua New Guinean, Micronesian and Pacific anaesthetists together for a refresher course and we will need ASA members to volunteer as locums. Many ASA members have already expressed an interest in this and it is fantastic to see such enthusiasm to help our Pacific colleagues. For more information contact me at rob.mcdougall@rch.org.au and keep an eye on the locums page on the ASA website.

DONATE TO LIFEBOX

Help us take a stand against unsafe surgery by making a contribution to send a Lifebox pulse oximeter to an operating room in need. Go to www.asa.org.au/anaesthetists/education/lifebox for more information or to donate.

RETURN TO CONTENTS

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

Curator Anna Gebels and Librarian Dr Peter Stanbury report on the recent initiatives undertaken by the History of Anaesthesia Library, Museum and Archives Committee (HALMA).

HALMA plays the important role of collecting, preserving and recording the history of anaesthesia and of the ASA.

HISTORY OF ANAESTHESIA EXHIBITION

23 January–3 May 2013

On 23 January the *History of Anaesthesia Exhibition* opened at Fisher Library, University of Sydney, as part of the International Symposium on the History of Anaesthesia. It is the first exhibition to grace Fisher Library's new exhibition space. Approximately 70 people attended the opening reception, which was hosted by the University.

The exhibition is a joint project by the ASA's Richard Bailey Library and Harry Daly Museum with Rare Books and Special Collections, University of Sydney Library. The internal exhibition space consists of 20 cabinets. Each cabinet contains a selection of books and anaesthetic equipment and objects relevant to a key theme which is outlined on a display panel at the top of the cabinet. The external display area for the exhibition comprises 12 panels and cases featuring a physical representation of Dr Reg Cammack's 'History of Anaesthesia Timeline'. These panels include images illustrating the key points and also incorporate windows into which books or objects are inserted to physically illustrate the history.

The exhibition features rare and significant items from all three collections. One of the most significant books exhibited is *Memoire sur la decouverte du magnetisme animal* (1779) by Franz Anton Mesmer from the Richard Bailey Library. In this seminal work Mesmer came to the conclusion that the human body itself is a magnet and that the physician, using his own body magnetically, can produce the most effective cures. (Crabtree's bibliography, 1988). It is bound with several other important works.

Also on display is James Esdaile's *On mesmerism in India and its practical application in surgery and medicine* which was first published in 1846. James Esdaile used mesmerism as an effective anaesthetic while removing the huge (up to 80 pounds in weight) scrotal tumours endemic in India. Remarkably, even his native assistants could also use the procedure effectively given sufficient preparation. The Deputy Governor of Bengal appointed a committee that selected ten patients for a trial to see if Esdaile's claims could be substantiated. Seven out of ten were successfully treated and their tumours removed with little or no pain. Esdaile performed over 250 operations using this technique in his 20 years in India.

A favourite has also been Cauncy Leake's *Letheon, the cadenced story of anaesthesia* (1947). It relates the whole history of anaesthesia in verse.

The exhibition is free and open to the public during library opening hours. For more information visit www.asa.org.au/asa/history.

Image: The administration of Nitrous Oxide and Ether by means of a Clover's Portable Ether Inhaler, a special form of Stopcock, and a detached Gas-Bag
Frederick W. Hewitt, Anaesthetics and their Administration (1893)
Rare Books and Special Collections, University of Sydney

HISTORY of ANAESTHESIA EXHIBITION
23 JANUARY–3 MAY 2013

PRESENTED BY THE **AUSTRALIAN SOCIETY OF ANAESTHETISTS** WITH **RARE BOOKS AND SPECIAL COLLECTIONS, UNIVERSITY OF SYDNEY LIBRARY**

VENUE
Exhibition Space
Level 2, Fisher Library
Eastern Avenue, Camperdown Campus
University of Sydney

INQUIRIES
T +612 9351 2992

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

QUEENSLAND COMMITTEE

Dr Gerry Turner, Chair

Well the festive season is over and Queensland weather is up to its old tricks. First it's drought, then it's a cyclone and now it's monsoonal rain! Some people have suffered damage and loss, but hopefully not too severely.

