AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • APRIL 2014

ANAESTHESIA WORKFORCE SUMMIT

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MDA National Member

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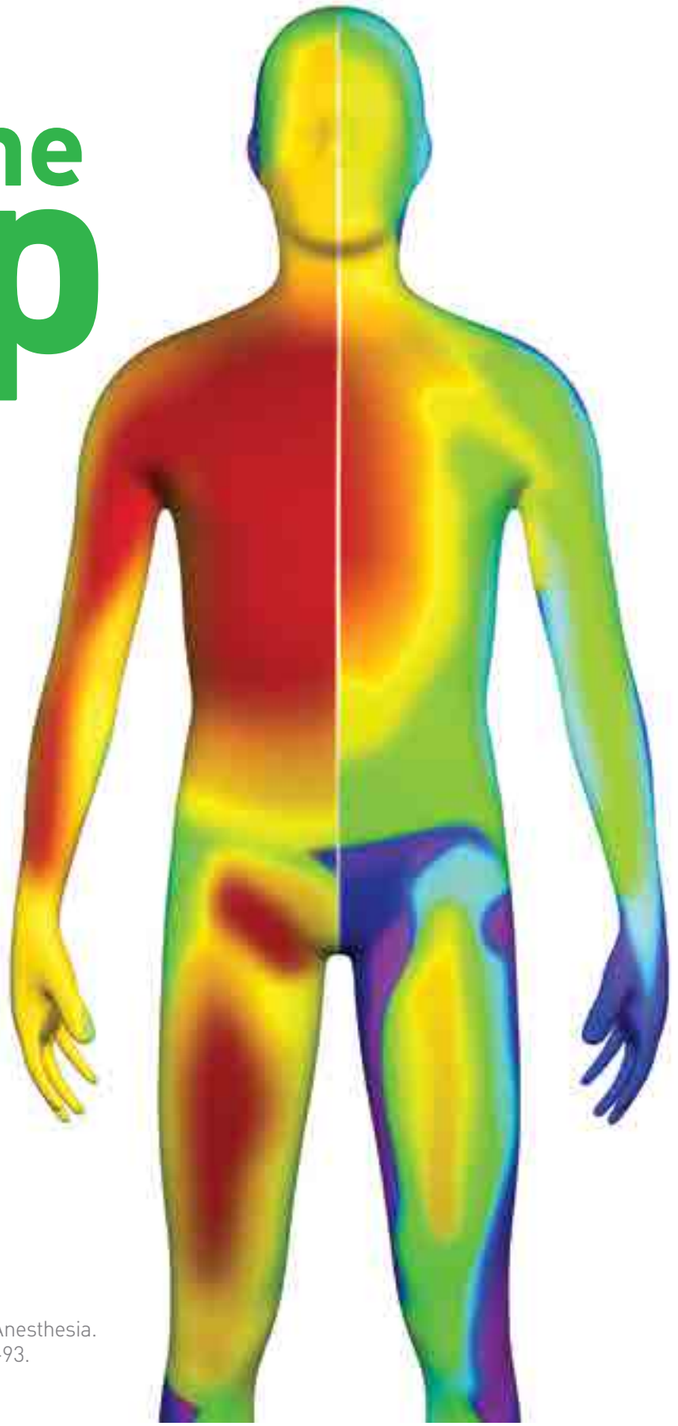

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During anaesthesia, the effects of the anaesthetic drugs/pharmaceuticals and the effects of the anaesthesia coupled with a reduction in metabolic heat production means patients are at an increased risk of hypothermia, which is defined as a core body temperature below 36°C. This can be exacerbated by a cold environment.

1. Sessler DI. Chapter 7 Temperature Regulation and Anesthesia. ASA Refresher Courses in Anesthesiology. 1993;21:81-93.

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ASA
Australian Society of Anaesthetists

12 WORKFORCE REPORT

REGULARS

FEATURES

LIFESTYLE

INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The August issue features of *Australian Anaesthetist* will focus on public practice.

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

- Intention to contribute must be emailed by 16 May 2014.
- Final article is due no later than 13 June 2014.

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

REGULAR | ASA EDITORIAL FROM THE PRESIDENT

REGULAR

ASA EDITORIAL FROM THE PRESIDENT

DR RICHARD GRUTZNER, ASA PRESIDENT

I would like to welcome members to the April 2014 edition of *Australian Anaesthetist*. The Society hosted a Workforce Summit at our new North Sydney head office on 7 December 2013. The Summit arose out of concerns expressed by our members, particularly our younger members, in relation to achieving satisfactory employment outcomes at the completion of anaesthesia training.

The Summit included representatives from the ASA, NZSA, ANZCA and AMA. It was also the first major meeting held at our new head office, which was appropriate given the importance of this issue to all Australian anaesthetists. The meeting was chaired by Dr Jim Bradley, Chair of the Professional Issues Advisory Committee, and his comments about the Summit, along with the opinions of a number of the participants, are included in this edition of *Australian Anaesthetist*.

Concerns have been expressed by many young anaesthetists about an inability to find suitable employment following the completion of anaesthesia training. Historically, most young Australian anaesthetists have spent a significant proportion of their time working as either staff anaesthetists or visiting medical officers with a significant number of weekly sessions in the public hospital system. They may then stay in the public system or move some or all of their time into the private system. This system has worked well and enabled a period of consolidation as anaesthetists transitioned from trainees to established practitioners. This reality was recognised by the then Faculty of Anaesthetists of the Royal Australasian College of Surgeons (now ANZCA) in 1988 with the creation of the Provisional Fellowship Year. This year was intended as one of consolidation. In addition, many anaesthetists undertook subsequent fellowships in sub-specialty areas prior to entering practice.

The reasons why young anaesthetists are having trouble securing suitable employment are complex and multi-factorial. There has been an increase in the number of anaesthesia graduates over the last ten years, which is entirely appropriate given the predicted increase in demand for services related to a growing and ageing population with high expectations of access to sophisticated medical care.

What we have seen recently is a failure of the matching of resources with the increase in demand

Other factors, such as the increase in female trainees entering the workforce and generational changes, were predicted to increase the demand for anaesthetists. The other major assumption has been that resources would be provided by state governments to meet the demand for care in the public hospital system. What we have seen recently is a failure of the matching of resources with the increase in demand. We have seen the development of increasing waiting lists for elective surgery and the new phenomenon of the hidden waiting list. The hidden waiting list is the waiting period required to see the surgeon who is then able to place the patient on the elective surgical waiting list. The waiting list to see, for example, an orthopaedic surgeon in some Victorian public hospitals may be as long as 18 months. All that this achieves is to artificially lower the politically sensitive waiting list for elective surgery. It may seem self-evident, but patients on either waiting list do not need a single nurse, a single operating theatre session, a single prosthesis, a single surgeon or a single anaesthetist. In many parts of the country, and particularly in Victoria, there have been significant budget cuts, resulting in reduced elective surgical throughput. Not surprisingly, the perception among young anaesthetists is that the workforce situation is worst in Victoria. I am however also hearing of problems in Tasmania, South Australia, Western Australia and Queensland. Even in rural New South Wales locations, which have traditionally relied on locums or overseas trained specialists, positions are now occupied by Australian graduates. Many rural locations which have used fly in, fly out locums no longer do so.

Throughout the developed world we are hearing of unsustainable increases in both the proportion of gross domestic product spent on healthcare and the absolute dollar amount. In countries such as Australia and New Zealand, healthcare represents up to 10% of gross domestic product and 20% of all government outlays, with increases above inflation continuing year on year. The ability of governments to continue to fund unlimited access to medical care has become or is becoming problematic. This has a negative impact on the demand for anaesthetists. At the same time, there is a healthy supply of anaesthesia graduates trained on the basis of predicted future demand.

In many parts of the country, and particularly in Victoria, there have been significant budget cuts resulting in reduced elective surgical throughput

This mismatch is an important reason for some of the current problems. Simultaneously, we understand from our member survey that Australian anaesthetists really enjoy their work and understandably are in no hurry to retire from practice. The plans of many anaesthetists to retire have also been delayed by the impact of the global financial crisis. This has placed further pressure on positions in some of our public hospitals, as has the ten-year moratorium on access to provider numbers for overseas trained specialists working in public hospitals in areas of need.

Is the situation faced by young anaesthetists any better or worse than that faced by graduates in other disciplines? Judith Sloan, in a recent opinion piece in *The Australian*, discusses this issue[1]. Between 2007 and 2012 there has been a 23% increase in the number of domestic university students, to reach a total of 934,000. Course completions over the same time have increased by 21%. Over a longer time frame, from 1999 to 2012, the number of course completions has increased by 82%, far in excess of the population growth. In 2013, 71% of bachelor degree graduates secured full-time work after graduation. There are now graduates in law, dentistry, veterinary science, nursing, speech pathology and education unable to find work in their chosen field. The prospect of medical graduates unable to work in medicine is real and is already occurring in parts of Europe.

Why then are anaesthetists any different from the rest of the graduate population, and why is it important that anaesthetists find suitable employment following graduation? Volume of clinical practice is an essential metric both for anaesthetists in training and for those in established practice. The ANZCA curriculum has volumes of practice (albeit minimum numbers) for trainees to achieve as part of the completion of the various study modules. For example, trainees need to be involved in the provision of anaesthesia to at least 50 women undergoing caesarean section during training.

Achievement of volume of practice combined with study of the basic and applied clinical science underpins the evolution of the anaesthetic trainee into an expert clinician. ANZCA, in the Professional Standard 16 (2008) Statement on the Standards of Practice of a Specialist Anaesthetist, states that "Regular work in anaesthesia of appropriate volume and complexity is necessary to maintain clinical skills"[2]. Similarly, the ASA Position Statement 11 Code of Conduct for Members requires that anaesthetists "Maintain the skill and competence levels required of them"[3].

The ASA vision statement is "to promote and protect the status, independence and interests of Australian anaesthetists and the welfare of their patients". Similarly, the ANZCA mission is "to serve the community by fostering safety and quality patient care in anaesthesia, perioperative medicine and pain medicine". The common thread between these statements is the provision of high-quality anaesthetic care for our patients. In order for any anaesthetist to provide the highest quality care, adequate volume of practice must be maintained along with participation in continuing professional development. The presence of underemployed, underscoped anaesthetists is not in accordance with the achievement of the stated aims of either the ASA or ANZCA and affirms the importance of recent graduates securing suitable employment at the completion of training.

Volume of clinical practice is an essential metric both for anaesthetists in training and for those in established practice

Other Australasian colleges regard volume of practice as an essential element in the assessment of adequacy of training positions. The Royal Australasian College of Surgeons assesses training positions with respect to the volume of practice among other factors, including appropriate level of supervision as part of the accreditation process. Among anaesthesia trainees we have heard concerns that the volume of practice in some clinical areas is being diluted among a larger number of trainees. This is regarded by the trainees themselves as having a detrimental effect on the quality of training.

One of the important points of consensus from the Workforce Summit was the recognition that we need high-quality data, particularly related to younger anaesthetists and those nearing retirement. I urge all members to respond to any future workforce

REGULAR

surveys of both the Society and ANZCA in addition to others such as MABEL and the information provided to the Medical Board of Australia as part of annual registration. Our advocacy on behalf of members is much easier with strong data, and we depend on you all for this. The National Medical Training Advisory Network, which has been developed subsequent to the Health Workforce Australia *Health Workforce 2025* report, appears to be proceeding. This body has the potential to control the number of training positions to ensure that a balance of supply and demand is achieved. There will however be ongoing pressure of increasing numbers of medical graduates to receive postgraduate training. Australian anaesthetists would not be surprised to know that anaesthesia is a very popular specialty among graduates. Recent information from the Medical Student Outcome Data shows that up to 9% of first-year medical graduates would like to pursue a career in anaesthesia. This percentage is much higher than the percentage of anaesthetists in the overall medical population and, combined with the increasing number of medical graduates, would suggest that there will be ongoing pressure for training positions despite the difficult employment situation for current graduates.

The brunt of the current workforce situation is being felt hardest by the youngest members of our profession

There is also a moral and ethical dimension to this problem. Trainees in anaesthesia spend many years developing highly specific vocational skills with limited applicability in other areas of employment. As a profession we have a moral responsibility to ensure that there is strong likelihood of graduates achieving satisfactory employment outcomes. If we are heading into a period of austerity where governments are not able to meet the community demand for medical services then it is clear that we will need fewer trainees, not just in anaesthesia, but most medical disciplines. The brunt of the current workforce situation is being felt hardest by the youngest members of our profession and, if for no other reason than equity, we as the leaders of the profession must strive to ensure we leave the profession in a better state than we found it. Please read the accompanying articles related to the workforce situation, engage with all of the professional organisations concerned with this issue and, as always, feel free to contact me at the Society with further comments or suggestions.

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

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

WORKFORCE SUMMIT—7 DECEMBER 2013

ASA President, Dr Richard Grutzner

Workforce delegates deliberate the issues at hand

PIAC Chair, Dr James Bradley

ASA CEO Mark Carmichael, ANZCA President Dr Lindy Roberts, ASA President Dr Richard Grutzner and ANZCA CEO Linda Sorrell

ANZCA General Manager Policy, John Biviano, and ASA Policy Manager, Chesney O'Donnell

Drs Andrew Mulcahy, Richard Grutzner and Guy Christie-Taylor

REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

At the fifth cricket test match of the recent Ashes Series played in Sydney between Australia and England, a member of the Sydney Cricket Ground (SCG) made headlines when she was refused admission to the members area. The reason: her dress was deemed too short. The woman, a lawyer, contacted the Sydney Morning Herald and the matter was played out in the popular press, with accompanying photographs, over the ensuing days.

It appears the member objected to the decision not to allow her to enter the ground and, as a result, requested that her membership be cancelled and that the names of her two sons be removed from the waiting list for membership. From media reports it would appear that the Sydney Cricket Ground Trust obliged and that was where the matter ceased, unless of course there are other actions being taken to which the public are not privy.

The matter created an interesting sideline to what turned out to be a rather short and one-sided test match. However, it did prompt a great deal of discussion on the value of membership, in this case with the SCG. On a broader scale it made for discussion on why someone chooses to become a member of anything, be it a sporting venue such as the SCG, a golf club or a professional body such as ASA?

There are a myriad of reasons and, in the case of the ASA where we have over 3000 members, the reasons are wide and varied. The marketing gurus use the phrase "the value proposition" to explain why someone joins a particular body. The value proposition is meant to explain what the appeal or value of being part of the organisation is meant to represent.

With this in mind I asked rhetorically, what is the value proposition for being a member of the ASA? With so many members, there must be something of value that makes anaesthetists want to remain or become a member.

The key element appears to be in why the Society exists—an organisation, focused purely on representing, supporting, connecting and educating members. At the same time, the Society is governed by a Council comprising of members who volunteer their time for the benefit of others. This concept of professionals wanting to voluntarily work to assist their current and future colleagues is indeed a powerful one and represents a significant aspect of the value of being a member of the ASA.

Spinning off from this higher principle are of course the more tangible benefits that go with membership. Such things as member advocacy and representation are critical. ASA advocates on behalf of members at a wide range of levels, including state and federal governments, the Medical Services Advisory Committee, private health insurers and other medical organisations such as the AMA. At the same time, its active and focused attention to the development of appropriate position statements and active participation in matters concerning rebates and fees are very clear reasons as to why it is essential to be a member.

This concept of professionals wanting to voluntarily work to assist their current and future colleagues is indeed a powerful one

An example of the Society working for members both current and yet to join is in relation to the debate concerning workforce. Have we got the right number of anaesthetists now? Are the training opportunities sufficient to ensure the ongoing quality of training which has been the hallmark of the speciality? What are the work opportunities for the next decade looking like? These are all questions being addressed now which have serious implications for the future.

The extensive educational opportunities made available to members and trainees is another aspect of the value proposition of ASA membership. Continuing Professional Development is a core offering of the ASA. This is further enhanced by the array of awards and scholarships on offer. Of particular value are those generous scholarships made available annually to the Group of ASA Clinical Trainees (GASACT) to attend the leading overseas society meetings. It is evident from the reports provided by those fortunate enough to attend such a meeting how appreciative they are of the opportunity made available to them.

The extensive educational opportunities made available to members and trainees is another aspect of the value proposition of ASA membership

On another level, the volunteer work delivered under the auspices of the Overseas Development and Education Committee (ODEC) is a very real example of members at work and provides an important avenue for any member who is wanting to provide assistance and aid beyond Australia's shores.

Members often comment about the value of the printed material made available through the Society, be it via *Anaesthesia and Intensive Care*, the *Anaesthesia & You* brochure or the access provided to a variety of international journals via MEDLINE (which is available to all members and can be found in the members section of the website under the 'Education and Events' tab).

The above is in no way an exhaustive list of the benefits of being a member. However, what it does do is shine a light on how different aspects of the Society appeal to different members and how members can take advantage of their membership in a variety of ways.

In light of the thought-provoking events at the SCG, I encourage all our members to reflect on the real value of ASA membership and the many opportunities that it offers.

