AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • AUGUST 2015

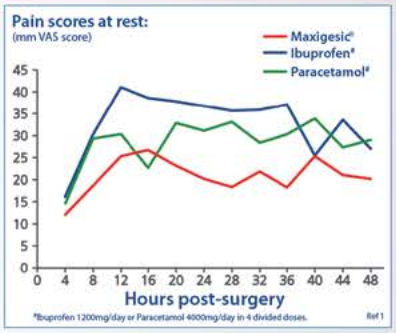
CSC 2015: What have the Invited Speakers got to say?

Hospital Safety: the discussion continues

Perioperative medicine

ASA
Australian Society of Anaesthetists

MAKE THE SWITCH TO MAXIGESIC®



PROVEN EFFECTIVENESS IN DENTAL STUDIES

Clinically proven to **reduce pain levels by at least 32% more** than a **full daily OTC dose** of either Paracetamol or Ibuprofen alone.[1]

DELIVERS MAXIMUM DOSAGE

MAXIGESIC® is the **only combination analgesic** that delivers the **maximum recommended daily OTC dose** of Paracetamol 4000mg and Ibuprofen 1200mg, if required.*

SIMPLE, FLEXIBLE DOSAGE REGIMEN

1–2 tablets up to 4 times per day, if required, offers **flexibility and control** in managing daily pain.

* 2 tablets of MAXIGESIC® taken every 6 hours over a 24 hour period

Please review the full Product Information before recommending at **www.maxigesic.com.au**

HARTLEY ATKINSON, Pharmacologist and Inventor of MAXIGESIC®

DOUBLE ACTION PAIN RELIEF WITHOUT CODEINE

References: 1. Merry, A. F., Gibbs, R. D., Edwards, J., Ting, G. S., Frampton, C., Davies, E. and Anderson, B. J. (2010). "Combined acetaminophen and ibuprofen for pain relief after oral surgery in adults: a randomized controlled trial" British Journal of Anaesthesia 104(1): 80-88. Result achieved in a trial of post-operative pain relief after removal of 1–4 wisdom teeth using Maxigesic® compared with Paracetamol 4000mg or Ibuprofen 1200mg alone per day in four divided doses.

Maxigesic® film coated tablets (Paracetamol 500mg and Ibuprofen 150mg; 10s, 16s and 30s) are a Pharmacist Only (S3) Medicine for the temporary relief of pain and reduction of fever. The usual dosage for Adults and Children over 12 years is 1-2 tablets taken every 6 hours with a full glass of water, as required, up to a maximum of 8 tablets in 24 hours. Patients should not take more than 8 tablets in a 24 hour period. Incorrect use can be harmful. Do not use in children under 12 years or if patients have kidney disease. Do not use if patients have asthma or a stomach ulcer. Do not combine with any other Paracetamol or Ibuprofen containing medicines. Patent No. 2005260243.

AFT Pharmaceuticals Pty Ltd | Sydney | ABN 29105636413 | **WEBSITE** www.aftpharm.com
FREE PHONE 1800 2387 4276 | **FREE FAX** 1800 041 026 | **EMAIL** customer.service@aftpharm.com

AFT pharmaceuticals
Working to improve your health

AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

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

Letters to *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.

Contact us:
Australian Society of Anaesthetists, PO Box 6278
North Sydney NSW 2059, Australia.
T: 02 8556 9700
F: 02 8556 9750
E: asa@asa.org.au
W: www.asa.org.au

Printed by:
Ligare Book Printers Pty Ltd

ASA
Australian Society of Anaesthetists

REGULARS

FEATURES

10 RESPONSE TO 'HOSPITAL SAFETY'

LIFESTYLE

INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The December issue of *Australian Anaesthetist* will be with members prior to Christmas. 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 September 2015.
- Final article is due no later than 12 October 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

In its most recent health-related publication, *Efficiency in Health*, released April 2015, the Productivity Commission, has made several recommendations in relation to workforce issues, writes ASA President, Dr Guy Christie-Taylor.