The 37th Annual Queensland ANZCA/ASA Combined CME Conference is scheduled for 22 June 2013. The conference will once again be held at the Brisbane Convention and Exhibition Centre. Our theme this year is *Together everyone achieves more! Anaesthesia in the team environment*. Just a reminder that there is a very important rugby match that night: the Wallabies vs the British Lions! Why not come from interstate and do both? Continuing professional development points and a rugby match—who could ask for more?

We held our Part 0 Course on Saturday 16 February. Once again it went well, with the 22 attendees saying it was very beneficial. Congratulations to Dr Louis Guy who won the draw prize, which was an entry fee to the ANZCA primary long course valued at $550. I would like to thank Drs Mitch Morse, Josh Daly and Ms Jennifer Burgess for all their hard work in arranging this.

Unfortunately the visiting medical officer agreement at the Mater Hospital is ongoing. An emergency meeting was held in February for further discussion. I will keep members informed of all new developments regarding this issue.

NEW SOUTH WALES COMMITTEE

Dr Murray Selig, Chair

The New South Wales Committee consists of the following members: Drs Murray Selig (Chair), Michael Farr (Vice Chair/ANZCA Representative), Sudeep Apana (Secretary), Ian Woodforth (Immediate Past Chair/Honorary Treasurer), Elizabeth Feeney (Past President/AMA Representative/EAC Representative), Ming Chan (Rural Representative), Catherine Downs (Iamonline Representative/CME Representative), Ian Cox (Committee Member), Michael Levitt (Committee Member), Gregory Purcell (Committee Member), Adam Hill (GASACT Representative) and Trylon Tsang (GASACT Representative). Together, we are currently working on a number of projects.

The GASACT representatives Drs Adam Hill and Trylon Tsang recently organised a very successful GASACT Part 0 Course, as well as a GASACT social event. Both of these events were well attended and I would like to thank Drs Hill and Tsang for their efforts. .

On Saturday 16 March, Dr Michael Farr convened the New South Wales CME, which was themed *Updating today's practice and thinking about tomorrow*, and took place at the Sydney Hilton. It was a very successful meeting and we received excellent feedback from attendees.

Prof Stephen Gatt recently resigned from the Public Patients Advisory Committee. Prof Gatt was our representative on this Committee, as well as being the Chair. As such, a new representative from the New South Wales Committee of Management will need to be appointed.

AUSTRALIAN CAPITAL TERRITORY COMMITTEE

Dr Guy Buchanan, Chair

The anaesthesia community of the ACT, with the leadership of Dr Mark Skacel as Convenor, is busy preparing for the National Scientific Congress which will be held this spring in Canberra. We are looking forward to welcoming the wider anaesthesia community to our lovely city and a dynamic meeting with a scientific program of wide interest has been prepared, as well as a strong GASACT stream. The social program promises to be a highlight, with the Gala Dinner set to take place in the Great Hall at Parliament House. I am personally looking forward to viewing samples of the botanical species that undergird much of pharmacology with one of the planned workshops taking place at the National Botanical Gardens!

In other news, visiting medical officer contract negotiations are commencing shortly with ACT Health and hopefully there will be some goodwill to address some systematic issues which have been undermining morale, as well as ensuring positive financial outcomes.

Dr Dinuk Jayamanne was the inaugural winner of the ASA ACT Registrars Prize with a presentation on research conducted regarding a rescue method for damaged endotracheal tubes pilot balloon. The competition was keen and thanks to the other presenters as well as our judges, Drs Linda Weber, Vida Viliunas and Prof Brussel, and those who attended and we look forward to this year's registrar presentations.

VICTORIAN COMMITTEE

Dr Mark Suss, Outgoing Chair

The Victorian Committee was pleased to host the annual GASACT Part 3 Course late in 2012. As always, this was an opportunity for senior trainees to learn about consultant life, but also to inform senior colleagues of their priorities and concerns, especially in the current challenging practice environment.

Our Annual General Meeting took place on 24 February at Kooyong and featured a fascinating presentation by Dr Suzi Nou about her ongoing anaesthetic projects in Phnom Penh, Cambodia, and elsewhere. Dr Peter Seal, who has contributed hugely to the Victorian anaesthetic community as a longstanding education officer, was elected as the new Victorian Chair, with Dr Antonio Grossi as Vice Chair. I wish to thank the Committee for the enormous amounts of effort and time they have donated to their community.

