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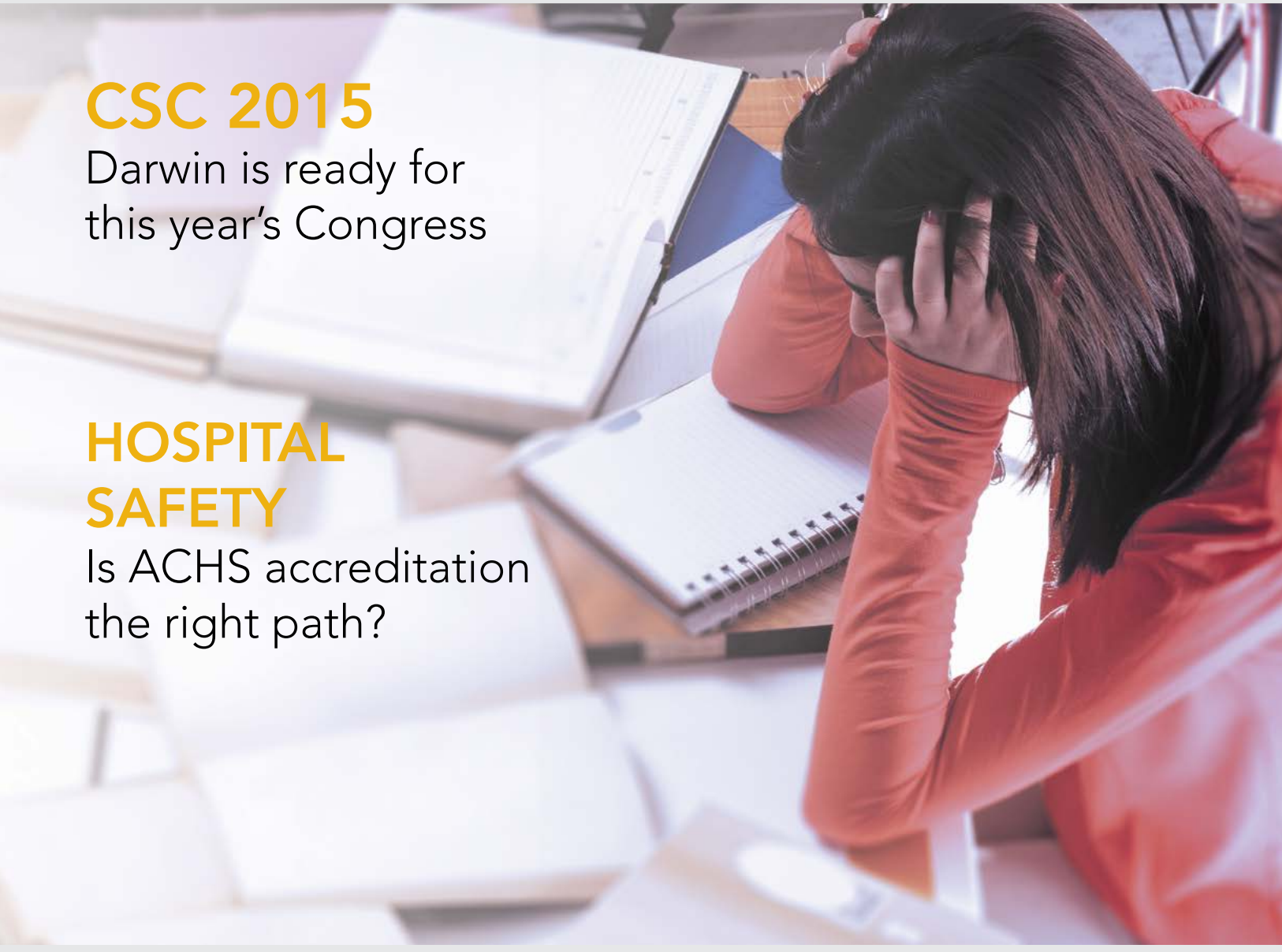

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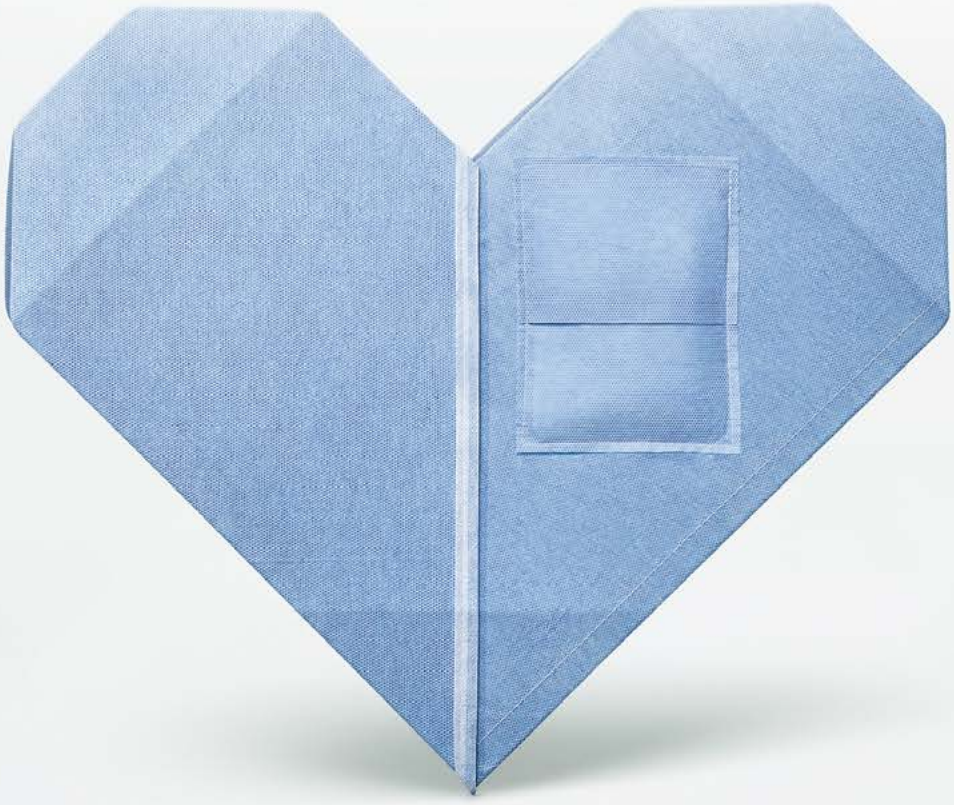

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The Australian Society of Anaesthetists (ASA) exists to promote and protect the status, independence and best interests of Australian anaesthetists.

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

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Australian Society of Anaesthetists

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INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The August issue features of *Australian Anaesthetist* will focus on **Perioperative Care** If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by **15 May 2015**.
- Final article is due no later than **12 June 2015**.

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

REGULAR

ASA EDITORIAL FROM THE PRESIDENT

DR GUY CHRISTIE-TAYLOR
ASA PRESIDENT

This edition of *Australian Anaesthetist* contains articles compelling us to consider two crucial workforce-related issues, writes ASA President, Dr Guy Christie-Taylor.

Firstly, are we facing an oversupply of anaesthetists with the potential for under- and unemployment? Secondly, how might we need to change the nature of our work in order to address the challenges and opportunities offered by perioperative medicine and the demand to effectively and efficiently integrate care of the surgical patient before, during and even well after surgery?

The ASA has long been concerned about an emerging oversupply of specialist anaesthetists and convened its Workforce Summit in December 2013 in order to begin to address this issue. Following on from this, our member survey, conducted last year, and a subsequent snap follow-up survey of our younger members (those within five years of qualification) revealed some worrying trends (see page 42 for a detailed report).

The significant increase in medical student numbers in recent years has resulted in a lack of places in the so-called 'medical training pipeline' and this matter is of concern to the AMA, who envisages the real prospect of under-employed and unemployed doctors.

Our younger colleagues not only require access to the best quality training, they must also then have opportunities to improve the skills and expertise they have acquired and to lead meaningful, productive lives in the pursuit of their chosen profession.

No anaesthetist should have to suffer the ignominy of unemployment. No society should sanction the waste of such a valuable human resource and patients should not be denied access to the care they are able to deliver.

The results of our surveys, together with data from the ANZCA New Fellows' survey, provided the basis of a submission, made in conjunction with the AMA and ANZCA, to the National Medical Training Advisory Network (NMTAN).

The submission emphasised the growing concern that the anaesthetic workforce has moved into a position of oversupply, urging the NMTAN to prioritise research to identify whether this is the case or if the problem is potentially one of distribution.

Involvement with, and management of, our workforce supply and distribution should be one of the profession's key priorities. We cannot relinquish responsibility for this issue to external entities or in any way disengage ourselves from this often complex and fraught matter. Collaboration with organisations that have data and expertise is essential, but we need to be actively monitoring and contributing to the debate. Any concern with appearing to be self-serving or anti-competitive must be mitigated by the motivation to maintain the highest levels of training and practice, as well as the independence and integrity of our profession.

The reinvigoration of the NMTAN and potential development of a National Training Plan is welcomed and we need to remain integral and critical to any decisions the NMTAN may make in relation to anaesthesia.

The 'Boojums' meeting in Adelaide (see page 24 for Dr Macklin's wrap-up), the Tasmanian Combined ANZCA/ASA Annual Scientific Meeting theme of 'Optimising perioperative outcomes: Science to bedside', as well as the release by the Royal College of Anaesthetists of their Perioperative Medicine's 'The Pathway to Better Surgical Care' document all challenge us to examine our perioperative role and indeed the very nature of what is our 'work'.

We have been in the business of perioperative medicine for a very long time – so long in fact that many anaesthetists have 'evolved' into intensive care physicians and pain medicine specialists.

The challenge this presents seems to be two-fold: the first is to maintain our place in the operating theatre as the providers of anaesthesia. The remarkable success of our speciality and the attendant decrease in intraoperative mortality has made it tempting to assume that anaesthetic care can simply devolve to other providers.

A recent editorial by Steven Schafer – 'Anesthesiologists Make a Difference' (*Anesthesia and Analgesia*, March 2015, Vol. 120 (3); pp 497–498) – points out that, despite sounding like a marketing slogan,

the article's title is actually a statement of fact. The editorial was written in response to a paper by Glance and colleagues about how the choice of anaesthetist affects the outcome in cardiac surgery. Patients managed by anaesthetists in the lowest quartile had nearly twice the chance of dying or having serious complications as patients managed by anaesthetists in the highest quartile. If performance of individual anaesthetists can have this impact in the sub-speciality area of cardiac anaesthesia, then it is conceivable that the quality and training of providers in other areas of practice will have an impact on patient outcome as well. We need to ensure that we maintain the highest standards of anaesthesia delivered by medically qualified personnel.

The second challenge is to lead the perioperative care team and to integrate and coordinate the patient's care along the entire continuum from preadmission to well into the recovery phase. The opportunity here is to evolve our skills, not only as physicians, but also as managers. The benefit for the health system is a coordinated and streamlined process that is productive and efficient and allows the conduct of more complex surgery on older and increasingly frail patients.

The exact nature of our role and any extension of it will, in many cases, be determined at a local level and may look quite different between sites. The issue is that we are prepared to examine critically what value we might add to the system that will ensure we expand our relevance and role.

The opportunities might not present themselves in the same manner across the public and private sectors. Each might demand a different response; this should not deter us, but rather allow a greater means to examine a variety of models and responses.

These two issues of workforce and perioperative medicine will provide us with some challenges, but also with opportunities. We might just have the manpower to explore other ways of doing business, to utilise our expertise in expanded and extended roles, to staff roles that have previously been under-resourced and look to make an impact outside of the theatre and even the hospital.

CONTACT

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

STATEMENT OF THE HEALTH OF PEOPLE SEEKING ASYLUM

The Australian Society of Anaesthetists supports the statement made by the College of Intensive Care and the Australian and New Zealand Intensive Care Society as stated below:

- Access to healthcare is a basic human right and should not be compromised for those seeking asylum.
- The conditions in detention facilities, in on-shore and off-shore, and regional processing centres should not compromise the mental and physical health of asylum seekers.
- Long term severe negative health outcomes can result from prolonged detention and uncertainty.
- Detaining children can have profound detrimental impacts on the health and development of this already highly vulnerable group.

Yours Sincerely,

Dr Guy Christie-Taylor
President

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REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

By now, the New Year's greetings have probably long faded from memory, perhaps along with some of its accompanying resolutions! You could have heard someone exclaim, "goodness, it's April already, where is the year going?" Maybe you have even uttered those words yourself!

While a year does seem to go quickly, when we reflect on things, a lot can be achieved in a few short months, and the ASA is no exception. From that standpoint, I would like to take some time to reflect on what has already happened this year and on some of the things that lie ahead in 2015.

An area of constant focus for the Society is that of member services. Already this year, we have seen some major innovations which have been well received by a large proportion of members. Significant developments have occurred in the publishing of *Anaesthesia and Intensive Care*, as well as the *Relative Value Guide* and both publications are now available in an ASA app format. These initiatives were planned and executed throughout 2014, so it is pleasing that they have been made available to members as scheduled.

Whenever something new, like presenting the Journal in an app format, is undertaken, there is always some nervousness about how it will be received. For all involved, those nerves have been replaced with smiles, as members in their hundreds are happily downloading the AIC Journal app. The same can be said for the upgraded and ASA-managed *Relative Value Guide* app, as large numbers of members are also keen to access the new-look version. At the time of writing, over 600 members had downloaded the *Relative Value Guide* app and it is expected that this will number will be close to a thousand by the time this article goes to print.

Membership renewal is another process that has been streamlined through the behind-the-scenes efforts of ASA staff. While an online renewal facility has been available previously, improvements made to the membership database back-end mean that now, when members renew, the changes made to their membership status are processed almost instantly. This small, but important, improvement has led to a significant increase in the number of members completing their renewal online. For the small number of members who have not yet renewed their membership, I encourage you to take advantage of the improved online portal and appreciate the ease with which renewal and payment can now be completed.

While on the subject of membership, I would like to encourage all members to act as advocates for the Society to those anaesthetists who have yet to join. While membership does continue to grow, the prospect of an even stronger ASA, able to represent a larger pool of members, is a desirable and worthwhile objective.

Looking ahead to the rest of the year is indeed exciting. In the immediate future we have the 2015 Common Issues Group meeting in Washington, D.C. scheduled for the first three days of May. This is an important meeting, attended by representatives from the ASA alongside delegates from the Anaesthesia Association of Great Britain and Ireland and the American, Canadian, New Zealand and South African Societies. Key issues this year will be workforce and anaesthetist welfare. This meeting provides a valuable opportunity for information sharing and collaboration with our international 'cousins'. I look forward to providing a summary of the meeting upon my return.

Also not far away is the 2015 Combined Scientific Congress, scheduled for 12 to 15 September, in Darwin. This year, the meeting will be a combined event with the New Zealand Society of Anaesthetists and promises to be a wonderful experience on all levels. The Organising Committee is working extremely hard to ensure a very special few days in a truly unique city. Abstracts can be submitted up until 15 May, so it is not too late to contribute to the Congress dialogue. I certainly look forward to meeting attendees up north.

This year, I am delighted to congratulate Society members Associate Professor David Baines (NSW) and Drs Richard Willis (SA) and Neil Street (NSW) on each being awarded a Member of the Order of Australia award (Members in the General Division) for their work within the field of anaesthesia, as part of the annual Australia Day honours bestowed on a wide range of remarkable Australians.

At the same time, the Society was saddened to learn of the passing of Dr Greg Wotherspoon (NSW) earlier this year. Greg was President of the ASA from 1994 to 1996, as well as a Life Member of the Society. The Society extends its condolences to his wife Deborah and their family.

2015 has been, and will continue to be, a busy and productive year. The Society is committed to its vision of looking for suitable ways to support, represent and educate its members to enable the provision of the safest anaesthesia to the wider community.

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.

TIPS AND TRICKS

'Tips and Tricks' is written by members for members, as a medium to share hints and skills for all areas of practice, whether it be in theatre, the office or consultations.

SNAP AND SEND

If you see an arrhythmia on the anaesthetic monitor which you are not quite sure about, you can take a photo and SMS it to the cardiologist on call for help with diagnosis.

I have done this a couple of times now, resulting in a timely diagnosis and advice for treatment.

There are many uses for our smart phones in the operating room if help is required and the above is just one of them.

Dr Matthew Swann

Mona Vale, New South Wales

FINDING DIFFICULT VEINS.

A manual BP cuff can be used to expose difficult veins. Inflate to 20 mmHg above systolic pressure and have the patient open and close their hand.

After 30 seconds or so, when the patient comments their forearm is aching, let the cuff down to 80 mmHg. The resulting reactive hyperaemia will inflate the veins optimally.

Dr Ken Wishaw

Sunshine Coast, Queensland

HAVE YOU GOT A TIP OR TRICK TO SHARE?

Sharing is caring! And in this instance it could really help your fellow members. Have you got a clever way of doing something? Perhaps a different approach to a common practice?

Australian Anaesthetist wants to hear your Tips and Tricks. Share the knowledge in 300 words or less, and if you think a picture of diagram will help explain, send it through as a high-res (270–300dpi) PDF or JPEG.

Please email us at editor@asa.org.au to submit your nugget of knowledge.

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FEATURE

CARING FOR YOU

At an anaesthetic training position interview, the candidates' brighteyed looks, white smiles, crisp shirts and smartly pressed suits present only outward evidence to selection panellists that these hopeful individuals have not only survived medical training and built impressive CVs, but also have insight and resilience to care for themselves as individuals on behalf of their patients, writes Welfare of Anaesthetists Special Interest Group Chair, Dr Marion Andrew.

Training is structured and time-limited and trainees are expected to jump the prescribed exam hurdles, maintain full-time shift work, study, keep records of training and assessments, contribute to department education and projects, show consistently 'near-perfect' performance and sometimes deal with adverse events. Outside work, trainees are often, at this time in their lives, establishing lasting relationships, marriages, buying homes and having children. Even for the devoted health junkie, it can be difficult to maintain an exercise regimen, healthy sleep patterns and good nutrition. Overall, I think it can be agreed that the anaesthetic profession can be a pretty demanding one – from start to finish.

WHAT DO WE KNOW ABOUT THE HEALTH OF ANAESTHETISTS?

A survey of doctors in South Australia (2007) identified that 40% of the profession were without their own doctor[1]. From welfare literature, we know that trainees below 30 years of age are at risk of experiencing stress and potential burnout, with exams being the major trigger[2]. beyondblue recently identified that anaesthetists showed the highest rating of stress related to exams, with psychological distress, depression and suicidal thoughts also prevalent. Being aware that anaesthetists are at risk of suboptimal health, physically and mentally, urges us to do what we do well – risk manage!

SUPPORTING THE PHYSICAL SELF—CARE AND COPING WITH STRESS

Knowing what you need to know is important. Unnecessary stresses evolve if we don't have all the information or fail to meet training targets. The new curriculum

and portfolio system has defined outcomes and timelines. Increasingly, rotational training schemes are running Part 0 courses which succinctly outline this information, so trainees can focus on the academic learning. Most regions run Part 1 and 2 courses and maximising access to these will make studying easier and allows the sharing of resources with other trainees. Taking advantage of these courses and gaining tips from those who have just completed their training is invaluable.

What about physical health? It's not rocket science and we all know what we 'should do'. We know, in theory, how to look after ourselves – eat well, get enough sleep, exercise etc. If we do have a physical illness, we know we need to be mindful of limitations. When we first start off, we are often able to maintain a balance and awareness, but it gets harder as exams loom and overtime increases and the pressures of senior responsibility build. An excellent GP can be one of your best allies. Those used to caring for doctors know how bad we are at looking after ourselves. Even if you have no physical complaints, making time to have regular check-ups to reflect on health issues such as sleep, fatigue, alcohol intake, diet, stress and exercise provides an opportunity to review the most important physical element of training – ourselves.

At a conscious level, we are aware that maintaining friendships, having hobbies and taking well-earned holidays relieve stress. When our schedules allow, we take time to do these things…but subconsciously we tend relegate them to the bottom of the list when we become stressed. Close friends and family outside of medicine can be good barometers of support by helping you identify when/if you are losing your sparkle or displaying your less charming side in an ever-increasing pattern of anger, irritation or lack of involvement in the rest of your life. Peer group members in anaesthesia are a big support too and socialising with them forms bonds that last. They become our friends, colleagues and informal mentors. They often have different strengths to us and, if they do something well and easily that you don't (like being organised and logical in study methods), ask how they do it and how you can learn from them. Some people appear to sail through training effortlessly, this is because they put a lot of work into utilising time effectively.

DO I KNOW MYSELF? HOW DO I RESPOND TO STRESS?

How we deal with stress and whether we care for and monitor ourselves physically and mentally is largely determined by our personality. Within each personality are great strengths (conscientiousness, agreeableness, ability to be assertive); though unfortunately, many individuals experience their less productive traits (neuroticism, low self-esteem) and the resultant defensive behaviour when under stress. These can cause unconscious self-sabotage. The smart, friendly and gregarious trainee whose low self-esteem and need to be liked may defend vehemently against thinking for themselves and taking on responsibility. Over time, they may be judged by others as lacking in decision-making skills and failing to be an assertive advocate for safety. Being aware of how we respond to difficult situations and seeking honest feedback can be an essential step in coping with stress.

HOW DO I STAY MOTIVATED?

Though trainees are all aiming at the same target, we each have different motivations and needs. We are motivated by, and need recognition of, ourselves as well-intentioned people, for a job well done, for using our time effectively, the relevance of what we do and appreciation of our role in a team. For some, having fun and social interaction is an essential need and, when denied this, motivation lags and stress behaviour develops. Recognising what our particular needs are and making sure those needs are met keeps our batteries topped up. So ask yourself this – what do I need to stay motivated?

WHAT CAN I LEARN FROM OTHERS?

Understanding both our strengths and those areas where improvement is required is something we can address through having a mentor. A mentor/mentee relationship can be made either through a formalised scheme, or by selecting one yourself. This relationship can help you in maintaining perspective and balance. Mentors support with feedback and guidance through training and with recalled experiences that demonstrate the wisdom of humility in glory, self-forgiveness in disaster and maintaining persistence and purpose throughout life's inevitable ups and downs.

WHAT RESOURCES ARE AVAILABLE?

The wellbeing of anaesthetists is a primary concern of the ASA and ANZCA, both in training and throughout professional life, whether in public or private practice, and they support research and projects that encourage and inform a healthier profession.

The Welfare of Anaesthetists Special Interest Group was formed to highlight and support the health and wellbeing of anaesthetists by providing online assistance through the ANZCA website and guiding trainees to independent, non-judgemental resources (doctors' health programs, beyondblue etc.) that are available to enhance self-care and professionalism. Special Interest Group conferences each year focus on wellbeing, with activities that teach stress-reducing techniques like mindfulness and meditation. Courses to learn about ourselves and stress responses are available on the ANZCA website under the 'Events' section.

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1. Sexton R. Doctors need a doctor. *MIGA Bulletin*. August 2012.
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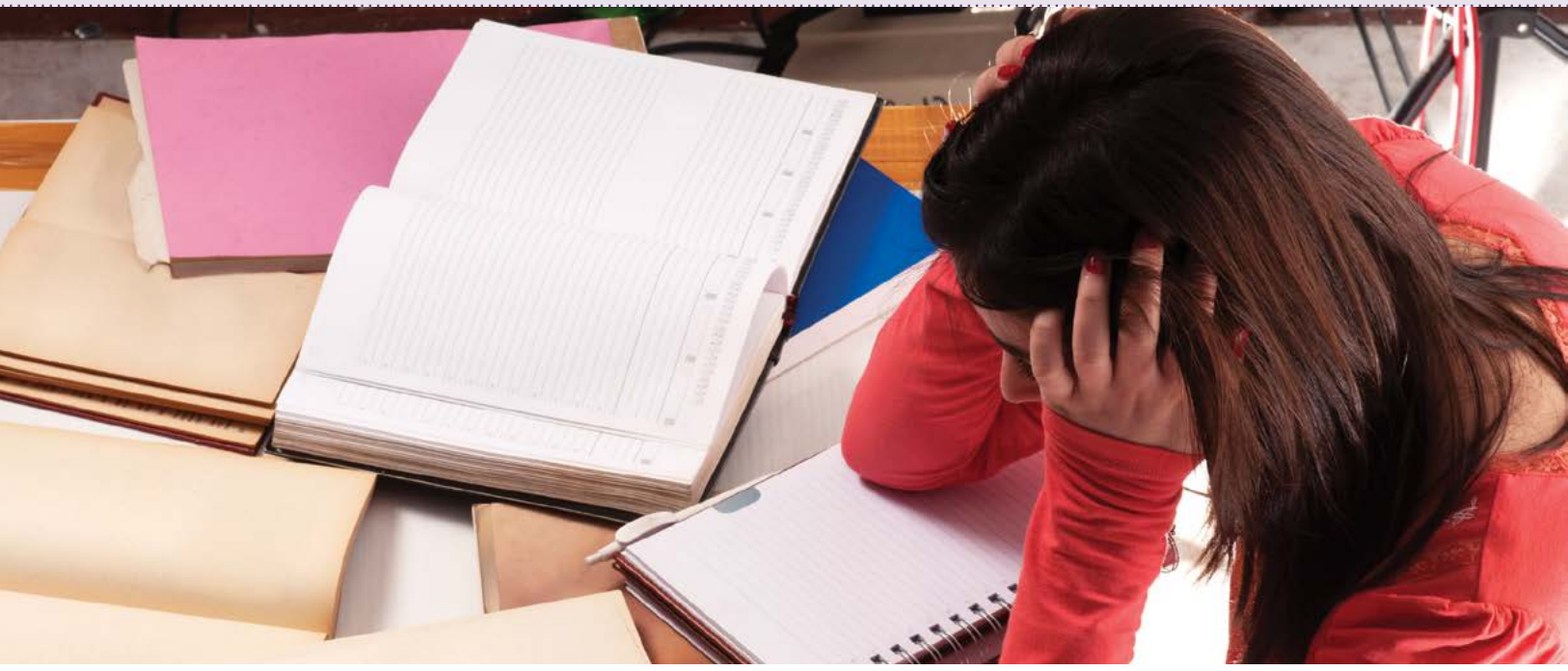

LEARNING TO COPE

With careful planning and implementation of the right coping strategies, the personal challenges faced by anaesthetic trainees are not insurmountable, writes recent FANZCA graduate and Welfare of Anaesthetists Special Interest Group member, Dr Cath Purdy.