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REGULAR | LETTERS TO AUSTRALIAN ANAESTHETIST

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LETTERS TO AUSTRALIAN ANAESTHETIST

CALLING ALL ANAESTHETISTS

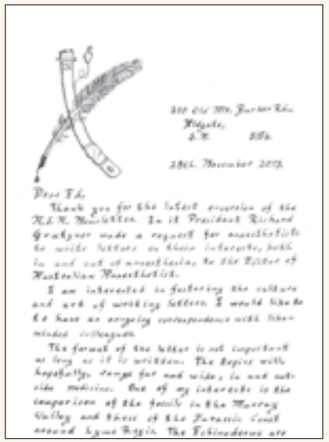
Thank you for the [August edition of] *Australian Anaesthetist*. In it President Richard Grutzner made a request for anesthetists to write letters on their interests, both in and out of anaesthesia, to the Editor of *Australian Anaesthetist*.

I am interested in fostering the culture and art of writing letters. I would like to have an ongoing correspondence with like-minded colleagues.

The format of the letter is not important as long as it is written. The topics will hopefully range far and wide, in and outside medicine. One of my interests is the comparison of the fossils in the Murray Valley and those of the Jurrassic Coast around Lyme Regis. The echinoderms are of particular interest.

Leaving anaesthesia in retirement, I developed an interest in the areas of medicine that had either been spawned or facilitated by anaesthesia. A couple of years ago I made a small bronze statuette called *Spiritus Anaesthesiae*, which embodies many of the ideals of anaesthesia. To go with it I wrote a slim book on the topic because I believe the permeation of medicine by anaesthesia is part of that spirit. We are part of the solution!

Dr Dave Fenwick
210 Old Mt Barker Rd
Aldgate SA 5154



Dr Dave Fenwick's handwritten letter

WORKING TOGETHER

This year I was appointed Hon. Archivist for the Obstetric Anaesthetists' Association, which was founded in 1969 by Jeff Selwyn Crawford, Donald Moir, Michael Rosen and Bruce Scott, among others.

Most of us involved in the development and evolution of OB Anaesthesia as a sub-speciality in the UK, European Union, Australia, New Zealand and elsewhere throughout the past 40 years or so were OAA members and gained much needed help and guidance from the Association's work in the UK.

During the next one to two years or so I aim to sort the history and archives of the OAA and to document its many and significant achievements since its foundation.

This work will include the links and work with Australia and other countries during that time, and its links with other professional bodies such as the faculties and colleges of anaesthesia, associations and societies.

When completed, the final report will be made available to the Royal College of Anaesthetists, the Australian and New Zealand College of Anaesthetists, the ASA, the Association of Anaesthetists of Great Britain and Ireland, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the History of Anaesthesia Society and other relevant groups and societies.

If you have or anyone you know has any documents, abstract books, anecdotes or other information that may be relevant to this work, please contact me, preferably by email.

Thank you in anticipation.

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RE: DR LEW TARGETT'S LIFESYLE OFFERING, 'CYCLING THE RONDE VAN VLAANDEREN 2013', AUSTRALIAN ANAESTHETIST DECEMBER 2013

Lew, you are a bit of a wuss as, while you describe your getting on your bike, Lycra-clad, climbing a few 'bergs' through some mud in 'brilliant weather', I wonder did you give a thought to Captain A. J. Corfe, khakhi-clad, battling on the Western front through mud and bad weather as well as enduring almost nightly bombing, just on a hundred years ago, and about 50 kilometres to the west of your tour-course.

In the Harry Daly Museum, there is an ether vapouriser constructed from materials at hand, namely a spent artillery shell-case and some Horlick's malted milk bottles. The plaque reads "Blendecques, 25.5.1918".

Maybe next time you'll spare a thought.

Richard J. Bailey, Sydney, NSW

Vapouriser made from discarded items in the field in WWI by Australian soldiers in France. Photo reproduced from the Harry Daly Museum.

UPCOMING PUGH DAY LECTURE

Dr Christine Ball is giving the third annual Pugh Day Lecture this year on Sunday 15 June 2014 at 2 pm in the Meeting Room at the Inveresk site of the Queen Victoria Museum and Art Gallery, Launceston.

The lecture commemorates Dr William Russ Pugh's performance of the first general anaesthetic for a surgical procedure in Australia. This procedure took place on Monday 7 June 1847 in his private hospital, St John's Hospital and Self Supporting Dispensary, in Launceston, Tasmania.

The title of Christine's talk is: 'Cobras, chloroform and consumption—the life and times of Joseph T. Clover'. William Pugh gave the first anaesthetic in Australia just as Joseph Clover was finishing his medical studies and training to be a surgeon. Ultimately his career led him to become the leading anaesthetist in Victorian London. Discover what led to this highly commendable career move and the many patients he encountered on the way—from royalty to the supremely reckless.

Dr Christine Ball is an anaesthetist at the Alfred Hospital in Melbourne and has been an honorary curator at the Geoffrey Kaye Museum of Anaesthetic History for 25 years. She is currently researching a biography on Joseph Clover.

Dr John Paull, TAS

HAVE YOUR SAY

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

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

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

FEATURE

WORKFORCE REPORT

The Chair of the ASA's Professional Issues Advisory Committee, Dr James Bradley, reports on the ASA's recent Workforce Summit and introduces the feature articles that appear in this special workforce-themed edition of *Australian Anaesthetist*.

As reported elsewhere within this issue of *Australian Anaesthetist*, a Workforce Summit was held at the new ASA head office on 7 December 2013. This was a unique meeting which brought together the Presidents and CEOs of the Society and College, as well as Society councillors, members of the Professional Issues Advisory Committee and Society guests.

Following concern expressed to the ASA in 2012 in relation to access to practice, both public and private, particularly in Melbourne and Brisbane, a survey of members had identified issues that were addressed at the Summit, which was titled 'The anaesthesia workforce: is there a problem?'

Presentations and discussions addressed medical workforce studies to date (including previous studies into the anaesthesia workforce), the contemporaneous Health Workforce Australia reports (in particular Volume 3 'HW2025' addressing the medical specialty workforce, including the anaesthesia workforce) and its instrument for addressing identified problems, the National Medical Training Advisory Network. Dr Lindy Roberts (ANZCA President) presented the 'ANZCA workforce action plan', which members who are College trainees or Fellows will have seen, and Dr Andrew Mulcahy (Craft Group Representative) presented the views of the AMA. Presentations were then made by members and guests who represented ASA demographics, such as trainee and junior members, staff specialists and general practitioner anaesthetists. Three particular themes which had been identified by the member survey were considered in depth: these were 'consolidation' (or 'what turns a Fellow into a good anaesthetist'), 'dilutions of the specialty' (the industrial and political ramifications of any oversupply of practitioners) and 'the under-scoped workforce' and its medical indemnity implications.

In canvassing the question, the need for good data to identify short and long-term options and solutions was identified

Discussion turned to the question: is there a problem with the anaesthesia workforce? In canvassing the question, the need for good data to identify short and long-term options and solutions was identified, as were the 'key players' in the induction of vocational trainees into anaesthesia training. It was clear that state health departments were the key determinants of the number of trainees and that the actual numbers of trainees depended very much on short-term state budgetary issues and an intent to employ service providers at the least acceptable budgetary pain. Other issues peripheral to this, but still significant, included ongoing 'medical migration' and the associated 'Skilled Occupations List'.

In the accompanying feature articles dealing with the anaesthesia workforce, Dr Lindy Roberts notes that the College shares the concerns of many specialists and trainees about the current workforce environment. The need for 'a balance of supply and demand' and 'meaningful work for Fellows' is noted, along with the 'three-pronged approach' of the College; that is, advocacy, data and communication. Dr Roberts identifies that 'those hardest hit by oversupply will be more recent graduates' and 'whilst the College does not directly employ trainees and specialists, it has a responsibility to advocate on behalf of its members'. In relation to 'data', the need for good long-term data and modelling is identified. In an accompanying article, Dr Richard Waldron (ANZCA Councillor) provides an example of how 'advocacy' at the level of state government was able to direct monies provided to Tasmania to training positions that were identified as addressing unfilled needs, as opposed to funding other positions.

Dr Natalie Kruit presented the views of GASACT at the Workforce Summit and in her article in this issue of *Australian Anaesthetist* addresses a current focus for GASACT: the consequences of a progressive increase in the aggregate number of trainees and their future employment opportunities. Continuing concern with the accreditation of training hospitals as opposed to training positions is explored.

Dr Mark Suss, as a former GASACT National Chair and ASA Victorian Chair, addresses workforce issues from the particular perspective of a younger specialist practitioner. The exigencies of private practice (which can become the default employment option in the absence of teaching hospital appointments) are explored and a call for a discussion of an increased reliance on consultant care in public departments is made.

Finally, Dr Simon Reilly, a senior anaesthetist, former ASA Victorian Chair and current member of the Professional Issues Advisory Committee, details the concept of 'consolidation'—the pathway from registrar to consultant. 'Consolidation' is a term which has gained much currency within the Society as workforce issues are debated.

The three aforementioned articles are personal viewpoints and as such do not represent the views of ASA Council, but they are views that have been expressed by many Society members. In saying so, it is timely to remind readers—and ANZCA—that the Society fully endorses the training processes of ANZCA and the quality of its Fellowship and did so in its submission to the Australian Medical Council in 2012 when its comment was sought.

SO WHAT NEXT?

The Workforce Summit and subsequent activities have been 'high on emotion' but short on data. Short-term palliatives include restricting the flow of Specialist International Medical Graduates (SIMGs), engaging the employers (largely state health departments) and prosecuting our viewpoint on any 'maldistribution' of the anaesthesia workforce. We need professional assistance with the acquisition and analysis of workforce data. The latest report of the Australian Institute of Health and Welfare already shows that the predictions of HW2025 are just that: predictions. And above all, any solution to the problem, whatever the problem in fact is, will be politically driven.

FEATURE | ANZCA ACTION ON WORKFORCE

FEATURE

ANZCA ACTION ON WORKFORCE

Dr Lindy Roberts is the President of ANZCA and works as a staff specialist in anaesthesia and pain management at Sir Charles Gairdner Hospital in Perth. Pictured above with ASA President Dr Richard Grutzner at the recent Workforce Summit, in this article she shares ANZCA's perspective on the current workforce climate.

The Australian and New Zealand College of Anaesthetists shares the concerns of many specialist anaesthetists and trainees about the current workforce environment. Workforce has been high on the agenda of the ANZCA Council and its major committees in recent times. Our deliberations have been informed by ANZCA's regional and national committees and trainee committees, hospital visits by ANZCA CEO Linda Sorrell, and other individual and collective feedback. We have a plan of active involvement using a three-pronged approach—advocacy, data and communication.

Our goal must be a balance of supply and demand. We need to ensure adequate specialist services, aligned with ANZCA's mission to serve the community by fostering safety and high-quality patient care in anaesthesia, perioperative medicine and pain medicine. We also need to ensure meaningful work for our Fellows. There are risks with both undersupply and oversupply. The former impedes access to specialist anaesthesia care and may open the door to non-current high healthcare standards. The latter impacts not only on individual doctors and their families, but is a poor outcome for the community which has invested in their training. Those hardest hit by oversupply will be more recent graduates. Whilst the College does not directly employ trainees and specialists, it has a responsibility to advocate on behalf of its members.

ADVOCACY

As the accredited provider of specialist medical education for anaesthetists and a representative organisation for its graduates, the College is working hard to ensure that Fellows have a meaningful voice in workforce debates and that we actively contribute to workforce solutions. The situation is extremely complex, with many factors at play, numerous decision-makers and, unfortunately, no simple or quick fixes. Current influences include unsustainable health budgets, political manipulation (especially of public sector healthcare funding affecting both supply and demand), the rising tide of junior doctors with pressure on vocational training places, geographical and specialty maldistribution, changing and sometimes unpredictable work patterns (for example, part-time and interrupted practice, retirement plans and new procedures and techniques), international migration and the yet-to-be-finalised plans of the new federal government.

The College is navigating this complicated environment by developing constructive relationships with leading workforce decision-makers. This includes numerous policy submissions on diverse workforce matters (for example, expanded prescribing beyond doctors and the cap on self-education expenses); supplying data to Health Workforce Australia (HWA); providing input to, and feedback on, their modelling; and contributing to the HWA National Medical Training Advisory Network to develop a nationally coordinated approach to training. ANZCA supports this collaborative approach. Additionally, the ANZCA President and CEO meet, on a quarterly basis, with policy makers and other colleges through the Committee of Presidents of Medical Colleges, which has an important voice with government. At a state level, we are working through our regional committee chairs with health departments, advising them on their workforce modelling and decisions.

DATA

Workforce modelling is prone to error because of the limitations of the assumptions made, as well as the long lag-time from medical school to specialist practice. Accurate longitudinal data and iterative modelling are crucial. ANZCA regularly contributes data to the Australian Government health department's Medical Training Review Panel. In its own right, the College closely monitors workforce trends (including Fellows, trainees, international medical graduate specialists, GP anaesthetists and areas of need).

Recently, we have established an annual new Fellow survey in order to better understand the work situation for our recent graduates (ANZCA Bulletin March 2014). Fellows can contribute by responding to surveys, ensuring representative results.

COMMUNICATION

The College provides regular workforce updates for its Fellows and trainees via the ANZCA E-Newsletter and Twitter (@anzca), as well as employment advertisements on its website. The quarterly *ANZCA Bulletin* includes a regular column 'ANZCA and Government', as well as feature articles such as 'Workforce, a hot topic: what is the College doing?' (March 2013) and 'Talking Workforce' (December 2013). The latter addresses the question of training numbers and why the College accredits departments and not posts (publically available at www.anzca.edu.au/communications/anzca-bulletin).

The 2013 ANZCA community survey revealed a big gap in community understanding. Many laypeople do not know that our training is as rigorous as that of surgeons or that we care for patients outside as well as inside operating theatres. Therefore, ANZCA promotes the valuable and specialised roles, skills and training of anaesthetists both in the media and our own publications. Examples of positive news stories about our profession and the highly successful 2013 relaunch of National Anaesthesia Day can be found at www.anzca.edu.au/communications/media. This is part of our longer-term strategy to educate the public and jurisdictional decision-makers about what we do, so that our work is valued and appropriately considered in healthcare policy decisions.

In summary, ANZCA takes workforce issues very seriously; we recognise specialist and trainee concerns and remain committed to achieving sustainable, long-term solutions.

Dr Richard Waldron is an ANZCA Councillor and Fellow. Practising as a Specialist Anaesthetist with the Hobart Anaesthetic Group, here he shares an example of the College's action on workforce in Tasmania.

Anaesthesia graduates are facing an increasingly competitive environment for work. Without effective workforce planning, this situation will likely continue into the future as the number of university graduates increases. In the past ten years, the number of medical schools in Australia has doubled from 10 to 20 (six in 2007 and 2008).

A recent article in *The Australian*[1] warns that 'job prospects for graduates may get worse as the historic expansion of Australia's tertiary system pumps more jobseekers into a deteriorating job market'.

Last year, the federal government announced the Training More Specialist Doctors in Tasmania package, representing $40 million of a $325 million Tasmanian health rescue package. Funding was proposed for additional specialist training capacity (not just in anaesthesia) commencing in 2014.

In a planned approach, ANZCA, through its Policy unit, formed a working group comprising the ANZCA Tasmanian Regional Committee (with a trainee representative), the Faculty of Pain Medicine, and Diving and Hyperbaric Medicine (DHM) specialists. ANZCA workforce data revealed 105 FANZCAs, 33 trainees and two GP anaesthetists in Tasmania. Few specialist positions were likely to be available in teaching hospitals in the next 24 months. Further analysis, however, identified limited pain medicine in northern Tasmania, few DHM specialists and the need for anaesthesia experience for emergency medicine (EM) and intensive care medicine (ICM) trainees. A submission was formulated to address these needs.

The ANZCA Policy unit negotiated with both state and federal health departments. As a result, two training positions were created in pain medicine and one each in DHM, ICM, EM and perioperative medicine. Significantly, the College was successful in creating 2.5 specialist positions. This is an example of effective advocacy as part of the ANZCA workforce action plan.

1. *"Red flag over university graduate jobs" by Bernard Lane Jan 29, 2014 .*

FEATURE | WORKFORCE ISSUES—A TRAINEE'S PERSPECTIVE

FEATURE

WORKFORCE ISSUES—A TRAINEE'S PERSPECTIVE

Dr Natalie Kruit currently works as an anaesthetic registrar at Westmead Hospital. She is also an active trainee representitive as Chair of the Group of ASA Clinical Trainees (GASACT) and comments on the current state of the anaesthetic workforce from a trainee perspective.

The issues currently facing the anaesthetic Fellow and trainee workforce are varied and complex. A key current focus for GASACT is to seek to address this. We believe these issues arise from a progressive increase in the aggregate number of trainees, which ultimately results in increasingly limited employment opportunities for trainees once they have completed their training program.

GASACT considers the chief cause of diminishing specialist employment opportunities to be a limited degree of centralised decision-making, coordination and planning in respect of junior public hospital staff numbers. As a result, the responsibility for resourcing falls instead to individual hospital departments which understandably are focused on their immediate service requirements and employ registrars accordingly.