It proposes that state and territory ministers initiate role expansions, based on evaluations of past and current trials, and amend scopes of practice accordingly, and that the Federal Minister for Health identify where there would be benefits in expanding the types of health professionals that can access reimbursement for the MBS as well as promoting workforce reforms at the national level.

The purported benefits for these reforms include:

1. Greater workforce flexibility
2. Potentially lower labour costs
3. Better patient access
4. Higher workforce satisfaction

At a legislative level, there seems to be an appetite for job substitution and expanded scopes of practice and nowhere is this better illustrated than in Bill H.R.1247.

Mr Sam Graves, a Republican Congressman from Missouri, introduced this Bill into the US House of Representatives on 4 March 2015.

The underlying motivation for this Bill is to potentially improve access to healthcare services in rural Missouri.

SO, WHAT IS BILL H.R.1247…

…and why is an obscure piece of legislation introduced into a foreign parliament relevant to an anaesthetist in Australia?

The legislation states:

> *(a) IN GENERAL. – Notwithstanding any provision of law of a State, the Secretary of Veterans Affairs may authorise a covered nurse to practice to the full scope of the nurse's practice, as defined by the applicable national professional association, under a set of privileges approved by the Secretary, regardless of the State in which the nurse is employed by the Secretary*

The covered nurses are advanced-practice nurses, including:

1. Nurse midwives
2. Clinical nurse specialists
3. Nurse practitioners
4. Certified registered nurse anaesthetists

The set of privileges under which the nursing workforce will operate within the Veterans Heath Administration (VHA) are being rewritten in a draft policy document from the Office of Nursing Services – the 'Nursing Handbook'.

The new policy would abandon consensus team-based care and require all Advanced Practice Registered Nurses (APRN), including nurse anaesthetists, to practice solo – without physician oversight, supervision or direction – in all states and in all VHA facilities regardless of state nursing licensure or the type of patients receiving care at the facility.

What, then, are the implications for patient safety and quality of care for Veterans in the US?

According to the American Society of Anesthesiologists, if implemented as proposed, the new policy would fundamentally change how healthcare services are delivered in the VA health system;,especially those receiving care in the surgical/anaesthesia setting. Specifically, the policy would abolish team-based care delivery – a key principle of anaesthesia care – within the VA.

The American Association of Nurse Anesthetists (AAN) have commenced a public-awareness campaign to educate key audiences about the role and value of CRNAs. The campaign features a website, www.future-of-anesthesia-care-today.com, and the mantra is that CRNAs are the future of anaesthesia care today.

The American Society of Anesthesiologists has countered with its own political advocacy campaign – "When seconds count, Physician Anesthesiologists save lives" (www.asahq.org).

Many of you would be aware of the ongoing, and at times difficult, relationship between CRNAs and Physician Anesthesiologists in the US and of the relentless efforts of the CRNAs to achieve independent practice and to move out from under the control and supervision of physicians.

Similarly in Australia, clinical perfusionists have advocated strongly for changes to their status, with a desire for fully independent practice and access to Medicare funding. Their recent political advocacy campaign has resulted in a change to the Medicare Schedule; they have not been given access to the Schedule, but the requirements for payments to medical perfusionists have become more stringent.

In New Zealand, there is ongoing debate about the roles and relative value of the anaesthetic nurse versus the anaesthetic technician and how these two entities will practice within the anaesthetic space.

Queensland Health has embraced the notion of the nurse endoscopist and a similar program is under consideration in NZ, and of course, the pharmacists continue to relentlessly look for ways to increase the scope and extent of their practice.

SO HOW TO RESPOND?

Perverse as it might seem, I think we should be advocating for our nursing colleagues. The failure of basic nursing care is highlighted in the Frances Report following the Mid-Staffordshire inquiry. In the Executive Summary of his report, Robert Frances QC states that one of the key aims of his recommendations is to:

> *Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.*

Nursing **care** is an absolutely fundamental plank of our healthcare system. Providing that **care** is often hard work – hard on your feet, hard on your back and hard on your heart. We should never permit that role to be demeaned nor diminished and, in fact, we should be advocating that it is rightly and appropriately rewarded (and in particular, financially). Lowering the acceptable standards for nursing entry and labelling it as a simple set of competencies that mainly involve "beds and backs" is a dreadful misrepresentation of what it involves and risks undermining the **care** that we expect and often take for granted.