Recent Victorian media coverage reminds us how misunderstood our work as anaesthetists can be. All members are urged to increase their profile on all relevant committees such as medical advisory committees at their local hospitals if they wish to retain control over their working environment.

Looking ahead, we anticipate an excellent combined ANZCA/ASA Winter Meeting on 27 July at the Sofitel, themed *Mythbusting in Anaesthesia*. Save the date.

TASMANIAN COMMITTEE

Dr David Brown, Chair

There was an anatomy workshop held for trainees in January, which was very successful, at the Medical Sciences Precinct in Hobart. We hope to repeat this workshop for consultants later this year.

Our State Meeting was held from 15–17 March 2013 at the Tramsheds in Launceston and it was a great success. The theme of the meeting was *Past, future, and what the?!!* Invited speakers were Prof Ross MacPherson and Drs Elizabeth Feeney and Paul Lee-Archer. Welcome drinks were held at the Stillwater wine bar on the Friday evening. The conference dinner was held at the Queen Victoria Museum and Art Gallery.

There will be a mid-year meeting on Saturday 3 August. This will be held at the Freycinet Lodge on the Tasmanian east coast. It will have a focus on current and future anaesthetic workforce and risk reduction strategies. Registrants will need to make their own accommodation and dinner arrangements.

As Chair, I wish to formally thank retired secretary Di Cornish for her outstanding work and dedication over the last 21 years. We invited Di to our annual scientific meeting in March in order to thank her more formally.

The ASA is keen to maintain its existing close relationship with the College and intends to utilise the new secretary for six hours per month.

The new Tasmanian Coordinator is Janette Papps. She is employed for 15 hours per week and is available Wednesday to Friday. Our intention is to see how this goes for 12 months and then review, depending upon the workload. Her office is in AMA House at 147 Davey Street, Hobart.

WESTERN AUSTRALIAN COMMITTEE

Dr Ralph Longhorn, Chair

Our new Secretariat Dr Melissa Roberts, Regional Coordinator and Louise Burgess, Regional Administrative Officer, have settled well into their roles and are already invaluable.

Our CME Committee has been busy as usual and we are looking forward to our Autumn Scientific Meeting at the club at the University of Western Australia. The theme is *All in a Day's Work*, focusing on day care anaesthesia. The Bunker Bay Update on Anaesthesia is to be held from 11–13 October and is on enhanced recovery from surgery. It is being convened by Dr Rupert Ledger from Fremantle Hospital.

We thank Dr Angela Palumbo for her hard work and enthusiasm as CME Officer and welcome Dr Lip Ng into the role.

The GASACT Committee hosted a successful Part 0 Course with a particular emphasis on the welfare of anaesthetists. So well done to the outgoing GASACT reps, Drs David Hoppe and Melissa Hacque, and good luck to the incoming Drs James Miller and David Janmaat.

CONTINUING PROFESSIONAL DEVELOPMENT COMMITTEE

Dr Vida Viliunas, Chair

The launch of the ASA Continuing Professional Development (CPD) Management System has been delayed due to technical issues, as mentioned within the President's e-newsletter.

The CPD Committee has been working tirelessly to produce a CPD product that:

- is outstanding, intuitive and user-friendly,
- enables members to find relevant and upcoming CPD activities,
- assists members to identify their CPD category,
- allows members to enter and attach their proof of participation, and
- provides members with the ability to track their CPD progress via multiple mobile device platforms.

The Committee has designed a system that is superior to the ones currently available for anaesthetists and that complies with Australian Health Practitioner Regulation Agency CPD requirements. It will be a system that busy clinicians will want to use.

The ASA looks forward to providing further updates about the development of the CPD Management System in the upcoming ASA magazines and e-newsletters. In the mean time, we appreciate and thank you for your interest and patience.

For further information on the CPD

INSIDE YOUR SOCIETY

Management System, feel free to contact the CPD Team by calling 02 9327 4022 or emailing cpd@asa.org.au.

ASA CPD—let's make it easy!

ISHA 2013—HISTORY MATTERS!