Anaesthetic departments are under constant pressure to cut costs, and an increasingly preferred approach among hospital administrators to preserve service levels while alleviating budgetary pressures appears to have a dual focus on reducing the aggregate number of "overtime" hours worked and increasing the number of staff to work only regular hours with minimal overtime.

The standard of anaesthetic training in Australia is world class and something that we should all be very proud of

All positions now require 'accreditation', resulting in more registrars proceeding to Fellowship. Confounding these problems is an increase in the numbers of medical schools and medical graduates, with the peak output expected in 2016. Overall, we have a situation resulting in more doctors applying for more vocational training positions.

GASACT acknowledges that the problem is multifaceted; however, it does feel that the accrediting of departments as opposed to the accrediting of training positions may be exacerbating the problem. We recognise that ANZCA has limited control over how many trainees are hired by each department, and, as the demands of departments grow outside of the operating theatre and safe working hours get stricter, anaesthetic trainee numbers are inevitably growing.

The standard of anaesthetic training in Australia is world class and something that we should all be very proud of. The standard of anaesthesia is best maintained through large volumes of practice. Trainees fear that the increase in trainee numbers could eventually dilute their pool of experience if left unchecked. The long-term implications of this are that, in areas where public appointments are limited, new consultants would be entering a private practice environment that is quite isolating and less well supported. New consultants may not feel as equipped for independent practice at the end of their training as they wish to be.

There is the strong feeling that the solution lies in ANZCA having tighter control of how many people the department employs as accredited trainees. Recognising that departments still need to meet service requirements leads to the suggestion that accredited trainee numbers be restricted and unaccredited registrars or senior registered medical officers (SRMO) are reintroduced.

There is no real difference between a first-year accredited registrar and an SRMO who is essentially doing the same job—in fact, it would be cheaper for the department to employ this sort of model. The difference being that accredited trainees get their modules and progress in their training. We recognise, however, that this is also problematic. SRMOs may not be able to meet all service requirements, thus leaving a gap for staff specialists and visiting medical officers to fill, which would be more expensive. This model also risks evoking the same problems that our surgical trainees are facing, where some of them may do three or more years of unaccredited training before entering accredited training.

This is a complex environment and while it will be tempting to move swiftly to implement reforms, solutions that may be appropriate now will shape the workforce environment for many years

Another suggested solution that has been discussed is that ANZCA could accredit the departments depending on how much exposure the department offers. We feel that a more rigorous accreditation process of each department should take place; however, we also recognise the difficulty in assessing just how much volume of practice departments provide trainees.

As a caveat to this, ANZCA needs trainees to use their Training Portfolio System appropriately, recording their volume of practice so that they can get an accurate assessment as to what volume of practice each training centre offers.

At the end of the day, we need good, robust workforce data. This is currently lacking. Perhaps the problem new consultants are facing is not only due to an oversupply of anaesthetists but also to underfunding. If government increased funding to reduce waiting list times then there is likely to be more work.

This is a complex environment and while it will be tempting to move swiftly to implement reforms, solutions that may be appropriate now will shape the workforce environment for many years. A solution which seems appropriate for the shape of the current workforce may not necessarily remain appropriate in future. For example, a knee-jerk reaction to drastically reduce trainee numbers may result in a future shortage of anaesthetists, prompting the introduction of non-medical providers of anaesthesia as a solution to workforce shortages. This would be undesirable for our entire profession. Instead, we must look for a sustainable solution based on our desire to maintain a high standard of anaesthesia and provide varied and plentiful exposure and adequate employment opportunities for all of our highly skilled junior specialists.

FEATURE

WORKFORCE ISSUES: THE TALK OF THE TOWN

Dr Mark Suss is a former national Group of ASA Clinical Trainees (GASACT) and ASA Victorian Chair. Based in Melbourne, Mark currently works in both public and private practice. Having completed his Fellowship training in 2008, he comments on the hot topic of workforce issues from his perspective as a younger specialist practitioner.

Walking in theatre corridors, in private hospital tearooms between cases and in public anaesthetic department meetings, workforce issues are a major topic of conversation.

Traditionally new Fellows were able to obtain at least a moderate amount of public hospital work, which was important to both provide them with a livelihood and to develop their skills as they gained independence. Over the last few years, initially mild concerns have grown massively. The 'no vacancy' signs went up in anaesthetic departments in the inner city, then in outer Melbourne, and already several years ago out into regional cities.

I convened the Victorian GASACT Part 3 Course in November 2012 and asked for a show of hands by those who had any public work confirmed for the next year. Not one hand was lifted.

What public work there is has often changed in nature. There is a move to sessional bookings, which may be cancelled at short notice, and in some cases new Fellows are being used for emergency rosters despite not having any regular elective sessions.

What public work there is has often changed in nature

Other avenues too are becoming closed off to new Fellows. Large, respected private hospitals which potentially offer support similar to that of public hospitals often cannot even offer on-call work or ad hoc cases due to the number of Fellows applying.

The crisis is not simply one of new Fellows chasing more income. In fact, increasing numbers of fully trained consultants appear to be performing 'honorary' duties at various places in order to maintain their skills. The crisis is fundamentally that of a large cohort of highly trained doctors finishing the most intensive phase of their training and facing the possibility of losing precious skills.

PRIVATE PRACTICE—AN ALTERNATIVE?

Nevertheless, in terms of economic or workforce opportunities there are certainly some positive developments occurring. Private health insurance continues to be popular, many hospitals are expanding, and it needs to be remembered that there are still around two million surgical admissions each year in Australia.

Anaesthesia has never been more important or ubiquitous and there is no reason this will change any time soon. But even if new Fellows were able to move into busy private practice early on, many have questioned whether this is an ideal outcome. Clinical aspects of public and private practice differ significantly. Some trainees have relatively limited exposure to procedures which are common in the private sector, such as arthroplasty. Theatre turnover and time management are often very different.

Aside from procedural issues, there are other unfamiliar aspects of private practice which might in the past have been gradually mastered as a practice slowly grew.

These include:

- personally managing preoperative and postoperative calls from patients,
- developing systems for preoperative management and postoperative care without the support of an entire department,
- trying to negotiate financial arrangements that prevent exploitation of any party—patient, anaesthetist and surgeon, and
- setting boundaries regarding location and scope of work.

The crisis is fundamentally that of a large cohort of highly trained doctors finishing the most intensive phase of their training and facing the possibility of losing precious skills

Many Fellows would benefit from a gradual introduction to these issues, as happens when a full-time public anaesthetist gains experience and begins to branch out into private work.

THE ANSWERS?

Having received so many expressions of concern, we have asked for constructive suggestions from members.

Other articles in this issue provide several ideas. Three more that have been raised with me and presented for discussion follow:

- increased reliance on consultant care in public departments. This would ensure that both public and private patients have their care closely supervised by FANZCAs—night and day. Perhaps this would allow trainee numbers in each department to be more closely aligned to the need for consultant anaesthetists. It could also provide a feedback mechanism that prevents a shortage of anaesthetists sometime in the future,
- recognising the reality that increasingly large numbers of trainees are taking up local and overseas paid or unpaid fellowships, and that a more structured Senior Fellow/Junior Consultant role may provide a job and supervision. It should be noted that this has proved extremely controversial in both Ireland and the UK,
- open discussion among members of the various organisations regarding active management of training numbers, fully recognising the complexities of the issues at stake.

It is crucial that members make their voices heard and present their opinions. A safe anaesthetic workforce with recency of practice sufficient to maintain skills is crucial for the health of our speciality.

FEATURE | THE PATHWAY FROM REGISTRAR TO CONSULTANT

FEATURE

THE PATHWAY FROM REGISTRAR TO CONSULTANT

Dr Simon Reilly is a former ASA Victorian Chair and a current member of the Professional Issues Advisory Committee. Practising in Melbourne, he reports on the increasingly challenging journey that budding anaesthetists face in their quest to become junior consultants from his perspective as a senior anaesthetist.

Most of us realise that having passed our final exams and completed our senior registrar year we have not achieved our full competence nor excellence. Some may never achieve it; however, wherever we end up in the spectrum of anaesthetic practice, we will always be learning and developing.

We need to look at what happens in that period beyond obtaining our certificate and becoming full consultant specialists in anaesthesia and what extra provisions we have to provide for those who are still in the developmental phase but don't have the necessary support structures.

The current training program of ANZCA is designed to progress doctors from junior to senior positions with the aim of them becoming fully fledged consultants. Some of the tasks and disciplines required as a consultant are developed within the training program, but we believe there are a number of areas where full maturation occurs only once the anaesthetist is working as a consultant. For this to occur properly and completely, young consultants need support and continued training.

THE IMPORTANT ASPECTS OF BEING A GREAT ANAESTHETIST

Our working environment has much in common with other safety-critical, high-technology industries such as aviation or nuclear power, characterised by highly dynamic workplaces, uncertainty, time pressure, ill-formed problems, complex interactions and risk.

We can quantify the core activities we want from an anaesthetist. The UK Royal College of Anaesthetists has 12 core activities required for anaesthesia certification:

- Maintain your professional performance,
- Apply knowledge and experience to practice,
- Keep clear, accurate and legible records,
- Put into effect systems to protect patients and improve care,
- Respond to risks to safety,
- Protect patients and colleagues from any risk posed by your health,
- Communicate effectively,
- Work constructively with colleagues and delegate effectively,
- Establish and maintain partnerships with patients,
- Show respect for patients,
- Treat patients and colleagues fairly and without discrimination, and
- Act with honesty and integrity.

However, these are more generalised and don't take into account the anaesthetic non-technical skills (ANTS) which are thought to make a good consultant.

A survey carried out by the University College London anaesthesia department[2] looked to rank the top five most important attributes of a good anaesthetist. The results varied depending on the grade of the anaesthetists (Table 1).

In junior years, the emphasis is all on knowledge. However, as maturation occurs non-technical skills become important. In this study, the top four most important attributes ranked by consultants can be regarded as non-technical skills that must be developed; however, our current curriculum has its biggest emphasis on the technical skills and clinical knowledge.

In particular, keeping calm under pressure is one ANTS highlighted across all categories in the top five. It is a combination of experience, confidence and effective communication. The consultant who is anxious and agitated makes the rest of the team members feel uncomfortable, which may lead to sub-optimal performance.

These changes of maturation are actually changes in the personality between being a registrar and a consultant[6].

Failure to provide an environment where this transition can occur may lead to increased stress, psychological damage or maladaptive behaviour.

IN THE PAST, HOW HAVE CONSULTANTS DEVELOPED THESE TRAITS, AND WHAT PROBLEMS ARE WE SEEING WITH CURRENT JUNIOR CONSULTANTS IN OUR PRIVATE HOSPITALS?

In the past, anaesthetic registrars worked longer hours, often with less direct supervision, which allowed them to have increased responsibility and develop some of these non-technical skills. Current reduced hours produce trainees with the same levels of knowledge but possibly not the same levels of technical and non-technical ability.

The current requirements for modules appear to be only barely enough to develop the skills let alone consolidate them. This means registrars are on the bottom part of the curve for development of skills even in more senior years, leaving less time for the development of ANTS (Figure 1)[1].

Registrars become Junior Consultants either within their training establishment or as Fellows overseas, particularly in the UK, which:

- allows newly finished consultants to practice in autonomy but with the lifeline of the rest of the department to back them up,
- helps them with learning to deal with or avoid emergency situations without automatically calling a boss,
- means they become trainers of registrars and other students, which allows them to recognise faults in their own organisational skills while making sure they always perform best practice,
- allows them to develop a collegial rapport with surgical colleagues whom they may do private cases with—the surgeon and anaesthetists both develop together, honing their skills together, and
- allows for discussion with other colleagues regarding difficult cases and handling difficult situations.

The best anaesthetic trainees are still able to get positions within the public hospitals or good overseas training Fellowships, but those who are left (and the group is getting larger) are forced to look for any cases they can find within the private system. That or drive taxis!

The effect of this is multifactorial:

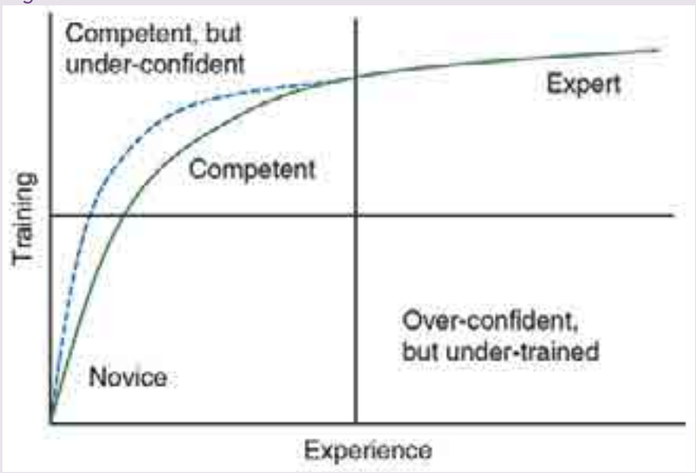
- There is less consolidation of their technical skills because they are suddenly doing much less work.
  — We had reports of people who had not given an anaesthetic for three months since gaining their Fellowship.

Table 1
Most important attributes of a good anaesthetist[2]

Consultants	Specialist Registrars	Senior House Officers
Clinical judgment	Communication skills	Clinical knowledge
Teamwork	Clinical judgment	Keeping calm under pressure
Keeping calm under pressure	Keeping calm under pressure	Knowing your limits
Communication skills	Clinical knowledge	Attention to detail
Clinical knowledge	Attention to detail	Keeping up to date with research

FEATURE

Figure 1[1]



Distribution of skill development

- There is less or slower development of non-technical skills, which may lead to:
  — decreased leadership skills, as senior role models are missing, and
  — poor understanding of the rigors and expectations of private practice.
- There is less feedback from other consultants and registrars to develop good practice.
- In effect, anaesthetists are being shut out and marginalised:
  — there is little public work,
  — they are unable to gain accreditation in some hospitals at all because they are saturated with anaesthetists, and
  — many of the large private groups are full.
- What is left is small day surgeries on fringes of cities, perhaps replacing GP anaesthetists in small towns, potentially exploitative practices as employees of other doctors or in-office based anaesthesia.

WHAT IS NEEDED?

My impression is that many of the junior consultants are underdone clinically and in non-clinical skills, a fact highlighted by the College's own survey in 2009[8].

In particular, there are core areas where there is poor skill development:

- difficult intubation and airway skills,
- subarachnoid and epidural blocks,
- arterial cannulation,
- organisational capacity, and
- prioritisation.

I believe that the College and the ASA need to work more closely with the public hospitals to increase the availability of some work in those institutions. This may mean moving out more senior people from those departments to make way for new consultants or adding more or extra Fellowship years.

Additionally, the college needs to stop accrediting so many jobs so there are positions for the continued development of all junior consultants.

We need the commencement of a mentor program for all anaesthetists, especially those who are junior with minimal public hospital access. We also need encouragement and provision of overseas Fellowships for new consultants to further develop their skills.

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FEATURE | THE ASA'S ONLINE MAKEOVER

FEATURE

THE ASA'S ONLINE MAKEOVER

In November 2013, following months of feedback from members, the ASA launched its new-look website: www.asa.org.au. The ASA's General Manager of Marketing and Communications, Nicola Morgan, shares the highlights of our exciting new online makeover.

Over the last couple of years, under the guidance of the Communications Committee, the Society has tried to improve its branding and image to be more like you—our members; that is, professional with a clean, snappy look. The website has been one of the biggest projects undertaken to improve the branding of the organisation to date. We had received feedback on our old website that information was hard to find, that it was difficult to navigate around and that it was just generally unattractive.

The new design reflects the direction in which the Society is trying to take itself. We've seen this echoed in the 2013 launch of this magazine's new look and in the redesign of the *Relative Value Guide* that you received in January.

We've simplified the design without sacrificing information so that it is clear what you'll find in each section. With a single navigation bar at the top of the page, navigating around the site is now a lot more streamlined and intuitive. We want you to be proud of your organisation and the way it appears and we hope we have achieved this.

THE NAVIGATION

The navigation has been broken down into seven simple categories: Membership, News, Education and Events, Publications, Patient Information, Advertising and Sponsorship, and About Us. To ensure we are providing some services only to you—our members—there is member-only content that you are only able to view once you have logged into the Membership section.

The following is a brief overview of some of the information you'll find under each heading:

Membership

In the public area of the website, the Membership section details the benefits of membership, pricing and types of membership available. Once you are logged in, you can update your personal details, see your billing information and learn more about the ASA's sponsor discounts and Advantage program.

News

This section features all the latest news from the Society, including economic and professional issues updates. Links to the most recent issues of the President's enews are available once you have logged into the members section.

Education and Events

In the members section of this tab you'll find links to iamonline, free access to MEDLINE and the latest information on upcoming events, as well as resources such as ASA Position Statements.

Publications

Once logged in, you'll be provided to exclusive member-only access to all of the Society's key publications such as the *Relative Value Guide*, *Australian Anaesthetist* magazine and our journal, *Anaesthesia and Intensive Care*. Members can also purchase merchandise including *Anaesthesia & You* brochures, anaesthetic charts and medical warning cards for use in your practice.

Patient Information

We've added a section to assist patients in their search to learn more about what anaesthesia is and what they can expect before, during and after anaesthesia, as well as additional information on billing.