The ANZCA training program is designed to lead and assist us as anaesthetic trainees through the five years of training required to become a practising anaesthesia consultant. Those five years, while certainly rewarding, are often extremely difficult. Recognising the inherent challenges of training allows us to prepare ourselves for future hurdles, as well as develop coping strategies.

In 2013, a survey of New Zealand trainees highlighted the nature and degree of stress leading to potential burnout. Out of 250 trainees contacted, 49% responded and, from those responses, a lack of knowledge of available supports was identified. The primary and secondary exams were seen as the most difficult aspects of training overall, followed by criticism from colleagues. Since then, Australian mental health initiative, beyondblue, conducted a national survey of the mental health of medical professionals and students, the results of which mirrored many of the themes of the New Zealand trainee survey. In the beyondblue survey, anaesthetists performed poorly, with the highest rating of any medical profession in terms of stress relating to exams, the second highest rating of suicidal thoughts in the last 12 months and the third highest rating in experiences of depression and psychological distress.

The personality traits that may serve us well academically, make us good anaesthetists and help us to pass exams – conscientiousness, agreeableness, neuroticism and low self-esteem – are unfortunately, not those that enable us to be resilient. Conversely, those traits that are predictive of resilience – extroversion, gregariousness, assertiveness, the ability to form interpersonal relationships and playfulness – are also those associated with a high early exam failure rate.

Thankfully, there are a great number of support systems and strategies available to us; and their implementation during our training years will aid in the development of our long-term careers.

The anaesthetic exams are the greatest challenge most trainees will face. The key is to find a balance between studying hard and living healthily. It is important to look after your mental health and wellbeing. Simply put, if you are mentally healthy and know how to manage stress, you will study more effectively. If you lack mental stamina and the ability to recognise and manage stress, your studies may suffer. Even if you study best alone, link in with the other trainees sitting near you. You will become each other's greatest support.

Engaging in a mentoring program, whether formal or informal, is a great way to create a space for dialogue, resulting in reflection, action and learning for those involved. The mentor can provide a listening ear, feedback, guidance and advice (if solicited) in many areas, as well as acting as a role model, teacher, resource facilitator and coach.

The personality traits that may serve us well academically...are unfortunately not those that enable us to be resilient.

Keeping your Grass Greener is a publication written for medical students, but the advice it offers is just as relevant to us in anaesthesia-specific training. The central advice from author, Dr Sally Cochrane, to "get a GP, get a hobby and get a life" encompasses three of the most important strategies for maintaining a satisfactory work-life balance.

If you have a family GP, keep them. If you don't have a GP yet, find one. Take the time to find the right GP for you – someone you can be a patient with, confide in and obtain support from. Simply being a patient is something you need to work at and it gets more difficult the longer you are a doctor. It is good medical practice to have your own GP, rather than to prescribe for yourself and family and self-refer for specialist appointments.

Maintaining friendships and hobbies outside of medicine is also important. By keeping connected with people, we increase levels of wellbeing, confidence and opportunities to participate in physical activities, all of which aid in achieving a healthy work-life balance.

The Welfare of Anaesthetists Special Interest Group was formed to heighten awareness throughout the anaesthesia community about the importance of personal health and wellbeing and ways to achieve it. The Group has developed guidelines for assisting and supporting anesthetists, from training and exams through to recognising depression and anxiety in colleagues and dealing with the aftermath of an anaesthetic catastrophe.

Across Australia and New Zealand, formal bodies such as the Doctors' Health Advisory Service, the Victorian Doctors Health Program, beyondblue, as well as other employee assistance programs, offer confidential support and advice to anaesthetists. These non-judgemental services are dedicated to improving the health and wellbeing of those within the profession.

While your future career may seem like a long time to plan for financial health, having a plan to manage debts at both ends of your career (student debt repayment and planning for retirement, respectively) also needs careful consideration. We are doctors trained in anaesthesia, pain medicine and intensive care – we do not receive specialist training in financial matters, so it is sensible to seek expert advice. I would advise others to have a financial plan for both your professional and personal life and to review those plans and your options on a regular basis. Many organisations, including the ASA, have guidelines about how to choose a financial advisor and what questions to ask of him/her.

Finally, in recent years there has been an explosion of research regarding mental resilience. It is very similar to being physically fit. Being resilient allows us to withstand the stressors, frustrations and annoyances that beset medical doctors. Elements of 'positive psychology' such as mindfulness, gratitude and compassion can change our attitudes and help to develop skillful means in order to flourish. For more information on these techniques, see www.calm.auckland.ac.nz.

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WHO TO CONTACT

Doctors' Health Advisory Service:

http://dhas.org.au/

Victorian Doctors Health Program:

http://www.vdhp.org.au/

beyondblue:

http://www.beyondblue.org.au/

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FEATURE

CAN WE IMPROVE OUTCOMES?

A recent study published in *Anaesthesia and Intensive Care* has examined substance abuse amongst anaesthetists. The paper – 'A retrospective survey of substance abuse in anaesthetists in Australia and New Zealand from 2004 to 2013'[1] – adds to two earlier ten-year surveys on the topic within Australia and New Zealand, published in 1993 and 2005[2,3]. Dr Robert Fry and med student Lewis Fry, authors of the study, comment here on their findings and the management and rehabilitation paradigm in Australia and New Zealand.

CASE

Timothy is a bright 28-year-old anaesthetic registrar. Recently you noticed a change in his behaviour at work – he is more irritable, often looks tired and you once wondered if he was asleep during a case. He has been working very hard and volunteering for extra night-calls. One morning, you observe him taking a half empty vial of propofol. You report this urgently to the Head of Department and an intervention is quickly arranged as you suspect he might have been intoxicated while at work. Timothy admits to diverting and using propofol, even while at work, and is suspended from duties. A mandatory notification is made to the Australian Health Practitioner Regulation Agency and he is referred for rehabilitation. But what options are available to Timothy for rehabilitation? Should he be allowed to re-enter the operating room?

DEFINING SUBSTANCE ABUSE

Substance abuse disorder and addiction are chronic medical conditions and, while they are treatable, they are also subject to exacerbations and relapses, especially without appropriate therapy and follow-up[4].

The incidence of substance abuse disorder in anaesthesia in Australasia has most recently been estimated at 1.2 cases per 1000 anaesthetist years, similar to other international figures[1,5,6], but it is acknowledged that the incidence is generally underestimated. It is more common in registrars and may affect approximately 1 in every 133 registrars entering the five-year training scheme[1].

Substances most commonly abused by anaesthetists include opiates and, to a lesser extent alcohol; however, recent studies suggest propofol is rapidly becoming the drug of choice and the most commonly abused drug by anaesthetists[1,7].

The causes are multifactorial, including stress at work, family problems, long hours, time pressure, personality problems, anxiety, depression and high expectations. Denial or the lack of insight inherent in any addiction problem, plus feelings of shame, leave the doctor increasingly vulnerable and isolated. Impaired physicians generally struggle with the decision to seek treatment. Early identification and appropriate initial intervention remain the key to subsequent treatment and rehabilitation.

THE CURRENT MANAGEMENT MODEL

Management of impairment is both complex and individualised as there is no standard policy for impaired anaesthetists. Depending on the substances involved, formal treatment may include both inpatient and outpatient treatment, 12-step programs and pharmacotherapy such as naltrexone[7,8]. Referral to a long-term support program is optimal. Physician Health Programs (PHPs) were pioneered in the United States to assist in the rehabilitation of impaired physicians. They do not provide treatment, but provide evaluation and diagnosis, facilitate formal addiction treatment and then offer ongoing confidential support, case management and biochemical and workplace monitoring[8,9]. A core component is an individualised care contract lasting up to five years to ensure compliance with appropriate treatment by a team including a psychiatrist or addiction specialist, psychologist and general practitioner. Ongoing peer support is also recommended through a facilitated Caduceus collegial support group open to medical practitioners and students with substance abuse issues, and has been shown to play an important role in recovery[10]. The Victorian Doctors Health Program offers the only full-time PHP of its kind in Australia. It is confidential, independent of the Australian Health Practitioner Regulation Agency and it is open to both doctors and medical students[9].

TREATMENT OUTCOME RESEARCH

Unfortunately, rehabilitation following substance abuse is a complicated process and relapses, and even death, may occur. The optimal management of the impaired anaesthetist can be controversial and difficult and, although the literature is extensive, research to guide this is limited. Most originates from the PHP, in the United States.

Consistently, studies have shown success rates of 75% to 90% after five years for American physicians treated through PHPs[7,11]. Preliminary data from the Victorian Doctors Health Program indicate similar Australian five-year success rates[9].

[substance abuse] may affect approximately 1 in every 133 registrars entering the five-year training scheme

There is some debate however as to whether anaesthetists have as successful rates of recovery as other specialties. Early studies into substance abusing-anaesthetic registrars showed a 34% successful re-entry for those using parenteral opioids and a 14% death rate[12]. This is supported by recent data showing a 32% return-to-work rate amongst substance-abusing Australasian anaesthetists, with particularly poor outcomes with opiates and propofol[1].

In contrast however, results from American PHP data indicate that anaesthetists have excellent outcomes, with similar success and relapse rates to other specialties and, following a PHP program, 76% continue to practise at five years[7].

In a recent 30-year study of Substance Use Disorder in anaesthetic registrars...43% relapse[d] with mortality at first relapse at 13%

Relapse rates in anaesthetists are important to consider, as daily exposure to their drug of addiction within the workplace is a challenge in a condition requiring life-long abstinence for recovery. Longer-term studies indicate poor lifetime relapse rates. In a recent 30-year study of substance use disorder in anaesthetic registrars, Warner found a 43% 30-year relapse rate with mortality at first relapse at 13%. This has been supported by earlier surveys of program directors, who noted particularly poor relapse rates of 66% in those abusing parenteral opioids[12].

Data on relapse rates from those who have attended PHPs, however, is more hopeful. While only measured over a five-year period, a large study of PHPs reported only 22% of physicians in PHPs had a detected relapse and anaesthetists only had a an 11% relapse rate, challenging ideas that anaesthetists typically have poorer relapse rates compared to other specialties.

The recent survey of Australasian teaching hospitals indicates poorer outcomes compared to the US. Only 32% of substance-abusing anaesthetists successfully remained in their chosen career. Although the data is limited, 80% of those treated for more than 12 months made a successful return to work compared to 43% and 33% for those treated less than six months and three months respectively.

FEATURE

WHAT CAN BE DONE TO IMPROVE MANAGEMENT?

Outcome improvement recommendations

The PHP model exists in Australia in the form of the Victorian Doctors Health Program. Extension of this organisation throughout Australasia would be a reasonable initial consideration to oversee physician impairment management. Standardisation of specific care models, treatment facility accreditation, education and prevention measures, plus research, could be initiated. Cost is, however, a significant issue in the implementation of the above recommendations. The average American state PHP manages between 65 to 75 physicians a year at an annual cost of USD$521,000. This is primarily paid for by an additional $23 charge to licensing fees, whilst formal treatment costs are covered by health insurance complemented by personal physician contributions[11]. It is important to note that some PHPs produce better outcomes than others and that implementation should replicate published successful models and be followed with outcome evaluations[13,14].

Our current method of Australasian research through retrospective surveys of department heads is flawed

Formal inpatient treatment for substance abusing anaesthetists appears to be the exception rather than the norm in Australasia, with only 11% reporting inpatient treatment[4]. There were no deaths amongst anaesthetists treated as inpatients compared to three deaths amongst those treated as outpatients. In contrast, 78% of impaired physicians in American PHPs were admitted for formal inpatient treatment, for two to three months, followed by outpatient treatment for six to nine months. The remaining 22% underwent intensive day treatment[11]. It is postulated that the intensity of the American PHP inpatient treatment and support programs contributes significantly to their 78% success rate in preventing relapse at five years, compared to non-physician, public, court-ordered programs with success rates of just 52%[8].

Formal inpatient treatment for substance abusing anaesthetists appears to be the exception rather than the norm...with only 11% reporting inpatient treatment

The majority of American PHPs also manage the drug testing for participants, conducted approximately four times per month in the first year, usually by third parties, and reducing in frequency throughout the length of the five-year contract using hair, breath and saliva. Participants are subject to testing five out of seven days of the week[8]. This is something to consider as a standard within formal treatment protocols.

Methods of prevention are also increasingly discussed. These include organised departmental educational programs, more stringent drug control and management systems for detection of drug diversion. Random drug testing in medical school, training programs and in the workplace has also been recommended[15,16]. This is in the context that up to 39% of PHP admissions have a prior history and could be detected earlier[16].

Research recommendations

There is a significant need for a database of substance use disorder. This could be achieved with the establishment of state based PHPs maintaining confidential databases. Prospective information that is clearly documented by specialty and substances abused, and outcome based to assess whether those abusing particular substances should return to, in this case, anaesthesia would be ideal. Our current method of Australasian research through retrospective surveys of department heads is flawed.

THE FINAL QUESTION

Is returning Timothy to anaesthesia the correct choice?

There has been extensive debate in the anaesthetic literature as to whether substance-abusing anaesthetists should be given a chance to rehabilitate or whether they should immediately be excluded from anaesthetic practice. Substance abuse is a disease and individuals suffering from it deserve treatment. A 'one strike and you're out' policy would discourage those who might otherwise seek help from doing so, due to the concern that such action might immediately end their career. If Timothy is entered into a scientifically based, highly regulated and controlled treatment program with success rates similar to US based PHPs, then doesn't he deserve a single chance to continue in his chosen career? Of course, there are other factors to be considered associated with an increased risk of relapse, including a family history of substance use disorder, the use of a major opioid, plus the presence of a coexisting psychiatric disorder. Propofol abuse remains an enigma, so every case of substance abuse should probably be evaluated on an individual basis. Is it time for the medical community and the regulatory authorities to look at a national system of PHPs to oversee physician impairment in Australasia?

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PROBLEM?

Speak out

Contact your Department Head. Your State Chair is also there to give you advice. And don't forget the Welfare Special Interest Group!

Research

Whether it is you, or a colleague, suffering from substance abuse, research the problem. Educate yourself on the situation at hand.

Focus

Keep that goal in sight. Coming forward with a problem is the first step to finding the solution.

RETURN TO CONTENTS

FEATURE

BACK TO BASICS

Adjunct Senior Lecturer on the Academic Board of Anaesthesia and Perioperative Medicine at Monash University, Dr Pierre Bradley, and honorary Associate Professor for the Department of Anaesthesiology at the University of Hong Kong, Dr Keith B. Greenland, discuss the importance of airway assessment and documentation and its forgotten place as a means of avoiding a 'can't intubate, can't oxygenate' (CICO) crisis.

We appreciate that there is a drive to ensure we can all manage a CICO crisis but we may be forgetting the importance of airway assessment as part of avoiding that crisis. Over the last few years, we have had the opportunity to review a number of difficult airway cases. Many of these cases were identified either via Riskman or the medical emergency team (MET) call systems. What is surprising is the higher number of 'near misses' than expected, the high frequency of limited preoperative airway assessment, the lack of intraoperative airway details and the frequency of poor decision-making. In some cases there was no documentation at all. These findings are highlighted in the National Audit Project 4[1,2].

Specifically, the authors of the National Audit Project 4 noted:

1. Deficiencies in the undertaking or recording of an airway assessment.
2. Even when abnormalities were detected, the strategy adopted was not always likely to manage the problem successfully.
3. Poor judgement was the most common contributory factor identified.

Some anaesthetists may believe that, given the individual airway assessment tests' low positive predictive values, it is not necessary to perform these simple and fast assessments and document them. Airway assessment, however, remains one of the cornerstones of anaesthetic practice in formulating a management plan with appropriate contingencies to maintain oxygenation in the event of difficulties. In 2002, Yentis wrote an excellent editorial[3] on the prediction of difficult intubation that we would highly recommend as essential reading.

A South Australian study[4] revealed that there were significant deficiencies

in the preoperative airway assessment and intraoperative airway information. Airway assessment documentation deemed to be compliant with ANZCA's position statement occurred in 59% of cases. Regional anaesthetic cases were significantly less likely to have any airway documentation than a general anaesthetic or sedation case. There was a 76% chance that the airway device used was documented in the anaesthetic record. The information documented was more likely to be incomplete in the emergency setting.

In spite of a thorough airway assessment, case documents show little consideration for changing the airway plan to safer options

Similarly, a survey of European, including United Kingdom, anaesthetists[5] reported that they asked about any previous general anaesthetic issues in 91.7% (666/726) of cases, 67.5% (416/616) stated they always did an airway assessment prior to a caesarean section, 61.6% (447/726) before a general anaesthetic and 42.7% (305/714) before a regional anaesthetic. These results are not what we would call ideal.

As a standard of professional practice, the minimum airway assessment required is to ask the patient if they have had any previous problems with anaesthesia, any reflux or indigestion, mouth opening, modified Mallampati score, examination of their teeth and thyromental distance. In addition, there are a whole range of other variables that should be considered.

As an overview, the nine core airway assessment questions used to determine your airway plan are:

1. Is there any information about any previous airway difficulties?
2. Is there any altered cardio-respiratory physiology?
3. What is the impact of the surgery on the airway?
4. How difficult will it be to bag-and-mask ventilate the patient?
5. How difficult is it to place a supraglottic airway?
6. How difficult will it be to intubate the patient?
7. How difficult is it to perform an infraglottic airway?
8. What is the risk of aspiration?
9. How easy will they be to extubate safely?

It is also possible to use the airway assessment as a guide to picking the right tool for the right job. For further information, Dr Greenland's YouTube channel (https://www.youtube.com/user/keithgreenland) provides a short video on airway assessment and choice of equipment based on his Two-curve and Three-column Model airway assessment theory[6].

In spite of a thorough airway assessment, case documents show little consideration for changing the airway plan to safer options. It is also prudent to consider a risk assessment on the merits of the surgery versus the degree of risk imposed before proceeding with the operation.

[there is a] situation of putting consultants into an unfamiliar private hospital environment [with] limited support...creating a financial pressure to proceed with cases they might not otherwise do unsupported in the public system

For example, a patient for an urgent procedure is predicted to have a difficult bag-and-mask, difficult supraglottic airway insertion, difficult intubation (the unholy trinity of difficult airway management predictors) and an aspiration risk. The plan proposed is a rapid-sequence induction using a non-channelled hyper-angulated videolaryngoscope with a bougie. In our opinion, we would consider this a very questionable option at best, given that all your rescue options are predicted to be difficult. This would imply to us that an awake technique should be used if at all possible and we would include regional or awake intubation (fibreoptic, laryngoscope or videolaryngoscope). Finally, if you really were going to use the rapid sequence induction option, with a non-channelled hyper-angulated videolaryngoscope, the use of an appropriately angulated styletted tube might have been a better choice than a bougie.

Elhalawani highlighted that there was a 24% failure rate to document the airway device in anaesthetic records[4]. Intraoperative airway documentation needs to detail the device and airway conduit used. This is important not only for any subsequent anaesthesia but also medico-legally. If any problems occur, they should be documented with information included about how they were solved and how easy it was to bag-and-mask. It is also useful to note if any damage to the teeth occurs or not.

For example:

Easy Bag-and-mask.

No guedel used.

cMAC #3 direct view grade 3, indirect view POGO 75%. Styletted 8.0 ETT used.

Teeth intact. Minor lip laceration. First pass.

Note: it is quite clear that the indirect view is different to the direct view. There are other alternate grading systems for the indirect view that can be used such as the Freemantle score[7].

In recent years, there have been some workforce concerns about the staffing of on-call private hospital rosters. Specifically, the concerns have been about the degree of experience and volume of practice required to be on these rosters, as they tend to have very limited support. There has been much discussion about levels of technical and non-technical abilities, given the reduced exposure to clinical workload in relation to the safer working hours and additional out-of-theatre experiences.

FEATURE

The mean number of airway interventions to reach a 90% probability of achieving a degree of competency in basic intubations in ideal conditions is between 47 (±11.2) and 57[8,9]. Applying the same logic to difficult airway management, a minimum of 36 difficult intubations is required to gain competency. A grade 3 or 4 is considered a difficult laryngoscopy and it occurs about 3% of the time in the general population. The number of intubations required to achieve clinical competency in difficult airway skills would be 1200 general cases. Obviously, different hospitals may have greater exposure to difficult intubations and the number of cases required may be less, for example, in a trauma hospital.

there was a lot more unsupervised or distant supervision of practice, with longer hours, which meant you learnt to be self-sufficient earlier

Clarke's 2010 paper[10] on Western Australian anaesthetic trainees' exposure to airway management demonstrated that anaesthetic trainees were getting an average of 155 intubations and 0.5 fibreoptic intubations a year. This would equate to 775 (or 23 difficult) intubations over a five-year training program and 2.5 fibreoptic scopes in a five-year training period. We appreciate that most trainees have prior anaesthetic experience before commencing a training program and, when we extended these figures to seven years of training, we got 1085 (or 32 difficult) intubations and 3.5 fibreoptic scopes. Dawson's survey[11] showed a median of four fibreoptic intubations were performed per year by New Zealand trainees, which is still less than what is required to gain competency.

These extrapolations would seem to correlate well with our impressions about the consolidation of airway skills in relation to years of training and early consultancy, especially in relation to fibreoptic skills. Bench training in fibreoptic skills goes a long way to overcoming this shortfall[12] but may not be universally available across all training sites. We look forward to Clarke et al's next cohort study, given we have started a new training program for the trainees.

Recently, there has been a lack of public hospital opportunities for newly qualified consultants. This has created a situation of putting consultants into an unfamiliar private hospital environment that has very limited support for them and creating a financial pressure to proceed with cases they might not otherwise do unsupported in the public system.

This is not the ideal transitional environment for new consultants. In addition, in times gone by, there was a lot more unsupervised or distant supervision of practice, with longer hours, which meant consultants learnt to be self-sufficient earlier and had a greater exposure to the number of cases performed. There has been some discussion about what timeframe should be used before newly qualified staff be allowed to participate in the on-call system and a mentorship model.

It is difficult to quantify the number of intubations required to maintain the skill once acquired but it would seem prudent to attend an advanced airway course to ensure up-to-date knowledge of equipment and preservation of one's skills[13,14].

Finally, if any difficulties are encountered, tell the patient, write them a letter, write a letter to the GP and specialist involved in their care, advise them to get a medical alert bracelet and fill in a webAIRS report.

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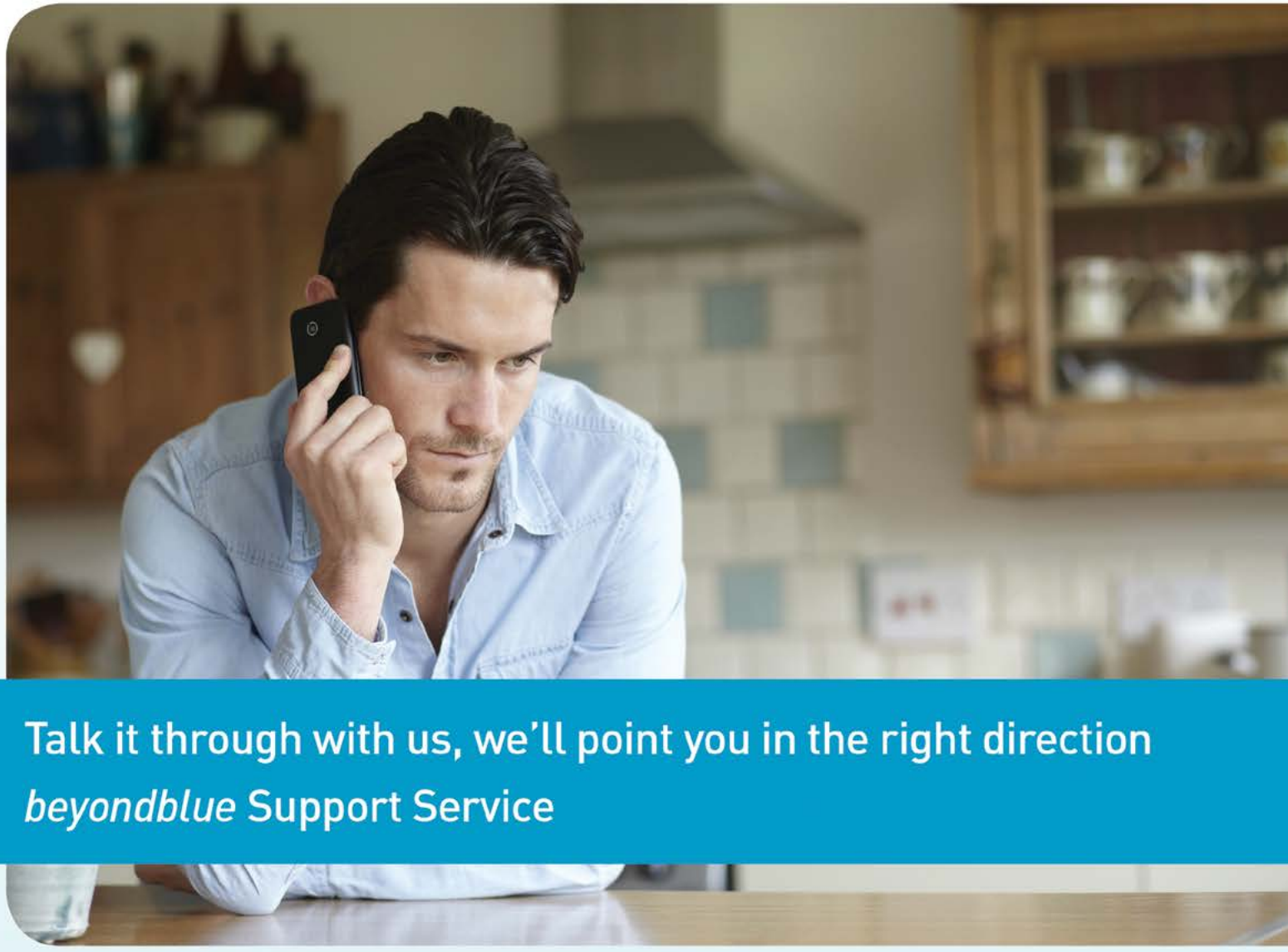

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FEATURE

HOSPITAL SAFETY: IS ACHS ACCREDITATION THE RIGHT PATH?