It should not be necessary for a nurse to move from care to diagnosis and cure to be valued.

We need to ensure that what we do is of the highest standard, is maintained to that standard over the full extent of our working lives, adds value to and enhances the productivity of any entity in which we carry out our professional activities, maintains a team-based focus that values all our colleagues, never loses sight of our fundamental focus on patient safety, and makes full use of all the facets derived from our comprehensive education and training as doctors.

Associate Professor Peter Hill, writing in the *Weekend Australian Review*, makes the following observation: "After all, the word 'doctor' really means teacher – from the Latin *docere* – which Cicero defined as 'providing truth through evidence and argument'".

Therefore, the challenge is for us to provide "evidence and argument" and to ensure that the potentially profound disruption to the health workforce as envisaged by bills such as H.R.1247 does in fact *not* drive up cost, reduce access to care, lower standards and safety, drive further fragmentation and 'specialisation', divide and disrupt team-based models of care, exacerbate inter-professional rivalries and provide fertile ground for other agencies i.e. government and insurers to provide 'solutions'.

The fundamental relationship within healthcare still remains that between the doctor and the patient. The reasonable expectation from the patient is thus that we are intimately involved in all aspects of their care including the provision of the best-possible workforce structure by which their **care** is delivered.

The other fundamental principle underpinning the Society's position and policies is that anaesthesia, in all its subtlety and complexity, is a medical act.

Supporting our GP colleagues who provide high-quality anaesthesia services in areas that are rural and remote is crucial to ensuring the ongoing provision of these services. Engaging in debate and discussion about the often-difficult and complex matter of rural, remote and regional service delivery is crucial to ensuring an equitable allocation of resources to all Australians. The ASA must ensure, as the AMA has recently done, that due resource and recognition is give to our members who provide service in the rural environment.

We cannot rest on our laurels or give in to complacency, what we do is of absolutely fundamental value to our community and stakeholders; we are however, obliged to continually demonstrate that value and continue to add to it.

CONTACT

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

REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

Arriving in Washington D.C. is to come face-to-face with the engine that runs the America we know today, writes ASA CEO, Mark Carmichael. To see such landmarks as the White House, Capitol Hill and the World Bank is to be reminded that this is the seat of political 'power' within the United States.

Having the opportunity to be shown around the Mall serves to reinforce the message that many influential and intelligent individuals have shaped both the US and the rest of the world. To see the monument to Thomas Jefferson and to read his Declaration of Independence, to visit the Lincoln Memorial and read his Gettysburg Address, all 72 words of it, to stand where Martin Luther King addressed the crowds during the Freedom Rallies in the early '60s, makes you realise that many important decisions and events occurred within this city, the repercussions of which are still being felt today.

And so this was the backdrop for the 2015 Common Issues Group Meeting. This year, hosted by our American colleagues, the meeting brings together the anaesthetic leaders of the Societies from Great Britain and Ireland, the US, Canada, as well as our South African and New Zealand colleagues. President, Dr Guy Christie-Taylor, Vice President, Dr David M Scott, past President, Dr Richard Grutzner, and I represented the ASA. Staged over three days, the meeting provided a forum for all member societies to share their concerns and knowledge and learn from the experiences that being an anaesthetist presents within each of the jurisdictions represented.

At the meeting in Tasmania in 2012, which was hosted by the ASA, the then Canadian Society President, Dr Patricia Houston, posed the rhetorical question, "why are we here?" The answer to this has become more and more apparent over the intervening years and was reinforced at the Washington meeting. In 2012, Dr Houston was looking for tangible outcomes from the meeting, and the subsequent meetings in Banff, London and Washington have certainly delivered those.

Arising from the Washington meeting was the undertaking that the various societies would take carriage of particular issues, with each member feeding back to the "Issue Parent" so as to form a world view on how certain issues are managed or unfolding. Ideally, this will lead to a greater pool of knowledge which can be accessed easily.