Advertising and Sponsorship

We often get approached by organisations wanting to advertise in our publications or sponsor our events, so this area is primarily for them.

About Us

Want to read more about the Society, see lists of committees, find out about our museum and library or simply contact your state office? This is where you'll find all that information and more.

Just like any makeover, the first transformation is only the beginning. We will be making ongoing enhancements to the website to ensure it remains a valuable resource for you all. If there is anything additional you would like to see on the site, please send us an email to web@asa.org.au and we'll look into it for you. We'd love to hear what you think of the site and welcome letters to *Australian Anaesthetist* in our August edition.

REGULAR | CAREERS IN ANAESTHESIA

REGULAR

CAREERS IN ANAESTHESIA
PUBLIC PRACTICE

ASA Vice President Dr Guy Christie-Taylor works in public practice in South Australia. We found out what it is like to work in public practice and why anaesthetists might consider taking a step in this career direction.

WHERE DID YOU STUDY? WERE CAREERS IN PUBLIC PRACTICE EMPHASISED THROUGHOUT YOUR TRAINING?

I studied medicine at the University of the Witwatersrand, South Africa—Wits for short and easier to pronounce. I'm not sure that careers in public practice were emphasised during this time. What seems to stick with me is the competitiveness to complete the course and get the internship job you wanted in order to set yourself up for your specialist training, either in South Africa or—more importantly for many—overseas. In many ways studying hard and setting exacting academic standards for oneself was an easier alternative than confronting the many difficult social and political challenges in the country during the 1980s. Have my classmates entered public practice? I'm not sure to be honest, what I do know is that whatever form of practice they entered, they have done so in a variety of countries!

HOW DID YOU GET INTO PUBLIC PRACTICE?

My route into public work in Australia was largely determined by the immigration process. Having accepted an area of need appointment at the Lyell McEwin Health Service in South Australia in 1996, I commenced as a consultant in November 1997. It was an interesting time in the 'Labyrinth', and the paperwork and uncertainty that attends such an undertaking is at times daunting. Having completed the requirements for registration and permanent residency, the 19AB exemption then limits access to a provider number for ten years. From my point of view this contentious arrangement did not limit my access to the work I most wished to pursue—my interest in cardiothoracic anaesthesia. I commenced as a full-time staff specialist at the Royal Adelaide Hospital in 2000.

TELL US ABOUT SOME OF THE JOBS THAT YOU'VE HELD THROUGHOUT YOUR CAREER AND ABOUT THE POSITION YOU NOW HOLD

My career path has been rather 'unspectacular' in terms of depth and variety of jobs and has been largely confined to ICU and anaesthesia. Following my intern year I completed a term in ICU at Baragwanath Hospital in South Africa, followed by a year in the UK doing a variety of locum jobs at Senior House Officer level, then back to South Africa to a job in a private cardiothoracic unit, and then onto the anaesthesia training scheme in Johannesburg. Following this, I was appointed as a consultant anaesthetist at the Johannesburg General Hospital for two years, after which I left for Australia.

My time at the Royal Adelaide Hospital allowed me to develop my interest in cardiothoracic anaesthesia, and during this time we have seen the evolution of such things as a cardiothoracic pre-admission clinic, an intraoperative transoesophageal echocardiography service, minimally invasive mitral valve surgery and robotic surgery, among others. South Australia's unique geographical and demographic characteristics will always influence the status and capacity of its cardiothoracic service, and it will continue to grapple with the tyranny of distance and a small and sparse population. I am currently Head of Unit: Cardiothoracic Anaesthesia.

WHAT ARE THE BEST ASPECTS OF WORKING IN PUBLIC PRACTICE?

I am very pleased with my career so far in the public hospital service. It needs to be said that my 'public ' job has not completely excluded me from a reasonable exposure to life in the private sector. I think this is true for many staff specialists and in my view is one of the strengths of the Australian system. There are many points of overlap between the two systems, which, when managed fairly and equitably, provide for a robust, productive system. For me, one of the most compelling reasons for continuing in a public job is the capacity to generate a supportive and collegial environment in which difficult and complex cases can become 'fun'.

DOES IT TAKE A PARTICULAR TYPE OF PERSON TO WORK IN PUBLIC PRACTICE?

I'm not sure it takes a particular type of person to work in public practice. I think there are as many 'types' of anaesthetists in the private system as there are in the public system. Anaesthetists move in and out of the two streams during various stages of their careers. The desirability of work in each sector may change according to prevailing economic conditions and the terms and conditions of employment in the two sectors. An individual with an interest in research or teaching may be more inclined to remain in the public sector, but there are examples of individuals who, having achieved successful academic and teaching careers, move into private and the same is true in the opposite direction. In my view, having two healthy and thriving options is good for the profession and for patient care.

HOW DOES PUBLIC PRACTICE COMPARE TO PRIVATE?

In my view they share some similarities but also some quite profound differences. The most significant being that in private you are essentially a small business owner with all the attendant risks this brings with it—and also considerable financial reward if done well. As a public employee, that is what you are—an employee (even if it is a well-paid one). For many people, the ability to set your own fees, organise and manage your work structure and foster good working relationships with surgical colleagues are powerful motivators, where for others the more predictable and structured nature of public practice is more appealing. For me, the biggest risk associated with private practice is the notion that the most important 'contracts for supply of work' you have are in no way contractually obligated to continue the relationship. They also fall ill, retire or die at unpredictable moments and with little warning. Relying on a small client base, as many anaesthetists do, makes them particularly vulnerable to these risks.

WHAT ARE SOME OF THE CHALLENGES ASSOCIATED WITH A CAREER IN PUBLIC PRACTICE?

A career in the public sector does also bring with it some inherent frustrations.

There are the workplace relationship issues and 'office politics' that invariably arise in any work site, particularly where the workforce is highly motivated, intelligent and individualistic. Increasing bureaucratic intervention and expectation together with frustrating and often unreasonable and difficult enterprise bargaining processes can make work in this sector demoralising at times. At times just 'maintaining' your job and complying with requirements competes with actually doing your job.

DESCRIBE ONE OF THE MOST REWARDING EXPERIENCES YOU'VE HAD THROUGHOUT YOUR CAREER

My career does not have any one single most rewarding moment. Rather, anaesthesia is made up of many small but rewarding moments: successfully inserting the epidural into the 150 kg parturient, the 'pain-free' postoperative thoracic patient, the 'difficult airway' that goes smoothly, the information from the intraoperative transoesophageal echocardiogram that changes outcome, or the surgical acknowledgement that 'anaesthesia' made a difference.

HOW DO YOU SEE THE CAREER PROSPECTS FOR ANAESTHETISTS IN PUBLIC PRACTICE IN AUSTRALIA AT THE MOMENT?

The matter of workforce is currently one of considerable interest to the Society and its membership. There is an increasing number of accounts, particularly among younger colleagues, of anaesthetists struggling to find adequate jobs or amounts of work. It certainly seems that the shortages that prevailed at the time of my migration to Australia have been filled and that areas that used to traditionally struggle to find staff are now well served. Quantifying this accurately and finding workable short-term mechanisms to assist colleagues is a priority for the Society. The problem of maldistribution between urban, regional and remote areas remains problematic, and it is difficult to speculate whether an absolute increase in numbers of anaesthetists will resolve this issue.

WHAT ADVICE WOULD YOU GIVE TO TRAINEES WHO ARE DECIDING WHETHER TO ENTER PUBLIC OR PRIVATE PRACTICE?

There is no right answer to the question of public versus private. It is a profoundly individual decision that is often informed by 'misinformation' or 'perception', is often born of necessity or serendipity and will vary over time and with both individual needs as well as political vagary.

REGULAR | ANAESTHETISTS IN TRAINING

REGULAR

ANAESTHETISTS IN TRAINING
POLISHING YOUR CV

Dr Vida Viliunas is a specialist anaesthetist currently working in both public and private practice in Canberra. She served for 12 years as an examiner for the Final Fellowship exam and for two years as Chair of the Final Examination Subcommittee. In this issue, Vida offers some advice to help GASACT members prepare for Provisional Fellow or junior consultant job interviews, with specific focus on polishing your curriculum vitae (CV).

So, you've been successful in the Final Fellowship Exam (*Australian Anaesthetist* August 2013 pp. 52–53) and you have prepared for the job interview (*Australian Anaesthetist* December 2013 pp. 48–49). Part of the preparation for the job interview includes refreshing or writing your CV. What follows are some suggestions as to how you might optimise the impression that your CV creates.

COVER LETTER

Just as you prepared your 'script' for the job interview, weave your past achievements into your cover letter. Your research of the facility, its staff and the particulars of the job description will help you to match your special skills and distinguishing contributions to the needs of the department.

This letter is where you make a case for how you can give expression to your particular interests and motivations. That is, your research of the department or facility indicates that your special professional interests, anaesthetic specialty, research or workplace management might be of mutual benefit.

GENERAL COMMENTS

- Just like your first impression in the interview room, your CV has about ten seconds to make a first impression.
- Your CV should be visually clear, concise, complete and current.
- Use a template or whatever you need to create a logically ordered document that summarises your achievements to date.
- Do not lie. The concept of a 'small world' applies equally to our regional centres, the nation and the planet.
- If applying for an international position, do some research on the particular expectations of a CV for that country.
- Send an electronic copy of your CV with your job application and bring along a few extra printed copies to the interview.
- Be prepared to walk the interviewers through your CV. Do not just read it, but highlight the parts that make you the pick for the job.
- Create a professional signature for your email communication. Include your mobile number and your website, postal and email addresses. Consider creating a logo (Google it).
- Select a layout that ensures visual clarity—you can use a CV template, your own creation or that of a colleague. The one you choose should satisfy sensible guidelines for CV writing.
- Ensure that the file size is less than 10 MB.
- Number the pages, consider using a header and include a legend.
- Use spell check and grammar check, as well as getting someone to proofread your document.
- Consider including a small photograph.

CV TEMPLATES

There are many references for CV templates, including the following:

- http://paperpkads.com/cv/anesthesiologist-cv-template/
- http://www.resumeok.com/anesthesiologist-resume-examples/
- http://www.sampleresume.net/Resume/Anesthesiologist-Resume.html

CONTENT HEADINGS

- **Contact information:** name (include post-nominals), address, mobile, email, website, other
- **Legend**
- **Personal information:** date and place of birth, citizenship, visa status (optional personal information may include gender, marital status, spouse and children)
- **Education and training history (in chronological order):** high school, university (undergraduate, graduate and non-anaesthesia qualifications), anaesthesia training. In the anaesthesia training section, itemise the training type (under basic training, advanced training and Provisional Fellowship training), facility and date, and include sub-specialty exposure and courses
- **Employment history (in chronological order):** work history, academic positions, research and training—this might be a small part for a new CV
- **Awards/honours**
- **Publications/books/chapters**
- **Presentations**
- **Professional memberships**
- **Other interests/achievements:** such as talents, languages or volunteer work
- **Referees**

REFEREES

Choose these carefully. Decide on who to ask for a reference based on the job for which you are applying. Evaluate referee 'gaps' in the range of people you are considering—for example, whether you choose all anaesthetists (and consider their sub-specialties) or add a researcher, manager, pain specialist or statistician will depend on the job and a few other things.

A referee needs to be able to comment in a meaningful (and hopefully positive) way about the characteristics and talents you intend to highlight. Recent and reasonably significant exposure to a referee gives practical credibility to their endorsement.

FOR THE FUTURE: MAINTAINING A CURRENT CV

Make it easy on yourself—regularly update your CV.

Create a diary alarm to enter courses, conferences, lectures (as participant or presenter), articles (read or written), contributions to research/literature, teaching, volunteer work, committee work or other enterprise.

In conclusion, keep it concise, keep it real, keep it straight (avoid flippancy at all costs), and keep it current. Best wishes to you all!

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REGULAR | WEBAIRS NEWS

REGULAR

WEBAIRS NEWS

Since our last update, the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) has appointed a new Chair and made some important program improvements, among other developments, writes Adj. Prof. Martin Culwick.

CHANGE OF ANZTADC CHAIR

ANZTADC was formed in 2006 following the recommendations of two taskforces set up by Professor Michael Cousins during his tenure as President of ANZCA. These were the Quality and Safety Taskforce and the Data Taskforce. Both of these taskforces included representation from the ASA and the New Zealand Society of Anaesthetists (NZSA) in addition to ANZCA. Tripartite support continued, resulting in the formation of ANZTADC. This committee continues to function with the close support, ideas and knowledge of the three founding organisations. Professor Alan Merry led the formation of the committee and guided it through its infancy into the mature organisation that it is today.

Following the development of a strategic plan and evaluation of existing software, webAIRS was created. It is based on knowledge of best practice in incident recording and has become a pre-eminent morbidity and mortality reporting resource. Alan led the development of a robust framework for both committee function and software development with a focus on integrating webAIRS into a tool that is available to every anaesthetic department and private practice group in Australia and New Zealand.

It had always been intended that the Chair of ANZTADC would rotate periodically. The incoming Chair is Dr Neville Gibbs, well known for his role as the Chief Editor of *Anaesthesia and Intensive Care* as well as previously being Chair of the ANZCA Mortality Subcommittee. His experience will be invaluable as webAIRS has now collected a critical mass of around 2000 events, which will be analysed and published.

ANZTADC wishes to sincerely thank Professor Alan Merry for supervising the creation of ANZTADC and the webAIRS website. His expertise and insight has been invaluable and he will stay involved as a committee member. ANZTADC warmly welcomes the incoming Chair, Dr Neville Gibbs, for this next phase of analysis and the publication of existing and future data.

Outgoing ANZTADC Chair, Prof. Alan Merry

Incoming ANZTADC Chair, Dr Neville Gibbs

PROGRAM IMPROVEMENTS

The webAIRS program has been updated and now includes a feature that allows a single email address to be used to log in to multiple hospitals, day surgeries or private practices. In order to add additional sites to an existing account, first of all, log in and then select 'Register' from the menu. Registered users will then be able to select from existing sites or will be able to add new sites. For Fellows without an existing account, register as a user and then select or add sites as above. Local administrator functions have been upgraded, and during 2014 more user functions will be added to give feedback to all users.

PRESENTATIONS AT ANNUAL SCIENTIFIC MEETINGS IN 2014

The first presentation of the year was at the AACA and ASURA combined 2014 meeting in Auckland, titled 'Insights from the ANZTADC web-based anaesthesia incident reporting system (webAIRS)'. The second presentation will be a summary of the webAIRS airway events, risk factors and outcomes. This will be presented at the Airway Special Interest Group meeting, which immediately precedes the 2014 ANZCA Annual Scientific Meeting in Singapore. The third presentation will be at the ANZCA Annual Scientific Meeting on Thursday 8 May, where webAIRS data will be presented in the Human Factors and Patient Data session. This will be titled 'A standardised but flexible approach to managing anaesthetic incidents' and will explore the active use of data to improve safety in anaesthesia. Finally, ANZTADC will be organising a patient safety session at the ASA National Scientific Congress at the Gold Coast in October 2014. Details of this ASA session will be announced in a future edition of *Australian Anaesthetist*.

ASA 2014 CONTINUING PROFESSIONAL DEVELOPMENT PROGRAM

Reporting, case discussion or analysing incidents using webAIRS will qualify for two credits per hour in the new 'Practice Evaluation' CPD category. After reporting an incident there is an option to email a confirmation of the credits to your email

For more information, please contact:

Adjunct Professor Martin Culwick, Medical Director, ANZTADC

E: mculwick@bigpond.net.au

Administration support:

anztadc@anzca.edu.au

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

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

APOC
Australasian Perioperative Outcomes Collaboration

Clinical Application of Advanced Haemodynamic Monitoring Workshop

Saturday 17th May 2014 | Miles Lowell Education Centre, Edwards Lifesciences, North Ryde NSW

Course Topics:

1. **LIMITATIONS:** of current haemodynamic monitoring
2. **PRINCIPLES:** of advanced haemodynamic monitoring
3. **HANDS ON:** sessions with a variety of devices
4. **REAL SIMULATION:** to mirror real-life theatre scenarios
5. **LIVE DEMONSTRATIONS:** real-time haemodynamic monitoring in action

At the end of the educational program, participants can expect a deeper understanding of the benefits and limitations of advanced haemodynamic monitoring and how best to apply these principles to improve the care of their patients.

Cost: **$375** | Trainees: **$250**

To register, or for more information, contact Kate Kelly
kate_kelly@edwards.com | 02 8899 6309

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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 progress of the ASA's applications to the Medical Services Advisory Committee, the 2014 Practice Managers' Conference and informed financial consent.

DEPARTMENT OF HEALTH

The three ASA applications to the Department of Health (DoH) Medical Services Advisory Committee (MSAC) have made some progress. There have also been changes to the way MSAC handles certain applications, as detailed below under the discussion of the pain medicine application.

Members will recall that when the introduction of new Medicare Benefits Schedule (MBS) items, or changes to existing items, are proposed, MSAC has the role of assessing the relevant clinical and economic evidence. Once this is done, a recommendation is made to the Minister for Health and Sport. The Minister can choose not to follow this advice, based on fiscal (or any other) concerns, although an MSAC recommendation to reject a particular proposal would almost certainly be followed.