Dr Jeanette Thirlwell, Co-Convenor

The recent International Symposium on the History of Anaesthesia (ISHA) was a great success, thanks to the enthusiasm and attention to detail by all members of the Organising Committee in the planning of the meeting. We continue to receive emails of appreciation and congratulations from our attendees, especially Dr David Wilkinson's glowing summary of the whole event. David, a well-known anaesthesia historian and current President of the World Federation of Societies of Anaesthesiologists, made special mention of the opening of the Symposium by Her Excellency Professor Marie Bashir AC CVO, the Governor of New South Wales, which added significance and elegance to the occasion.

The list of speakers was largely a 'Who's Who' of anaesthesia historians and we were honoured; many of them travelled long distances to attend.

Congratulations are due to Ms Anna Gebels, Curator of our Harry Daly Museum and Dr Peter Stanbury, former Curator, now Librarian of the Richard Bailey Library, for their incredible mounting of a magnificent display titled *History Matters* in the Rare Books Collection at Fisher Library. The opening on 23 January, the first evening of ISHA, was very well attended. The exhibition continues through to 3 May.

Accommodation arrangements for ISHA attendees also worked well. The whole organising committee are to be congratulated. Thanks are also due to Robert Campbell and Katie Fitzgerald for their smooth organising of registrations and accommodation and the other duties they performed.

RETIRED ANAESTHETISTS GROUP, NEW SOUTH WALES

Dr David Gibb, Chair

A luncheon for retired anaesthetists was held on Sunday 30 September 2012 at the 71st National Scientific Congress of the Society in Hobart. It was a lively meeting attended by 17 members and their guests. I was somewhat alarmed when I received a cryptic note stating that "PM will be arriving early". Our previous luncheon in Perth had been honoured by the attendance of new ANZCA President Dr Lindy Roberts and new CEO Ms Linda Sorrell, so I was not too fazed by the prospect of entertaining the 'PM'. I did, however, contact our secretary asking her to request that all attendees wear formal attire, exhibit exemplary behaviour and not mention the 'Mad Monk'. Our secretary explained that there had been a misunderstanding as 'PM' referred, not to Julia Gillard, but to Peter MacLean, the ASA Corporate Services Manager, who would be arriving early to ensure that the luncheon venue had been prepared in accordance to our requests.

This function gave me the opportunity to report the award of honours to three of our members: Dr John Keneally AM for his work in paediatric anaesthesia; Dr Rod Westhorpe AOM for his contributions to anaesthesia; and Dr Graham Grant who received the David Dewhurst Award for his engineering work on neonatal cribs. Regrettably, it was also my sad duty to record the deaths of 14 retired members including two personal colleagues: Dr John Keneally, who died shortly after receiving his Australia Day Honour; and Dr Warren Gunner, a foundation member of the pioneering cardiac surgery unit at St Vincent's Hospital in Sydney.

Following the luncheon I was approached by several members indicating how much they had enjoyed the get-together. They all spoke in favour of the refectory-style table provided for the luncheon, as it facilitated easier communication between colleagues than the standard circular dining table. I would again like to thank all those who attended the luncheon and the Society for sponsoring this most enjoyable occasion.

RETIRED ANAESTHETISTS GROUP, SOUTH AUSTRALIA

Dr David Fenwick, Chair

The retired anaesthetists in South Australia attended the usual six lunches in 2012. Attendance varied from 12 to 22 at the lunches and they were all most enjoyed. The format of a meal and a chat seems to be the preferred option by the current members. Any anaesthetists visiting from other states are welcome to join us. Contact Dave Fenwick at phoenix22@bigpond.com for details.

Three new faces appeared this year after several years of static membership. Dr Vic Dreosti and I put this down to the global financial crisis and anaesthetists working later into their careers. The new anaesthetists were Drs Lachlan Dickson, John Richards and Dave Tomkins.

Sadly, we also learned of the deaths of three retired anaesthetists: Drs Jim Saunders, Peter Gartrell and Tom Allen.

Jim was the Director of Anaesthesia at the Queen Elizabeth Hospital in the west of Adelaide for many years. During that time, the department was accredited by the Faculty and College as a training facility for registrars. Jim expressed interest in attending Retired Anaesthetists Group lunches, but passed away just before attending the first one.