On 1 January 2013, 15 regulations developed by the Australian Council on Healthcare Standards (ACHS) were introduced nationally and made compulsory for the majority of public and private healthcare institutions. Director of Intensive Care at Cairns Base Hospital and Associate Professor at James Cook Medical School, Dr Drew Wenck, reports on the outcomes of this accreditation framework for *Australian Anaesthetist*.

Many Australian hospitals are in the process of accreditation assessment by the ACHS. This involves a very labour-intensive and arduous process documenting adherence to 15 National Standards. These standards are very broad, incorporating all aspects of patient care and the overarching systems of corporate governance. The accreditation process attempts to identify areas with the greatest consequence for patient health and instigate a new process assessing performance, including an ongoing monitoring cycle. Key areas such as blood transfusion and recognition of the deteriorating patient and audit and feedback for continuous improvement are pertinent examples of these aims, respectively. However, I was recently at an ACHS preliminary hospital audit and observed the absence of any other senior medical staff. Thus, the ACHS accreditation process appears to be devoid of the key personnel integral to its successful functioning – senior medical staff.

It appears that this mammoth task is being approached by hospitals the way I approached my anatomy finals in medical school – a massive, intense 'cramming' of information right up to the final minutes (usually after having been up all night!), which was then quickly forgotten in the immediate aftermath of the exam at the Royal Exchange Hotel adjacent to the University. The Health Service employs numerous project officers on temporary contracts tasked with auditing the present systems and systematically creating a process that responds to any shortfalls. It is then assumed that these newly created systems will roll in a continuous cycle of audit, response and improvement; the auditors will be satisfied and we can forget about accreditation for another three years. However, what remains after the 'cramming' is a massive load of

paperwork, unrealistic audit expectations and a tsunami of data that is not put to use and only overwhelms the staff. To clearly comprehend the impact of the ACHS standards, I will follow the process using a fictional patient admitted to hospital. For this patient, I will demonstrate the amount of data collected and the audit levels required to satisfy the ACHS standards.

IMPACT OF ACHS STANDARDS

Mrs Raylene India Parker (RIP) is a 74-year-old female in relatively good health, although she is a type 2 diabetic on an oral hypoglycaemic and diet control. She lives alone and drinks four standard alcoholic drinks every day. She presents to the emergency room confused, dehydrated and complaining of abdominal pain. Due to the National Emergency Access Target (NEAT), the emergency room must diagnose, treat and admit RIP to a ward bed within four hours. NEAT is a federally mandated target that provides vital hospital funding – if NEAT targets are not met, then, subsequent to routine audit, this essential funding is not provided. RIP has acute cholecystitis (inflamed gall bladder), so she is given antibiotics and admitted to a hospital ward as a surgical patient. Unfortunately, there are no surgical ward beds, so, to ensure that the patient doesn't breach the four-hour rule, she is moved to the orthopaedic ward. Here the drama begins…

what remains after the 'cramming' is a massive load of paperwork, unrealistic audit expectations and a tsunami of data

The admitting nurse completes the Adult Admission and Discharge assessment, which is essential to many of the ACHS Standards (4, 8, 10 and 12). This single form has 160 data points for each patient admission and it requires auditing four times a year! RIP scores high on her pressure ulcer risk assessment, so a formal Waterlow Pressure Ulcer risk assessment is undertaken. The Waterlow form has over 32 data points and it too is audited four times a year. The admitting nurse locates a pre-existing pressure area on RIP that was acquired in her confused state at home; now a Wound Management and Assessment form is also required. This form has 30 data points and must be audited as per Standard 8. RIP's alcohol intake is noted, so an alcohol withdrawal risk assessment form is completed, a further 20 data points. RIP's confusion places her in a high falls risk category, so a Falls Assessment and Care form is commenced, which has 35 data points and is audited for Standard 10. RIP also requires a Venous Thromboembolism Risk Assessment, which has 30 data points and is audited for Standard 12. As RIP has previously had an adverse reaction to some foods and some medications, an Adverse Reactions and Alerts form is completed, which has seven data points and may be audited for Standard 4. Surgeons assess RIP and suggest she might need to undergo an operation, so a Perioperative Patient Record form is completed, which includes the Surgical Safety Checklist containing 102 data points and is audited for Standards 3 and 6.

Finally, observations of RIP's vital signs, including oxygenation and mental state, need to be taken. These are recorded on the Adult Deterioration Detection System chart and a total score is calculated that relates to a level of deterioration risk. This chart has seven data points and it requires a calculation; it is regularly audited at least six times a year.

The medical officer commences their admission paperwork. RIP will need her current medications recorded and continued, as well as any newly prescribed medications. A medication chart is filled in, which is audited as per Standard 4. RIP needs a blood transfusion, so a separate consent form for blood is required, which is audited as per Standard 7. Her indication for transfusion and prior transfusion history must also be recorded and this process is audited four times a year. RIP's blood transfusion requires completion of a special blood transfusion observation chart and this too is audited. Unfortunately, RIP suffers a mild transfusion reaction: her temperature increases and she develops a rash. Standard 7 mandates that this is recorded in a special data bank and investigated, as all transfusion reactions (even minor ones) must be audited and reviewed by the Blood Transfusion Committee.

Upon admission to the ICU, RIP's clinical information is entered into yet another database

RIP's condition starts to deteriorate and her increased Adult Deterioration Detection System chart score initiates a medical emergency team (MET) call. Having been inappropriately admitted to an orthopaedic ward, RIP's treating nurses and doctors are unfamiliar with her condition and this call is delayed. When the emergency team arrives, they find RIP has low blood pressure, low oxygen in the bloodstream and that she is only semi-conscious (in a depressed mental state). She is admitted to the intensive care unit (ICU). All events of the MET call must be recorded in the patient notes as well as on an additional MET form with over 90 data points. This must then be entered by the treating MET nurse into a specifically designed MET database that is audited monthly for Standard 9. Upon admission to the ICU, RIP's clinical information is entered into yet another database – a very comprehensive tool developed by the Australian and New Zealand Intensive Care Society that contains a minimum of 50 data points for a short admission and potentially thousands for a complicated long-term ICU stay. This is audited every three months nationwide and it directly relates to Standard 1.

FEATURE

RIP goes to the operating theatre and a gangrenous gallbladder is identified and removed. Back in the ICU, she requires more substantial intravenous line access, so a vascular access (central line) device is inserted. The time and date of insertion and removal must be recorded and any infection noted and entered into the Central Line Associated Blood Stream Infection database. Central line infections are reported four times a year, relating to Standard 3. RIP's prescribed antibiotics are also recorded in a database and a report for these prescriptions is generated four times a year as part of the antibiotic stewardship program, which directly relates to Standard 3.

For RIP, data collection continues post mortem

Finally, after ten days of intensive care therapy, RIP improves enough to leave the unit and return to a hospital ward. Although she is deemed fit for discharge from ICU on Friday at 0800h and a patient summary is generated to hand her over to her ward doctors (audited as per Standard 6), she is denied a bed in the surgical ward as a patient waiting in the emergency department has priority as per NEAT. The ICU has no urgent admissions, so RIP remains there until a ward bed becomes available at 0200h on Monday morning. A child with meningitis admitted to the ICU takes priority over RIP, who is moved to an orthopaedic ward again. Against ICU patient care protocol, RIP is transferred to a ward in the early hours. The orthopaedic ward is 100% occupied but has low staff levels overnight, with few senior nurses present. For a sick, elderly patient, a change in location overnight can be very disorientating. Once she arrives, RIP becomes confused and, in her confused state, she manages to climb out of her bed and falls and hits her head on a porcelain basin near the bed. She suffers a closed head injury (a subdural bleed) and dies within the next few hours. As RIP dies while in hospital care, her death becomes a coroner's case and it is scaled as a Severity Assessment Code 1 event. Her death and the cascade of events are investigated as per Standard 1. This Root Cause Analysis investigation takes over two years to commence due to a backload of other investigations. All investigation findings require feedback through the hospital governance structure. For RIP, data collection continues post mortem – it is not over until her illness and comorbidities are coded to ensure compliance with the Activity Based Funding model, which governs the patient care aspects of the hospital's funding.

WHY WASN'T THIS PATIENT'S DEATH AVOIDED?

All her paperwork was completed correctly, which for nursing staff to do requires a minimum of two uninterrupted hours, per shift! All of the standards were met, yet there was a fatal outcome. In my view, the ACHS focuses on completely the wrong aspects of patient care. I consider a better system to be the following.

Before a hospital is even considered for accreditation, certain minimum standards need to be achieved. Firstly, the hospital must have an average occupancy of less than 85%, as this allows the hospital system to cope with sudden surges in patient admissions and avoid inappropriate ward allocation. Secondly, the hospital must be able to demonstrate adequate staffing at nationally agreed upon benchmarks. Thirdly, financial targets, such as NEAT, shouldn't be prioritised over patient safety, as they clearly dictate poorer treatment for those outside the emergency room. This system warrants auditing, not just a time limit of four hours. Finally, only when each hospital has achieved safe occupancy and staffing levels and patients are allocated to appropriate wards, should these factors (alongside timely transfers between the ICU and hospital wards) be further assessed against the 15 Standards.

When a hospital complies with these essential standards, the ACHS must then apply a formula to ensure the correct staff numbers are available to continue the cycle of auditing and improvement. There can be no more 'cramming'. Moreover, the inclusion of senior medical staff in the ACHS process is essential to building a successful final product. Senior medical staff are not fools. In their day-to-day medical practice, hospital-based senior medical staff are continuously struggling to cope with occupancies in excess of 100%, inadequate nursing levels and ridiculous levels of paperwork. They view the ACHS standards with derision, as compliance with them has no effect on the fundamental issues, hence their disengagement. I am handing a red card to the emperors of hospital accreditation – you need to put your clothes on and get back to basics.

These opinions are those of the author and do not represent the views of his employer, the Australian Society of Anaesthetists or any other representative body.

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FEATURE

BOOJUMS OF ADVERSE EVENTS – WRAP-UP

Boojums of Adverse Events: can we prevent them? was held at the Adelaide Convention Centre on Saturday, 7 February in the Riverside rooms, writes SA/NT Chair, Dr Simon Macklin.

It was supported by the ASA and sponsored by MDA National. In the weeks leading up to the event, it became apparent that the demand for registration was going to exceed the capacity of the space originally booked for the meeting. This was a welcome result for the convening committee, as gauging interest in this meeting was difficult to predict. When the seventh finally arrived, Adelaide turned on a beautiful summer's day and delegates were able to spill onto the terrace overlooking the River Torrens and the all-new Adelaide Oval during the refreshment breaks. These breaks constituted a vital component of the meeting as debate surrounding the issues raised during the sessions continued.

It was a great pleasure to welcome such a diverse audience to a meeting that may play an important role in shaping future perioperative management. It is always a concern that such a meeting will simply attract like-minded people for an issue that may have been seen as relevant only to South Australians. Although that possibly was the case, the audience comprised of senior private hospital administrators (CEOs and Directors of Nursing), general physicians with an interest in perioperative medicine, orthopaedic surgeons, GP anaesthetists, pain medicine specialists and anaesthetists. It was pleasing to see a good mix of local and interstate anaesthetic colleagues from both the public and private sectors. In addition, there was representation from interested parties from the healthcare industry.

THE MEETING

The first session was devoted to preanaesthetic assessment. Dr Jim Bradley highlighted the changing face of this vital component of a patient's journey through their surgical process. There has been a dramatic rise in day-of-surgery admissions over the last 20 years. Although there are advantages for anaesthetists – namely avoiding the

run around hospitals for night-before assessment (which, in my personal opinion, was a somewhat futile exercise as it left little time for collection of medical information or for optimisation of comorbidities, should that be needed) – it has also increased the pressure on anaesthetists, as this change has often not been accompanied by appropriate facilities for such a task.

There is little guidance on who is responsible for postoperative management

Limiting time available for the preanaesthetic assessment may compromise both procedural and financial consent. Further to this, staggered admissions have subsequently crept into the equation. It is easy to see this as convenient for hospitals, as they struggle to process large numbers of patients arriving over a short period of time, and for patients who'd rather wait under their own terms and conditions rather than in a hospital. These are both understandable, but may decrease the efficacy of the vital preanaesthetic assessment processes. Dr Justin Porter outlined his approach and emphasised the collaboration between surgeon and anaesthetists' PAs. Developing a 'timeline' for patients undergoing major surgery was a process that could easily be incorporated and would ensure that all necessary work-up had been completed. Dr Tom Painter outlined a new model of care currently undergoing 'live' evaluation that uses a comprehensive questionnaire to gather information by telephone, which can be used to determine if a face-to-face meeting is necessary. Even without the face-to-face interview, the anaesthetist will have detailed information regarding the patient.

Mr Allan Morrison completed the line-up for this session and highlighted the squeeze felt by private hospitals in South Australia in the remuneration from the health insurers.

The second session involved local chairs of the Australian Orthopaedic Association (A/Prof David Campbell), Royal Australasian College of Surgeons (Dr Sonja Latzel), Australia and New Zealand Intensive Care Society (A/Prof Mary White), ANZCA (Dr Angelo Ricciardelli) and the ASA PIAC Chair, Dr Jim Bradley. The intended focus was on postoperative management and the guidelines from the respective colleges and associations. It soon became apparent that there is little guidance on who is responsible for postoperative management and most of the session was directed at preadmission decision making. The role of the general physician was raised and it is clear that much reliance is placed on them in the orthopaedic universe. It may be that a more meticulous approach with greater collaboration between physician and anaesthetist needs to be developed. In addition, greater involvement from the GP may be valuable – communication between groups can always be improved!

The future direction of perioperative management is unclear but not altogether gloomy

A/Prof Mary White pointed out that admission to an intensive care facility is no guarantee of a successful outcome in the presence of significant comorbidity! It continues to be alarming that there are still episodes of failure to recognise and failure to respond. The widespread introduction of the 'detection and response' charts, whilst anticipated to reduce the 'failure to recognise', do not necessarily avoid the 'failure to respond'. There may be many reasons for this and the hierarchical nature of medicine may contribute. Resident medical cover for many smaller private hospitals may not be the answer for reasons of funding and quality.

It is crucial to involve the private sector in patient management, particularly if there are concerns regarding the suitability of a patient for a given facility.

After the lunch break, focus turned to the specific issues surrounding postoperative complications. A/Profs John Loadsman and Pam Macintyre presented the latest thoughts on sleep-disordered breathing and the impacts of obesity and obstructive sleep apnoea on respiration.

The statements made by the Coroner would be analysed by the legal profession to be used as an angle of attack in any perioperative legal proceedings

These highlighted the challenge of providing adequate ward-based respiratory monitoring in an environment with limited staffing and equipment resources. Dr Chris Huxtable and Mr Colin Brown then provided somewhat disconcerting information regarding post-discharge opioid medication.

The final session of the day began with Mr David Walsh raising concerns regarding the future of surgical training that is occurring in a more task-focused manner to streamline training programs and reduce surgical training times. Dr Mark Finnis emphasised A/Prof Mary White's opinion that 'failure to respond' and 'failure to rescue' remain a concern and that it is too early to determine the impact of the 'Response to the Deteriorating Patient' charts that have recently been introduced. There are concerns that this will lead to deterioration in clinical skills, as further reliance is placed on charting vital statistics to identify clinical deterioration. Finally, Mr Allan Hunter, solicitor, reminded the audience that, although the SA Coroner's recommendations held no legal obligations, the statements

FEATURE

made by the Coroner would be analysed by the legal profession to be used as an angle of attack in any perioperative legal proceedings.

SUMMARY

It is apparent that there are a number of stakeholders with differing agendas and requirements for management of the perioperative patient and providing a forum for these to meet is an important step in improving the established quality of care that underpins our patient management. Understanding and accepting these agendas, by all parties, can only be to the benefit of all.

The future direction of perioperative management is unclear but not altogether gloomy and I am optimistic that Saturday, 7 February 2015 will be seen as a day that has set the ball rolling to an era of greater understanding between groups for the benefit of patients, hospitals, anaesthetists and surgeons. Further development of the Australian Council on Healthcare Standards Clinical Indicator program may highlight existing deficiencies in the current model of perioperative management that give a clearer picture of the incidence of 'near misses'.

Couldn't attend? Want to know more?

A post event survey has been conducted to hear your thoughts on the event. Keep an eye out in ASA enews and future issues of the magazine for survey results!

General enquires or post-event follow-up, email us at: asa@asa.org.au

Or, let us know what you thought of the event, the outcomes and the future directions.
Email us at editor@asa.org.au.

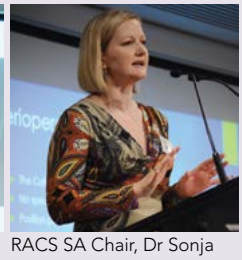
BOOJUMS OF ADVERSE EVENTS: CAN WE PREVENT THEM?

ASA SA/NT Chair and Meeting Convenor, Dr Simon Macklin welcomes attendees


ASA President, Dr Guy Christie-Taylor


Assoc Professor David Campbell, SA Orthopaedic Association


APHA SA, President, Dr Allan Morrison


RACS SA Chair, Dr Sonja Latzel (RACS)


Assoc Professor John Loadsman

Past Chair, ANZICS, Associate Professor Mary White


Drs Guy Christie-Taylor, Allan Hunter, Mark Finnis, Margaret Cowling and David Walsh (Presenting)


ANZCA Vice President, Dr David A. Scott


Dr Vida Viliunas


Drs Sonja Latzel, Angelo Ricciardelli and Assoc Professor Mary White

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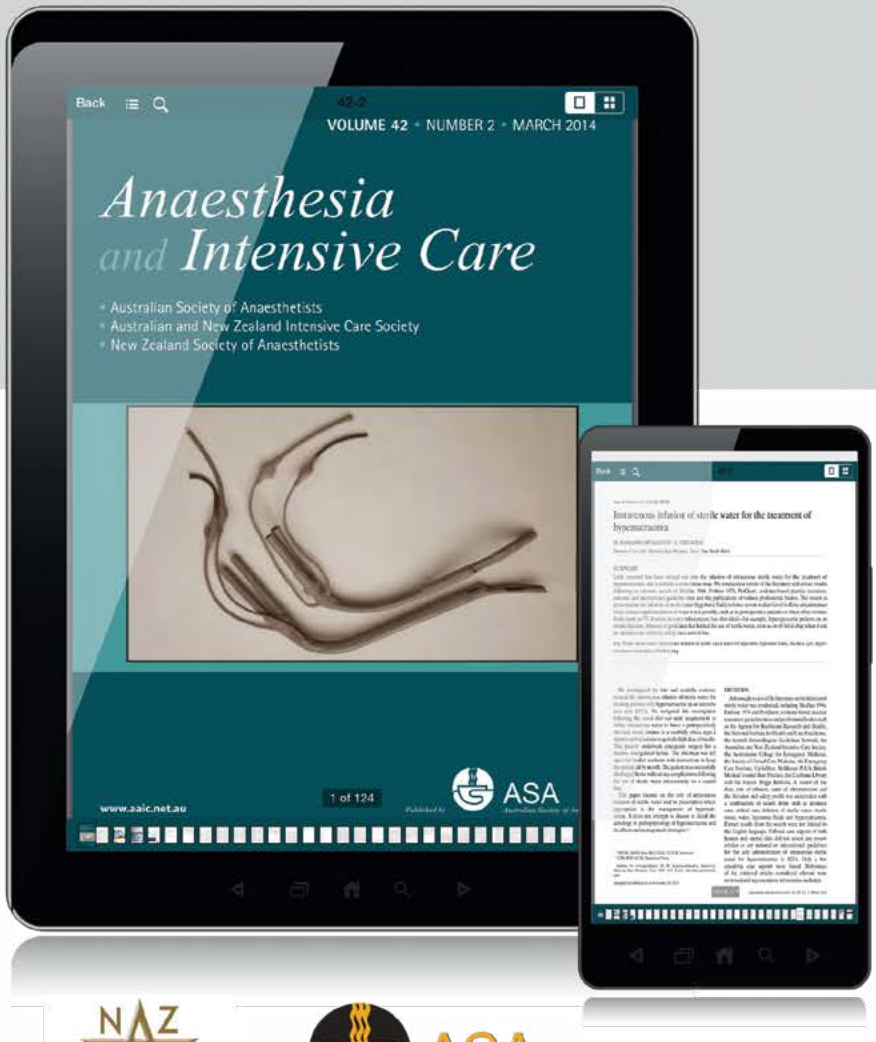

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FEATURE

COME TO OUR NORTHERN FRONTIER – CSC 2015

For many reasons Darwin may be regarded as Australia's frontier – its location on our northern coast, its booming economy and growth, its melding of Australia's original peoples with the European settlers; a place to push the boundaries of our knowledge. So, it is to Darwin that we invite you to travel for our 74th annual National Congress. This year also marks our 7th combined meeting with the New Zealand Society of Anaesthetists and is therefore known as the ASA/NZSA Combined Scientific Congress.

Our working life is only part of our existence, as you can see in David Elliott's following article covering the scientific program. Our social program, on the other hand, is designed to enhance the appeal of trekking north, maximising the outdoor lifestyle and laid-back nature of the Top End – learning *and* leisure.

In the middle of September, you will experience Darwin at the end of the dry season, leading into the 'build-up' or 'Gurrung' in the local Aboriginal tongue. It will be hot and dry and, for that reason, we wish to encourage a relaxed Top End style of meeting – please leave your jackets, ties and smart dresses at home and bring your casual gear. For the annual Gala Dinner we have taken that idea to the extreme and are planning an open-air party with "Loud & Colourful" as the theme.

Some of you may already be familiar with the very large crocodiles at Crocosaurus Cove, but come and get up-close and personal again, bring the kids to see a real live dinosaur! Located in the heart of Darwin city and only a short walk from most of the hotels, Crocosaurus Cove affords visitors a unique audience with Australia's iconic saltwater crocs. The Cove is home to some of the largest saltwater crocodiles in the country and boasts the world's biggest display of Australian reptiles. If you're feeling brave, you can bring your bathers and 'Swim with the Crocs' or jump on the 'Fishing for Crocs' platform and smile for the camera while holding a baby crocodile.

Watching the sun set at Mindil Beach Markets before browsing the many stalls for dinner and gifts is quintessential Darwin. There will be buses to the markets so that you can enjoy all the treasures and trinkets Darwin has to offer. Just make sure to pause in your bartering and spending to grab a snack and sit on the beach to watch the sun go down over the Arafura Sea.

The annual Gala Dinner will be Top End casual for an open-air tropical night under the stars – bring your loudest and brightest clobber to feast under the lamp-festooned night sky at the Sky City lawns. There will be ample opportunity to enjoy the food and wine of the evening before our live entertainment gets your feet moving. But if dancing is not your preferred post-dinner activity, we've got you covered with a great location for relaxing with friends.

Now, we know you're most likely coming quite far for this Congress, so why not sample more of what the Northern Frontier has to offer? Why not turn the Congress into a getaway, bring the family and explore some of the greater Northern Territory.

We could go on and on with what to do up north! Details on all of these experiences and more are available on the Congress website.

For those from the slowly thawing south of Australia and over the ditch in New Zealand, Darwin and the Northern Territory in September are sublime. We hope you'll make the trek north to join us on the edge of the Arafura Sea, to widen your knowledge and life experiences in the Top End at Darwin 2015.

We look forward to greeting you at the ASA/NZSA Combined Scientific Congress in Darwin this September.

Dr Piers Robertson
Convenor, ASA/NZSA CSC 2015 Darwin

MINDIL BEACH MARKETS

Here food is the main attraction – Thai, Sri Lankan, Indian, Chinese and Malaysian to Brazilian, Greek, Portuguese and more. You can browse the various food vendors and purchase whatever takes your fancy. Colourful arts and crafts vendors peddle their wares – handmade jewellery, natural remedies, artistic creations and unique fashion statements. Shop til you drop, catch a fire show, stop for a massage or be entertained by buskers, bands and talented performers as you wind your way through the palm-lined boulevards of the Mindil Beach Sunset Markets.

Credit: Peter Eve & Tourism NT

TIWI ISLANDS

Take a day trip to the Tiwi Islands and discover why they are nicknamed the 'Islands of Smiles'. Take on the locals in a game of Aussie Rules! But remember – they play barefoot!

Info

Transport: SealinkNT

Price: One-way Adult $55; Concession $40; Child $30 (under 5yo free)

Time: Approx 2.5 hours each way

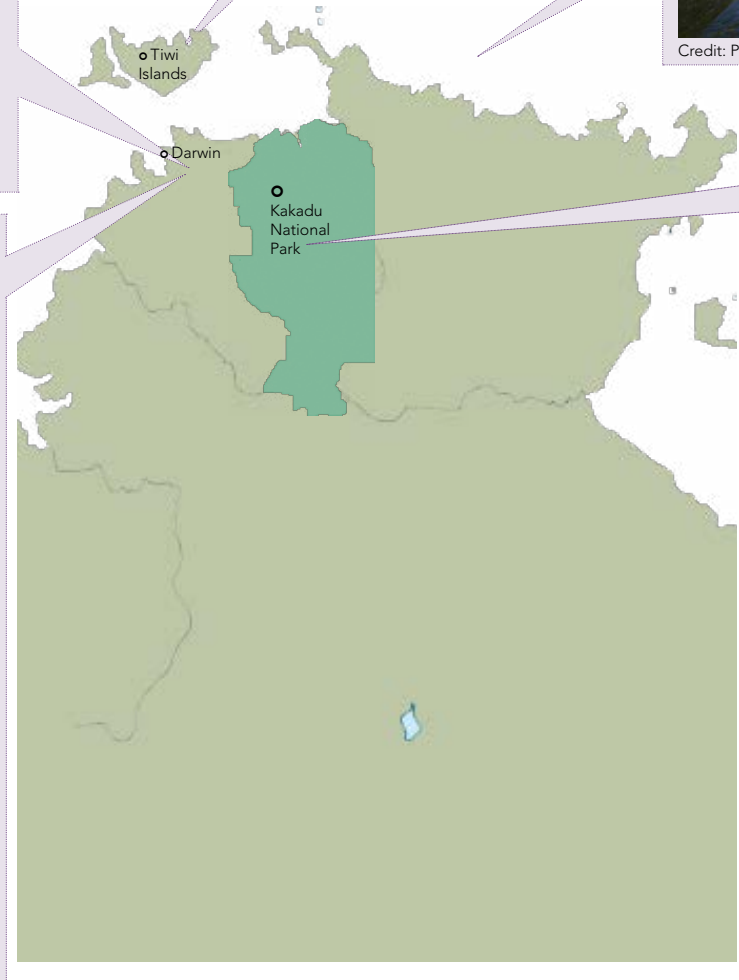
Website: www.sealinknt.com.au

Credit: Peter Eve & Tourism NT

BARRAMUNDI

Keen fisher? Try your luck at hooking the great barramundi on trips from Darwin, Kakadu or the Tiwi Islands.