So what are those issues? The first is the welfare of the anaesthetist. This is a topic that all attendees recognised as critical to the profession. The AAGBI has completed a significant body of work in this area, and volunteered to be the "Parent" for this issue. They also agreed to be the home for the issue of "Aid Metrics". This is the concept of evaluating the impact of the foreign aid initiatives that they deliver, most often in Africa. In a different direction, our American colleagues are struggling with the very real issue of nurse anaesthetists, and how they may impact on the anaesthetic profession in the longer term. As a consequence, they will be most active in keeping members informed of developments in this area. A second key issue for the American Society is the Perioperative Surgical Home (PSH), one of the leading initiatives of their strategic plan on Developing Care Models. The American Society developed the PSH learning collaborative in 2014, which includes 44 participating healthcare organisations, with pilot projects in orthopaedics, total joint replacement, urological procedures, bariatric procedures, paediatric spine and tonsil procedures. The American Society of Anesthesiologists is beginning the data-collection phase for those groups who have launched a pilot – the current collaborative group ends in November 2015. At present, plans call for development of additional resources to assist anaesthetists in learning about the model, developing the model in their own organisation and, potentially, to lead in a certification process for PSHs. The American Society agreed that it would keep all members informed of developments within this area. From the Australian perspective, we agreed to take on the issue of "Exceptional Circumstances", specifically the question

of when anaesthetists can leave the theatre. ASA President, Dr Guy Christie-Taylor, put forth this topic during the meeting and it was apparent that no one had a simple answer. As a consequence, the ASA has agreed to provide whatever information it can for consideration and further discussion at the 2016 meeting.

The CIG will serve as a key building block for anaesthetic issues far outside of our borders. At the same time, we must not forget our local activities, in particular the upcoming 2015 Combined Scientific Congress, to be staged in Darwin in conjunction with the New Zealand Society, from 12 to 15 September, and under the direction of Convenor, Dr Piers Robertson. The Congress offers a wonderful educational and social program, which I am sure many of you will take advantage of. I certainly look forward to seeing you there.

CONTACT

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

WE WANT TO HEAR FROM YOU!

WRITE TO *AUSTRALIAN ANAESTHETIST*

We would love to hear your feedback on our magazine and its content.

All letters are welcomed and will be considered for publication.

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.

HAVE YOU GOT A TIP OR TRICK TO SHARE?

Sharing is caring! Have you got a clever way of doing something? Perhaps a different approach to a common practice?

Share your knowledge in no more than 300 words. If you think a picture or diagram will help explain, please 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.

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.

REGULAR

THE PRESIDENT'S TOUR

COMMON ISSUES GROUP MEETING AND US LEGISLATIVE CONFERENCE WASHINGTON D.C., MAY 2015

In May, ASA representatives Drs Guy Christie-Taylor, David Scott and Richard Grutzner, as well as CEO, Mark Carmichael, were welcomed by the American Society of Anesthesiologists at the Hay-Adams Hotel, Washington D.C. for the CIG meeting and ASA (USA) Legislative Conference.

COMMON ISSUES GROUP MEETING

The aim of the Conference was to address the gross disparities in access to safe, essential surgical care worldwide and the alarming lack of global focus on the widespread provision of quality surgical services.

Welfare of anaesthetists was, again, a key issue, with particular focus on the matters of substance abuse and suicide which were discussed at great length. It is the intention of the CIG to continue to share information and ideas regarding these issues, to assist each other in formulating strategies to manage them on an ongoing basis.

It was again made clear that, as in Australia, workforce issues are an ongoing matter globally. South Africa stood out as a country with a critical short supply of anaesthetists, but for the rest, there seemed to be a reasonable balance, with the usual ongoing intractable problems of maldistribution in more regional and remote areas. In the USA, as in Australia, there appears to be a growing and increasingly pressing issue with the increase in numbers of medical students failing to obtain intern positions.