Peter was in a successful private practice. For many years he was a visitor at the Queen Victoria Hospital for Women, providing service in and out of hours. He was also Regional Chair of the Faculty Committee for South Australia and he was Chair of the Anaesthetic Morbidity and Mortality Committee for South Australia and the Northern Territory.

INSIDE YOUR SOCIETY

DR MICHAEL F. BEEM
1954–2013

Mike Beem died on 25 January 2013 aged 58, just over eight years after a surfing accident which left him a ventilator dependent quadriplegic.

Mike was a University of Queensland graduate and, after initial postgraduate practice at the Launceston General Hospital, trained in anaesthesia within the Princess Alexandra Hospital in Brisbane and its associated hospitals. He attained his FFARACS in 1984.

Mike was a good doctor in the broader sense and loved being a member of the medical profession. He was destined to have a successful practice.

After a senior registrarship at the London Hospital in 1985 and 1986, accompanied by his wife Sylvia and two small children, Mike joined the Brisbane Clinic Anaesthesia Group, becoming also a visiting medical officer at the Royal Brisbane Hospital.

Mike's contribution to the specialty and the profession went beyond his immediate private and public practice: he was State Chair of ANZCA at the time of his accident, a keen supporter of the ASA and a significant contributor to the Wesley Hospital, which subsequently honoured him as an Emeritus Fellow. Mike also put an enormous amount of work into the administration of what became Wesley Anaesthesia and Pain Management—something always underestimated and at times incompletely appreciated.

Mike's accident occurred on Burleigh Beach on Thursday 30 December 2004. Always busy, a surf before an afternoon list was planned. Sylvia and the children were with him. There are varying accounts of what happened in the first few hours at the Gold Coast Hospital and then at the Princess Alexandra Hospital. A diagnosis was, however, immediately forthcoming: he was a ventilator dependent quadriplegic. His friends and colleagues were shocked, but hoped that somehow there could be some miraculous and significant improvement in his condition. This was not to be.

Mike's courage in the intensive care unit at the Princess Alexandra Hospital was apparent and remarkable, as was the complete support given by Sylvia. Even at this early stage, Mike was concerned about the effect his accident might have on his Group. Mike experienced the usual torrid time that quadriplegics undergo. Surviving a number of near fatal intercurrent events, he finally got a 'speaking valve'—a miracle: the brain as good as ever, those perfect non-smoking lungs just a little sandy. Mike was utterly determined to get home and many of his friends and colleagues attended his 51st birthday—a triumph for him and his family. The ASA Benevolent Fund was a vehicle that facilitated the installation of a lift that enabled him to negotiate his home.

It is necessary at this juncture to state that Mike felt that he had been deeply affronted, frustrated and saddened by what he felt was his management by some of the staff in the intensive care and spinal units. He dictated his recollections about these experiences in early 2012 and it is hoped that these will be published at a future date.

Mike's ongoing passion for the profession was ultimately, a number of us think, best expressed through his special relationship with his team of carers, many of whom attended his funeral, and many of whom maintained contact with him even after they had moved on. An appreciable number were medical students, it having become known within medical student circles that there was a doctor who needed high-dependency care. It was a pleasure to watch Mike 'talking shop' with students who are now doctors, and in one case, an advanced trainee in anaesthesia.

Only after his death were we, I think, fully aware of the frenetic round-the-clock activity that was needed to keep Mike in such good health while he was in such immediate and continuous peril. His only pressure sore occurred while he was hospitalised, not while he was at home. His final short illness was related to sepsis and was sensitively and appropriately managed by his general practitioner and a palliative care physician at home, as he would have wished.

Through all of this, what we witnessed that impressed us most was Mike's ongoing good humour and courage, and Sylvia's unwavering commitment to him. It was inspiring. One of Mike's friends and classmates expressed it this way a few days after his death:

"Michael was a man of immense courage. His love of his wife, children and friends imbued him with a quality of life unimaginable with such a degree of disability. He was a great friend who will be missed forever".

Mike is survived by Sylvia, his children Kylie and Jason, his parents, his brother Chris and his sister Anne-Marie and their families.

Dr James Bradley

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from September 2012 to March 2013.