Credit: Peter Eve & Tourism NT



Credit: Tourism NT

CROCOSAURUS COVE

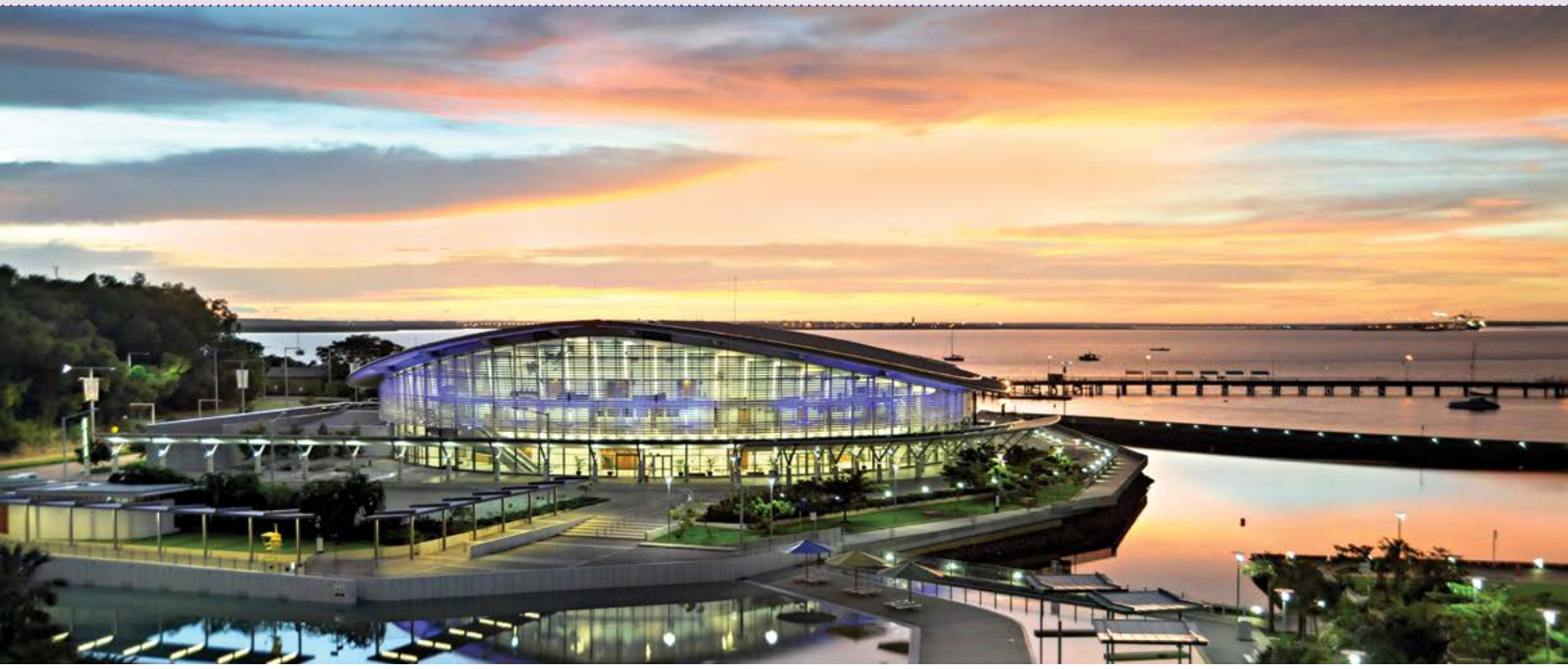
Crocosaurus Cove is also home to the famous 'Cage of Death', the only cage in the world that brings you face-to-face with some of the largest saltwater crocodiles in captivity. We will be organising some 'Cage of Death' experiences for those willing. This is a once in a lifetime opportunity to be in the same environment as one of the world's deadliest predators, and not as their dinner! This is an evening for the whole family – just double-check the head-count on your way home!

Jim Jim woodlands, Kakadu National Park.
Credit: James Hunt

KAKADU

Take a tour to Kakadu or into Arnham Land to experience wildlife and Aboriginal culture at a level you won't have seen before. Stay in the luxurious lodges at Bamurru Plains or Seven Spirit Bay or, if the Kimberley is not too far, try El Questro, the Berkeley River Lodge, Faraway Bay Camp or the Kimberley Coastal Camp.

FEATURE



2015 7TH ASA/NZSA COMBINED SCIENTIFIC CONGRESS, DARWIN

The scientific program for this year's annual National Congress is shaping up to be a one-stop shop for all the latest news in anaesthesia. There is a stellar line-up of international and Australasian speakers who will cover the entire gamut of our specialty. The following is just a glimpse of what you can expect to hear about at this year's meeting.

SPEAKERS

Professor Debra Schwinn is Dean of the University of Iowa Carver College of Medicine and, in addition to being a practising anesthesiologist, has an active research interest in pharmacology and medical education. Her plenary lecture on genetic variability and why similar patients have different outcomes promises to shed light on one of the hottest topics in anaesthesia.

Bobbie-Jean Sweitzer is Professor of Anesthesia and Critical Care at the University of Chicago and has a special interest in perioperative risk assessment and management of the high-risk patient. In addition to presenting in a plenary session on this subject, Professor Sweitzer will be involved in a number of concurrent sessions, each one looking at a different aspect of identifying and managing the most at-risk patients that we care for.

Associate Professor, Alicia Dennis, from the Royal Women's Hospital in Melbourne is this year's Australasian Visitor. A/Prof Dennis is an obstetric anaesthetist who is a world leader in the field of preeclampsia and, in particular, the use of transthoracic echocardiography to help walk the difficult therapeutic tightrope that is characteristic of the unwell parturient with this condition. Alicia also has a broader interest in the health issues that face women around the world and what we anaesthetists can do to help.

Dr Kelly Byrne is a consultant anaesthetist at Waikato Hospital and the New Zealand Invited Speaker. By way of background, 2015 is a Combined Scientific Congress (CSC), as opposed to the more familiar National Scientific Congress (NSC), due to it being a combined ASA and NZSA meeting. Dr Byrne has a wide range of clinical and research interests including cardiac

anaesthesia, acute pain management and the use of ultrasound to facilitate novel approaches to regional anaesthesia and analgesia. Amongst other presentations, she will attempt to unravel the ongoing debate as to where the true risk-benefit of regional versus general anaesthesia lies.

The last, but definitely not least, of our named invited speakers is Professor John West who will deliver the Kester Brown oration at the Congress Opening Session on Saturday, 12 September. Yes, this is the same John West known to us all as the author of that well-read and dog-eared copy of *Respiratory Physiology* you have on your bookshelf. Now in its ninth edition, this text remains the gold-standard for understanding respiratory physiology. Expect a stimulating series of lectures across the Congress from Professor West, ranging from his fascinating pioneering work on high-altitude, aviation and space physiology to the latest news from his ongoing research lab at University of California, San Diego. Please keep in mind that the Opening Session and the Kester Brown Oration is open for accompanying partners to attend even if they have not registered for the meeting.

SCIENTIFIC PROGRAM

Unfortunately, space does not permit a full list of all the speakers from across Australia, New Zealand and around the world, but suffice to say, what has been described above is just the tip of the iceberg. You can choose from multiple concurrent specialist sessions covering everything from Special Interest Group sessions to indigenous affairs as well as a dedicated GASACT stream tailored for trainees on Sunday, 13 September. The final session of the Congress will be held after lunch on Tuesday, 15 September and will run along the lines of a 'hypothetical', involving both audience participation and a panel of experts from our invited speakers – you can expect to be informed and entertained to the very last.

In addition to everything that is new, you can also look forward to a rolling series of refresher-style presentations across all four days of the Congress. These refresher lectures will each cover one particular aspect of anaesthesia and be very much focused on the practical clinical aspects of the subject matter. Topics include updates on cardiology, haematology, acute pain management, neuroanaesthesia, sleep disorder, trauma management, the latest on monitoring, orthogeriatrics and secrets of perioperative fluid management.

As always, a plethora of problem-based learning discussion sessions and workshops will be on offer, including multiple opportunities to attend workshops that qualify for the 'Emergency Response' category of Continuing Professional Development.

So, for anyone looking to update their anaesthetic knowledge in one of the most exciting locations in Australia at a great time of the year, make sure you pencil 12 to 15 September 2015 in your diary now.

We look forward to welcoming you to a magnificent ASA/NZSA Combined Scientific Congress in Darwin this year.

Dr David Elliott

Scientific Convenor, ASA/NZSA CSC 2015 Darwin

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2015 AWARDS, PRIZES & RESEARCH GRANTS

PRE-CSC 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.

Jackson Rees Research Grant

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

Eligibility
Applicants must be a member of the ASA.

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

APPLICATIONS CLOSE 30 JUNE 2015
To apply for these awards, visit http://bit.ly/APRG2015

PRE-CSC ADJUDICATED CONTINUED

Jeanne Collison Prize

Description

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

Eligibility

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

Award

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

CSC PRESENTATION AWARDS

Gilbert Troup ASA Prize

Description

The Gilbert Troup ASA Prize commemorates the contribution to Australian anaesthesia by Dr Gilbert Troup of Perth, Western Australia. Applicants should submit an abstract via the online submission process for papers to the annual CSC or NSC once the 'Call for Papers' is issued. This submission page is found by following the 'Application' link for the Award on the CSC website. All papers submitted are reviewed by the committee as to their eligibility and suitability prior to acceptance. Those accepted for presentation at the CSC 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 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 CSC-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 CSC, 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 2015

To apply for these awards, visit http://bit.ly/APRG2015

NSC PRESENTATION AWARDS

GASACT Best Poster Prize

Description

The GASACT Best Poster Prize was introduced in 2011 and is only open to GASACT members who present a poster at the CSC.

Applicants should submit an abstract via the online submission process for papers to the annual CSC once the 'Call for Papers' is issued. This submission page is found by following the 'Application' link for the Award on the CSC website. All papers submitted are reviewed by the committee as to their eligibility and suitability prior to acceptance. Those accepted for presentation at the CSC 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 CSC will be sent out prior to the CSC.

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 CSC, 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.

ASA Best Poster Prize

Description

Applicants should submit an abstract via the online submission process for papers to the annual CSC once the 'Call for Papers' is issued. This submission page is found by following the 'Application' link for the Award on the CSC website. All papers submitted are reviewed by the committee as to their eligibility and suitability prior to acceptance. Those accepted for presentation at the CSC 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 CSC will be sent out prior to the CSC.

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 CSC, 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.

NON-NSC PRESENTATION AWARDS

Rupert Hornabrook Day Care Special Interest Group Prize

Description

Rupert Hornabrook was a pioneer of anaesthesia in Australia, devoting the bulk of his practice in the years following the Boer War to promoting the specialty. He was honorary consultant in anaesthesia to the Melbourne General Hospital for many years and published extensively on issues of safety in anaesthesia. He was an early advocate of improved cardiovascular monitoring and was influential in popularising ethyl chloride-ether as an alternative to chloroform. This award in his name recognises his contribution to Australasian anaesthesia.

Researchers are invited to present an oral presentation at the CSC in Darwin.

Eligibility

Applicants must be a member of the Day Care Special Interest Group.

Award

Presentations will be judged by the Day Care SIG executive on the basis of scientific content, relevance and standard of presentation. The Hornabrook prize attracts a medical book voucher to the value of $1,000. For further information regarding the prize and how to apply, please email asa@asa.org.au.

APPLICATIONS CLOSE 30 JUNE 2015

To apply for these awards, visit http://bit.ly/APRG2015

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ASURA 2015 WRAP-UP

Between Saturday 21 and Monday 23 February, Perth played host to the 2015 Australasian Symposium on Ultrasound and Regional Anaesthesia (ASURA) event, welcoming over 250 delegates, exhibitors, sponsors and faculty. On offer was an interactive lecture program, backed up by practical workshops, as well as an opportunity to attend a dedicated short-course cadaver workshop at the University of Western Australia's Clinical Training and Evaluation Centre (CTEC).

Convenor, Dr Steve Watts, kicked off the meeting with an engaging opening speech and welcomed like-minded colleagues with interests in regional anaesthesia and perioperative pain management, as well as the panel of international invited speakers – Drs Jens Borglum (University Hospital, Copenhagen, Denmark), Mike Fredrickson (Anaesthesia Institute, Auckland, New Zealand), Milton Raff (Christiaan Barnard Memorial Hospital, Cape Town, South Africa) and Svetlana Galtizine (John Radcliffe Hospital, Oxford, United Kingdom).

The program provided expertise across the full range of regional anaesthesia applications. Over the three days, delegates chose from a number of workshops offered by the faculty covering a range of topics, such as Advanced Life Support Cardiac Arrest, OrthoPlastic Extravaganza, Ultrasound-guided Regional Anaesthesia for Chronic Pain, Maternal Collapse, Anaesthesia for Lower Segment Caesarean Section, Catheter Techniques, Post-Block Neuropathy and Eye Blocks.

More than 160 delegates opted to attend a CTEC workshop and were assigned to groups. The workshops were based on the CTEC Australian Regional Anaesthesia and Cadaveric Ultrasound Seminar program and exposed attendees to hands-on regional anaesthesia techniques utilising fresh frozen cadavers, prosections and live models. Registrants covered upper and lower limb blocks, trunk blocks

and neuraxial ultrasound anatomy. Each workshop saw the ASURA invited speakers act as the group's instructors.

On the Saturday evening, 100 delegates and their partners joined the ASURA faculty, invited speakers and exhibitors for a welcome reception at Perth's Public House where canapés and drinks were served. The venue created a relaxed environment for old and new friends to meet, catch up and discuss the upcoming sessions.

PLENARY SESSIONS (MONDAY 23 FEBRUARY): INVITED SPEAKERS

Dr Svetlana Galitzine, 'Should Australasia have its own diploma in regional anaesthesia?'

Dr Galitzine questioned the necessity of a higher diploma in the subspecialty of regional anaesthesia. The training for regional anaesthesia is mostly based on acquiring and mastering practical skills (apprenticeships) and – certainly in the UK at present – suffers from decreased trainee working hours. However, we know too well that there is much more to regional anaesthesia than just 'putting the right stuff in the right place'. Therefore, there has long been a need for anaesthetic trainees and specialists to be able to focus on all aspects of regional anaesthesia and obtain higher qualifications in the subspecialty. Although such qualifications are not compulsory, in a situation where the labour market is highly competitive, as in the UK, a regional anaesthesia diploma can allow individuals to stand out from the crowd and secure their dream job. At the same time, established specialists, especially those with an interest in teaching, may wish to obtain a higher qualification in regional anaesthesia as part of their continuous professional development. Dr Galitzine argued that, from her personal experience, she believed regional anaesthesia diplomas can add value to a clinician's work in multiple respects. Working towards such a diploma gives structure to continuous professional development activities in specific areas of anaesthesia, making it somewhat target-based, while also stimulating and organising the learning process. The resulting diploma gives a sense of achievement to the clinician and additional confidence to the patients.

Dr Jens Borglum, 'Like an epidural but better: regional anaesthesia for abdominal surgery'

In his session, Dr Borglum focused on alternatives to the epidural. He mentioned that there is increasing evidence that alternative techniques can be as effective or, in some cases, even better than the epidural. There is no doubt that the epidural remains the gold standard for labour analgesia, but it can be replaced or alternated with several other surgical procedures of the abdominal wall. The oblique subcostal transversus abdominis plane (TAP) block (Hebbard, 2010) or the bilateral dual-TAP block (Borglum, 2011, 2012) are effective in providing anaesthesia to the antero-lateral abdominal wall, but ultrasound-guided TAP blocks (administered in the anterior abdominal wall) will not affect visceral pain. However, both TAP blocks can certainly be an alternative to the epidural technique without the risk of the many adverse effects associated with the administration of epidurals.

Dr Mike Fredrickson, 'Bang for your buck: economics of regional anaesthesia'

Dr Fredrickson expressed concern that healthcare costs have continued to increase, both in absolute terms and proportional to nations' GDPs. He noted that the global financial crisis of 2007 has had little impact on easing this burden. Nevertheless, hospital administrators have an obligation to control costs, attitudes about which inevitably get passed on to medical staff. In the past, debate and research around the economics of regional anaesthesia has focussed on the cost-effectiveness of regional versus general for surgical anaesthesia. Studies have shown that any extra cost related to slower set-up time for regional anaesthesia can be offset by reduced post-anaesthesia care unit stays. Such savings, however, are dependent on a high success rate and such time savings can be translated into a reduced requirement for nursing staff. Further savings are realised with the availability of anaesthesia staff and a so-called 'block room'. The balance of evidence has shown there is little cost difference between regional and general anaesthesia – the issue then becomes a clinical question of what is best for the patient. In many practice settings, successful implementation of regional anaesthesia may be hindered by a need to optimise operating room throughput in order to maximise operating room utilisation at the expense of delayed recovery. Dr Fredrickson also mentioned the less frequently studied, though still important, concept of how anaesthetists can optimise regional anaesthesia efficiency for given block techniques. Methods explored in the lectures included ultrasound guidance, nerve stimulation, catheter visualisation, echogenic needles, aseptic technique and the disposable cost of ambulatory local anaesthetic pumps.

FEATURE

Dr Milton Raff, 'Can we make opioids obsolete?'

Dr Raff posed the question, should we make opioids obsolete? He explained that the class of drug has been used as therapeutic agents for hundreds of years. Similarly, oxygen has been available on aircrafts 'in the unlikely event of decompression'. Aviation has evolved to such a standard that this oxygen is rarely ever needed, but it has not been removed from aircrafts. Similarly, though anaesthetists now have a variety of drugs and interventions that have decreased the necessity for opioids, this does not mean that these agents are not required in certain circumstances. Dr Raff highlighted the sites and mechanisms of actions of the various analgesics that anaesthetists have at their disposal, explaining how he and the fellow colleagues can use these agents with local anaesthesia to decrease the use of opioids.

WANT TO KNOW MORE?

For information on the Regional Anaesthesia Special Interest Group, please visit www.acecc.org.au or contact asa@asa.org.au.

SNAPSHOT OF ASURA 2015

Dr Svetlana Galitzine

Dr Mike Fredrickson

Dr Jens Børglum

Registrations

An attentive crowd

North Ballroom Lecture

FEATURE

PTC ISN'T ALL ABC—WHAT COMES AFTER C?

Primary Trauma Care (PTC) is helping to ease the burden of trauma death and disability in the developing world. In this issue of *Australian Anaesthetist*, Dr Haydn Perndt describes the progress in Myanmar.

The recent October 2014 Primary Trauma Care Masterclass in Myanmar was convened by mercurial Hong Kong surgeon James Kong, who, since 2009, has been shuttling back and forth from Hong Kong to Yangon more often than White House frequent flyer, John Kerry, travels between Washington and the Middle East!

PTC was brought to Myanmar by Drs Georgina Phillips and James Kong, following Cyclone Nargis, which in May 2008 devastated the Ayeyarwady Delta region of the country. Over two-and-a-half million people and thirty-seven townships were affected by the cyclone with an estimated 84,500 deaths and the disappearance of 53,800 inhabitants.

The introduction of PTC to Myanmar was an opportune development and capacity-building response to this tragic disaster. Dr Kong has directed the resultant Royal Australasian College of Surgeons' AusAID-funded program for the past six years. Two senior Burmese orthopaedic surgeons, Professors Myint Thaung and Zaw Wai Soe (now the Rector of the University of Myanmar) are the regional PTC leaders who have been enthusiastic and effective local champions from the very beginning.

PTC has had remarkable success in establishing itself in Myanmar. In total, 43 courses have been run, training over 2000 doctors and 150 new instructors. There are PTC Centres in Yangon, Mandalay and the new capital Nai Pyi Taw as well as a local PTC Society under the umbrella of the national Myanmar Medical Association.

But what is PTC? It's a franchise fee-free advanced life support trauma management system created specifically for developing countries by Hobart anaesthetist Marcus Skinner and Oxford intensivist Douglas Wilkinson in 1997. Now in over 60 countries, PTC aims to be part of the solution to the epidemic of trauma in the rapidly industrialising low- and middle-income countries.

Ninety percent of trauma deaths occur in developing countries where resources to deal with the problem are extremely limited. Trauma injury is a major global

health problem. It causes the deaths of over 5 million people each year and millions more are disabled, resulting in disastrous economic losses for the countries *that can least afford them*[1,2].

Much is needed to be done to lower the burden of death and disability from trauma in the developing world. Preventative measures such as safer roads, driver education, seatbelts and mandatory helmet use could make a big impact, but these must be implemented in countries *that cannot afford them*.

Training trauma responders in dispensaries, clinics and district and central referral hospitals is the *raison d'être* of the PTC Global Program

National Trauma plans, ambulance systems and networks of Trauma Centres are systemic interventions and high on the Overseas Development Assistance wishlist in countries *that may never be able to afford them*.

Training trauma responders in dispensaries, clinics and district and central referral hospitals is the *raison d'être* of the PTC Global Program. At its simplest, PTC is 'ABC' (Airway, Breathing and Circulation). PTC is a sequential examination of the trauma patient to reveal the imminent threats to life in a logical and systematic way. This is the PTC approach to reducing the deaths and disabilities in this pandemic of trauma.

But what comes after 'C'? '*D*isability' (a rapid assessment of the central nervous system) and '*E*xposure' (a quick head-to-toe look), certainly. But perhaps more importantly: '*D*oes the training work?' and 'how do we *E*valuate the PTC courses?'.

Impact measurement can be summarised by three questions: "What did the participants like?", "What did they learn?" and "What behaviour was changed?"[3] A reduction in avertable trauma mortality in the first 24 hours in patients presenting to hospital would be a powerful impact measurement. A project is being designed at this time to measure just this.

The faculty for the 2014 Yangon course included two emergency physicians (Georgina Phillips and Antony Chenhall), two anaesthetists (Yu Fat Chow and Haydn Perndt) and a surgeon, James Kong. This week-long course would not have been possible without the inspiration and dedication of Dr Vijay Kumar, who has been the leader of the Myanmar PTC teaching program since its inception. He was ably assisted by Dr Aung Maw. Four young doctors, Aung Thar Oo, Aung Pyi Soe, Theikdi Oo and Zay Yar Thaw, provided the majority of the vital logistical and practical day-to-day support. Their assistance was invaluable.

The high points of the 2014 Yangon PTC were Dr Kong's strategy-planning day, which was remarkably free of team-building and executive games this year (and thankfully no rubber chickens!), as well as the superb Instructors' Course, run entirely by local Myanmar faculty. On the final two days, the new instructors ran their very first course, mentored by the more senior instructors who had taught them just one day before. It was a rewarding display of the PTC cascade: teach the course; teach the teachers; the new teachers teach their first course.

Reducing deaths from trauma requires a multi-faceted solution. Training trauma care providers is a very logical place to start.

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2. World Health Organization. Injuries and violence: the facts. From http://www.who.int/violence_injury_prevention/key_facts/en/index.html. Accessed December 2014.
3. Personal communication. Dr Antony Chenhall, Long Term Advisor, Emergency Department, Hospital Nacional Guido Valadares (HNGV) Dili, Timor Leste.

FIND OUT MORE

To stay updated with the latest in Primary Trauma Care in Myanmar, 'like' the PTC Myanmar Facebook page at: http://on.fb.me/17PxRDq

To learn more about developments in Primary Trauma Care around the world, visit the Foundation website at: www.primarytraumacare.org

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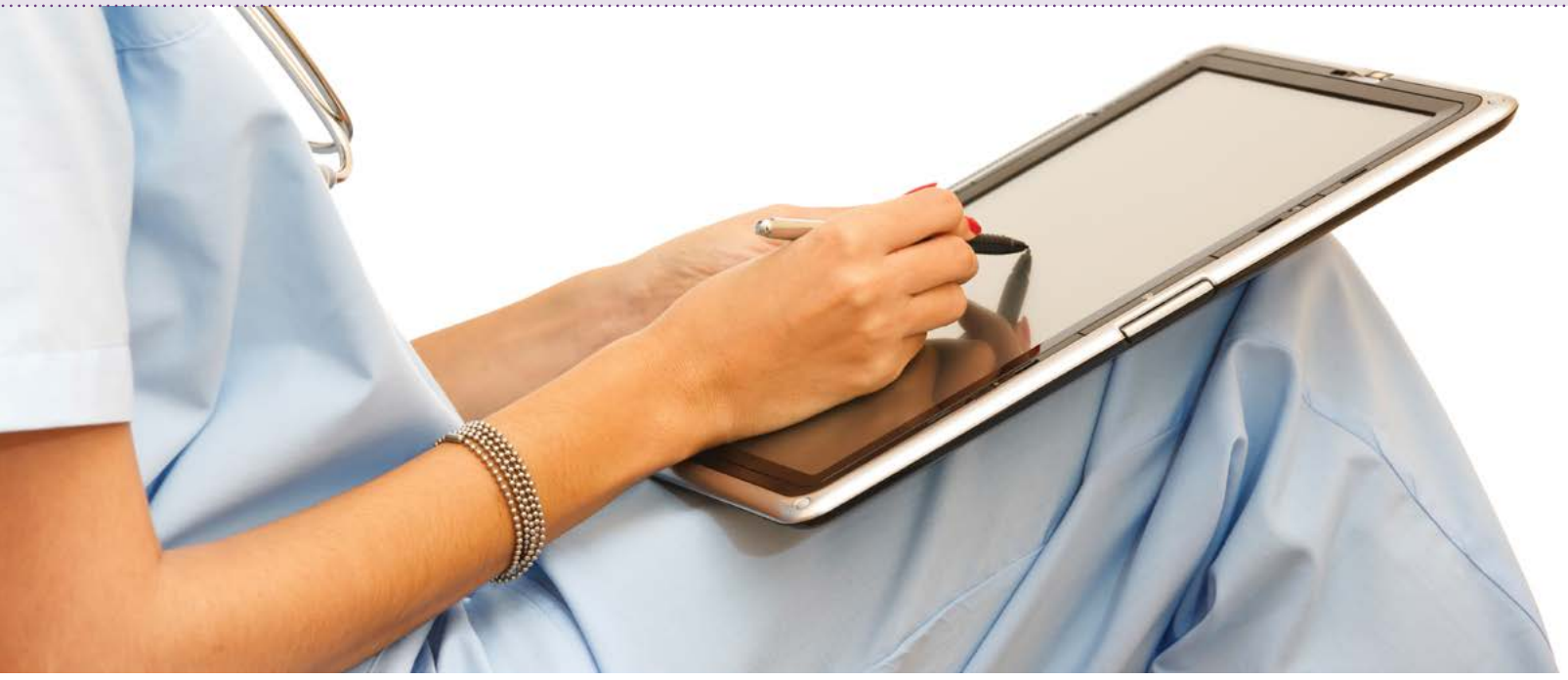
FEATURE



YOUNG MEMBER SURVEY

The ASA is aware of anecdotal evidence of an oversupply of specialist anaesthetists. In particular, there is growing concern amongst our younger colleagues about mounting difficulty in obtaining appropriate quantities and types of work. The ASA has aimed to understand this problem more clearly through member surveys.