Application 1183: 2D ultra-sound guidance for vascular access and nerve blocks

The assessment of the evidence base for the use of ultrasound to guide certain vascular access and nerve block procedures was performed by the Health Technology Assessment group (HTA). The ASA handed this task to HTA rather than performing it 'in house', as it was clear that the detailed economic evidence, presented in the way MSAC requires, is beyond our capability. The HTA has completed its first draft. In summary, the report supports the claims for the clinical benefits obtained by using ultrasound guidance. However, the evidence for economic benefits is less certain. The ASA expected this was likely to be the case, and unfortunately this could jeopardise the application, given MSAC's stated intent to focus heavily on economic issues.

However, EAC has identified weaknesses in several of the economic arguments posed. The intention is to obtain independent expert economic assessment of this HTA analysis before making a formal response to MSAC.

Application 1308: local anaesthetic nerve blocks for postoperative analgesia

At the time of writing this report, the second draft of MSAC's Decision Analytic Protocol (DAP) has just been received. Members will recall that the aim of the DAP document is to summarise the medical service involved and to pose questions regarding the justification for its funding. In our experience, DAP drafts have generally been of poor quality and have shown a lack of clinical knowledge, sometimes even at a most basic level. The DAP for application 1308 showed some improvement, but there were still a number of issues identified. By the time of publication, EAC will have responded to this second draft.

Once the DAP is finalised, the application will again go to HTA for an assessment of the clinical and economic evidence. This process may take at least nine months.

Application 1309: complex initial consultations in the practice of pain medicine

MSAC recently sought a meeting via teleconference with representatives of the EAC to discuss application 1309. This application relates to the Medicare funding of Item 2801 (MBS Fee $150.90) for initial consultations in the practice of pain medicine. This item applies to the services of anaesthetists who are Fellows of the Faculty of Pain Medicine of ANZCA. However, if the Fellow of the Faculty of Pain Medicine is also a Fellow of the Royal Australian College of Physicians, Item 132 may be applied (MBS Fee $263.90). It is the view of the ASA that Item 2801 does not provide adequate patient funding for the long, complex assessments that are often required and that funding at the level of Item 132 is warranted in all such cases.

We were informed at the teleconference that this application will not involve a DAP, nor any detailed HTA assessment, as with the other two applications. Perhaps not surprisingly, MSAC has found it difficult to apply its processes to consultation services, as opposed to procedural services and new devices or technologies. These generally have a large and easily accessible literature base, which consultation services do not. Therefore, MSAC will simply require a detailed submission from the ASA, outlining the clinical and economic merits of the proposal. While this is good news to some extent, the process will still remain difficult. MSAC focuses strongly on economic issues, which are always subject to estimations and uncertainties.

The EAC is grateful to Dr Roger Goucke (past Dean of the Faculty of Pain Medicine) for his assistance with this application.

PRACTICE MANAGERS' CONFERENCE

By the time of publication, the 2014 Practice Managers' Conference will have been held in Melbourne, at the Mantra on Russell (Friday 28 March). These events have been held regularly for a number of years now and are always popular. Registration is free of charge for attendees who work for ASA members. Members are reminded that their Practice Managers can register with the ASA and gain access to some of our online resources. Members' practice staff are also welcome to seek advice from the ASA's Policy department and the EAC.

INFORMED FINANCIAL CONSENT

The EAC and also the Professional Issues Advisory Committee (PIAC) continue to receive patient complaints regarding fees and informed financial consent (IFC) on a regular basis. In almost all cases it is not the fee alone that is the problem, but rather a perception that the service provided did not warrant the fee charged. Naturally, the time an anaesthetist spends with an awake patient can be minimal compared to the time in theatre, and, as acknowledged frequently in the past, obtaining IFC is more difficult for anaesthetists than other doctors (surgeons, for example). Nevertheless, best possible IFC practices are essential. Clearly it is far better for the profession to take ownership of the issue, rather than risking rules or regulations being imposed on us by others. While the issue is not receiving as much publicity as it did a few years ago, it is certainly not off the agenda of consumer representative groups, health insurers or politicians.

Also, we should do everything possible to ensure patients are aware of the quality of the care we provide. This may entirely depend on our dealings with our patients in the pre-anaesthesia and post-anaesthesia periods. The ASA brochure *Anaesthesia & You* is certainly of help here, and we encourage members to distribute it as widely as possible.

The ASA Policy department, EAC and PIAC are only too happy to assist with queries on these or any other issues. Further information, including resources to assist with IFC, is available on the ASA website or by contacting the ASA on 1800 806 654 or policy@asa.org.au.

INSIDE YOUR SOCIETY | PROFESSIONAL ISSUES ADVISORY COMMITTEE

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

Dr James Bradley, Chair of the ASA's Professional Issues Advisory Committee (PIAC), reports on the commitee's recent activities.

The annual PIAC 'face to face' meeting was held at the ASA head office in North Sydney on 1 February 2014 and followed a Society Executive meeting held earlier in the day. This facilitated attendance by senior office bearers at the PIAC meeting, and a dinner held that evening allowed a more relaxed exchange of views between PIAC and Executive.

ANAESTHESIA WORKFORCE

The major current item of business for PIAC is 'the anaesthesia workforce'. Workforce issues are comprehensively addressed throughout this issue of *Australian Anaesthetist*. While perceived 'big issues' and possible 'short-term fixes' have been identified, it was determined that the acquisition of accurate data would be essential to the prosecution of any position and that Australian Institute of Health and Welfare data (contained, for example, in the recently released *Medical Workforce 2012* report) would underpin this. Although the perception is that we are currently 'high on emotion but low on data', this does not apply to our belief in the concept of 'consolidation' and how the lack of access to public teaching hospitals is seen by younger members of the Society as an impediment to the development of their practices. 'Workforce' will preoccupy PIAC throughout the coming year and will be an issue that we will canvass at forthcoming meetings with ministerial advisers.

GOVERNMENT AND NON-GOVERNMENT BODIES

PIAC is reviewing the commissions and agencies that currently set the terms of contemporary medical practice. These include the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, Health Workforce Australia and its Medical Training Review Panel, the Australian Workforce and Productivity Agency, the National Lead Clinicians Group, the Independent Hospital Pricing Authority, the National Health Performance Authority, the Professional Services Review, the Australian Institute of Health and Welfare, and state health complaints bodies and associated agencies.

It is gratifying that there is no current need for discussion of medical indemnity issues or medical indemnifiers.

The activities and publications of the two major national hospital representative groups (the Australian Healthcare and Hospitals Association and the Australian Private Hospitals Association) are noted.

PATIENT INFORMATION AND ASA WEBSITE

The Society's benchmark information document *Anaesthesia & You* has undergone some minor amendments, and the full suite of Mi-tec patient information brochures and their briefer 'online patient advisories' summaries are being reviewed. All of these documents in their current forms have now been uploaded to the new ASA website and the attention of members is drawn to this resource.

ASA POSITION STATEMENTS AND MEMBER ADVISORIES

Most requests for assistance from PIAC by members concern matters which are underpinned by the content of our 'position statements'. Given that access to clinical privileges and 'scope of practice', along with concerns related to practice issues in private facilities (as opposed to public), are common features, the opportunity was taken to review ASA PS16 and ASA PS07, which deal with private hospital governance issues and credentialling and 'scope of practice'. Members with concerns in both these areas are invited to contact the Policy section at the Secretariat.

'NON-MEDICAL PROVIDERS'

Developments in nurse endoscopy were considered at the last PIAC meeting, along with reports of activity at trial sites. The work (and expense incurred) of Health Workforce Australia in this area is noted. In relation to a request by the NSW Agency for Clinical Innovation regarding proposed 'Minimum Standards and Toolkit for Safe Procedural Sedation', the Society submitted that it was unable to endorse any proposal for 'sedation' which failed to meet the standards of the multi-collegiate document PS9, as well as ASA PS13, which deals specifically with gastroenterological anaesthesia.

THANK YOU

The contributions to PIAC from the Australian Medical Association—through the multi-hatted Liz Feeney (AMA Federal Treasurer) and Andrew Mulcahy (Craft Group Representative)—and from ANZCA by Rod Mitchell (ANZCA Councillor and Chair, Fellowship Affairs Committee) are acknowledged. I thank all three for their valued contributions. I also thank all the other attendees at the PIAC 'face to face' for their frank and constructive views and good humour.

The next PIAC meeting is planned to be a teleconference held on Tuesday 13 May 2014.

INSIDE YOUR SOCIETY | OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

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OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

REAL WORLD ANAESTHESIA COURSE

Overseas Development and Education Committee (ODEC) member Haydn Perndt reports on last year's Real World Anaesthesia Course (RWAC), which trains anaesthetists to work in the developing world.

Chris Bowden's weeklong RWAC in Frankston last October marked the 15th anniversary of the Antipodean Developing Country Anaesthesia courses.

The course was originally started in Tasmania in 1999 by George Merridew and Haydn Perndt as the RSDCDCA impossible acronym course. The aim was to give practical and theoretical training to anaesthetists wanting to work out of their comfort zone in the 'Remote Situations and Difficult Circumstances of Developing Countries'. The RWAC course now rotates between Frankston, Christchurch and Darwin.

This year's course took experiential "encounter group" learning into some new areas. In one session participants were grouped into multinational aid teams (International Committee of the Red Cross, Médicins Sans Frontières, Action Contre La Faim and Oxfam) in order to prepare for incoming casualties from a complex humanitarian emergency in Frankston-istan. The teams were tasked to put together draw-over anaesthesia systems for emergency field surgery in order to be camera-ready for the arrival of a CNN news team. There was a small mountain of Meccano parts with which to construct the circuits. The only problem was that none of the multinational team members spoke the same language.

The course is a packed week of didactic, interactive and group work. The curriculum covers such wide-ranging topics as ether, vapouriser maintenance, and obstetric and paediatric problems, as well as preparation for service trips and longer missions. Sessions on the Boyle's machine, blood supply issues and the psychology of adaptation complete a very full program.

'...there are 234 million major surgical procedures worldwide each year, one for every 25 people. This figure is more than twice the number of yearly births, and seven times the 33.2 million people infected with HIV'[1,2]

The North American Global Outreach courses and the Oxford/Kampala Anaesthesia in Developing Countries course obviously share much of the same content, but each course has its own unique flavour. Two Canadian lecturers, Tom Coonan and Dylan Bould, were on the Australian course this year.

Undoubtedly one of the highlights of the RWAC course is the practical work. The in-theatre draw-over is unique to the Australian and New Zealand courses. While not every "Real World" bound anaesthetist will use draw-over anaesthesia, the simulation of unfamiliar equipment, unreliable monitors and unrealistic expectations of the visiting expert is a powerful tool for insight and anticipation of the real world. All RWAC patients are anaesthetised fully in compliance with ANZCA guidelines, but the RWAC participants imagine they are in an African civil war, a tent in post-tsunami South East Asia or an Interplast mission to the Pacific.

An afternoon spent at the Moorooduc Estate winery allowed many more questions to be asked and even more stories to be told. This important 'in between time' complements the formal teaching of the lectures and group work.

Chris Bowden designed a great program for the week and was superbly assisted by Tzung Ding, who arranged much of the detail of the course with such meticulous attention. The course handbook and photography are two tangible products of his creative skills. The teaching faculty have between them almost a quarter of a millennium of experience from which to share. The fantastic support of the Frankston anaesthetic department and theatre staff ensured the week was an immensely memorable one for lecturers and attendees alike.

Not many participants were aware prior to the course that ether could be used to reseat tractor tyres or that untethered oxygen cylinders can potentially become missiles. The thousand-yard stare and the joys of halothane will hopefully be experienced to very different degrees by this year's alumni. But if previous course surveys are any guide, over two-thirds of the participants will find themselves in remote situations, difficult circumstances and developing countries for some real world anaesthesia.

'30% of the world's population receives 73.6% of the world's surgical procedures and that the poorest third receives only 3.5% of all surgical procedures… If we assume no differences in the burden of surgical disease between rich and poor countries, these findings suggest that despite the number of procedures done world wide, there is an enormous unmet need for surgical care in poor countries'[1,2]

The next course will be in Christchurch on 3 to 7 November 2014. The convenor is Wayne Morriss. For more information, email w.morriss@me.com.

References

1. Weiser TG, Regenbogen SE, Thompson, KD et al. An estimation of the global volume of surgery: a modelling strategy based on available data. Lancet 2008; 372:139-144.
2. Bickler SW, Spiegel DA. Global surgery—defining a research agenda. Lancet 2008; 372:90-92.

Steve Kinnear in theatre teaching

Meccano session

George Merridew discusses the finer points

TYPHOON HAIYAN DEPLOYMENT

Typhoon Haiyan, the most powerful storm ever recorded to make landfall, struck the central Philippine islands of Leyte and Samar on 8 November 2013. Dr Daniel Holmes writes of his experience in the wake of the natural disaster.

In November 2013, for the first time ever, a truly national, civilian, Australian surgical Foreign Medical Team (FMT), including field hospital, was deployed to provide humanitarian aid in the aftermath of a natural disaster. Included were four anaesthetists who helped provide care for 2700 people, including over 220 operations. This deployment was just after the publication of the first World Health Organization consensus guideline for FMTs in sudden onset disasters[1].

The apocalyptic combination of 315 km/hour winds and a storm surge of over five metres lasted 16 hours, destroying towns and villages and leaving over 6000 people dead.

As part of the Australian Government's multi-million dollar disaster response package, the Australian Medical Assistance Team (AusMAT) deployed to Tacloban, a city of 220,000 people in an area that suffered around half the total fatalities from Haiyan. AusMAT was deployed for four weeks, with a multidisciplinary team trained in post-disaster medical and surgical care. Doctors, nurses, midwives, paramedics, pharmacists, radiographers and logistic personnel, representing every state and territory in Australia, along with a 36-bed field hospital travelled to Tacloban. Included in the first team were a general surgeon, an orthopaedic surgeon and two anaesthetists, along with comprehensive emergency and ward-care staff. The entire team were replaced after two weeks by a second deployment.

The first things to deal with in such a deployment are the inevitable logistical difficulties. Where do you site a hospital in an area of widespread devastation, surrounded by people who have lost everything, while making it both accessible and secure? Then there's a period of heavy manual labour for all involved as enormous tents are erected and medical equipment is located among the 25 tonnes of gear constituting the AusMAT baggage allowance.

One often-repeated mantra when giving anaesthesia in challenging environments is that ketamine is king

The field hospital includes two operating tables within one large theatre, allowing two procedures to be performed simultaneously. As anaesthetists we had many of the drugs we use in everyday practice available, but there were some

INSIDE YOUR SOCIETY | OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

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compromises on monitoring equipment. Investigations were limited, though mobile digital radiography was available. Sophisticated surgical instrument sterilisation was also facilitated using a steam sterilisation system.

General anaesthetics could be delivered using draw-over anaesthesia with isoflurane. Two oxygen concentrators, each able to deliver 8 l/minute, were available, though they could not safely run the transport ventilator. Running the ventilator via oxygen cylinders would very quickly have depleted our supply, meaning manual ventilation was necessary if the patient could not breathe spontaneously. Limits on cost, space and equipment malfunction also left us short of monitoring at times, though we were always able to keep to international monitoring guidelines. Nevertheless, listening for a manual blood pressure with the arm tucked under the drapes and the incessant roar of Hercules C-130 aircraft overhead meant a finger on the pulse was a constant companion.

One often-repeated mantra when giving anaesthesia in challenging environments is that ketamine is king, and that almost anything can be done with ketamine alone. While this might be true, we learned it can be done much better with ketamine and propofol. Without the luxury of specialist recovery nurses able to provide one-on-one postoperative care, it was important that our patients were awake as quickly as possible. In addition, patients often move under ketamine and emergence hallucinations are a well described phenomenon. We found that a number suffered distressing recall of the typhoon, calling out for lost family members and demolished homes. This was also upsetting for staff, particularly local Filipino nurses.

> ...the incessant roar of Hercules C-130 aircraft overhead meant a finger on the pulse was a constant companion

Using a smaller dose of ketamine (around 1 mg/kg) and adding propofol to assist in induction and maintenance reduced these problems. The airway was usually self-maintained and the majority kept oxygen saturations of 98 to 100% even without supplemental oxygen. Occasionally fentanyl or clonidine was added to improve analgesia, though at the expense of prolonged recovery times.

Ketofol was the mainstay of our general anaesthesia practice, but the single most common anaesthetic we delivered was spinal anaesthesia. There were significant bed pressures and a curfew from 8 pm, meaning it was imperative that people mobilised quickly and could be safely discharged. This meant 4 ml of 2% lignocaine was a common choice. Many patients had suffered lower limb injuries requiring repeated debridement and occasionally progressing to skin grafting. Spinal anaesthesia was perfect for this group and the 2% lignocaine worked well. There were no cases of transient neurological symptoms[2].

A relatively small number of patients received what would be considered a 'normal' general anaesthetic in Australia. Laparotomies were performed for strangulated hernias, gunshot wounds and trauma victims. Head injuries and seizures in children required airway control, and there were a few 'spaghetti wrist' nerve and tendon repairs. Out of 224 procedures in Tacloban, we inserted one laryngeal mask.