ORDINARY MEMBERS

Dr Marion Irene Andrew	SA
Dr Linda Aykut	VIC
Dr Stephen Victor Bianchi	QLD
Dr Matthew Wan Chiew	NSW
Dr Emily Dickson	VIC
Dr Thomas John Douch	NSW
Dr Alex Fang	NSW
Dr Jeremy Fernando	QLD
Dr Ian Forsyth	WA
Dr Shivakumar Hampasagar	NSW
Dr Conrad Hermann Heim	QLD
Dr Mario Salvador Henriquez	NSW
Dr Madeleine Ho	VIC
Dr Zoe Keon-Cohen	VIC
Dr Ann-Lynn Kuok	WA
Dr David C. Liessmann	QLD
Dr Knox Critchton Low	NSW
Dr William Charles Macaulay	NSW
Dr Pieter Stapleberg Peach	VIC
Dr Srinivas Rachakonda	QLD
Dr Fiona Reardon	NT
Dr Nicole-Maree Sheridan	VIC
Dr Jonathan Mathew Shirley	QLD
Dr Namrata Singh	NSW
Dr Dana Stanko	NSW
Dr Philip Stephen's	QLD
Dr Johnson Ravi Symon	VIC
Dr Stanley Tay	NT
Dr Jason David Thomas	VIC
Dr Clement Tiong	NSW
Dr Ravi Tiwary	QLD
Dr Radha Vivekananthan	VIC
Dr Ashley Webb	VIC
Dr Charles Willmott	QLD
Dr Andrew Norman Richard Wing	SA
Dr Italo Augusto Zamudio Villarroel	WA

TRAINEE MEMBERS

Dr Alexandra Elizabeth Zanker	SA
Dr Kate Barrett	VIC
Dr Camilla Bourke	WA
Dr Brigid Brown	SA
Dr Paul Cheng Loon Chan	VIC
Dr Samuel Timothy Costello	VIC
Dr Emma Culverston	NSW
Dr Tim Donaldson	SA
Dr Paul Drakeford	NSW
Dr Matthew Luke Durie	VIC
Dr Nancy Fammartino	VIC
Dr Alicia Jane Gauden	TAS
Dr Rafsan Halim	VIC
Dr Anna Karen Hayward	WA
Dr Margot Heaney	NSW
Dr Adam Hill	NSW
Dr Michael Francis Hussey	QLD
Dr Alistair Kan	QLD
Dr Sarika Kumar	SA
Dr Anna Loughnan	VIC
Dr Josephine Maria	QLD
Dr Katie McCloy	ACT
Dr David Neale	ACT
Dr Catherine Pease	VIC
Dr Katelyn Priester	NSW
Dr Colm Quinn	WA
Dr David Brian Anthony Rawson	WA
Dr Rajesh Shankar Reddy	ACT
Dr Lalitha Sivagnanam	VIC
Dr Johan Joseph Smit	SA
Dr Mei Quinn Tan	SA
Dr Hani Tayeh	QLD
Dr Claudia Tom	SA
Dr Samuel James Walker	TAS
Dr Megan Walmsley	NSW
Dr Bernadette Jane White	VIC
Dr Suzanne Whittaker	VIC
Dr Chaminda Wijeratne	NSW

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr James Maurice Purchas, OAM, ACT, Drs William Foster Thompson, Robert Sweeney and Judith Williams, NSW, Drs William Thomas Reynolds and Michael Beem, QLD, Dr Betty Brenda Spinks, VIC and Dr Thomas Allen, SA.

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

Australian Society of Anaesthetists Membership Achievements

Australia Day Honours
Member (AM) in the general division of the Order of Australia:

Dr Alan William Duncan, Floreat, WA. For significant service to medicine in the field of paediatric intensive care as a clinician and educator.

ASA 50 year membership:

Dr Alick Truscott Hobbes
Dr Donald Lang
Dr Geoffrey Joseph Long
Dr Jacqueline McLeod
Dr Richard Vousden Young
Dr Robert Ernest Steele
Dr Isabel Eliza Sutton (Wluka)
Dr Arthur F Woods, OAM, AM

All 50 year members receive a certificate and lapel badge.