Members will recall that a survey of the entire ASA membership was conducted in 2014. As a follow-up to this, the ASA surveyed its younger members specifically to track their responses in relation to their current professional practice, concerns about employment opportunities and the anaesthesia workforce at large.

Members within five years of registration with the Medical Board of Australia as one or more of 'specialist anaesthetist', 'specialist pain medicine physician' or 'specialist intensive care physician' were asked to complete the survey.

Two hundred and three ASA members who had commenced specialist practice within the last five years participated in the 2015 ASA Young Members Survey. Of those 203 participants, 63% were male, 34% were 35 years old or younger and 49% were between the ages of 36 and 40. Sixty-nine percent (69%) of young ASA members work in capital cities, 16% in metropolitan areas, 14% in rural centres and 0.53% in remote areas. Twenty-five percent (25%) of young ASA members work solely in public practice, while 7% work solely in private practice; the majority, 68%, work in a combination of public and private practice.

Members were asked to indicate their current employment status. Significantly, of the 189 that responded to this question, 98% were employed. Whilst this is very encouraging for our members, there were some underlying concerning trends.

It was asked if members had experienced periods of unemployment in the years since qualifying to become specialist anaesthetists. The majority, 86%, reported that they had not experienced periods of unemployment since qualifying. Nevertheless, a concerning 14% indicated that they have experienced some (one to 30 months) period of unemployment since becoming specialist anaesthetists. Members were also asked if they felt they had been under-employed at any period in the

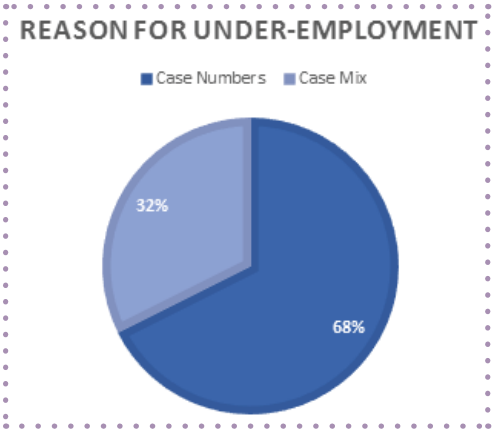


Figure 1: Reason for under-employment.

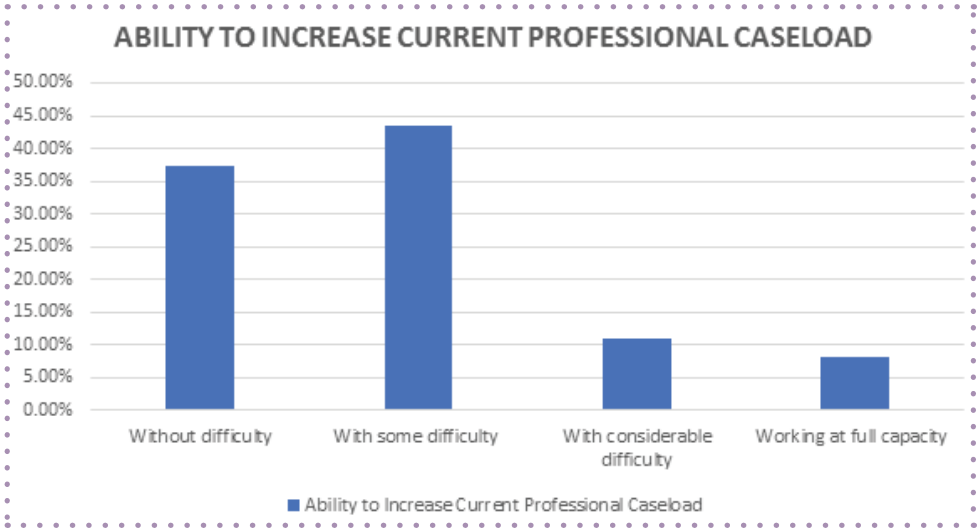


Figure 2: Increasing current professional caseload.

years since qualifying and a worrying 35% of members felt that they had. Those that reported experiencing periods of under-employment were also asked to specify whether that under-employment was either due to an absolute lack of case numbers or whether it was related to the quality of their case-mix (Figure 1).

Members were asked about their experience of finding employment or generating an income and whether this process was more difficult than they had anticipated. Interestingly, 50% of members found the process more difficult than they had anticipated.

The survey also looked into the ability of younger members to increase their current professional caseload. A majority reported that they could increase their current professional caseload without any or with some difficulty (37% and 43%, respectively) (Figure 2). Following this, respondents were asked if they felt that their current case-mix/practice profile was adequate for the purposes of maintaining their skills in anaesthesia. The majority (72%) indicated that their current caseload was adequate for the purposes of skill maintenance; nevertheless, a problematic 28% report that their skill maintenance may be suffering.

We also asked if, in the past year, they had felt obliged to perform work outside their 'comfort zone' due to economic pressures or workforce shortages/other professional pressures. A quarter of respondents reported that they had felt obliged to work outside their comfort zone due to economic pressures, while 30% reported feeling obliged to work outside of their comfort zone due to workforce shortages or other professional pressures.

Interestingly, 17% of members reported relocating to a rural or remote area to obtain an adequate anaesthesia caseload.

Finally, members were asked about the current Australian anaesthesia workforce and the training of anaesthetists in Australia. Members were of two views; 47% believe the current Australian anaesthesia workforce is sufficient, while 45% report that there are too many anaesthetists working in Australia. Likewise, 73% of members reported that too many anaesthetists are being trained (Figures 3 and 4).

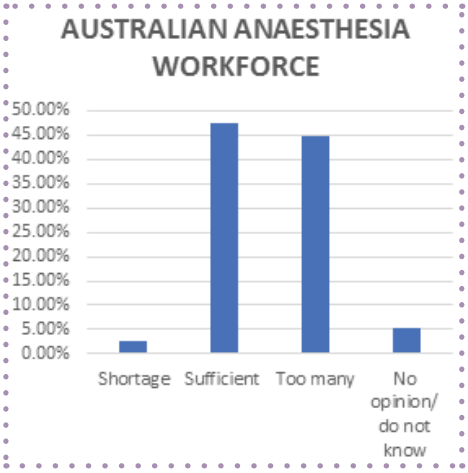


Figure 3: Australian anaesthesia workforce.

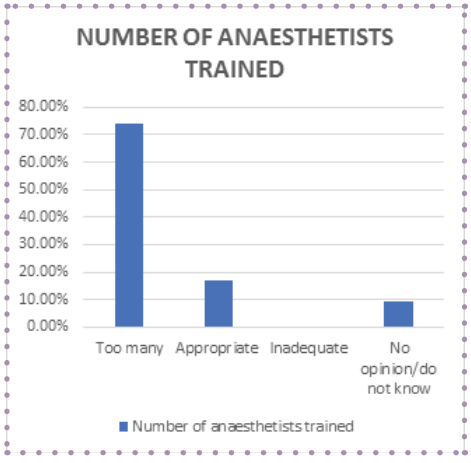


Figure 4: Number of trained anaesthetists.

Want more information on the Young Members Survey?

The Policy Team at the ASA can help direct your queries.
Simply email them at: policy@asa.org.au or call 1800 806 654.

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Patients who receive continuous regional nerve block recover faster and leave hospital earlier. They require fewer opioids – accelerating the recovery process and helping healthcare providers reduce costs by prescribing fewer drugs and sending patients home earlier. The ambIT® range offers flexible, programmable infusion rates to provide patient pain relief post-operatively, which then continues once the patient is discharged, enabling them to manage their pain at home.

Admedus Medical Products have been delivering ambIT® infusion pumps to hospitals throughout Australia for several years.

As well as providing technical support, Admedus teams deliver ongoing education to hospitals and their staff, to ensure they're using the pumps correctly. End-user support is a key element of the support offered by Admedus.

Healthcare providers have responded positively to this approach to pain management. With surgical site infusion, doctors are able to incorporate pain management into post-operative care before a procedure begins.

As well as faster recovery, early hospital discharge frees up beds and cuts waiting times.

Patients also benefit from being able to recover faster in their own home.

Accuracy of medication delivery is a major benefit of the ambIT® range of infusion pumps over the old technologically-dated elastomeric or mechanical pumps. The differences between both are stark. Elastomeric pumps are less accurate and unpredictable in their effectiveness and have limited flexibility options compared to the ambIT® range, which delivers all the features of larger, more sophisticated infusion pump technology at a low-cost – accelerating patient recovery times.

Using portable, ambIT® infusion pumps as part of a pain management regime presents both patients and doctors with a more targeted, specific and safe approach to medication delivery and treatment.

It's better for the patient and compliments an enhanced recovery plan.

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TO TREAT OR NOT TO TREAT? DOCTORS IN EMERGENCY SITUATIONS

Dominique Egan and Sarah Dahlenburg, Partner and Associate at TressCox Lawyers, outline the legal responsibilities of medical professionals who find themselves in emergency circumstances outside of practice.

Doctors are often called upon in emergency situations to provide medical care. The circumstances in which these calls take place can give rise to a number of considerations for medical practitioners: is it safe to do so, do I have the necessary means available to me to assist, is there someone else better placed than me to assist?

The duty of care at common law is well established. In more recent times, medical practitioners confronted with a difficult emergency situation, asking themselves the very questions above, have found themselves the subject of professional conduct proceedings for allegedly engaging in conduct that departs from accepted standards.

Generally at common law, the courts have not imposed a positive duty on bystanders to act to assist others who require aid or assistance. The NSW case of *Lowns v Woods* (1996) considered the issue of whether a medical practitioner was required to render assistance to someone who was not the medical practitioner's patient. In that case, a child was suffering an epileptic fit. The sister of the child ran to a nearby general practice to seek assistance. A request was made of Dr Lowns to attend to assist the child, who refused on the basis that the child should be brought to his practice and he would then render assistance. The child sustained brain injury due to a lack of oxygen during the epileptic fit.

The Court found that Dr Lowns owed the child a duty of care to attend and assist in the emergency situation in circumstances where he was asked to attend and assist and it was not unreasonable for him to do so. The decision was upheld on appeal by a majority in the Court of Appeal.

In addition to the duty of care at common law, there may also be a professional duty to attend in an emergency. The NSW *Health Practitioner Regulation National Law* (2009) provides that a medical practitioner may be found guilty of unsatisfactory professional conduct for failing to render urgent medical assistance. This provision does not apply in other states and territories, but a failure to attend in an emergency in other jurisdictions may still amount to unsatisfactory professional conduct. A practitioner who engages in conduct of a lesser standard than that which might reasonably be expected of them by his or her peers, or who practises in a manner that indicates that the knowledge, skill or judgment possessed or the care exercised by a practitioner may be below that reasonably expected may be found to have engaged in unsatisfactory professional conduct.

A breach of a Code or Guideline may also constitute unsatisfactory conduct. Clause 2.5 of the Medical Board of Australia's *Good Medical Practice: a Code of Conduct for Doctors in Australia* provides the following:

> *Treating patients in emergencies requires doctors to consider a range of issues, in addition to the patient's best care. Good medical practice involves offering assistance in an emergency that takes account of your own safety, your skills, the availability of other options and the impact on any other patients under your care; and continuing to provide that assistance until your services are no longer required.*

Two recent cases in Western Australia considered the professional obligations of medical practitioners to provide medical assistance or to act in emergency situations.

In the case of Dr Hoffman, the mother of a sick baby waited with her child outside a general practice that had not yet opened. The mother approached Dr Hoffman at the doorway of the practice and asked whether he was a medical practitioner, which Dr Hoffman denied. Neither the child nor the mother was a patient of Dr Hoffman. The child was later seen by another medical practitioner at the practice.

The Medical Board of Australia reprimanded Dr Hoffman and issued a

$1000 fine for misrepresentation. The Medical Board's decision was later set aside on appeal by the Western Australian State Administrative Tribunal. The Tribunal issued the doctor with a caution, noting the early admissions made by the doctor, which was considered adequate for the protection of the public and maintenance of the high standards and the good reputation of the medical profession.

The case of *Dekker v Medical Board of Australia* considered the duty of a registered medical practitioner to attend and assist a person involved in a motor accident. Dr Dekker was involved in a near-miss incident on a road near the town of Roebourne in Western Australia at night in 2002. The second vehicle nearly hit her vehicle and then rolled into an embankment. Dr Dekker heard the crash but did not see it. Rather than stopping to see if she could render medical assistance to the driver of the other vehicle, she drove to the nearest police station to report the incident.

Dr Dekker was charged with dangerous driving occasioning death and was convicted. The conviction was later overturned on appeal. Subsequently, Dr Dekker was the subject of a complaint by the Medical Board that she was guilty of infamous or improper conduct under the (then in place) WA *Medical Act* (1894). The Medical Board contended that Dr Dekker was under an obligation to stop and render assistance because she was aware of the possibility the driver of the vehicle may require medical assistance and she should have employed her medical skills to assist the driver. Dr Dekker argued that at the time she was in shock, it was a dark night and she had concerns for her safety and she did not have the necessary equipment with her. As such, she decided the better course was to report the accident.

In 2013 the West Australian State Administrative Tribunal found Dr Dekker's conduct in failing to stop and render assistance to the driver would be reasonably regarded by professional colleagues as improper and there was a sufficient link between her conduct and the profession of medicine to constitute improper conduct. The Tribunal found that she should have assessed the situation and the injuries and rendered first aid if she was able to and, even though she had no medical equipment in her car, she could have assessed the patient and rendered first aid, given her medical training.

Dr Dekker appealed the Tribunal decision. The West Australian Court of Appeal upheld the appeal on the following grounds:

1. There was no evidence of a specific professional duty brought before the Tribunal by a peer expert regarding the duty of the medical practitioner in the specific circumstances and therefore, it could not find as fact that there was a duty generally accepted by members of the medical profession of good repute.
2. The Tribunal could not draw on its own knowledge and experience and should have relied on expert evidence in order to find a specific professional duty.
3. There was no evidence to support the finding of a general duty to members of the public as applied to the specific circumstances of this case and therefore, its finding could not be upheld.

In conclusion, while there is an obligation for medical practitioners to assist in an emergency, it is not an absolute obligation. Medical practitioners have a duty of care to attend and assist in an emergency when asked to do so, provided the request is not unreasonable. A failure to comply may result in a negligence claim and may also result in professional conduct proceedings. Medical practitioners who do provide assistance in an emergency situation, in good faith, exercising reasonable care and skill and without expectation of financial reward, may rely on the 'Good Samaritan' defence if a civil claim is subsequently brought against the practitioner.

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TOP 10 WAYS TO USE YOUR ACCOUNTANT

LOMAX FINANCIAL GROUP
Integrated financial advice

In this edition of *Australian Anaesthetist*, Amanda Rogers, Adviser at Lomax Fincancial Services lists the ten top ways to get the most out of your relationship with your accountant.

With government spending reaching all-time highs ($69,973 AUD million in the third quarter of 2014)[1], you can expect the Tax Office will go into a revenue collection drive, focusing on high net-worth individuals and professional practices. So, now more than ever, it is time for you to be talking to your accountant in order to keep on top of increasing taxation and manage those Pay As You Go instalments. The following are the top ten issues you should be looking at with your accountant.

1. BEAT THE 49% TAX RATE!

With the introduction of the 2% debt levy from 1 July 2014 and the increase in the Medicare levy to 2%, those earning over $180,000 per annum will be paying 49% tax on income over $180,000, at least until 30 June 2017.

With interest rates at a record low, now is the time to consider negatively gearing into property or share investments. Speak to your accountant about different options available, such as purchasing a brand new property, or a property with recent renovations, in order to claim a tax deduction for depreciation.

You should discuss purchasing shares which, once positively geared, can be contributed or sold to your self-managed super fund.

2. TALK TO YOUR ACCOUNTANT BEFORE YOU BORROW MONEY OR MAKE A SIGNIFICANT PURCHASE OR INVESTMENT

Either talk to your accountant or get him or her to talk to your mortgage broker before entering into any financing or purchase arrangement.

Your accountant will want you to structure your loans tax effectively and ensure you are maximising any tax deduction or benefits from your asset purchase. They will explain, for example, why a separation of loans for deductible and non-deductible purposes is essential.

3.TALK TO YOUR ACCOUNTANT BETWEEN MARCH AND MAY EACH YEAR TO ESTIMATE AND REVIEW YOUR TAX POSITION

At the end-of-year tax planning time, your accountant should check whether you have paid the correct amount on your Pay As You Go instalments and superannuation, whether you need to go on an investing or spending spree and whether you are utilising a services trust appropriately. They should also be able to identify any other possible tax savings for you. Perhaps you would benefit from a 'bucket company' (see Tip 4) or prepaying interest on a loan. Get your accountant to complete a review, so there will be no tax shocks at the end of the financial year and no upset to your future cash flows.

4. ASK ABOUT 'BUCKET COMPANIES'

Formally known as corporate beneficiaries, bucket companies receive distributions from discretionary family trusts and effectively become investment companies. They are taxed at the flat 30% corporate rate and will benefit from franking credits, but won't get the capital gains tax discount. So, if you don't have a spouse or your spouse is already paying 39% tax and you have maximised deductible super contributions, the bucket company becomes the next best place to store savings. You can borrow funds from the company and pay interest at the Division 7A loan rate, with up to 23 months interest free. A bucket company can also make a great estate-planning tool.

5. SAVE ON BOOKKEEPING COSTS AND SWITCH TO CLOUD ACCOUNTING

Talk to your accountant about switching to one of the popular cloud accounting packages. Ensure the package has bank feeds and memorises transactions. The days of reconciling a bank account and data entry of numerous transactions are over! You will save time, bookkeeping

costs and enjoy greater accuracy. With cloud accounting, you and your accountant can log into your accounting records at any time and you will save on time spent with data transfer, backups and software updates too.

6. TALK TO YOUR ACCOUNTANT ABOUT SETTING UP A SELF-MANAGED SUPER FUND

Once you are 60, you can easily turn a self-managed super fund into a transition-to-retirement strategy and enjoy tax-free investment earnings within your super fund. Have control over your investments and consider purchasing commercial property in your self-managed super fund. Organise life insurance to be paid from your self-managed super fund. Enjoy greater benefits from franking credits and the deferral of contribution taxes. But be careful—don't let unscrupulous financial advisers switch you out of an industry fund-defined benefit scheme into a self-managed super fund!

7. USE A REPUTABLE ACCOUNTANT AND ALWAYS DOUBLE-CHECK YOUR TAX RETURN

Check the qualifications and experience of your accountant. Medium-sized firms will generally have a pool of resources and review processes to ensure you have the most up-to-date taxation advice and a correct tax return. However, it is always prudent to check your own tax return, as you, the taxpayer, are ultimately responsible for the information included in your return.

8. BE WARY OF TAX AVOIDANCE SCHEMES

Sometimes it can be hard to distinguish between tax-effective planning and a tax avoidance scheme. Many tax avoidance schemes use a series of complex transactions, moving funds through several entities (generally trusts) with the principal aim of avoiding tax. Some typical schemes include mortgage management plans, illegal early release of super schemes, self-managed super funds participating as beneficiaries of businesses, agribusiness-managed investment schemes and inflated tax deduction for the donation of goods to charity. If you are unsure whether a tax-effective investment is a scheme or not, ask your accountant or financial adviser if there is a product ruling associated with the scheme. If the ATO has issued a product ruling, then there will be certainty for you on the tax benefits of the arrangement.

9. REMEMBER THAT CONTRIBUTION THRESHOLDS HAVE INCREASED

From 1 July 2014, if you are aged 49 years or over, you are able to contribute a maximum of $35,000 of deductible contributions to your super fund. For those under 49 years of age, you are able to contribute up to $30,000 of deductible contributions.

10. TALK TO YOUR ACCOUNTANT REGULARLY

These days, most accountants do not charge for phone conversations, only on any follow-up work. Many offer fixed-price arrangements which include all telephone and email correspondence. Ideally, your accountant should also be talking to your financial adviser, so encourage those communications, which will mean less tax to be paid and a rewarding relationship for all concerned.

Amanda Rogers is a Fellow of CPA Australia and an Adviser at Lomax Financial Services Pty Limited (AFSL 235096) a member the Lomax Financial Group, Accountants and Financial Planners (BRW Top 100 Accounting Firm) in Chatswood, NSW.

References

1. Trading Economics. Australia Government Spending. From http://www.tradingeconomics.com/australia/government-spending. Accessed February 2015.

NOTE: This is general advice only and does not take account of your specific objectives, financial situation or needs. You must speak to your accountant/financial adviser to ascertain the suitability of this information.

For more information, please contact:

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CAREERS IN ANAESTHESIA
ANAESTHESIA IN YEMEN

For two months last year, Sydney anaesthetist, Dr Arj Nagendra, lent his medical expertise to Médecins Sans Frontières in conflict-ridden Yemen. He reflects on this experience – his second placement with the organisation – for *Australian Anaesthetist*.

Yemen is not a country that most people would be familiar with. It is typical of many countries that Médecins Sans Frontières (Doctors Without Borders) works in – it doesn't grab many international headlines but it certainly has its own share of problems.

Years of insecurity and instability have led to a surge in the number of people suffering from conflict-related injuries and also impacted on the availability and accessibility of healthcare. To address this need, Médecins Sans Frontières established a trauma hospital in the port city of Aden in 2012 to provide access to medical care for victims of violence and trauma.

Between May and July 2014, I worked alongside Yemeni doctors and nurses in Aden as the hospital anaesthetist. This was my first assignment with Médecins Sans Frontières as an anaesthetist, although I had previously worked with them in Nepal as a general doctor.

Three Yemeni surgeons and I were complemented by a group of general medical doctors who staffed the emergency department, wards, outpatient clinic and high-dependency unit. As the only anaesthetist at the hospital, I was continuously on-call for the duration of my assignment. I was also helped by Yemeni anaesthetic nurses who were all experienced and could anaesthetise uncomplicated patients under supervision. Together, we were able to run two theatres as required when we received multiple casualties.

In addition to the perioperative care of the patients, I was also responsible for the patients in the high-dependency unit and any major resuscitation in the emergency department or on the wards. There were also other experienced Médecins Sans Frontières expatriates who undertook all security, coordination, logistics and administrative work – essentially everything that needed to take place before a patient could be transferred onto an operating table.

you certainly felt you were having a significant impact on people's lives, most of whom would otherwise have received no treatment at all

The vast majority of patients we received had sustained gunshot wounds or blast injuries from grenades or improvised explosive devices. On an average week, we would take thirty to forty patients to theatre, either for primary procedures (exploratory laparotomies, fracture external fixations, wound explorations) or secondary procedures (dressing changes, debridements etc.).

There was a fairly even split between general anaesthetics with volatile agents, ketamine-based anaesthetics and procedures done under spinal/regional blocks. The anaesthetic machine was an old, but very robust and reliable, Monnal pressure-control ventilator with both a halothane and isoflurane vapouriser. Although we had no cylinder oxygen, an oxygen concentrator attached to our machine was perfectly adequate for our needs. In our second theatre, we had an Oxford Minature drawover vapouriser, which was also attached to an oxygen concentrator.

This type of work can be unpredictable and at times physically and mentally demanding

If there were no urgent cases or new arrivals to the emergency department, we would start each day with a morning medical handover meeting. I would then do a ward round with the surgeons, generally sorting out analgesia and blood product/fluid management and planning potential trips to theatre for any of our patients. Following this, the whole theatre team would have breakfast before starting the planned cases for the day.

However, this very orderly schedule was regularly upset when, due to spikes in fighting, our hospital would be inundated with injured patients. I remember one occasion being woken up early in the morning to attend the emergency department to find 30 patients all suffering gunshot wounds after a commuter bus had been attacked.

The medical and nursing staff worked tirelessly throughout the day and long into the night with the result that every patient survived – a pretty remarkable achievement given our resources.

Every now and then we had a few days when not much happened, which offered a good chance to catch up on emails, read a book or generally cruise around the hospital and have a natter to the patients or hospital staff. Yemenis are enormously hospitable people and if things were quiet it was never very long before someone would put a hot glass of sickly-sweet tea in your hands and sit you down for a chat.

The whole experience was immensely rewarding. The clinical work was great in that you certainly felt you were having a significant impact on people's lives, most of whom would otherwise have received no treatment at all. It was also great to be part of such a mixed multinational team.