During the busiest spells we performed 20 operations per day. On top of this we performed sedation and analgesia for ward dressing changes, trips to the emergency department and transfer of patients to other facilities. The surgical workload followed the typical post-disaster pattern—typhoon-related trauma and wound issues early in the deployment, with an increase in 'everyday' presentations such as appendicitis and motor vehicle accidents as time progressed. And one helicopter crash.

Tacloban City aftermath

Multi-trauma

Field hospital at dawn

Images provided courtesy of Dr Mark de Souza

Our hospital built a good reputation among the recovering Filipino facilities and non-government organisations, and after a helicopter crash-landed while delivering aid in a remote area the four most seriously injured patients came to us. It was a real pleasure working with our emergency department and nursing colleagues to triage, assess, stabilise and treat four multiple trauma victims at once in such an austere environment. Only one required immediate theatre (for a laparotomy) and the others were stabilised, put in plaster as necessary and transferred out by air towards luxuries such as CT scanners and neurosurgeons.

We found working in the humanitarian field both an exhausting and rewarding experience. The principle of AusMAT is that we are able, as far as possible, to provide developed world–level care in a post-disaster response. In terms of anaesthesia, this meant we were able to deliver more than basic field medicine, albeit with some limitations compared to our normal practice.

> We found that a number suffered distressing recall of the typhoon, calling out for lost family members and demolished homes

Given some of the situations and limitations we encountered, the disaster preparedness training provided by AusMAT proved essential. It was also helpful that all the deployed anaesthetists had previous experience of working in austere environments as well as using draw-over anaesthesia and providing both paediatric and obstetric anaesthesia as part of their routine work at home.

Over the four-week period, we worked alongside Filipino health professionals in our facility doing procedures that were not able to be performed in their recovering hospitals, in addition to providing instrument sterilisation for procedures that took place in Tacloban City. As we left, local health resources were repaired sufficiently that the people of Tacloban could receive quality ongoing surgical care in their own hospitals.

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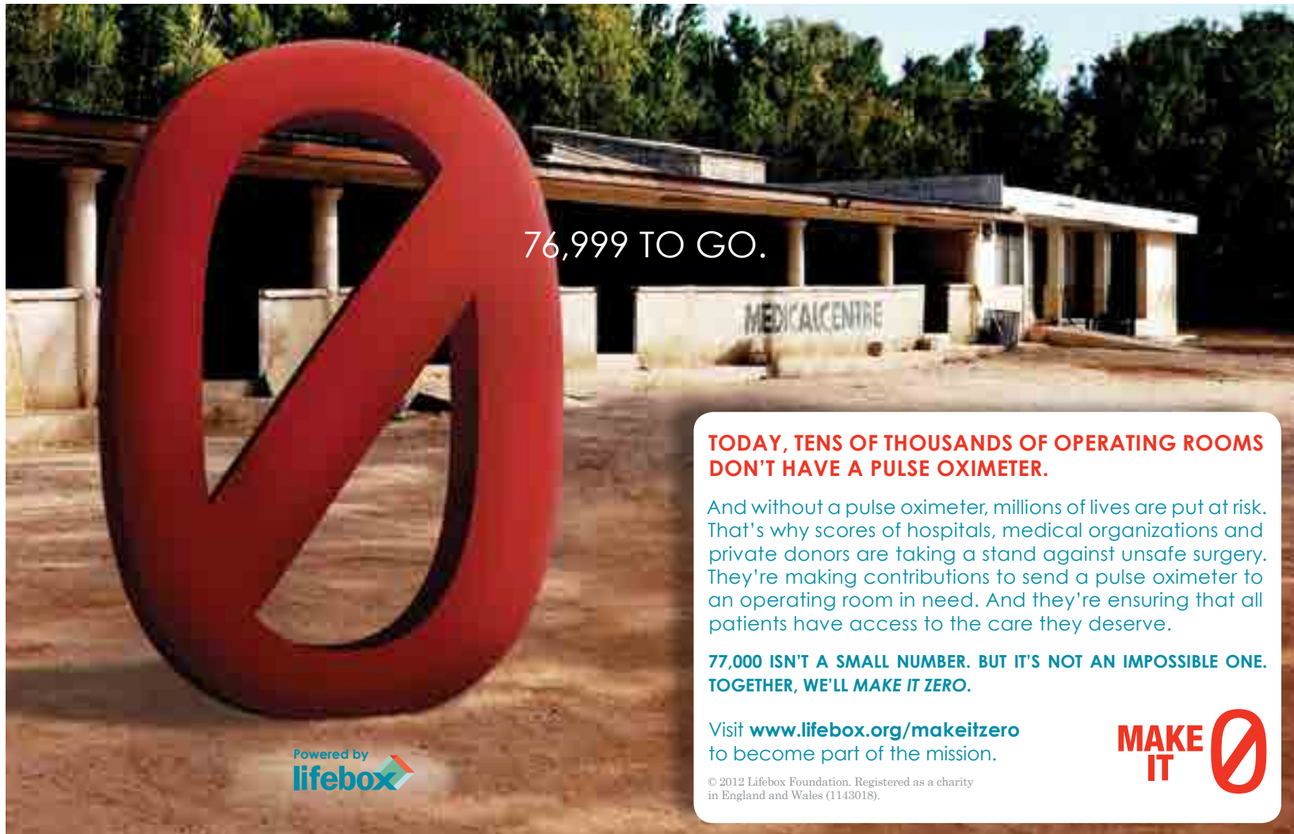


INSIDE YOUR SOCIETY | RETIRED ANAESTHETISTS GROUP

INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

Professor David Gibb, Chair of the Retired Anaesthetists Group, reports on their luncheon at the ASA's National Scientific Congress in Canberra.

A luncheon for the Retired Anaesthetists Group hosted by the Society was held in Canberra at the Australian Society of Anaesthetists National Scientific Congress on Thursday 26 September 2013. It was attended by 16 members and two distinguished guests, our President Dr Richard Grutzner and Vice President Dr Guy Christie-Taylor. A proposal to offer RAG members the opportunity of lodging a personal biography in the ASA archives was discussed.

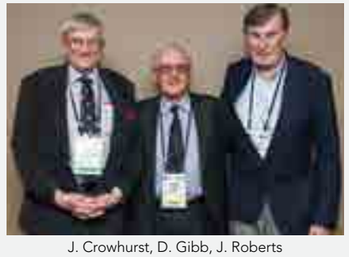
Dr Grutzner addressed the gathering, expressing appreciation for the contributions RAG members had made to the Society during their working lives, and pledged support for them in their retirement. Dr John Paull introduced us to his new book, *Not Just an Anaesthetist*, which records the remarkable life of Dr William Ross Pugh, MD. This is not only a scholarly history but also a rollicking 19th-century tale of adventure set in Tasmania.

It was a most enjoyable function and a welcome opportunity to renew old friendships. On behalf of those present I would like to express our thanks to the Society for providing such a quality luncheon with such excellent wines.

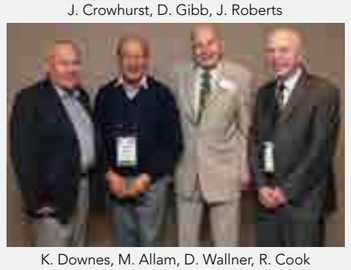
R. Westhorpe, J. Paull, R. Grutzner, D. Wallner, G. Christie-Taylor

K. Downes, D. Maxwell, D. Campbell, R. Young

J. Roberts, J. Crowhurst, R. Holland, R. Hare



J. Crowhurst, D. Gibb, J. Roberts



K. Downes, M. Allam, D. Wallner, R. Cook

Back Row: J. Roberts, D. Gibb, J. Mickelthwaite, R, Cook, R. Hare, J. Crowhurst, R. Grutzner, J. Paull, R. Westhorpe, D. Wallner, G. Christie-Taylor. Front Row: M. Allam, D. Maxwell, K. Downes, R. Holland, S. Bath, D. Campbell, R. Young

RETIRED ANAESTHETISTS GROUP BIOGRAPHY PROJECT

Dear RAG Member,

At the recent meeting of retired anaesthetists held during the Australian and New Zealand College of Anaesthetist's Annual Scientific Meeting in Melbourne it was proposed by Dr Diana Khursandi and Prof. John Gibbs that RAG members are offered the opportunity of submitting a brief personal biography to the Society of Anaesthetists for storage in the ASA archives. This biography is intended to convey not only aspects of professional career, but also of domestic and social life, and all areas of special interest.

Members wishing to avail themselves of this offer should submit a summary of their life history to the Society Archivist at the ASA head office in Sydney.

If you would like to participate in this initiative, please login to the ASA website and download the form from the Retired Anaesthetists Group page. The material contained in the biography is to remain confidential, not to be released without the RAG member's permission, as per the preferences selected by the member on the form.

Send your completed forms to agebels@asa.org.au. Or, if you would like the form provided in hard copy, please call 1800 806 654 and request that a copy be sent to you. Feel free also to send through up to three images (copies only—no originals will be accepted) you would like kept on file to accompany your biography.

Yours sincerely,

Prof. David Gibb
RAG Chairman

Anna Gebels
Curator

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

Anna Gebels, curator of the Harry Daly Museum, reports on the museum's incorporation into the National Library of Australia's Trove database.

THE HARRY DALY MUSEUM JOINS TROVE

By the time this magazine will have gone to print, the collection items of the Harry Daly Museum will have been harvested from our online collection management database, eHive, and integrated into Trove.

According to the National Library of Australia:

Trove is a free, online, national content delivery and discovery service built and managed by the National Library of Australia. The National Library gathers information and combines [it] under one search portal. Trove harnesses digital technology to take its users straight to the source of millions of resources from almost 2000 libraries and other cultural institutions around Australia as well as international digital collections of relevance.

The Harry Daly Museum is now one of these cultural institutions. When a member of the public searches Trove, and items of our collection are relevant to that term, the items will appear in the search results. Our objects will be found among books, digitised newspapers, journals, articles, archived websites, music, maps, sound, diaries, letters, people and organisations that may be relevant. Users are also able to create their own lists for research or 'mini exhibitions' combining items from our collection with those of others for personal and private use.

This is an exciting time for our museum. It will increase our audience and will enlighten them more about the history of humanity's quest for relief from pain, the history of anaesthesia and uniquely Australian advancements in the science and practice of anaesthesia. It will also potentially increase our own knowledge of our collection as more visitors will be directed to our eHive site and invited to add comments and enquire about individual collection items.

To explore Trove and the Harry Daly Museum on Trove, visit http://trove.nla.gov.au.

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

We have expanded the ASA Advantage Program to bring you more resources and savings to suit you and your practice. Our corporate partnerships include:

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- Hilton Hotel, Sydney

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- Westpac
- HLB Mann Judd
- MDA National

Vehicle Purchasing
- National Car Search
- BMW & MINI
- Volkswagen
- Mercedes Benz

For full details on the benefits available please visit the member section of **www.asa.org.au.**

ASA

2014 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
Applicants must be a member of the ASA.

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 a certificate and monies of $10,000.

APPLICATIONS CLOSE 30 JUNE 2014

To apply for these awards, visit the ASA website: www.asa.org.au

NSC PRESENTATION AWARDS

Smiths Medical/GASACT Best Poster Prize

Description
The Smiths Medical/GASACT Best 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 a cash prize to the value of $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/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 a cash prize to the value of $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.

RETURN TO CONTENTS

NSC PRESENTATION AWARDS CONTINUED

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 audiovisual 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 a cash prize of $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.

APPLICATIONS CLOSE 30 JUNE 2014

To apply for these awards, visit the ASA website: www.asa.org.au

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INSIDE YOUR SOCIETY

AROUND AUSTRALIA

WESTERN AUSTRALIAN COMMITTEE

Dr Ralph Longhorn, Chair

We held our Autumn Scientific Meeting on 15 March 2014 on the theme of "Anaesthesia for Bariatric Patients". This was an informative and topical meeting on an increasing problem, with lectures by local anaesthetic and surgical experts in this field. We welcomed Dr Richard Grutzner to the West to give us the latest ASA updates.

Within Perth there are major changes within the public sector, including the opening of a new hospital this year. The local ASA committee is working with the other stakeholders on the many workforce issues arising out of these changes.

Dr Wally Thompson is planning to start a WA Retired Anaesthetists Group, which will be a great social connection for our local retired colleagues, who all too often lose connection with our community.

TASMANIAN COMMITTEE

Dr David Brown, Chair

CME

Our annual State Meeting was held on the weekend of 28 February to 2 March, which included the ASA and ANZCA regional committees' AGMs. We were fortunate to have Professor Jose Carvalho from the University of Toronto as our guest speaker.

The Tasmanian winter meeting will be held on the weekend of 23 August at Freycinet Lodge. It will feature workshops on advanced life support and anaphylaxis management, as well as update lectures. This meeting is designed to assist in meeting some of the new CPD requirements. For those interested in some added luxury, there is the nearby six-star Saffire Lodge.

Our newly formed Combined CME Committee has done a fantastic job and is already starting to plan our 2015 State Meeting.

Politics

The Tasmanian State Elections were held on 15 March. They resulted in a change from a Labor/Green state government to a Liberal state government. Tasmania is currently experiencing a significant reduction in revenue, especially GST revenue, resulting in a significant deficit. This has resulted in a reduction in services, including health. Further reduction in GST payments to Tasmania will have a significant impact on services, especially given the large percentage of over 65-year-olds here.

Committee

This is my last report, as Dr Michael Challis will be taking over as the Tasmanian State Chair. I will remain on the committee as Vice Chair.

NEW SOUTH WALES COMMITTEE

Dr Murray Selig, Chair

The NSW Committee of Management at present comprises the following personnel:

Dr M. Selig (Chair), Dr M. Farr (Vice Chair), Dr S. Apana (Honorary Secretary), Dr I. Woodforth (Past Chair/Honorary Treasurer/NSW AMA Rep.), Dr E. Feeney (Past President), Dr G. O'Sullivan (ANZCA Rep.), Dr C. Downs (Iamonline Rep./ACE Rep./CPD Rep.), Dr M. Chan (Rural Rep.), Dr G. Purcell (Medical Services Committee Rep.), Dr C. Gilchrist (EAC Rep.), Dr M. Levitt (Committee Member), Dr I. Cox (Committee Member), Dr A. Ali Beck (Committee Member), Dr T. Tsang (GASACT Rep.), Dr A. Hill (GASACT Rep.), and Ms S. Donovan (Executive Officer).

The NSW Committee of Management has recently welcomed Dr Ammar Ali Beck to the committee. There is a plan to increase members to represent a wide area of NSW and to have some younger members involved in the committee.

Recently the committee welcomed Ms Fiona Davies, CEO of NSW AMA, to address the committee meeting, and a significant discussion followed on issues relating to specialist workforce situations and in particular the rural and remote area positions, including registrar training, rostering and GP anaesthetic services. Visiting medical officer contracts were discussed in detail together with public hospital and private hospital conditions concerning overall job satisfaction.

Dr Ming Chan represented the NSW ASA at the 'AMA NSW Regional Workforce Forum' in Wagga Wagga on 3 December 2013, discussing current training programs to better support regional practice, services to be resourced, specialist base hospital services to best support and maintain GP services in smaller district hospitals, and the political support required to promote regional practice.

Dr Tyron Tsang provided a report on a survey of GASACT members who expressed concern over the time and detail required to enter data for the Training Portfolio System.

Dr Michael Farr convened a very successful CME Meeting in March 2013 in Sydney and the GASACT Part 3 Course held on 30 November 2013 at the Four Points by Sheraton in Sydney, both being well attended.

QUEENSLAND COMMITTEE

Dr Nicole Fairweather, Chair

GASACT has Part 0 and Part 3 courses well organised for the year. The mid-year Combined ANZCA/ASA CME is still pending as several other conferences in the area require coordination in an effort to avoid sponsor or delegate fatigue.

Contract negotiations have failed with Queensland Health. The resulting contract is being rolled out by individual hospital and health services (HHS), and members are being asked to negotiate and participate in the creation of key performance indicators. This contract is unacceptable, unfair, dishonest and draconian. No-one should sign this contract without serious consideration of the alternatives open to them.

The main issues with the contract are:

- the lack of access to a proper dispute resolution process (including lack of access to an independent body with binding powers),
- the ability of the Department of Health and HHS to unilaterally alter several conditions of the contract (such as remuneration framework, enforced shiftwork, duties and directed professional development leave at own expense),
- the absence of a 'no disadvantage' clause, and
- senior medical officers will have significant portions of their income 'at risk', subject to key performance indicators which are not yet established—no guidance or funding is being given to the HHS to establish or monitor these key performance indicators. Visiting medical officers will not be subject to such conditions.

Members should be urged to contact their industrial representatives to gain the most up-to-date information as the information on this matter changes on a daily basis and may differ by the time of publication.

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin, Chair

The combined ASA/ANZCA Part 0 meeting was held on 18 January at the College of Anaesthetists offices in North Adelaide. This was a highly successful event attended by six participants and covered a range of relevant topics for newcomers to anaesthesia. It is also pleasing to note that all participants have submitted application forms for trainee membership. On the GASACT front, Adam Badenoch has stood down as Senior GASACT Representative to be replaced by Brigid Brown, who in turn has been replaced as Junior GASACT Representative by Nicole Diakomichalis. Welcome to Nicole, congratulations to Brigid and a heartfelt thanks to Adam for his energy and enthusiasm over the last four years. I know you have left GASACT SA/NT in good shape and in capable hands.