ASA
Australian Society of Anaesthetists

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UPCOMING EVENTS

MAY 2013

History of Anaesthesia Exhibition
Date: 23 January–3 May 2013
Venue: Exhibition Space, Level 2, Fisher Library, Eastern Avenue, University of Sydney, New South Wales
Contact: Anna Gebels, ASA
agebels@asa.org.au

Practice Managers Conference
Date: 31 May 2013
Venue: Mercure Sydney Hotel, 818–820 George Street, Sydney, New South Wales
Contact: Katie Fitzgerald, ASA
kfitzgerald@asa.org.au

JUNE 2013

New South Wales AGM
Date: 15 June 2013
Venue: Hilton Hotel, 488 George Street, Sydney, New South Wales
Contact: Shelly Dubois, ASA
sdubois@asa.org.au

Trauma and Airway Management SIG Meeting
Date: 29 June 2013
Venue: Langham Hotel Melbourne, 1 Southgate Avenue, Melbourne, Victoria
Contact: Hannah Burnell, ANZCA
hburnell@anzca.edu.au

Cardiothoracic, Vascular and Perfusion SIG Meeting
Date: 30 June–5 July 2013
Venue: Sea Temple Resort and Spa, Mitre Street, Port Douglas, Queensland
Contact: Lana Lachyani, ANZCA
llachyani@anzca.edu.au

SEPTEMBER 2013

Perioperative Medicine SIG Meeting
Date: 13–14 September 2013
Venue: Byron at Byron Resort and Spa, 77–97 Broken Head Road, Byron Bay, New South Wales
Contact: Hannah Burnell, ANZCA
hburnell@anzca.edu.au

Combined Education, Management, Simulation and Welfare SIG Meeting
Date: 20–22 September 2013
Venue: Outrigger Little Hastings Street Resort and Spa, Little Hastings Street, Noosa, Queensland
Contact: Hannah Burnell, ANZCA
hburnell@anzca.edu.au

National Scientific Congress
Date: 26–29 September 2013
Venue: National Convention Centre, Canberra, Australian Capital Territory
Contact: Robert Campbell, ASA
rcampbell@asa.org.au
Website: www.asa2013.org.au

OCTOBER 2013

Real World Anaesthesia Course
Date: 28 October–1 November 2013
Venue: Frankston Hospital Department of Anaesthesia, 2 Hastings Road, Frankston, Victoria
Contact: Dr Christopher Bowden, Frankston Hospital
bowdencc@hotmail.com

FEBRUARY 2014

Combined Meeting of the 14th Asian Australasian Congress of Anaesthesiologists and the 4th Australasian Symposium on Ultrasound and Regional Anaesthesia
Date: 21–25 February 2014
Venue: SkyCity Convention Centre, Auckland, New Zealand
Contact: The Conference Company, NZSA
info@aaca2014.com
Website: www.aaca2014.com

MARCH 2014

Obstetric Anaesthesia SIG Meeting
Date: 21–23 March 2014
Venue: Shangri-La Hotel Sydney, 176 Cumberland Street, The Rocks, Sydney, New South Wales
Contact: Lana Lachyani, ANZCA
llachyani@anzca.edu.au