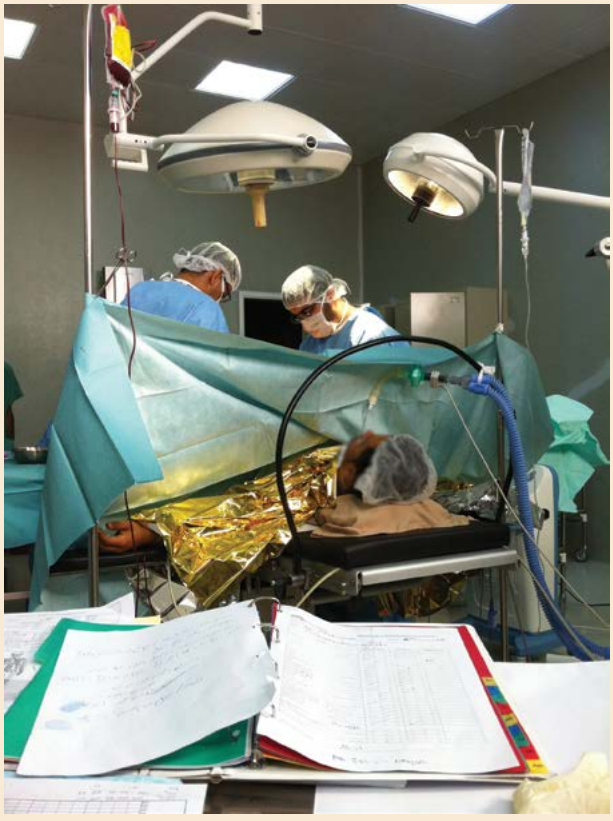
This type of work can be unpredictable and at times physically and mentally demanding, particularly as you are away from your natural support structures at home. As such, it tends to suit people who are flexible and unlikely to get too perturbed by unexpected changes.

There is a major shortage of anaesthetists for the various surgical assignments Médecins Sans Frontières are running around the world. It can certainly be difficult to plan an assignment around regular work commitments but it can definitely be done – in many ways, the most difficult part of the process is just making the decision!

WORK WITH MSF

To work with Médecins Sans Frontières as an anaesthetist, you need experience in general, paediatric, obstetric and trauma anaesthesia, while experience with intensive care, pain management and emergency medicine is highly valued. You also need to be a fellow of the Australian and New Zealand College of Anesthetists and available to commit to an assignment of six weeks minimum.

To learn more, visit http://msf.org.au/findoutmore/



Left: Dr Arj Nagendra and an MSF colleague in surgery in Yemen (note: the patient's face has been blurred to maintain anonymity).

Above: Dr Arj Nagendra in the operating theatre.

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ANAESTHETISTS IN TRAINING
UNDERSTANDING WORKPLACE POLICIES

Workplace policies outline the conduct expected of individual employees in both the private and public health sectors. In this instalment of Anaesthetists in Training, ASA Human Resources Manager, Corrinne Cochrane, explains what effective workplace policies look like.

Many medical and health practitioners, as well as support staff working within the healthcare sector, tend to maintain a focus on government policy affecting the industry (both public and private) with respect to things like professional practice, clinical services and practitioner training. What many of these professionals tend to not be as familiar with, however, are the requirements placed on them as *individuals* with respect to their employment. Irrespective of whether an individual works in a small private practice or a large public hospital, it is very important to understand what workplace policies are, what role they play in employment and job performance and how they are applied and enforced in workplaces.

Workplace policies are not contractual agreements between an organisation and their employees or contractors. Rather, these policies clarify and formalise an organisation's expectations and requirements of their people, as part of their employment activities. While, as individuals, we all have our own ideas about how our workplace should be run, it is important to understand that it is at the employer's own discretion to establish and enforce expectations for the running of the business with respect to people management activities such as how, when and what work is to be performed and by which people.

So, what do good workplaces policies look like?

- Policies should be written in clear, easy-to-understand language. They should clearly indicate who they are to apply to (e.g. employees, independent contractors, etc.), not be unnecessarily prescriptive or promissory and, ideally, provide organisations with some flexibility for the administration of the policies to take into consideration unique circumstances.
- Workplace policies, importantly, should NOT form part of contracts of employment, independent contractor agreements or workplace agreements. If policies are written in such a way as to form part of the employment contract, the parties to the contract are exposed to risks of contract claims for policy breaches by the other party.
- Policies should remain consistent with current and applicable legislation (e.g. occupational/work health and safety, discrimination, federal and state industrial relations legislation) and any relevant industrial instruments (e.g. enterprise agreements, modern awards, contracts of employment). These other industrial instruments set out the terms and conditions of employees' employment that employers are legally required to comply with. To the extent the policies are inconsistent, the terms of the applicable legislation and these industrial instruments will prevail. As such, it may be prudent to include a term to this effect in your policies and procedures.
- Consistency is important! Policies should not only be complied with, but should also be administered and enforced in a consistent manner in order to maintain their relevance and future enforceability.
- Policies should be regularly reviewed to ensure they remain compliant with current laws, continue to meet the needs of the organisation and reflect current work arrangements with staff. The 'way things work' in each workplace will differ and can change over time.
- When policy reviews are undertaken, employees should be notified of any amendments and be provided with further training if required.
- Employees should be made aware of the policies that pertain to their employment upon its commencement and should also be trained in relation to their individual obligations. Simply telling staff that there are workplace policies in place is insufficient to enforce compliance. Best practice requires that each employee signs an acknowledgment that they have been

provided with a copy of or access to the particular policy and have had training in relation to it.

- Managers, supervising practitioners and trainers should be properly trained in the organisation's workplace policies and procedures so that they can effectively administer them in a timely and efficient manner, as well as to help ensure compliance.
- Managers, supervising practitioners and trainers should be held accountable for the administration of policies and compliance by their subordinates and/or trainees, to ensure consistent practice is maintained.

Workplace policies that are well written in terms of both structure and content, involve consultation and communication with key stakeholders, appropriately address legal implications and are appropriately administered, will play an essential role in effective and efficient operation of activities within the practice. When the people clearly understand what is required of them, as well as what is required by their employer through formalised workplace activities, efficient and effective administration of operational activities is more likely to result.

Professional advice on understanding the employment requirements in your hospital or practice is always recommended where clarification is needed on your individual circumstances. Expert advice and assistance should be obtained by external human resources specialists or legal practitioners.

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WEBAIRS NEWS

There has been a steady increase in reporting since the webAIRS program commenced in 2009, including 852 events that were reported in 2014, write Drs Martin Culwick and Peter Casey. Reporting incidents to webAIRS is an important source of information to increase the knowledge learnt from adverse events as well as attracting 2 CPD credits per hour in the practice evaluation category.

Aspiration Outcome	Count
Not reported	1
Potential hazard	5
Near miss	20
Harm	51
Severe harm	6
Death	1
Total	84

The current leading category of incidents is the 'Respiratory/Airway' category, with 777 events reported in total since the program was released in 2009. The highest subcategory of this group is 'Aspiration', with 84 reported incidents. Aspiration of gastric contents has been known as an important potentially avoidable cause of anaesthesia-related morbidity and mortality since Mendelson's article was published in 1946[1]. It is still an important cause of adverse outcomes, as was noted in the Safety of Anaesthesia report (2009–2011)[2] as well as the most recent Victorian Consultative Council on Anaesthetic Mortality and Morbidity report[3]. In common with these recent reports, the webAIRS data confirms that it is not only the high-risk cases where this adverse event occurs but also during relatively minor cases such as upper endoscopy, colonoscopy and short duration cases where a laryngeal mask airway was used. Fortunately, most of the cases reported to webAIRS had a satisfactory final outcome; however, in the current webAIRS analysis, 8.3% suffered serious consequences including one death and six with serious harm. Fifty-one (60.7%) of the reports were associated with some harm, as well as 26 (31%) that were assumed to have no harm. This latter group included one case that was not coded, five reported as a potential hazard and 20 reported as a near miss. A detailed analysis of the webAIRS data is currently being performed and an article summarising the results is currently under preparation for publication.

PROGRAM IMPROVEMENTS

A new version of the registration program was released in February 2015. It includes updates to enable individual registration without registering a site and a new simplified ethics approval process. Firstly, regarding individual registration; up until recently, if a member wished to register as an individual, then they had to register a site under their own name. In the new registration program, individual registration is built into the registration process and is effective immediately. When membership is confirmed, the member can then register a new site such as a hospital, day surgery or private practice. Registration of a site is optional and a member can still report incidents and obtain CPD credits without registering a site using the standard individual option. If a member is registered both as an individual and at a site, then they can choose to report each incident either as an individual or to one of the sites where they are registered. If a member is already registered at a site, then they can add individual membership to their current username by selecting registration from the menu on the webAIRS website and following the 'Register as an individual' option.

The second important update to the registration process relates to ethics approval. In March 2014, the National Health and Medical Research council released a document relating to ethical considerations for quality assurance activities[4]. It is no longer always necessary to obtain ethics approval for the collection of de-identified data used for quality-assurance activities. Consequently, if a project meets the ethics considerations relating to the collection and the use of the data, then a formal ethics application is not always necessary. The webAIRS project has obtained formal ethics approval at multiple sites and, therefore, is certain that the data collected and the way in

which the data is handled meets the new ethical requirements. When registering a new site, members may choose between agreeing to the ethics considerations online or making a new low-risk ethics application. It is suggested that if your hospital has its own ethics committee, then it is worth discussing the ethics requirements with your committee to address any local concerns. However, individuals, private practice and smaller sites may wish to accept the findings of an ethics committee in their state. The latter may be performed online using the webAIRS website.

Finally, if any ASA member wishes to assist with the analysis of the webAIRS data please contact the Medical Director for further information.

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1. The aspiration of stomach contents into the lungs during obstetric anesthesia. Mendelson C.L. Amer. J. Obstet. Gynecol. 1946 52:191-205.
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3. Victorian Consultative Committee on Anaesthetic Mortality and Morbidity (VCCAMM) Annual Report 2007. Associate Professor Larry McNichol. Chairman VCCAMM.
4. Ethical considerations in Quality Assurance and Evaluation Activities. National Health and Medical Research Council. March 2014. (Available for download from the NHMRC website).

MORE INFORMATION, PLEASE CONTACT:

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Email: 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.

INSIDE YOUR SOCIETY

POLICY UPDATE

In this edition of *Australian Anaesthetist*, Policy Manager, Chesney O'Donnell, gives members an overview of how the Policy Team works to represent and further the needs of the ASA as well as what the team is currently working on.

SUBMISSIONS

The last few months have been a very active period for the Policy Team as we have continued to assist our committees with several submissions. With each submission, our main goal is to advocate on behalf of our members and the writing of submissions takes up a great deal of our time. Writing these submissions is a group effort and we work with many contributors from various committees to draw up drafts of each submission, which are then finalised by the relevant Chairs.

Primarily, we assist with the initial drafting, research and final proofing of each submission. Depending on the topic, this can take days, weeks or months. Ultimately, once the submissions have been approved, they will be uploaded onto the ASA website for members to access and refer to within their own practice. Some examples of recent submissions we have completed are:

- Australian Competition and Consumer Commission (ACCC) Annual Report to the Australian Federal Senate in relation to possible anti-competitive practices by private health insurance funds/providers.
- Australian Hospitals & Healthcare Association and National Competency Standards Framework for Pharmacists Consultation Paper.
- Independent Hospital Pricing Authority, Teaching, Training and Research, Costing Study Consultation Paper.
- Australian Competition and Consumer Commission Medicines Australia Limited Code of Conduct authorisation of edition 18 of Medicines Australia Limited's (Medicines Australia) Code of Conduct Consultation Paper.
- Collaborative paper with the AMA and ANZCA to the National Medical Training Advisory Network on workforce issues.

HEALTH ECONOMICS

The Policy Team will be sending representatives to the Centre for Health Policy at Melbourne University and Monash University to be a part of various courses and forums examining policy areas in applied health, labour and public economics. A catalyst in this area has been the recent studies conducted by the Centre for Health Policy at the Melbourne School of Population and Global Health.

In these studies, emphasis was placed on various trends within health outcomes and costs. Special reference was made to broader concerns about life expectancy and the impact it will have on the Federal Budget. Over the course of the 20th century, life expectancy in Australia has seen, on average, a 30-year increase per citizen; the jump in age went from around 50 to 80 years during this time. This is primarily due to the elimination of many childhood diseases and advancements in healthcare and availability of medicines.

While the effects of these developments have been good for health in general, healthcare costs are increasing substantially. In 2000, the federal government conducted the first Intergenerational Report on healthcare expenditure, findings from which indicated a concerning, sharp upward trend in healthcare spending.

What the Team has found through our involvement with preparation of submissions and agencies such as the Medical Services Advisory Committee is the ever-increasing need to take into account how healthcare reforms will impact the overall Federal Budget. We are cognisant of this and are constantly trying to keep pace with the rapidly changing political landscape that we currently find ourselves in, so that we may better assist members with the queries that come in on a day-to-day basis.

AUSTRALIAN COMPETITION AND CONSUMER COMMISSION POLICY UPDATES

The independent Harper Competition Policy Review currently being finalised has been quite timely, given the ASA's more recent submissions made to the ACCC. It is important for the ASA to keep an eye on these changes and to determine

whether there will be an impact on our profession.

A fundamental objective of the ACCC is to enforce guidelines against monopolisation. In principle, businesses should compete fairly under the *Competition and Consumer Act 2010* (CCA). Most of the CCA refers to corporations, falling under the corporations power of the Australian Constitution, s51(xxx). The Commonwealth Parliament has the authority to make laws concerning insurance and insurance companies under s51(xiv) and (xx) of the Constitution. The *Insurance Act 1973* and *Insurance Contracts Act 1984* are the main relevant legislations.

These acts work in conjunction with the *Corporations Act 2001* (Cth) (especially Chapter 7, which helps regulate how insurers carry on business and deal with people). The regulators are the Australian Prudential Regulation Authority (APRA) (power pursuant under the *Insurance Act 1973*), which has powers to "investigate a general insurer, freeze its assets or direct it to take specific action (for example, stop writing new business)" and the Australian Securities and Investment Commission, which assists with the general administration of the *Insurance Contracts Act 1984* (see s11A).

It is interesting to reflect upon the fact that 20 years ago, in 1995, the Australian Federal, State and Territory Governments agreed to implement a wide-ranging national competition policy (NCP). Reforms were said to have been produced to benefit consumers. For example, government monopolies were reformed to give consumers choice in relation to telecommunication services and electricity and gas providers, while price controls and restrictions on food products were removed, with retail trading hours extended.

The more recent Harper Review 2014 re-examined these reforms to determine future improvements and whether current laws were still fit for purpose. The review panel put forward draft recommendations and found three major areas of interests: globalisation, the ageing population and the digital revolution. Recommendations included the replacement of the National Competition Council, which oversaw the NCP, with a new national and independent body accountable to all Australian governments.

More recommendations were made involving the ACCC. It was suggested that the ACCC should retain both competition and consumer functions but that the creation of a separate access and pricing regulator with responsibility for regulatory functions currently undertaken by the Australian Energy Regulator could strengthen the ACCC enforcement and regulatory functions. Further suggestions included an enhanced government structure for the ACCC by the adding of a board. The final report by the Harper Review panel will be made available in March 2015.

CONTACT US

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

Email: policy@asa.org.au

Phone: 1800 806 654.

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INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

In this issue of *Australian Anaesthetist*, EAC Chair, Dr Mark Sinclair, talks about the Medicare Benefits Schedule, working in the public sector, the ACCC and Department of Human Services.

MEDICARE BENEFITS SCHEDULE

At the time of writing, the ASA has not yet received the final decision regarding Medical Services Advisory Committee (MSAC) application 1183, for Medicare funding for the use of ultrasound in the practice of anaesthesia; and whilst it is usually best to hope for the optimal outcome, there is good reason in this instance for pessimism.

A report was published in October 2014 by the Evaluation Subcommittee (ESC) of MSAC, after its final consideration of the clinical evidence and evidence for cost-effectiveness. Members will recall that in January 2014, MSAC released a paper assessing this evidence, as collected and analysed by the Health Technology Assessment group (HTA). The EAC made a detailed response to this paper, including an independent assessment by Deloitte Access Economics, which called into question many of the HTA/MSAC conclusions, particularly regarding the economic evidence.

Unfortunately, most of the concerns expressed in the EAC response were either ignored or discounted in the October 2014 ESC paper. Furthermore, some remarks made in this paper are simply opinions based on anecdotes and some are, in fact, clearly factually incorrect. For example, the paper states that the "benefits of ultrasound use accrue overwhelmingly to the anaesthetist in terms of clear time savings and simplification of delivery". This is still stated despite the repeated acknowledgement that ultrasound use clearly benefits patients in terms of safety and that any "time saving" is of benefit to the whole system, not just anaesthetists.

The ESC also stated that anaesthesia has "very high out-of-pocket costs" and expressed concern that new MBS items would "drive an increase to out-of-pocket costs by justifying an additional item on the patient's bill". Such comments from a body whose stated purpose is to act on evidence alone are most disappointing. There is clear evidence that over 85% of private patients receiving anaesthesia services have no out-of-pocket costs at all and that where such costs do exist, they are lower than for most other procedural specialties. This information is easy to obtain, as it is freely available from the government's Private Health Insurance Administration Council (PHIAC). The statement regarding the likely outcome of new MBS items is purely speculative. When new MBS items have been introduced (anaesthesia attendance items in 2006, for example), there has been no evidence of a 'drive' towards increased costs. In fact, the incidence of out-of-pocket anaesthesia costs has decreased since that time.

The full ESC report and the detailed EAC response are available on the Society's website under the 'News' tab.

The HTA report regarding MSAC application 1308 (three new MBS items to cover all local anaesthetic nerve blocks performed for postoperative analgesia) has also been released and is being reviewed by the EAC. On first reading, there again appears to be support for the claims for clinical benefit, but doubts regarding the economic aspects. A detailed response will be made.

The other important issue affecting the MBS across all professional groups is the freeze in indexation of Medicare benefits, which is currently intended to stay in place until 2018. The AMA is working hard to try to reverse this decision, as well as the proposed 'co-payment' for GP services. As mentioned in previous reports, the response of the various private insurance

providers has been mixed, with some insurers indexing by small amounts and others not at all. Members are encouraged to take ever-increasing practice costs into account when deciding on their level of fees. A failure to adequately index fees results in a steady erosion of income.

PUBLIC SECTOR

No doubt all Australian anaesthetists are aware of the problems faced by our salaried Queensland colleagues in recent times. Unfortunately, as predicted, the issue has not been confined to Queensland. The ASA has been assisting a member in another state who has had to deal with a similar problem – that of a contract of employment which is patently unfair to the employee. In this particular case, the anaesthetist was informed that non-signing of the contract, presented only a few days before the agreement was due to commence, would result in termination of employment.

The current workforce situation, with a shortage of job opportunities for anaesthetists in some areas, is apparently being taken advantage of by employers. The member referred to was well aware that there would have been numerous takers for the job if the contract was rejected.

However, it is important to note that, even if a contract is signed, employees have certain rights. The failure of a contract to acknowledge such rights does not necessarily mean they are lost. Discussions with the AMA in this member's state are ongoing and ASA members will be informed of any further developments.

AUSTRALIAN COMPETITION AND CONSUMER COMMISSION

The Australian Competition and Consumer Commission is due to make its annual report to the Australian Senate on "anticompetitive and other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket or other medical expenses". Submissions to the Commission were welcomed. The ASA has lodged a submission, emphasising the lack of information made available to health consumers by their insurers, for example any limitations to cover for certain procedures such as plastic/reconstructive surgery and insurers' rules regarding 'no-gap' and 'known-gap' policies. The submission is available on the ASA website. Unfortunately, similar submissions made in the past have had little or no mention in the Commission reports.

DEPARTMENT OF HUMAN SERVICES

Fellows of ANZCA received an email in late February, advising that the online government service site 'myGov' makes the address linked to their Medicare provider number available to patients. In some cases, doctors' provider numbers are linked to a residential address rather than professional premises. Obviously, for privacy reasons, a residential address is not ideal, but it is important to note that this address has always been available to patients making Medicare claims. Doctors wishing to change their provider number address need to apply for a new number via the Department of Human Services at: www.humanservices.gov.au/health-professionals/forms/1413.

The issue of anaesthetists having one provider number, but working at multiple locations, was also raised. For many years, there has been an acceptance that one provider number, for example at an anaesthetist's professional premises, is sufficient. However, the DHS has recently given contrary advice. Obviously, to have to register and utilise multiple provider numbers will place significant administrative burdens and costs on anaesthetists and their practice staff. The financial costs may have to be passed on to patients. It also risks slowing the Medicare claims process, with patients unable to receive rebates while new provider numbers are being generated. The ASA will strongly urge that no change is made to the current system. Members will be advised of any updates via the ASA's regular President's enews bulletins and the ASA website.

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INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

The PIAC met for its annual 'face-to-face' meeting in Sydney on 14 February 2015, writes Chair, Dr James Bradley. The agenda was complex, reflecting the complicated environment within which we, as anaesthetists, practice.

As foreshadowed, the Committee's activities have been restructured in order to assign Committee members to certain areas of activity that align with the Society's interests in professional contexts. These areas are:

- Medical regulators, complaints bodies and medical indemnity matters,
- Member and patient queries, publications and information,
- Government and non-government bodies,
- Workforce and survey and
- Professional practice issues.

MEDICAL REGULATORS, COMPLAINTS BODIES AND MEDICAL INDEMNITY MATTERS

These deal with the obvious: the Medical Board of Australia, its state branches and the medical indemnifiers who insure us as practitioners. The recurring issue of 'notifications' and our members is addressed in this area.

Members may be aware that the ACT Civil and Administrative Tribunal has imposed disciplinary action upon a practitioner for failing to make a notification upon becoming aware of notifiable contact. While the particular circumstances involved sexual misconduct by an associated practitioner, the need to be aware of what is a 'reasonable belief' in relation to conduct is apparent.

MEMBER AND PATIENT QUERIES

Member and patient queries with publications and information involves managing queries of a professional and/or practice nature, the provision of information for patients both on the website and as hardcopy and the formulation and ongoing review of ASA Position Statements.

Members will have received copies of revised Mi-tec patient information brochures over the last 12 months. These documents have been reviewed by the ASA and are felt to be valuable in the containment of 'material risk', particularly in the context of the short 'lead times' seen so commonly in private practice.

GOVERNMENT AND NON-GOVERNMENT BODIES

Government and non-government bodies include the panopoly of federal and state instrumentalities, including, most significantly, the Australian Commission on Safety and Quality in Health Care (ACSQHC), which addresses the specialty and the profession.

In particular, the ten 'National Standards' have imposed onerous reporting requirements on healthcare facilities, with the potential for malalignment between the contents of these documents and the professional documents emanating from the specialty and profession against which we, as practitioners, are assessed by the Medical Board of Australia.

WORKFORCE AND SURVEY

Workforce surveys incorporate our regular polling of members, both across the specialty and within it, for example, the recent younger member survey (addressed elsewhere within this issue).

The Society is comforted by the consistent findings of our recent surveys concerning the anaesthesia workforce. The information obtained has enabled us to advance the views of practising anaesthetists to the Australian Medical Association and the National Medical Training Advisory Network.

PROFESSIONAL PRACTICE ISSUES

Professional practice issues was a late afterthought. Some matters are too difficult, or too all-encompassing to classify and belong in this extra category.

THE YEAR AHEAD

PIAC has a membership that covers the states and territories and also has expertise and experience in a number of recurring problem areas, commonly hospital governance issues including disciplinary and registration matters. Members are reminded that the Committee is well equipped to help and that members and issues can be de-identified on request; contact is easily made via policy@asa.org.au.

The major areas of activity in the professional area this year are likely to include:

- Revalidation. It remains a topic of 'conversation' with the Medical Board of Australia, noting that it will not be introduced in 2015. What revalidation might entail in the Australian context, as opposed to the British, for example, given our particular public/private practice model and the existing requirements of the Medical Board of Australia, Australian Health Practitioner Regulation Agency and ANZCA, remains to be defined. It is incumbent upon the medical representative organisations, including the ASA, to ensure that any new process is appropriately targeted and not overly onerous or disruptive. The Society will be developing its position on revalidation throughout 2015.
- Risk containment, including material risk management.
- The ACSQHC, its national standards and their alignment or otherwise with the standards of the specialty and profession.
- Private hospital governance (including, in particular, preadmission and admission processes and the adequacy of inpatient aftercare). Private hospital governance and its application through institutional bylaws has also seen a number of members subjected to disciplinary processes with the threat of outcomes or actual outcome that are very severe. It is apparent that practitioners credentialled in private facilities enjoy far less 'job protection' than employees in public facilities. With facilities having bylaws which often differ in their detail, it is very difficult to be anything other than reactive when supporting members experiencing difficulties. The emphasis to date has been on insisting on transparent processes with independent clinical input.
- Proposals for restructuring of the healthcare (including medical) workforce.
- The anaesthesia workforce.

In closing, I would like to thank Drs Elizabeth Feeney, Richard Clarke and Paul Cook who have now stepped down from PIAC. All brought particular skills and talents to the Committee, as Past Presidents (Liz and Richard) and as Past State Chairs. Their successors are Drs Natalie Kruit (NSW), Moira Westmore (WA) and Peter Waterhouse (Qld). Natalie is the Past GASACT Chair and Moira is very well known within the specialty, also having been, in the past, an ANZCA Councillor.

PIAC meets, 14 February 2015, for its annual face-to-face. From bottom left, up around the table and back: Simon Macklin, Mark Sinclair, James Bradley, Chesney O'Donnell, Guy Christie-Taylor, Mark Carmichael, Liz Feeney, Josie Senoga, David Scott, Antonio Grossi Lindy Roberts, Richard Clarke, Simon Reilly, Stuart Day. Attendees not pictured: Drs Peter Waterhouse and Phil Morrissey.

GET IN TOUCH

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

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

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OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

ADVOCACY FOR SAFE ANAESTHESIA

Access to safe anaesthesia and essential surgery is excellent in Australia. Sadly, the same cannot be said for many parts of the world.

Only 3.5% of the estimated 230 million surgical procedures performed each year take place in low- or middle-income countries. In some of these countries, the anaesthesia-associated mortality rate is as high as 1 in 500. If half of these deaths are avoidable, then each year there are 35,000 avoidable deaths in these places.

The ASA and World Federation of Societies of Anaesthesiologists (WFSA) have been active in lobbying for recognition of this important issue and we are pleased to report that there has been some success on the matter, with the Executive Board of the World Health Organization recently including the agenda item of 'Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage' as a prelude to further discussions by the World Health Assembly in May 2015. This is recognition that access to safe surgery and anaesthesia is a significant issue that ranks alongside malaria prophylaxis and treatment, management of Ebola and other public health challenges.