The dates for the Combined ASA/ANZCA CME meetings have been finalised, so put these dates in the diary! I look forward to seeing you there.

- 21 May: Anaesthesia for the elderly. The SA/NT ASA Committee of Management will hold its AGM preceding this meeting
- 30 July: TBC
- 26 November: TBC
- 29 November: ASM program (TBC)

The AMA(SA) Gala Dinner will be held on 17 May at the Hilton. This promises to be an evening full of entertainment, fine dining and good company. Proceeds will support HeartKids SA. To book, go to www.amasagaladinner.oztix.com.au or call 1300 762 545.

The composition of the current SA/NT Committee of Management can be found on the ASA website. If you are interested in serving on this committee, please contact Simon Macklin on 0419 543 820.

We can be contacted via the ASA SA office on 08 8361 0105.

VICTORIAN COMMITTEE

Dr Peter Seal, Chair

The ASA NSC 2016 Melbourne Convenor, Dr Simon Reilly, has confirmed that the dates will be 17 to 20 September 2016. The Organising Committee has commenced meeting.

The 13th annual GASACT Part 3 course took place at Kooyong in November last year, convened by Drs Andrew Schneider and Debra Leung. Fifteen delegates attended, slightly less than the previous year, but the program was well received by delegates and sponsors alike. The workforce issue, with a lack of work opportunities for specialists, remains the most pressing concern.

To this end, following up from the Workforce Summit last December in North Sydney, and after the successful and informative evening last May, the New Fellows' Forum was repeated in March. Drs Michelle Horne and Usha Padmanabhan were the organisers, giving our more recently qualified anaesthetists a chance to tell of their experiences in the early part of their specialist practice.

Kooyong again was the venue for the Annual General Meeting and Annual Dinner on 2 March.

The Committee of Management congratulates Drs Paul Francis and Robert Gillies, who have become 50-year members of the ASA in 2014.

With much sadness, the Victorian membership notes the passing of Dr Diana Tolhurst, who was also a 50-year member.

INSIDE YOUR SOCIETY | OBITUARY

INSIDE YOUR SOCIETY

DR COLIN R. (DICK) CLIMIE
1923–2013

Dr Colin Richmond Climie, previously of Auckland and Sydney, died in Hobart aged 89 having dedicated his career as an anaesthetist to maternal welfare. Close friend, Dr Hugh Patterson, offers some insight into Dr Climie's contributions to the practice of medicine.

Dick's beloved wife Patricia predeceased him by some eight months. The couple had three children—Richard, Andrew and Elizabeth. Their children were all graduates of The University of NSW, Richard and Andrew from the Faculty of Medicine and Elizabeth from the Faculty of Arts.

Dick's forbears were much in demand in New Zealand as civil engineers. As a consequence Dick's early education was gained from a variety of schools in Nelson, Napier and Wellington. Dick in due course entered the Faculty of Medicine at Otago. There he met his future wife Patricia who was an undergraduate in the Faculty of Arts.

After graduation Dick spent the usual years of training in general hospitals where he developed an interest in anaesthesia. At that time there was no specialist college whereby he could gain a specialist qualification in anaesthetic practice in either New Zealand or Australia. This necessitated the family moving to the United Kingdom to further his career. As was the common practice at that time, the family travelled to England on a small merchant ship where Dick was the Medical Officer. In the UK he pursued his studies and was successful in passing at his first attempt of entry to the Specialist Anaesthetists section of the Royal College of Surgeons (London). He returned to New Zealand where he practised as a Specialist Anaesthetist.

In 1963 he was appointed as the inaugural Director of the Department of Anaesthetics at the busy Royal Hospital for Women in Paddington, Sydney. Dick introduced a revolutionary benefit to women in labour in the form of lumbar epidural anaesthesia. Prior to his arrival pain relief was attempted by injections of pethidine and, if delivery required, the use of obstetric forceps together with inhalational anaesthetic commonly by "open ether" technique. Pain relief in labour therefore was inadequate and if labour was prolonged the situation had inherent risk. Even without respiratory complications for some women who laboured with their babies initially in the 'occipito-posterior position', labour was slow and agonising.

The arrival of the new Director transformed labour into a painless and safe procedure. Dick made himself available to help on the labour floors with admirable yet modest zeal. He was also a great teacher and, importantly, instructed all his trainee registrars in the performance of this wonderful, then rarely available technique. They in turn, upon qualification, took this advance to other NSW hospitals. The era of the lumbar epidural had arrived and use of the "rag and bottle" technique in the administration of inhalational anaesthesia had gone.

Dick was an individual of enormous energy and conscientious devotion to his patients. Always a modest achiever, he quickly won the respect and regard of the midwives and obstetricians at the Hospital. Dick's capabilities within the specialty took him to lecture in Czechoslovakia and Brazil. He also served as a civilian anaesthetist during part of the Vietnam conflict.

Dick retired from the Royal Hospital for Women in 1984 and moved back to New Zealand with Patricia. They enjoyed 15 years of relative good health, building a cliff-top house in Auckland and sailing in the Hauraki Gulf. Their final move was to Hobart, Tasmania, in 1998 in order to be closer to their two sons and their young families.

Dick died on 27 July 2013 after a brief illness and will be remembered for being capable, intelligent, generous, unflappable and innovative. His contribution to the practice of medicine and his general good fellowship will be remembered with respect by many for a long, long time.

Dr Hugh Patterson

Reproduced with the kind permission of the Australian Medical Association (NSW).

DR PETER THOMSON
1940–2013

Peter Thomson was born on 12 June 1940 in Esher, near London. His mother May was a highly trained registered nurse. His Australian-born father, George Macdonald Thomson, was a medical graduate from the University of Sydney who qualified and practised as a surgeon in England in the 1930s until he was conscripted into the British Army in World War II.

Peter and the rest of the family spent the war in a heavily blitzed London. Many were the tales that May told of near misses from doodlebugs (German V-1 flying bombs). After the war, they left the United Kingdom to join George in Sydney in 1947, where he had been demobilised. George subsequently became a general practitioner and surgeon in Newtown.

Peter attended Burwood Public School and Fort Street Boys' High School. He entered medicine at the University of Sydney in 1957, graduating in 1963. After a year's residency at Royal Prince Alfred Hospital, he was a resident medical officer for two years at Royal Newcastle Hospital, developing an interest in anaesthetics, which he would maintain for the rest of his life.

While working at Lidcombe Hospital, Peter passed the first part of his Fellowship of the Faculty of Anaesthetists of the Royal Australasian College of Surgeons in 1967 and was awarded the Renton Prize. In 1969, he passed the second part of his Fellowship.

From 1968 to 1970, Peter worked at St Vincent's Hospital, Darlinghurst, where he was the anaesthetic registrar involved in the first heart transplant in Australia in 1968. He completed his training at Royal Alexandra Hospital for Children in Camperdown and went into private practice in 1970.

Peter was a visiting medical officer at Liverpool and Auburn hospitals, and then Concord Repatriation General Hospital. He also worked at many private hospitals, including Strathfield, Holroyd and Ashfield. He was a very skilled and devoted anaesthetist, highly respected by his surgeons and patients. He retired from active practice in 2007.

Besides medicine, Peter had many interests. He kept extremely fit by running, walking and cycling. He was a keen birdwatcher and photographer, and greatly enjoyed his Probus club activities.

Peter died on 21 June 2013. He is survived by his wife Sandra, daughters Lynda, Karen and Jenny, and stepdaughter Tammy.

George Thomson

Thomson, G. Peter Thomson MB BS, FFARACS. Med J Aust 2013; 199(11):802. © Copyright 2013 The Medical Journal of Australia. Reproduced with kind permission.

INSIDE YOUR SOCIETY | OBITUARY

INSIDE YOUR SOCIETY

DR PETER BRINE AM
1924–2013

Peter Brine was born on 27 December 1924 in Lancashire, England, and died in Albany, Western Australia, on 6 October 2013. He is survived by his wife Brenda, his children Nigel and Pippa and grandchildren Mia, James, Thea and Bryce.

During his long life he pursued his many interests with passion, and his achievements both within medicine and outside it were outstanding. His family home was in Norbreck, Lancashire, and he was a talented boy chorister, winning many choral contests and developing a love of music which lasted all his life. His secondary education was at Blackpool Grammar School and he originally intended to study engineering. However, the Second World War interrupted these plans and he served in the RAF for four years, two of which were in India when "his eyes were opened to the rest of the world" in his own words.

After the war he studied medicine at Cambridge and Kings College Hospital, London. According to the stories he told, the Cambridge years were noted for cricket, rugby, golf and squash and exams were passed "eventually". Peter and Brenda Jowett were married in 1949, the families having known each other for many years. It was a long and happy marriage of two people whose joy in each other's achievements and interests was always obvious.

He completed his anaesthetic training at Kings and had already developed an interest in paediatric anaesthesia. However, misgivings about the medical situation in the UK led the family to move to Canada to the small town of Cabri in Saskatchewan, where he was the town general practitioner for three years. The stories of this period were colourful, especially about the trials of the prairie winters. Nigel relates that the ambulance was also the hearse, and that it often contained an empty casket, an emergency kit and Peter's golf clubs. Peter also found that he was expected to be the town vet and cope with some unusual problems. He was much respected in Cabri but the medical political situation in Canada became difficult and to Australia's great benefit Peter decided to pursue his paediatric anaesthetic interests as a full-time anaesthetist at Princess Margaret Hospital for Children (PMH) in Perth. It was an inspired appointment for PMH.

He, Brenda, Nigel and Pippa arrived from Canada into a typical Perth heatwave in 1964 and rapidly settled into the lifestyle in what he described as a house on a sandhill at City Beach, really an attractive display home for the Commonwealth Games.

The early 1960s at PMH were exciting but frustrating times for paediatric surgery, paediatric anaesthesia and the developing field of intensive care. Until then most of the diagnosis and perioperative care was in the hands of the physicians who viewed surgeons and anaesthetists as mere technicians despite their specialist training. In particular, the introduction of prolonged nasotracheal intubation by Allen and Steven in Adelaide had enabled the Department of Anaesthesia to take over aspects of the care of medical patients which the physicians were at first reluctant to relinquish. Opposition to an Intensive Care Unit led to the patients being scattered throughout the hospital with very varied standards of nursing expertise and often late referral.

Into this busy and exciting scene came Peter as the second full-time anaesthetist. From the beginning it was obvious that he would be an enthusiastic and very skilful and congenial colleague who was willing to put in the long hours required both by the intensive care requirements and by the widening scope of anaesthesia in all the surgical specialties. Nigel's comment that his children saw very little of him during this time was undoubtedly true. Such was his dedication that the Hospital's administration hoped that with two full-time anaesthetists, the visiting anaesthetists could be dispensed with, an untenable concept, as they too were essential for the development of the anaesthetic and intensive care services. It was not until 1969 that a small Intensive Care Unit with a dedicated physician lightened the load of the Anaesthetic Department, and it was several more years before 24-hour specialist nursing care was provided.

Peter spent two years as a full-time anaesthetist before entering private practice in 1966. He then spent half his time at PMH and a large part of his private practice working with children at St John of God Hospital Subiaco. He worked with many surgeons in all the paediatric specialties and especially with paediatric surgeons Alasdair MacKellar and Gordon Baron-Hay. It is interesting to have his operative and perioperative account of one of their most challenging patients (an infant with an enormous haemangioma also described in Alasdair MacKellar's memoirs), which attests to Peter's outstanding standards of care.

He remained a loyal member of the Department of Anaesthesia at PMH until his retirement in 1989 when he was appointed Emeritus Consultant Anaesthetist.

One of his many major achievements was the establishment of the Same Day Surgery Unit in 1974, only the second such unit in Australia. This was achieved in minimal time in a hospital not noted for rapid change, with little administrative opposition. From the beginning it flourished with none of the predicted catastrophes and it was the forerunner of many such units, both paediatric and adult, in WA. It is hard to remember the days when even the most straightforward surgery required admission for two nights.

Peter was also an early exponent of local anaesthetic blocks combined with general anaesthesia, which contributed to the relief of postoperative pain and proved particularly useful in same-day surgery.

He was an outstanding and popular teacher of anaesthetic registrars. He always preached the importance of the team approach he worked "with" surgeons and objected to those surgeons who referred to "my" anaesthetist in a patronising way, and indeed he seldom worked with such surgeons. He placed great emphasis on high ethical standards in the speciality of anaesthesia and in the medical profession generally. His advocacy for the status of anaesthetists was mainly through the Australian Society of Anaesthetists (ASA), where he was the Federal President between 1976 and 1978, a source of pride because he was then still technically an Englishman. He also became President of the Medical Board of WA (1981 to 1994) and was a member of the Australian Medical Council and the National Specialist Qualification Advisory Committee. He became a Fellow of the AMA in 1989 for these contributions to the profession.

In 1996 he became a Member of the Order of Australia (AM) for services to paediatric anaesthesia and intensive care.

He was an outstanding public speaker and his opening address to the 2000 ASA Congress in Perth on 'Professionalism' exemplified his approach to life, the profession and our duty of care to our patients and ourselves. It should be widely read.

These achievements make him sound a very serious person but he had a wonderful sense of humour and wide interests outside medicine. He was a great raconteur and any gathering where Peter was present was never dull. Some of his best stories related to a memorable expedition along the Canning Stock Route in 1972, a feat which very few West Australians have achieved. He described himself as a "one eyed sandgroper" and so Australian that he ultimately barracked for Australia against England at cricket.

He was a great golfer and a proud member of Lake Karrinyup Country Club where he delighted in defeating young players who were deceived by his grey hair. He would then defeat them at the billiard table as well. His highest achievement was to win the Winter Cup, defeating the professionals.

Peter and Brenda retired to Albany, where Pippa and her family live, and they happily enjoyed the lifestyle and the view of Oyster Harbour from their home. Peter died in Albany, his health having declined after a stroke three years ago.

Nerida Dilworth AM

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from December 2013 to March 2014.

TRAINEE MEMBERS

Dr Ann-Maree Barnes	SA
Dr Andrew James Beck	QLD
Dr Cheryl Chooi	SA
Dr Paul Cosentino	WA
Dr Benjamin Darby	ACT
Dr Nicole Diakomichalis	SA
Dr Julia Alexandra Dubowitz	VIC
Dr Catherine Goddard	WA
Dr Kalyna Harasymiv	ACT
Dr Kathryn Hersbach	VIC
Dr Kritesh Kumar	SA
Dr Yeow-Kwong Kendrick Ling	WA
Dr Phuong Markman	SA
Dr Tejinder Mettho	VIC
Dr Bishoy Moussa	VIC
Dr Christopher James Mumme	NSW
Dr Vinay Rao	NSW
Dr Chetan Reddy	NSW
Dr Leah Rickards	QLD
Dr Lilyana Satiowijaya	QLD
Dr Timothy Richmond Sullivan	NSW
Dr Tuyen Minh Ngoc Tran	SA
Dr Elena Clare Vowels	SA
Dr Milena Marie Wilke	WA

ORDINARY MEMBERS

Dr Anne-Maree Aders	VIC
Dr Anton Willis Gerard Booth	QLD
Dr Sue Cheng Chew	VIC
Dr Andrew Alexander Lovett	NSW
Dr Joshua Simon Rath	NSW
Dr Peter Shea	VIC
Dr Iain Stewart	NSW
Dr Lara Joanne Tickell	VIC
Dr Heman Tse	ACT
Dr Hendrik Stephanus Viljoen	QLD

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Drs William James Wright (SA) and Diana Nowlan Tolhurst (VIC).

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

Associate Professor John Herbert Overton OAM RFD
For significant service to medicine, particularly in the area of anaesthesia, through clinical, administration and advisory roles, and to professional organisations

Professor Michael Cousins AM was awarded an Officer (AO) in the General Division

ASA 50-year membership:

Dr Nickel Crombie
Dr Kenneth Tweedale
Dr Victor Mills Wilson
Dr Vera Lukursky
Dr Brian Martin Smith
Prof. W. John Russell
Dr Paul Howard Francis
Dr E. Robert N. Gillies
Dr Lais Valerie Grewar

All 50 year members receive a certificate and lapel badge.