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

ACECC
Anaesthesia Continuing Education Coordinating Committee

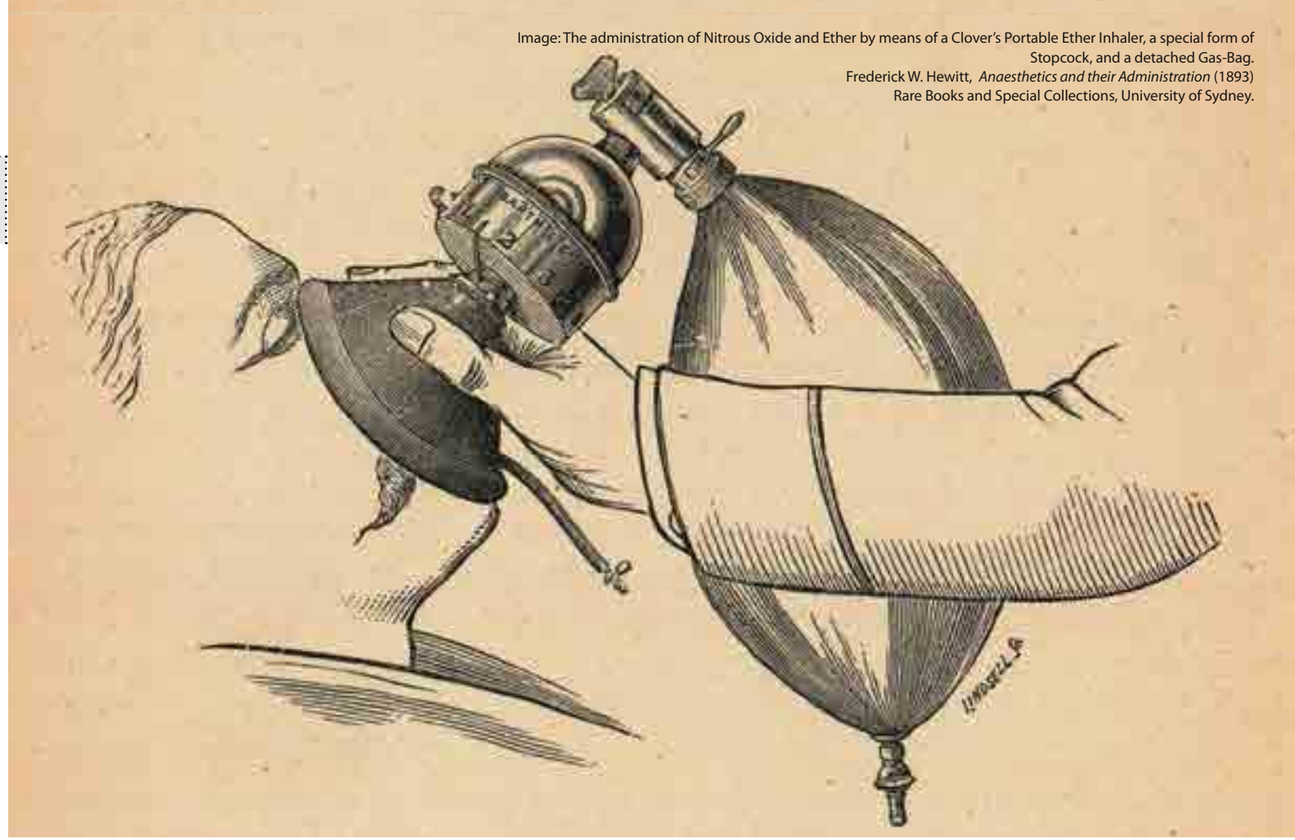

Image: The administration of Nitrous Oxide and Ether by means of a Clover's Portable Ether Inhaler, a special form of Stopcock, and a detached Gas-Bag.
Frederick W. Hewitt, *Anaesthetics and their Administration* (1893)
Rare Books and Special Collections, University of Sydney.

HISTORY of ANAESTHESIA EXHIBITION

23 JANUARY–3 MAY 2013

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AUSTRALIAN SOCIETY OF ANAESTHETISTS
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VENUE
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INQUIRIES
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www.asa.org.au/asa/history

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REAL WORLD ANAESTHESIA COURSE

Frankston Hospital Department of Anaesthesia 28 October–1 November 2013

This is the 22nd RWAC (formerly RSDCDCA) and the third to be held in Melbourne.

Course fee: AUD $2900 inc GST

Registration form: www.asa.org.au/events/future_events

The four and a half day course concentrates on the practical teaching of drawover anaesthesia in theatre and an interactive problem-based lecture series to prepare anaesthetists for work in a variety of humanitarian aid and civil disaster situations. There are also sessions on equipment maintenance where you can get your hands dirty.

The number of participants is limited to 16 so as to maintain personal teaching and provide adequate opportunities for hands-on practice.

Topics include:

- Drawover apparatus
- Ketamine
- Oxygen concentrators
- Equipment maintenance
- Obstetric challenges
- Teaching: who, how and what
- Tropical medicine
- Psychology of adaptation

Australian Society of Anaesthetists

Practice Managers Conference 2013

Friday 31 May 2013 | Mercure Sydney
818–820 George Street, Sydney
Registration opens at 8:30am for a 9am start

Topics for this year's PMC will include:

- RVG/Medicare update
- Practice management—update on latest trends/structures
- Legislation update on consent, informed financial consent
- Human resources/staff management matters
- Risk management

If you would like to register your interest please contact the ASA events team events@asa.org.au

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