ASA IN MYANMAR

In February, the ASA, WFSA and the Myanmar Society of Anaesthesiologists ran a very successful Emergencies in Anaesthesia course in Mandalay. This two-day course, run by A/Prof David Pescod and Drs Michelle Chan, Amanda Baric, Hella Deifuss of the Northern Hospital and Dr Stefan Sabato of the Royal Children's Hospital, was attended by 24 doctors and four nurses. A further half-day workshop was run in Yangon in conjunction with the Myanmar Society's biennial meeting.

The Emergencies in Anaesthesia course has been developed to teach:

- Principles of crisis management,
- Management of the difficult airway,
- Common cardiovascular problems,
- A systematic approach to the management of anaesthetic emergencies,
- Advanced life support and
- Basics of trauma management.

Emergencies in Anaesthesia has been previously run in Mongolia and in Myanmar in 2014.

As part of this visit, 50 Lifebox oximeters were distributed to hospitals in Myanmar. Twenty-five oximeters have been donated by ASA members and the other 25 were donated by Rotary. The Myanmar Society of Anaesthesiologists has requested 850 oximeters – this is just the start! A half-day Lifebox education workshop was run in Yangon by David Pescod and Amanda Baric. The workshop was attended by 35 doctors and nurses from remote Myanmar.

ASA VOLUNTEER DATABASE

Australian anaesthetists are reminded that the ASA has a database of those interested in assisting with humanitarian work overseas. If you are interested in receiving notifications about short- or long-term attachments for service or teaching, then register for the database via the 'Volunteering' section under the 'Membership' tab on the ASA website.

A request to find an anaesthetist for a two-week locum in Samoa will soon be publicised via the database.

WORLD CONGRESS OF ANAESTHESIOLOGISTS (WCA)

The 16th WCA will be held in Hong Kong from 28 August to 2 September, 2016, hosted by the Society of Anaesthetists of Hong Kong. The WCA is the major WFSA event and is only held every four years. ASA members have always been enthusiastic supporters of the WCA and now is the time to start making plans to attend.

OTHER ODEC ACTIVITIES

ODEC is continuing to assist with projects in Mongolia, Laos, Bhutan, Timor Leste, Cambodia, Micronesia and the Pacific. Projects are focused on education and are run in partnership with local societies of anaesthesia and the WFSA.

REAL WORLD ANAESTHESIA

On 2 November 2014, 12 participants joined with 14 faculty members over a meal as the prelude to last year's Real World Anaesthetic Course (RWAC) held by the Christchurch Hospital in New Zealand. What followed was a week of intense activity, including theatre, lecture and workshops sessions, all centred around the provision of anaesthesia services and education in low- and middle-income countries. These services, which we take for granted in Australia and New Zealand, are often rudimentary, and in some cases completely absent, in many low-income countries around the world.

As in all courses, it is the strength of the faculty that determines the quality of the event. The RWAC is now in its 15th year and, over that time, an impressive panel of quality clinicians who have 'been there, done that' has been assembled. Interestingly, their combined experience covered just about every sort of aid and development trip, from short-term surgical expeditions to extended placements lasting multiple years. This combined experience covered the Pacific region, Asia, Nepal, Mongolia, Western and Central Africa and the Caribbean. There were faculty members from the Australian and New Zealand Medical Assistance Teams for disaster relief who shared their experiences providing relief in Haiti after the 2010 earthquake. There was also a member of the Christchurch Hospital Anaesthetic Department, who shared his 'in-the-field' experience of the recent local earthquakes. Each faculty member drew on their own personal experiences to teach the special curriculum that has been developed over the years for this course.

Last year, the RWAC was joined by Dr Ron George, who is a faculty member of the parallel course run by our Canadian colleagues. Ron's special interest is in the provision of obstetric anaesthesia services to low-income countries, specifically targeting maternal and infant mortality. Some of these low-income countries suffer a maternal mortality rate of up to 200 times that of high-income countries, with lifetime maternal death rates as high as 1 in 6. He was able to show how, with the appropriate education and assistance, these rates may be greatly reduced.

Of special importance was the very practical nature of the course. Multiple theatre sessions were arranged so that the participants could perform draw-over inductions of anaesthesia with what might be described as historical pieces of equipment, including EMO (ether), Goldmann, Oxford, PAC and Diamedica vaporisers. In these sessions, outdated concepts of saturated vapour pressures and temperature compensation suddenly became important again. Discussion was also devoted to the assessment of trouble-shooting equipment that might be encountered in remote areas. While many other topics were covered (in fact, too many to document!), the course certainly gave special attention to potential occupational pitfalls and hazards and how to stay well and adjusted in the real world of anaesthesia.

In summary, this was a brilliant course and an absolute must for all those who might be considering extending their practice into these areas. The participants came from a range of medical professions, with many and varied interests, but all were highly motivated. The faculty also came with enormous energy and commitment – for them, it was an opportunity to pass on the baton to another group of colleagues who share their passion to help those less fortunate than we are in Australia and New Zealand. This year's RWAC will be run by the ASA in Darwin from 7 to 11 September, immediately prior to the ASA/NZSA CSC. The course has a history of booking out very quickly (last year's event was full by lunchtime on the day applications opened). If you are interested, don't hesitate to get involved – you won't regret it!

Dr Rhys Morgan, FANZCA

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INSIDE YOUR SOCIETY

GROUP OF ASA CLINICAL TRAINEES UPDATE

It is my pleasure to introduce myself, Dr Ben Piper as the new National GASACT Chair for 2015. I would like to extend my thanks to Dr Natalie Kruit as the outgoing Chair for her commitment and dedication to making GASACT a strong and meaningful voice for anaesthetic trainees. Following in such footsteps is daunting and I hope to build on the strong foundations that we now have thanks to my predecessor's hard work.

As the year is rapidly hurtling forward at a rate of knots, I remind the membership of the many opportunities that 2015 will offer GASACT members. The GASACT Common Interest Group scholarships are now open and represent a very generously funded opportunity to attend international conferences in either Canada, the UK or the US. The National Scientific Congress this year is a meeting between the ASA and New Zealand Society of Anaesthetists, to be held in Darwin and is anticipated to be one of the finest trainee events of the year. Key speakers such as Professor John West (THE man behind *West's Respiratory Physiology*) and the Real World Anaesthesia Course will be highlights of the trainee stream.

2015 is also looking to be a busy year with Part 0 and Part 3 courses running in most states. There are currently discussions being had between ANZCA and GASACT with regard to joint funding, uniform content and a formalised process for running these important courses in the future. I look forward to being able to advise the membership of these arrangements.

This year's professional issues are emerging to be along the lines of post fellowship employment opportunities, the ANZCA training portfolio system and discrepancy between trainee knowledge of expectations and those of the College. GASACT is also concerned about trainees' unrostered overtime commitments, with particular regard to unofficial departmental expectations that this should be unpaid. GASACT encourages trainees to seek guidance from us with regard to these issues as they arise.

Our role is to advocate for trainees and promote professionalism amongst our members, providing an independent voice for trainees on important issues that matter to them. Be it workforce, employment, education or training, we will be improving current and future conditions for our members. The GASACT team looks forward to bringing these issues to the relevant decision makers in 2015.

INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

NATIONAL

Prof. David Gibb

A Retired Anaesthetists Group luncheon was held at the 2014 National Scientific Congress on the Gold Coast. Members were again encouraged to participate in the Retired Anaesthetists Biography Project by submitting a personal biography for storage in the Society's archives. Finally, I would like to thank the Society for providing us with an excellent buffet luncheon and fine wines for the occasion (photos and further details of the event can be found in the December 2014 edition of the *Australian Anaesthetist*).

NEW SOUTH WALES

Prof. David Gibb

The Retired Anaesthetists Group NSW had their first function at the North Sydney office on Thursday, November 27 2014. The luncheon featured, as guest speaker, Assoc. Prof. Richard Morris, Director of Anaesthetics at St George Hospital in Sydney. Besides his reputation as an outstanding clinician, teacher and administrator, Richard is known for his involvement in the development of helicopter rescue and trauma services, his innovative work in the field of anaesthetic simulation training and his position as an editorial board member of *Anaesthesia and Intensive Care*. The subject of his address, 'Should the Anaesthetist be a Physician', was based on the philosophy and sayings of the famous Canadian physician, Sir William Osler, founding Professor of the Johns Hopkins Hospital and Regius Chair of Medicine, University of Oxford. Richard's presentation consisted of an interactive session in which quotations of Osler were discussed with the audience. This opportunity to participate in the proceedings was greatly appreciated by those present. I would like to take this opportunity to thank Ms Julianne Kiely for organising this inaugural RAG luncheon at North Sydney and the Society for subsidising the function.

RAG LUNCHEON AT NORTH SYDNEY HEAD OFFICE

Jack Micklethwaite, John Hood, Bob McGuiness, Richard Fear and Richard Bailey

Duncan Campbell, Richard Morris, Rod Clark and Ted Yarad

Richard Morris (presenting) to Rod Clark and Ted Yarad

Richard's presentation and the luncheon were greatly enjoyed by the 'full house' of attendees.

VICTORIA

Dr Pat Mackay

The Retired Anaesthetists Group VIC had a most successful year. Sadly, we lost five members: Drs Olympia de Sousa, Marie Swaney (Cockbill), Patricia Long (Scrivener), Diana Tolhurst (Furness) and Lelia Harris.

However, the numbers attending meetings have continued to swell and have been at record levels for the past two meetings; a tribute to the quality of the speakers. In addition, we have been able to attract interstate visitors who happen to be in town.

The themes for the meetings have been largely historical with the exception of the most recent November meeting, where Sherene Hassan, a board director of the Islamic Museum of Australia, provided a balanced insight into the Muslim religion. In 2015 our first speaker was ASA member, Dr Bob Hare, who will be discussing, from a personal point of view, the effects of World War II in North Africa. Suggestions for future meetings are sought.

The venue at the Lyceum Club has served us well, with good projection facilities and excellent dining at a reasonable price. It has been proposed that this should also be the venue for 2015 and we will need to make the bookings well in advance as the club is

extremely busy. We are most indebted to Christine Sweeney for the organisation and menu selection.

The Annual General Meeting was held on 18 November 2014 and, as there were no nomination for positions in 2015, the unusual step was taken to re-elect the entire current committee which had already served three years. One advantage is that the rationalisation of banking arrangements can be undertaken rapidly by the treasurer, secretary and president so that cheques are no longer essential.

The Committee as of 2015 consists of myself as President, Rod Westhorpe OAM as Secretary, Christine Sweeney as Treasurer and additional Committee Members, Jean Allison and Michael Davies.

It is my strong belief that we must remain engaged with our specialty and not be seen as a purely social club. So far, we have been fortunate to have had excellent speakers and several members continue activities, both with ANZCA and with the Victorian section of the ASA. We have also been requested to provide an assessor for the entries for the ANZCA Melbourne Anaesthesia Research Award.

I wish to express my appreciation of the sterling assistance of our Secretary, Rod Westhorpe, Treasurer and Social Assistant Christine Sweeney and Committee members.

We also value highly the facilities provided by the ever-helpful Lyceum Club Staff.

SOUTH AUSTRALIA

Dr John Crowhurst

Our Group in South Australia meets for lunch on the second Monday of every odd month at the Kensington Hotel. These meetings enable us to have our own private dining room and, from time to time, a guest speaker.

Our membership comprises of colleagues from the fields of anaesthesia, intensive care and pain medicine and now totals more than 70 retirees. Attendance at meetings during 2014 varied from 12 to more than 30.

Two of our members were 'guest speakers' during 2014. In September, I presented my lecture, 'The Historical Significance of the Anaesthesia Events at Pearl Harbor in December 1941', a précis of which was published in the History Supplement of *Anaesthesia and Intensive Care* last July. In November, Lindsay Worthley enlightened us about the writing of his recently published book: *Inside God's Shed – Memoirs of an Intensive Care Specialist*.

Two other colleagues have had books published in 2104, which have been discussed by the RAG. Prof. Garry Phillips wrote *Intensive Care Medicine in Australia – Its origins and development*, a detailed account of how the speciality evolved and of those who were responsible for the foundation of the Faculty and then the College of Intensive Care Medicine.

Dr Tony Swain was co-author of *Blood, Sweat and Fears* – an account of the services rendered in World War I by medical practitioners from South Australia.

These books, along with Lindsay Worthley's, pictured below, have been widely reviewed and are still available for purchase.

Sadly, two of our members, Rob Brooks and Tony Trewatha, have passed away in the last six months.

Any retired or semi-retired colleagues in South Australia who are not on the RAG list and any others from interstate are most welcome to join us on the second Monday of each odd month

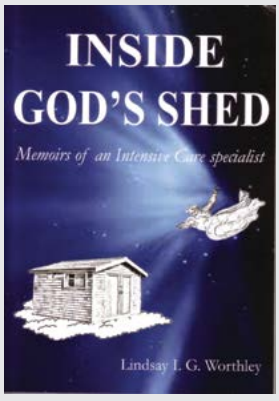
WESTERN AUSTRALIA

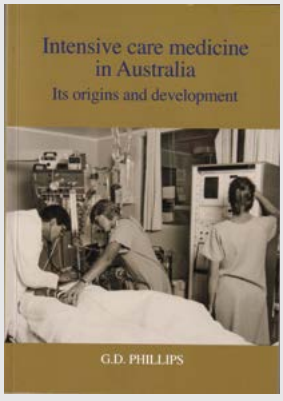
Dr Wally Thompson

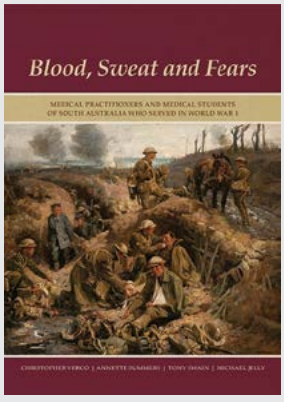
The Christmas Gathering of the Retired Anaesthetist Group in Western Australia was held on Thursday December 11 at the University Club in Crawley. The gathering was enjoyed by 15 attendees and there were 13 apologies (members were in such diverse places as Rottnest, North America and Lapland!).

The regular gatherings for 2015 restarted in March, commencing with the AGM, held on 14 March during the WA Autumn Scientific Meeting.

SOUTH AUSTRALIAN RAG PUBLISHED WORKS







GET IN TOUCH

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

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

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INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

The Richard Bailey Library is an inviting space for ASA members' research and report writing, writes Librarian, Dr Peter Standbury.

You are surrounded with anaesthetic and other medical books but, unlike many second-hand booksellers' shops, there is no cat sleeping in the sunshine of the window. There are no *cris de coeur* from offspring or partners. Co-workers do not disturb. Nevertheless, there could be distractions. Opening from the Library is the Harry Daly Museum and the Council's meeting room with its honour boards bearing distinguished past members' names. Beware too of browsing among the Library shelves – therein lie memories longer than a ball of string.

Wasn't that the text book you remember underling so avidly after midnight in a guilty swotting session? And doesn't that name of renown remind you of being in England (Scotland? America?) years ago? And is your name in that History of the Department of Anaesthetics at …? If a title intrigues, you may stop a while, browse and be thankful that you can postpone a little longer the task for which you came.

As the Harry Daly Museum adjoins, your eye may easily catch a now-antiquated piece of apparatus that used to be your daily tool. The layout is, in part, based upon the History of Anaesthesia timeline that is being continuously developed by the ASA's Honorary Historian Dr Reg Cammack and which can be unearthed from our website.

The Library itself even has its own simple changing display, based on an object in our collections. Exhibited below watchful eyes (of Geoffrey Kaye's portrait) could be a philatelic item featuring anaesthesia, a manuscript, letter or signature, a recent donation or even a significant publication from our (meaning your) collection (funded from your membership fees). Ideas for new exhibitions or new acquisitions are always welcomed!

Turning back to the Library itself, its contents, as you would expect, are mainly of an anaesthetic nature – no, that doesn't mean they will put you to sleep, needle you or be a gas, although some preclinical and general volumes remain for historical reasons. It is not a lending library but reasonable sections of text can be photocopied. It has a formal policy that can be referred to on the ASA website and this gives a little of its somewhat chequered history which dates almost from the beginning of the Society. Surprisingly, it wasn't professionally tended until 2004, when the Library received a significant boost by the purchase of books from lifetime collector, Dr Richard Bailey.

The arrangement of the Library is based on that of the National Library of Medicine in Maryland, USA. A summary of this classification can be found on the side of the bookcase immediately to the right as you enter. All monographs large enough to have a spine are kept in the main room of the Library, except as mentioned below.

Significant publications are mostly held in the Library's bookcase in the Board Room. Here is housed the finest Mesmerism collection in the Southern Hemisphere and our anaesthetic-related books published before 1850. The most recently acquired item is a wonderfully preserved copy of the *Illustrated London News* of 9 January 1847 describing the first use in England of the apparatus for inhaling sulphuric ether to make surgical operations painless, i.e. the first practical anaesthetic; this item is a very welcome gift from Dr Rod Westhorpe.

Also housed in the Board Room are pamphlets or publications too slim to have a titled spine. These are found in the drawers beneath the Mesmerism collection and are catalogued in exactly the same way as the ordinary books.

Lest you become too involved with the Library on the seventh floor, you can find runs of journals upstairs in the ASA office. The titles and numbers we hold can be referred to on a printed list within the Library or you can discover them (and all our books and pamphlets) online through our Library catalogue at www.ehive.com/account/5441. Alternatively, you can refer to the catalogue through the ASA website.

OUR NEW HARRY DALY MUSEUM – A SNEAK PEAK

The new exhibition in our Harry Daly Museum is taking shape and we are so excited about the result that we had to give you a sneak peak.

Please note that the Harry Daly Museum is currently closed while we develop our exciting new exhibition. Although we do not have a physical display, our collection has never been more accessible through our eHive website, where you can search and view every object that we possess. Go to http://ehive.com/account/4493, or follow the links from the ASA website.

CONTACT US

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

HARRY DALY MUSEUM & RICHARD BAILEY LIBRARY

Be amazed by the Harry Daly Museum and discover treasures in the Richard Bailey Library.

The Museum and Library are open to the public from 9am - 5pm Monday to Friday at the ASA head office by appointment.

To make a booking email asa@asa.org.au

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin, Chair

The festive season is usually a quiet time for the SA/NT Committee of Managment but the coming year will be full of interest.

In the public sector, SA Health has released its 'Transforming Health: Best Care. First Time. Every Time.' discussion paper. This report outlines a major reshuffle in both elective and emergency services to address a need to cut $332 million in healthcare expenditure. Meanwhile, the new Royal Adelaide Hospital continues to expand by the minute and many are wondering if we will be moving to the site in 2016. This seems an optimistic goal at present, with much apparently still to do. Concerns remain about SA Health's Enterprise Patient Administration System and how it can be integrated into treatment at the new hospital without compromising productivity and patient safety.

In the perioperative sector, 'Boojums of Adverse Events: can we prevent them?' was held at the Adelaide Convention Centre on 7 February. A full report of the day's outcomes appears elsewhere in this edition of *Australian Anaesthetist*. I am pleased to report that attendance exceeded our expectations and a larger venue at the Convention Centre had to be secured shortly before the event in order to accommodate the demand for places. It was a valuable day that brought together different components of the private healthcare delivery system to discuss and be educated about universal pre-anaesthetic assessment as a step to reducing postoperative morbidity and mortality. I would like to thank the members of the convening committee: Tim Benny, Margie Cowling, Guy Christie-Taylor, Pam Macintyre, Angelo Ricciardelli and Mark Sinclair. We were ably supported by members of the ASA secretariat, Tracey DiBartolo, Alaina Koroday and Nicola Morgan, and thank them for their encouragement and support.

In January, Part 0 and Part 3 trainee courses were run simultaneously at the ANZCA office and AMA House, respectively. I thank Brigid Brown and Nicole Diakomichalis, Senior and Junior GASACT Representatives, for their organisation of a highly successful day.

Part 3 and Part 0 Course Report, Brigid Brown and Nicole Diakomichalis

2015 has already provided ample learning opportunities for South Australian registrars at all stages of their training. On 17 January at AMA House, GASACT hosted a Part 3 course, designed to provide information and insight into the transition to consultancy, and received record-breaking attendance.

The day consisted of four main panels: 'Medical indemnity and the welfare of the anaesthetist', 'Financial issues for the anaesthetist', 'Transition to consultant, interviews and job-seeking' and 'Working as a new consultant in 2015 – changing conventions'. For many trainees, this was the first opportunity to consider financial planning, billing, the concept of mentorship and other workforce issues and the entire day was very well received.

ASA President, Dr Guy Christie-Taylor, addresses advanced trainees at the Part 3 course in Adelaide.

Drs Mark Sinclair, Andy Beinssen, Rowan Ousley and Yasmin Endlich discuss public versus private practice and beginning work as a consultant at the same event in Adelaide.

The Part 0 course was also held for our new intake of registrars in January. We welcome Brian Ambrose, Lisa

Biggs, Sophie Bradshaw, Sean Davies, Andrew Gillard, Rebecca John, Praveen Mamillapalli, Matthew Mathieson, Adelaide Schumann, Haran Somehsa, Lee Tayler, Tuyen Tran and Steven Wilson to SANTRATS, the SA/NT rotational training scheme! The ASA proudly sponsored this event, which introduced new trainees to welfare issues, helped in fulfilling College requirements and encouraged involvement within both ANZCA and the ASA. The day provided valuable insights into the anaesthetic journey ahead and our new recruits appeared very much looking forward to starting their training, albeit with some trepidation! Feedback from the staff at the College was that the day ran smoothly and that the speakers, including Christine Hildyard and Laura Wilington, were well received.

Professor John West

Advanced warning! After the ASA/NZSA Combined Scientific Congress in Darwin in September, Professor John West will be coming to Adelaide. His provisional program includes a special continuing medical education event on the evening of Thursday, 17 September, as well as an Adelaide University lecture on the evening of Tuesday, 22 September. He will be in Victor Harbour as a plenary speaker for the Thoracic Society meeting on the weekend of 19/20 September.

QUEENSLAND COMMITTEE

Dr Nicole Fairweather, Chair

At the time of writing, we are currently under a minority Labor government in Queensland, having just had an historic election non-result on 31 January. It seems likely that the LNP will challenge the results of the Ferny Grove electorate and may appeal the result in the Court of Disputed Returns. If they then win the seat in a by-election, they may also be able to form a minority Government with the support of the two Katter Party MPs. Politics in Queensland is never boring!

Meanwhile, the Palaszcuzk Government have committed in writing that public service doctors will be returned to the protections of an Award and collective bargaining along with access to the Queensland Industrial Relations Commission – this is what they were stripped of by the LNP Government's ideological reforms. We can only hope that they alter the laws before any challenges to their Government take place.

Therefore, I suggest that all members with public appointments consider joining a Union, if they did not do so during the Dispute, if they wish to be represented during any negotiations. This includes Visiting Medical Officers, whose representatives will need to create an entirely new 'Award', as one did not previously exist. It will be fascinating to see the same Queensland Health Executives who introduced the contracts have to negotiate another Collective Agreement, particularly if there is a possibility of them returning to LNP rule.

I think that it is worth mentioning that being an Australian Medical Association Queensland member does not afford members any representation in such matters. Unlike Victoria and Tasmania, where the AMA are industrial organisations, in Queensland this is not the case. The two unions which represent doctors are Together Union and Australian Salaried Medical Officers' Federation Queensland.One does not need to be an Australian Medical Association Queensland member to be an Australian Salaried Medical Officers' Federation Queensland member.

On an entirely separate matter, as a result of the outsourcing by Queensland Health to tenders for various services, anaesthetists have been neglected or ignored in negotiations to set fees for ophthalmology, gastroenterology and maxillofacial procedures. There are currently three surgeons from Specialist Connect (note: this is different to Surgery Connect) offering cataract lists with long-wait patients with complex and severe medical illnesses and are remunerating anaesthetists at $250 plus GST per case. This works out in most instances to be lower than the Medicare rebate! This is particularly true since the majority of cases are long-wait and therefore, duration of surgery is sometimes >1 hour, and with significant medical comorbidities.

Each case was allocated a set sum of money to cover the cost of the proceduralist, the facility, the equipment/ consumables and lastly, the anaesthetist. Once again, these cases are completely different to Surgery Connect which is paid at 68% of the AMA fee plus GST, for both anaesthetists and surgeons.

The Mater Hospitals are operating similar programs for their own public patients in their private hospitals and have offered some specialists below Medicare Rebate for procedures such as acute infarct angioplasty.

I would urge members to consider their worth and overheads prior to undertaking these cases (particularly in shared-care, emergency situations) as medicolegal coverage is not provided in these agreements. These prices are set by others without our input and should not be regarded as set in stone. An individual attempt at remuneration negotiation should always be made if members feel compelled to take this type of work for whatever reason.

Any fee set by a non-anaesthetist is a precedent that should concern the specialty going forward, especially when the fees for our services are set below the Medicare schedule. Medicare should always be the absolute lowest common denominator which is becoming increasingly less relevant as the Federal government has frozen its indexing. Acceptance of lower fees could impact on the ability of the specialty as a whole to negotiate appropriate fees for these procedures in the future.

INSIDE YOUR SOCIETY

PART 0 COURSE

Our Part 0 was held on 28 February and was a smashing success by all reports; and in a new format! In response to feedback, we are providing two streams of talks to include both pre-program residents and trainees, as well as those already on the ANZCA training program to help them prepare for their Primary Examination and Introductory Training. The sessions started together with common issues and then the groups separated into two. We had an unprecedented 30 folks attend which I can only hope is an example of our membership numbers to come!

VICTORIAN COMMITTEE

Peter Seal, Chair

Victorian events update

ASA NSC, Melbourne 2016

Solid progress is occurring in the organisation of the Diamond Anniversary 75th ASA National Scientific Congress. The Organising Committee has been meeting regularly under the auspices of Dr Simon Reilly. Venues for the main social events are being finalised and the academic program is beginning to take shape.