INSIDE YOUR SOCIETY

UPCOMING EVENTS

MAY 2014

Airway Management SIG Meeting

Date: 2–4 May 2014

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

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

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

JUNE 2014

Pugh Day Lecture

Date: 15 June 2014

Venue: Meeting Room, Queen Victoria Museum and Art Gallery at Inveresk, Launceston, Tasmania

Details: Dr Chris Ball delivers a speech on 'Cobras, chloroform and consumption—the life and times of Joseph T. Clover'

NSW Winter Continuing Medical Education (CME) Meeting

Date: 21 June 2014

Venue: The Hilton, Sydney, New South Wales

Contact: nswevents@anzca.edu.au

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

OCTOBER 2014

ASA National Scientific Congress

Date: 4–7 October 2014

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

Website: www.asa2014.com.au

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

NOVEMBER 2014

NSW Regional Conference

Dates: 1–2 November 2014

Venue: Crowne Plaza, Terrigal, NSW

Contact: Rhian Foster, ANZCA, rfoster@anzca.edu.au

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

4th World Congress of Regional Anaesthesia and Pain Therapy

Dates: 24–28 November 2014

Venue: Cape Town International Convention Centre

Contact: wcrapt2014@kenes.com

Website: http://www.wcrapt2014.com

FEBRUARY 2015

Australasian Symposium on Ultrasound and Regional Anaesthesia

Dates: 20–23 February 2015

Venue: TBA, Perth

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

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Anaesthesia Continuing Education Coordinating Committee

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LIFESTYLE | THE WONDERS OF SEA KAYAKING

LIFESTYLE

THE WONDERS OF SEA KAYAKING

Having a love of the marine environment like a number of other anaesthetists, Dr David Page has taken to sea kayaking as a sport. Wishing to introduce others to the delights of ocean paddling so that they can help conserve the environment under threat, David has skilled himself to gain a commercial qualification with Australian Canoeing as a 'Sea Guide'.

I now lead about 20 groups a year, mostly day trips from protected waters to the ocean. They expect me to provide the safety net for them to venture into a new world of swell, wind, local sea, rebound waves and current. These ventures are mostly around Sydney, with common trips including return harbour voyages from Clontaff to protected Shelley Beach, Pittwater to Maitland Bay or Cronulla to Marley Beach. Those that paddle need only scour the waterways and beaches for plastic and styrofoam waste to be welcome with me.

There are occasions where longer trips are offered, including return overnight expeditions from Nelson Bay to Broughton Island or trips around Jervis Bay's peninsula. Multiple-day wilderness trips, including from Eden to Malacoota, or longer trips to the Kimberley or Pilbara wilderness are undertaken with the more experienced paddlers, where fitness, technique and equipment are important.

All trips are dependent on the group size, experience and skill-set mix but are mainly conditional on the sea state and weather. My insurance allows me to take up to six paddlers into 20-knot winds. As conditions become more challenging, naturally the allowable group size decreases with the experience of the group. It is frequently the case by design that several reliable senior paddlers are in a group that includes the less experienced. This allows a leader to allocate roles to facilitate difficult situations, when it is comforting to have support.

These situations may involve managing sea sickness, exhaustion, injury or multiple capsizes. Sea sickness may render a paddler unable to stay upright in his boat and requires a support person to assist while both are towed to safety. Multiple capsizes can occur with novice and experienced groups depending on wave heights and steepness, chaotic conditions of rebound waves from cliff faces and sudden wind gusts or strong winds. As conditions deteriorate, the allowable group spread is reduced with buddying up of paddlers. Assisted rescues are then facilitated whereby a paddler on a boat aids and directs those who have pulled their skirt and done a wet exit. A very skilled paddler can roll an unconscious paddler upright while staying in their own boat.

Experienced paddlers practise these techniques on every trip to ensure that they can be swiftly performed. Novice paddlers are directed on self and assisted rescue techniques before hitting the water and then perform a wet exit at the beach. It helps mitigate the predictable panic response they might display when they suddenly find themselves upside down in a kayak. As a rule, only very experienced paddlers will roll up automatically. Even those with a bomb-proof roll in training tend to wet exit with an unexpected (what else would it be) capsize.

The safety gear carried depends on the route and the actual and forecasted conditions expected. These may be shared between the group at times. All open water trips are logged with Marine Rescue by phone or VHF radio. This allows for an external rescue if two scheduled call-ins are missed.

Each boat ideally has two waterproof compartments, a hands-free bailing system (electronic or foot bilge pump), a large bailing sponge, a skirt and a floating tow rope on deck as a minimum. Each paddler has sun and foot protection, access to (two litres carried) water from the cockpit and a Personal Flotation Device (PFD 2) with whistle attached. Helmets are needed for all surf landings and entry to sea caves and gauntlets. Each group, as a minimum, carries a spare paddle and hand bailing pump. For expeditions, a comprehensive fibreglass repair kit is carried.

> There is the excitement of having curious dolphins and whales coming right up to you

As leader, as many experienced paddlers also do, I carry a waterproof VHF and waterproof phone, flares, an Emergency Position Indicating Radio Beacon (or PLB), a GPS (and charts) with ocean and topographical data (in case a walk-out is needed), three tow ropes, a comprehensive medical kit and spare water and dry clothes for any paddler.

This medical kit is double-sealed and contains a number of rarely used items. Upon opening the second waterproof bag, a head LED light is found (it may be night time), with a towel to dry wet hands. All the usual adhesive bandages, salves and dressings of an expensive First Aid kit are supplemented with a surgical stapler and staple remover (scalp lacerations from rock encounters bleed profusely until closed) and a methoxyflurane inhaler ('green whistle'). Drugs include antiemetics, adrenaline, oral and intravenous antibiotics, oral and parenteral analgesics such as morphine and tramadol, glyceryl trinitrate and local anaesthetic ampules. There is also a surgical suture kit.

The intention is to be able to be self reliant in the wilderness. Calling in an outside rescue should not be considered as a planned option. Most medical and simple surgical emergencies can be stabilised before paddling back to civilisation or managed while awaiting evacuation.

Top Left, clockwise: 'Whale ahoy!', kayak under sail, and cleaning up the aquatic hitchhikers.

LIFESTYLE

Unassisted relocation of a shoulder is almost impossible due to protective muscle spasm from pain, but is easily facilitated with the intense analgesia given by methoxyflurane from a green whistle.

For longer trips, many kayakers have fitted sails on their boats. These reduce the exhaustion component at times of favourable winds. Although I see myself as a purist, I also see sails as a safety feature on expeditions. Unfortunately they also make capsizing more likely and make rolling impossible.

Small groups of paddlers share a camaraderie on the water that is difficult to describe. There is the excitement of having curious dolphins and whales coming right up to you, the exhilaration of handling a boat in difficult conditions, the shared experience of long paddles while chewing the fat and the satisfaction of training for and partaking in real rescues. Sitting around together at meal time without having impacted negatively on the environment is a real delight, particularly on a wilderness expedition. I am happy to paddle solo on long journeys with the environment and the animals for company, but also enjoy bringing others along with me on a journey of discovery.

The role of the Sea Guide is to safely take a group on a sea paddle. The ocean is an unforgiving environment and this requires careful risk management. Some planned trips are modified and some are cancelled or rescheduled due to the considerations mentioned above. That is as it should be. It also makes the trips taken a real treat.

While anaesthesia provides a satisfying occupation, sea kayaking is a true love as it combines friends and playing in an engaging environment. It also allows me to combine conservation with sport, with one of my kayaks having custom decals to increase brand awareness for the conservation society I am associated with, Sea Shepherd, which has as its mantra 'For the Oceans. To Preserve, Conserve and Protect'.

FURTHER INFORMATION ON PADDLING AND KAYAKING:

- Australian Canoeing: www.canoe.org.au
- The NSW Sea Kayak Club: www.nswseakayaker.asn.au
- Paddle NSW: www.paddlensw.org.au
- River Canoe Club of New South Wales: www.rivercanoeclub.com

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Watching the weather change

Jervis Bay seals

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ASA
Australian Society of Anaesthetists

LIFESTYLE

ANAESTHETIST AND HISTORIAN

Dr Richard Bailey, Emeritus Honorary Curator of the ASA's Harry Daly Museum and namesake of the Richard Bailey Library, sat down with us and discussed his second start as a historian and how he has pursued his passion in retirement.

WHEN DID YOU RETIRE AND CAN YOU TELL US A LITTLE ABOUT YOUR CAREER PRIOR TO RETIREMENT?

I gained my fellowship in 1962, following registrar positions at the Royal Alexandra Hospital for Children in Camperdown and St Vincent's Hospital, Sydney. After this, I spent three years overseas, two and a half years as a Fellow at Montefiore Hospital in New York and six months at Addenbrooke's Hospital in Cambridge.

My main hospital appointments, after my return to private practice with the Elizabeth Bay Group were to the cardiothoracic unit at St Vincent's Hospital and the Prince of Wales at Randwick, resigning from the latter after three years to join the honorary visiting staff at the Royal Alexandra Hospital for Children in Camperdown and Westmead.

In 1998 I ceased actively practising anaesthesia, proceeding to four years as medical advisor to the Department of Veteran Affairs. I finally retired in 2002, after which I have pursued a wide range of hobbies.

HAVE YOU ALWAYS BEEN FASCINATED WITH THE HISTORY OF ANAESTHESIA?

My fascination with the history of anaesthesia was nurtured by the 1974 publication of the history of the St Vincent's Anaesthetic Department. As I lived near Harry Daly, I was asked to interview him about the early days, an eye-opening story. To complete Harry's reminiscences I needed to conduct a fair amount of research into the early days of St Vincent's, which led me down the path of the arrival of ether into Australia, at a time when Gwen Wilson was investigating the same source material for her publication, *One Grand Chain*. The story proved a great attraction to me, prompting a more minute examination of the circumstances of each evolutionary step in the development of the specialty.

CAN YOU TELL US A LITTLE ABOUT YOUR INVOLVEMENT WITH THE ASA LIBRARY?

Research into the early literature required many library visits to read journals not readily available in departmental or even hospital libraries. When the opportunity arose to purchase some of these materials, the chance was seized upon to add to a nascent collection. Titles were sourced from dealer catalogues long before the internet provided many more opportunities to buy (as well as eliminating the need to do so). When I finally retired in 2002, the ASA purchased the core of my collection, the result of 30 years of interest in the origin of our speciality, with the residual being donated in order to maintain the library in its entirety.

CAN YOU TELL US ABOUT ONE OF YOUR FAVOURITE WORKS IN THE LIBRARY?

There are a few favourites for me! It is difficult to select just one. Perhaps a reprint of my first published paper 'Drumine—A new Australian local anaesthetic' (Anaesth Intensive Care 1977; 5:30-35), which tells the story of John Reid extracting an alkaloid from a South Australian weed, *Euphorbia drummondii*. Many articles and letters published in the *Australasian Medical Gazette* between 1886 and 1889 provided the basis for this fascinating saga.

Another is Valentine Greatrakes' letter to Robert Boyle, published in 1666, in which he justifies his use of the laying on of hands to effect cures in certain diseases. This was a forerunner to the use of mesmerism in proving pain relief for surgery—a very important phase in the evolution of anaesthesia.

CAN YOU GIVE US AN IDEA OF WHAT YOU DO AT THE ASA—A TYPICAL DAY?

Currently I visit the Society's new head office at North Sydney at least once per week; more regularly when necessary. With the move from Edgecliff, there has been much work generated setting up the library, archives and museum into a functional resource, my assisting in any way that the librarian and curator/archivist needs.

As an assistant to the editor of the *Anaesthesia and Intensive Care History Supplement*, papers for publication have to be selected, edited and corrected as necessary at all stages from raw material to pre-publication.

There are always questions to be answered, not always successfully, an opinion to be offered after further research. The offer to proofread any of the many publications always being prepared is a task I take on gladly in my pursuit for perfection, as well as a means of continuing my education in current practice. Regular meetings of the ASA History of Anaesthesia Library, Museum and Archives (HALMA) Committee keep one up-to-date with our collections.

DO YOU HAVE ANY TIPS ON HOW OTHER RETIRED ANAESTHETISTS WHO ARE INTERESTED IN HISTORY CAN PURSUE THEIR PASSION?

Anyone who has retired from practice is living history. I recall my early days of administering rag and bottle ether, as well as plenty of chloroform anaesthetics as an obstetric resident for six months, progressing to relaxants no longer in current use. I suggest to the curious, think of the number of relaxants you have used in your career and why not research one in some depth! What about equipment or technology long-forgotten (but always of interest, even surprise, when brought to one's attention). It is only a matter of members contacting the HALMA Committee through the Library or Museum to be able to guide anyone interested in days gone by.

ARE THERE ANY OTHER HOBBIES YOU HAVE PURSUED IN RETIREMENT?

Retirement has allowed plenty of time for family history research (with two Irish convicts in 1816 and 1823 for starters), painting in acrylics, paper-making, gardening and volunteering in remedial reading.

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Call for Papers

The Scientific Programme Committee of the 73rd National Scientific Congress (NSC) of the Australian Society of Anaesthetists (ASA) invites you to submit a paper for presentation as a free paper at the Congress on the Gold Coast in October 2014.

Online paper submission is now open! All abstracts are due by Friday 30 May 2014.
Please go to www.asa2014.com.au for submission instructions and requirements

Presentation Formats and Prizes

The following prizes will be presented at the 73rd NSC:

- Gilbert Troup ASA Prize
- Smiths Medical/ASA Best Poster Prize
- Smiths Medical/GASACT Best Poster Prize

The poster presentation is the default format for the NSC with the Smiths Medical/ASA Best Poster Prize awarded to the best presentation in that format.

The most prestigious prize, the Gilbert Troup ASA Prize, is awarded to the best paper at the Congress. This is judged during specific sessions on an oral delivery of a paper, you must apply for this prize during the submission process to be considered.

Anaesthesia trainees who are members of GASACT will be eligible for the Smiths Medical/GASACT Best Poster Prize, and can apply for this specifically during the submission process.

www.asa2014.com.au

2014 AUSTRALIAN SOCIETY OF ANAESTHETISTS NATIONAL SCIENTIFIC CONGRESS

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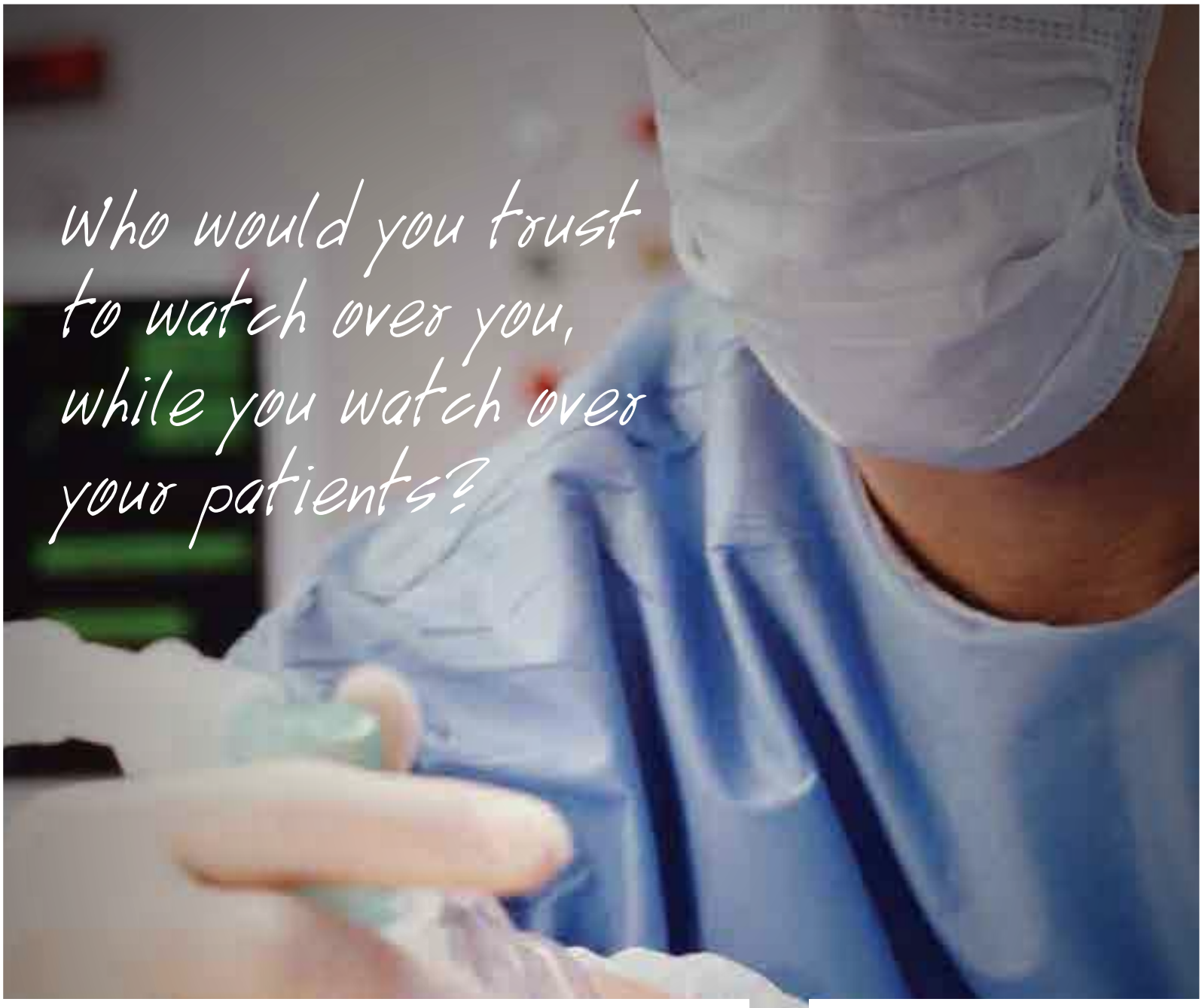

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