ASA Rural Meeting 2015–16

It is hoped that, after an absence of four years, a Rural Meeting will be arranged to take place once more, either in October/November 2015 or February/March 2016. The most likely venue is a return to beautiful Creswick, just near historic Ballarat.

Annual General Meeting, March 2015

The 2015 Annual General Meeting and dinner took place on the evening of Sunday, 1 March at Kooyong Lawn Tennis Club. Victorian state disaster planning officer and trauma expert, Dr John Moloney, delivered a fascinating presentation on 'Anaesthesia and disaster response'.

GASACT Part 3 Course, November 2014

Dr Debra Leung hosted another successful Part 3 meeting at Kooyong Lawn Tennis Club on 15 November. There were many presentations with excellent content. Yet again, special thanks must go to Dr Andrew Schneider for the considerable amount of time he put in behind the scenes to ensure a successful day was had.

ANZCA/ASA Combined Quality Assurance meeting, October 2014

Another well-subscribed Quality Assurance meeting occurred at ANZCA House in October. The ASA remains steadfast in its support of these commitments.

ASA/ANZCA Victorian Regional Committee Combined Continuing Medical Education (CME) Meeting, October 2014

Dr William Harrop-Griffiths from England, one of the invited speakers at last year's Gold Coast NSC, re-delivered several of his entertaining talks at ANZCA House in Melbourne on the evening of Wednesday, 8 October. He recounted 'The revalidation experience in the United Kingdom – welcome to my nightmare', as well as 'Insights from incident reporting in the UK and Ireland'. Once more, his fine oration was well received

ANZCA/ASA Combined CME Meeting, July 2014

The 35th Annual ANZCA/ASA Combined CME Meeting was held at the Sofitel Hotel last July. As convenor for the very last time, Dr Mark Hurley from the ANZCA Victorian Regional Committee did an outstanding job in assembling a program that drew widespread acclaim.

Currently, new Education Officer Dr Michelle Horne is putting together the 36th Annual ANZCA/ASA Combined CME Meeting, which will take place in July 2016.

New Fellows Forum, June 2014

Last year's New Fellows Forum occurred in June, complete with lively and engaging conversation. There appeared to be more optimism amongst guests, despite the tough prevailing workforce conditions for early-career anaesthetists. Nevertheless, the general impression was that, while many new fellows had found their feet and were doing well, others continued to struggle and it was difficult to know how to address this second group effectively. Another cohort altogether had re-entered the public system in order to retrain and gain an extra fellowship, in areas such as intensive care and chronic pain. Drs Michelle Horne, Usha Padmanabhan and Peter Seal organised proceedings. Another forum is scheduled to take place in the first half of 2015.

Mentorship

It is hoped that a mentorship program for Victorian members will be initiated this year. It is possible that two separate models will be offered, one involving the establishment of a mentor team for each prospective mentee, and the other regarding peer-review groups.

Transport Accident Commission and WorkCover

In Victoria, we have endured low levels of rebate from both the Transport Accident Commission and WorkCover for over a decade. Now, both happen to be run by the same administration and deem that the fees they pay are reasonable, even though their respective definitions of what is reasonable differ from each other. The Transport Accident Commission in Victoria boasts the lowest rebates in Australia, while WorkCover is just ahead of our South Australian counterparts. The majority of states pay AMA rates for both of these different services. It could be argued that this is not unreasonable, given that the payment of premiums for drivers and employers of workers, respectively, is compulsory. Also, patients are automatically covered under either system and cannot choose their own private insurance.

Some anaesthetists consider that these rebate levels are fair as they are and have no issue with them. Victorian members should be aware of the low levels of remuneration in these respective systems. If service providers feel that these rebates do not cover their fees, then they may feel entitled to charge out-of-pocket costs to patients. This is stated clearly in the approval letters sent out by the particular organisations.

Presence in the operating theatre

Anaesthetists are reminded of their responsibilities in caring for and staying in theatre with patients undergoing general anaesthesia in particular, and also those undergoing regional anaesthesia with some degree of sedation. Understandably, failure to do so is being looked upon quite unfavourably by the private hospital groups.

Committee of Management update

The Committee of Management has welcomed a recent valuable addition in the form of New Fellows Officer, Dr Suzi Nou. She has been, and continues to be, a dynamic force for education in medicine and anaesthesia, as well as trauma management in developing counties in the Asia-Pacific region, particularly Cambodia.

Hearty congratulations to both our GASACT Representatives, Drs Debra Leung and Greg Bulman, for successfully passing the Part 2 examination last year. Both have been working as senior trainees at the Alfred Hospital. In addition, a special commendation must go to Greg for becoming a recipient of the prestigious Cecil Gray Prize.

Warmest felicitations are extended also to Dr Usha Padmanabhan, who gave birth to a little girl last August. Usha is now on maternity leave and she and her daughter are well. Dr Michelle Horne joins her as Education Officer. Michelle has swapped portfolios with Dr Zoe Keon-Cohen, who has returned from her overseas sabbatical, and she will team up with Suzi in the New Fellows role.

AUSTRALIAN CAPITAL TERRITORY COMMITTEE

Dr Mark Skacel, Chair

I would first of all like to acknowledge our past ACT Chair, Dr Guy Buchanan, for his contribution over the last few years to regional and federal ASA affairs.

It is with great sadness that I report the death of our colleague Dr Thomas Lo, who died at the age of 47 after a short illness. Thomas made many wonderful contributions to ACT anaesthesia over his career and he will be greatly missed by his family, friends and colleagues.

In November last year, the ACT Registrars' Presentation night was held. Dr Elizabeth Merenda was awarded the Chairman's Prize for her presentation 'Audit of emergency appendicectomy outcomes '.

Drs Carmel McInerney and Girish Palnitkar were joint convenors for the local ACT Art of Anaesthesia meeting, held on the weekend of 14 March. The theme of the meeting was 'Great expectations: but can we deliver?', with Sunday morning workshops on the topics of 'can't intubate, can't oxygenate' scenarios and advanced life support. The scientific program proved comprehensive, with a variety of topics covered, including anaphylaxis, thoracic echocardiography and obstetrics. Readers may note that committee discussion has been had about moving the Art of Anaesthesia meeting back to its original September date to coincide with the Floriade flower festival.

On the political front, local debate has focused around ACT Health's contract to move all public orthopaedic joint replacements from The Canberra Hospital to the private Calvary John James Hospital. Issues that have arisen from this include the effect on registrar training and safety concerns for ASA score 3 and 4 patients. Is it acceptable to operate on a patient with renal failure in a hospital with no renal replacement services? Obviously ACT Health and The Canberra Hospital think it is.

NEW SOUTH WALES COMMITTEE

Dr Michael Farr, Chair

Firstly, the members of the ASA NSW Committee wish to extend our best wishes to our ASA NSW members and friends in the hope of a rewarding 2015.

Industrial and Workplace Issues

Whilst there are numerous ongoing industrial and workplace issues that the ASA attempts to keep abreast of, the NSW Committee would like to direct our members' attention to two specific recent issues of note in the state.

The first began as a VMO dispute at a public hospital in rural NSW. In short, the hospital had approached the AMA and Ministry of Health to request endorsement of a uniquely proposed plan to prevent payment of the 25% after-hours on-call loading, in certain circumstances, to its VMO anaesthetists. Following consideration, this proposal did not appear to be acceptable to members of our NSW Committee. The AMA was approached and endorsement of the proposal was revoked shortly thereafter, however, the issue has not yet been completely resolved. The ASA continues to watch this matter evolve, as it appears the Ministry of Health is also considering re-examining and perhaps redefining what constitutes appropriate after-hours and/or call-back rates in public hospitals in NSW.

The second issue was addressed in a dedicated email to our NSW members dated 19 January 2015, referring to a 2.27% increased payment for services for NSW public VMO anaesthetists from 1 July 2014. This had been negotiated in the Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2014. The determination can be readily accessed online. In January this year, a member of our NSW Committee discovered that this 2.27% increase (which applies to all sessional rates and loadings) had not yet been passed on to VMOs. The AMA NSW was alerted to this apparent disparity. A request for clarification was sought from Andrew Took (Director, Medico-Legal and Employment Relations, AMA NSW). Very soon thereafter, NSW Health provided confirmation and assurance of an imminent back-pay from 1 July 2014. Of note, although discovered by our ASA NSW Committee, this ruling applies not solely to VMO anaesthetists, but to all sessional VMOs in public hospitals across the state.

GASACT

We wish to congratulate and welcome Dr Ben Piper from NSW, who has been

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named as the new National GASACT Chair. The NSW ASA has also emailed our GASACT members seeking expressions of interest regarding taking over the role as NSW GASACT Chair. For more information, please contact Sue Donovan at sdonovan@asa.org.au.

Lastly, what I believe was our best ASA Part 3 course to date was held on Saturday, 29 November 2014 at the Swissotel in Sydney's CBD. This annual event for all registrars was primarily convened by Dr Callum Gilchrist (member of our NSW Economics Advisory Committee). With many thanks, he was also supported by some excellent speakers. A social event followed. The day was well attended and the resultant feedback was very encouraging.

TASMANIAN COMMITTEE

Dr Michael Challis, Chair

Earlier we held our very successful Tasmanian combined ASA/ANZCA Annual Scientific Meeting – 'Optimising Perioperative Outcomes: Science to Bedside'. Hobart turned on the weather for the record number of delegates, which included a record interstate contingent and several people from New Zealand. We had a very successful Trainee Day on the Friday and the registrars (including several from interstate) were lucky to hear from the two keynote speakers for the main conference – Professors Daniel Sessler (Cleveland Clinic) and David Story (University of Melbourne). They also enjoyed some simulation-based training covering 'Can't Intubate, Can't Oxygenate' situations, as well as advanced life support and paediatric resuscitation. The main conference kicked off with drinks on the waterfront on Friday evening. Over the next two days, the conference provided many opportunities for delegates to listen to world-class speakers discuss many things related to perioperative medicine. There were also several workshops covering difficult airway management (with cadaver-based skills stations and 'Can't Intubate, Can't Oxygenate' scenarios) and anaphylaxis, both providing opportunities for delegates to earn category 3 CPD points. Feedback has been fantastic and I wish to thank the organising committee, particularly the convenor, Dr Peter Wright, for putting on a first-rate conference and helping to showcase Tasmania to our visitors.

Planning is well under way for our one-day winter CME meeting, which will again be held at Freycinet National Park on Saturday, 29 August. The meeting will focus on the intellectual and interpersonal side of anaesthetic practice. There will be opportunity for registrants to participate in the popular 'Key 2 Me' workshop, or alternatively an ANZCA-recognised advanced life support refresher course. We hope that interstate people will take the opportunity to join us in this pristine part of the world and earn some CPD points at the same time.

On the industrial front there has been a successful outcome in relation to the Salaried Medical Practitioner's Award. The President of the Tasmanian Industrial Commission has issued his decision, which the government has publicly accepted. The President agreed with the majority of improvements put forward by the AMA Tasmania negotiating team. I want to thank the team for the extraordinary amount of work that went into the process and congratulate them on achieving a good outcome for all Tasmanian salaried medical practitioners. The finer details and implementation are in the process of being negotiated, but hopefully will be finalised soon.

As a side note, at our recent AGM the Committee was re-elected unopposed and I will continue as State Chair for another year.

WESTERN AUSTRALIAN COMMITTEE

Dr Ralph Longhorn, Immediate Past Chair

The Fiona Stanley Hospital is now in operation. Elective surgery in selective services has been taking place for several weeks and the emergency department will have opened by the time of publication. At the same time, the Fremantle hospital emergency department will close.

An enthusiastic department of anaesthetists are working their way through the many problems of opening a new hospital and should be congratulated on their efforts to make Fiona Stanley a great place to work, be trained and, not least, be a patient.

The Winter Annual Scientific Meeting was held on 14 March 2015 with the theme 'What's Hot'. This was an interesting day, featuring sessions on malignant hyperthermia and total intravenous anaesthesia. We welcomed Dr Andrew Davidson as our interstate speaker. The meeting was convened by the tireless Dr Lip Ng.

Perth also hosted the ASURA recently. This was an excellent event and the convenors did a wonderful job of combining sound theoretical and practical training in regional anaesthesia for all levels of participants with various crises management workshops. This provided great value for money and time for participants in their pursuit of CPD points.

We once again held a popular and informative Part 3 course at the end of last year, at which particular emphasis was placed on setting up practice in a tightening job market. Around the same time, GASACT held a Part 0 course, which was also well attended.

At our Annual General Meeting in March, Dr David Borshoff took over as WA State Chair.

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INSIDE YOUR SOCIETY

DR THOMAS LO 1967–2014

This obituary has also appeared in the March edition of the *ANZCA Bulletin*

Family, friends and colleagues were deeply saddened by the recent death of Canberra anaesthetist, Dr Thomas Lo, aged 47. He will be missed by many.

Thomas was born in Hong Kong on 30 September 1967, the eldest of three brothers. His parents, Dickson and Susannah, migrated to Australia with the family in 1974, settling in Canberra. Thomas undertook his primary and secondary education at Higgins Primary School, Ginninderra High and Hawker College, being named Dux of the school at the latter two. Thomas went on to attend the University of Sydney between 1986 and 1991, where he also excelled academically, graduating with an MBBS with First Class Honours. After graduation, Thomas completed an internship and residency at The Canberra (then Woden Valley) Hospital, followed by anaesthetic and intensive care training in Newcastle, Canberra and the Gold Coast.

Whilst Thomas worked and trained interstate at various times, the vast majority of his life and professional career was spent in Canberra. One of the first anaesthetic registrars to train predominantly in the ACT, he proudly identified as a 'Canberra boy' and never seriously entertained working anywhere else in the longer-term.

Thomas commenced his consultant career in Canberra in 2002, as a Visiting Medical Officer at The Canberra and Calvary Hospitals, as well as numerous private hospitals and day surgeries across the ACT. In 2003, Thomas became one of the founding members of ACT Anaesthesia, a group private anaesthetic practice in Canberra. His quiet determination, attention to detail, practical problem-solving abilities and generosity to fellow anaesthetists and staff members alike resulted in him becoming known as 'The Practice Whisperer'.

Thomas was a superb clinical anaesthetist, much respected and admired by patients, surgeons and his anaesthetic colleagues. He was extremely efficient in his work, kind and compassionate to his patients, procedurally gifted and always available to help a colleague in need. He could move effortlessly between hospitals and subspecialties at will. His humble and good-humoured manner seemed to rub off onto those around him. He always rose above the petty rivalries and politics that sometimes creep into the work environment. Even-tempered, yet firm when he needed to be, Thomas could calmly work through a long and busy list, all the while maintaining good cheer and meticulous attention to detail, and then be home in time to read a bedtime story or help his girls with their homework.

Thomas also applied his considerable knowledge and skill to many non-clinical aspects of anaesthesia. He was always willing to pitch in where required, whether it be contributing to a session at a conference, sitting on a regional committee or teaching trainees. Aptly, the weekend before being hospitalised (his illness rapidly progressing) was spent teaching the local registrars at a simulation course.

Family and friends were always extremely important to Thomas. He met Vivienne while working in Newcastle in 1995, marrying her in 1999, and their beloved daughters Camille and Genevieve were born in 2001 and 2003, respectively. They were always his main priority and the greatest tragedy of his premature passing is the future he won't be able to share with them.

Thomas was also someone who always kept his work-life balance in good stead. Though devoted to his young family, other passions of golf, skiing, computing and nice (preferably German) cars were also entertained. He relished a night out with friends and colleagues, a drink or two (never to excess) and was always ready to don a fancy-dress costume. A very accomplished photographer, many people benefited from his artistic eye behind the lens, whether at social functions, school concerts or as the club-sanctioned photographer for his girls' soccer team. Always an incredibly hard worker, he continued working right up until the time his advancing illness required his admission to hospital. He confronted his rapidly worsening health, with its initial uncertain diagnosis and eventual cruel prognosis, with his characteristic dignity and seemed more concerned about the effects it was having on those around him than on himself.

Thomas passed away peacefully on 19 November, 2014 in Canberra. He touched many people's lives and his kindness, dedication and generosity will live on in many ways. He will be sadly missed by Vivienne, Camille and Genevieve, his parents, his brothers Wilson and Alan and their families, as well as by his many friends and colleagues in the wider medical community.

Vale Thomas

Phil Morrissey, FANZCA

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from December 2014 to March 2015.

TRAINEE MEMBERS

Dr Natalie Akl	WA
Dr Brian Ambrose	SA
Dr Lucas Bailey	QLD
Dr Lisa Biggs	SA
Dr Sophie Bradshaw	SA
Dr Maya Calvert	WA
Dr Andrew Herbert Emanuel	NSW
Dr Jonathon Fanning	QLD
Dr Martha Ghaly	NSW
Dr Julia Hoy	ACT
Dr Ryan Patrick Hughes	TAS
Dr Jodie Jamieson	WA
Dr Carl Lee	WA
Dr Luke John McConnell	NSW
Dr Dennis Millard	WA
Dr Desiree Vanguardia Perez	QLD
Dr Joanne Darleena Samuel	TAS
Dr Adelaide Denise Schumann	SA
Dr Archana Chandrashekar Shrivathsa	WA
Dr Amanda Jane Taylor	NSW
Dr James Robert Tester	NSW
Dr Steven Robert Wilson	SA

ORDINARY MEMBERS

Dr Rachel Di Lernia	SA
Dr Candy Skye Edwards	VIC
Dr Joseph Isac	VIC
Dr Kylie Jean Ravenscroft King	NSW
Dr Christopher Leech	WA
Dr Shailesh Murty	VIC
Dr Yoon Leng Ooi	NSW
Dr Grace Mei Ling Seow	VIC
Dr Rafik Monir Nessim Zakharious	NSW

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Drs Thomas Lo (ACT), Gregory Paul Wotherspoon (NSW) and Robert John Brooks (SA).

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

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UPCOMING EVENTS

JUNE 2015

2015 National Blood Symposium: showcasing excellence - standard 7: blood and blood product

Date: 11 to 12 June 2015

Venue: Brisbane Convention and Exhibition Centre, Brisbane, Queensland

Contact: contact@blood.gov.au

Website: www.blood.gov.au/events

NSW Winter CME Conference

Date: 13 June 2015

Venue: Sydney Hilton, Sydney, New South Wales

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

History of Medicine Conference 2015

Date: 30 June to 04 July 2015

Venue: Australian Catholic University, North Sydney, New South Wales

Contact: hom2015@dcconferences.com.au

Website: www.dcconferences.com.au/hom2015/

JULY 2015

Rural SIG meeting

Date: 03 to 05 July 2015

Venue: Hilton, Darwin, Northern Territory

Contact: Elodie Garcia, ANZCA, egarcia@anzca.edu.au

Cardiothoracic, Vascular & Perfusion SIG Meeting

Date: 05 to 08 July 2015

Venue: Cradle Mountain Hotel, Cradle Mountain, Tasmania

Contact: Fran Lalor, ANZCA, flalor@anzca.edu.au

SEPTEMBER 2015

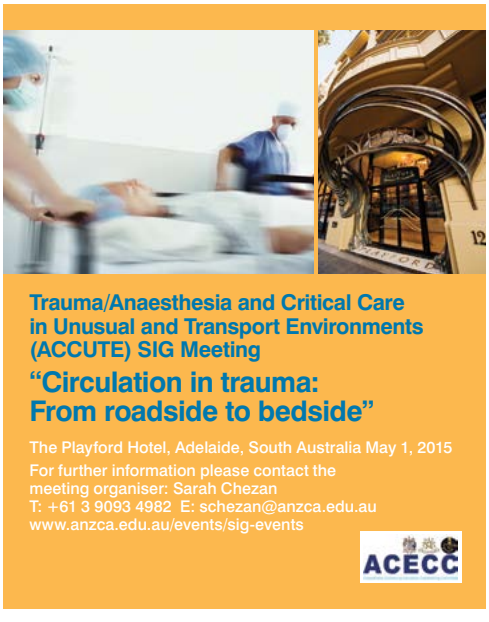
ASA & NZSA 2015 Combined Scientific Congress

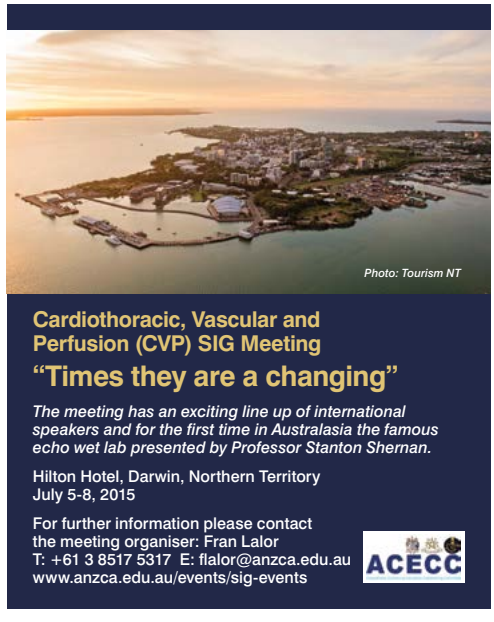
Date: 12 to 15 September 2015

Venue: Dawrin Convention Centre, Darwin, Northern Territory

Contact: Alaina Koroday, ASA, events@asa.org.au

Website: www.csc2015.com





The 12th Annual Combined Communication, Education, Management and Welfare SIG Meeting

Date: 25 to 27 September 2015

Venue: Outrigger Little Hastings Street Resort and Spa, Noosa Heads, Queensland

Contact: Alexis Marsh, ANZCA, events@anzca.edu.au

OCTOBER 2015

The 4th Annual Australasian Symposium of Perioperative Medicine

Date: 15 to 17 October 2015

Venue: Outrigger Little Hastings Street Resort and Spa, Noosa Heads, Queensland

Contact: Alexis Marsh, ANZCA, events@anzca.edu.au

Joint Airway Management and Obstetric Anaesthesia SIG Meeting

Date: 24 October 2015

Venue: ANZ Pavilion, Arts Centre, Melbourne, Victoria

Contact: Sarah Chezan, ANZCA, events@anzca.edu.au

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

ACECC
Anaesthesia Continuing Education Coordinating Committee

Australian Society of Anaesthetists Membership Achievements

Australia Day Honours
Member (AM) in the General Division of the Order of Australia

Associate Professor David Baines,
Dr Neil Street and
Dr Richard Willis
were awarded a Member (AM) in the General Division.

ASA 50-year membership:

Prof. Barrie Fairley
Dr George Jerogin
Dr Donald Runcie
Dr Jeanette Thirlwell
Dr Miriam Stocks
Dr William Power
Dr Kenneth Hales
Dr Richard Connock
Dr William Grey

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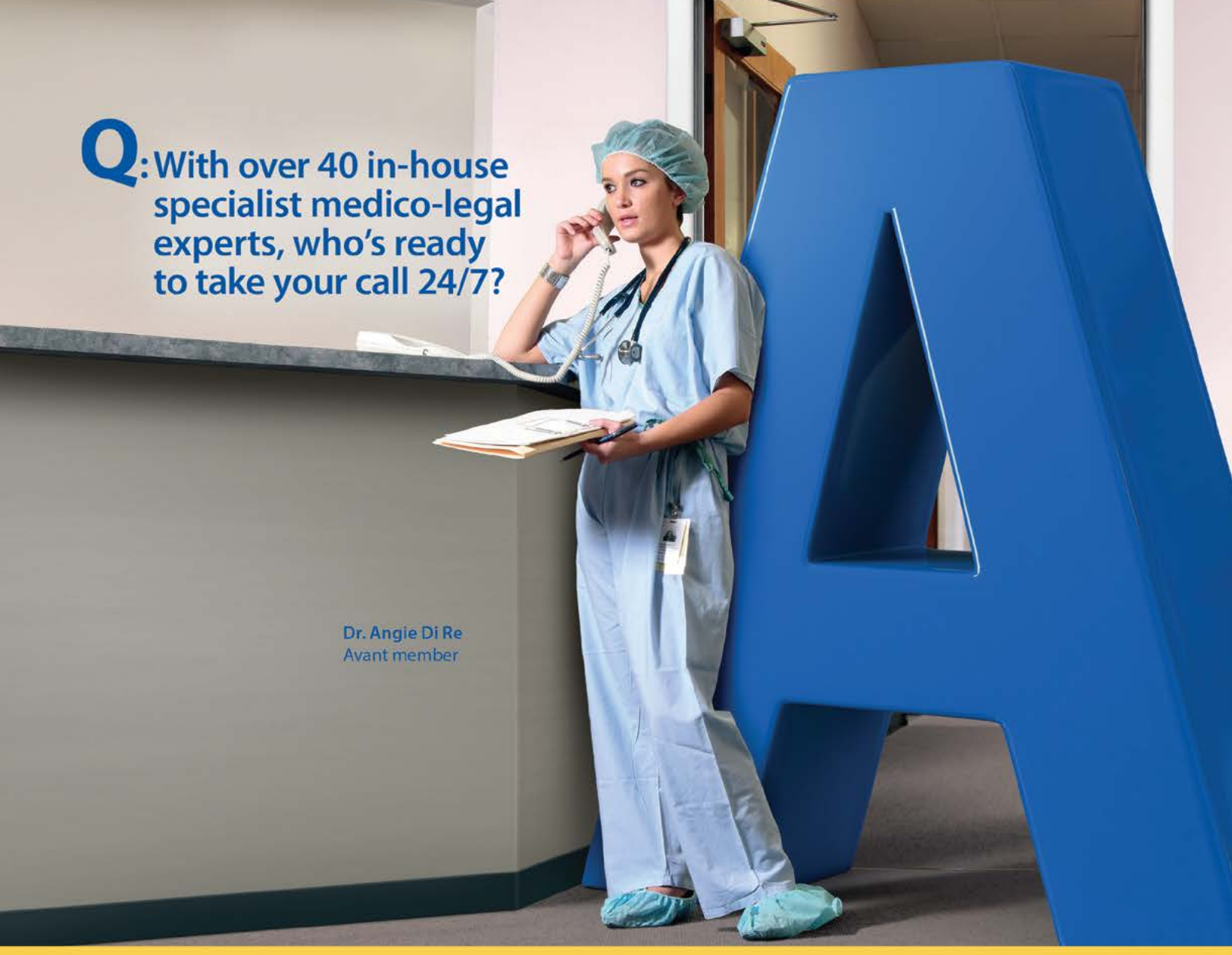

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