The ASA raised the matter of the definition of the 'exceptional circumstances' under which it is reasonable for an anaesthetist to delegate care of the anaesthetised patient. We also discussed the matter of what state the patient must be in to be safely handed over in recovery. This led to much discussion and it was agreed that statements and guidelines would remain flexible but the AAGBI intends to adopt the issue for debate and to progress it further. It is our intention to remain very engaged in this debate and to clarify our position as far as reasonable and in keeping with our international partners.

Models of perioperative care were discussed with considerable interest generated about the American concept of the 'Perioperative Surgical Home'. It is important to understand the context in which different models of care are created. In the US, the recent repeal of the Medicare Physician Fee Schedule Sustainable Growth Rate (SGR) formula will result in alternative payment models – the new payment structure – a new structure built around programs known as the 'Merit-Based Incentive Payment System', or MIPS program, and the 'Alternative Payment Model' (APM) program.

The 'Perioperative Surgical Home' concept might just be the perfect model for an APM program.

So, in advancing our specialty, it is important that we understand any new model of care in the context of the economic and political structure in which it's evolve.

There is no doubt that emphasising the wider physician role of the anaesthetist is a crucial element in maintaining and advancing our specialty in the face of ongoing and relentless challenges from alternative providers and to demonstrate additional value and productivity.

Essential drug shortages continue to remain a problem, with variable penetrance within each country. The Government Accountability Office in the US recently undertook an investigation of the issue and its conclusion indicates some of the complexities in addressing the matter:

> *DEA should take five actions to improve its management of the quota process; DEA and FDA should quickly update their MOU and agree on steps each will take regarding drug shortages. HHS agreed with the applicable recommendations. DEA neither agreed nor disagreed, but raised multiple objections to this report.*

The AAGBI has successfully put together a National Essential Anaesthetic Drug List (NEADL) which could form the basis for any other country's endeavor to draw up a similar list.

Sedation by non-anaesthetists was, again, raised and it is apparent that regional practice variation and regulation are important to this process. There was acknowledgement of the difficulties in defining the various levels of sedation and it was indeed challenging to arrive at a broad consensus on definitions or practice models.

The 'Smart Tots' initiative and anaesthetic neurotoxicity was put forward and it seems that progress of this important work is dependent on ongoing research funding.

The AAGBI was keen to find organisations willing to assist in lobbying for the manufacture of 0.5% chlorhexidine with alcohol for skin preparation. They are certain that the lower concentration is as efficacious as a 1% or 2% formula but reduces the risk posed by inadvertent impregnation.

The American Board of Anesthesiology (ABA) has launched its new version of Maintenance of Certification in Anesthesiology (MOCA) and has a very novel concept called MOCA Minute.

> *The MOCA Minute application, an interactive learning tool that we began piloting in 2014, will replace the MOCA Examination as the Board's MOC Part 3: Assessment of Knowledge, Judgment, and Skills.* You may learn more about the MOCA Minute application in the 2015 edition of ABA News.

Instead of administering a single examination, the Board will issue an MCQ each week for completion, together with a model answer.

The Nursing Handbook

The key problem occupying the minds and attention of the American society at this time, and the pivotal advocacy issue it will raise at its Legislative Conference, is the apparently benign matter of the Veterans Affairs Nursing Handbook.

The Nursing Handbook is a proposed document that the VHA has been working on for the past several years to centralise, modernise and improve regulations.

The proposals within the Handbook would recognise the Full Practice Authority (FPA) of all advanced practice registered nurses (APRNs) including CRNAs working in the VHA healthcare system.

There are currently two pieces of legislation that address the FPA of APRNs in the VHA. In particular is H.R.1247, sponsored by Representative Sam Graves (R-MO) and Jan Schakowsky (D-IL), which allows nurses in all four APRN roles to assume their full practice authority.

The Senate S.297 'Frontlines to Lifelines Act', sponsored by Sen. Mark Kirk (R-IL), recognises only three of the four APRN specialities for full practice authority in the VHA *omitting* CRNAs.

The implications of such a profound change in the healthcare delivery team model are difficult to predict and will have many unintended consequences. There is no guarantee that this will either increase access to healthcare or that they will improve safety and quality and certainly no evidence that it will be cost-effective.

Such a change in the US will undoubtedly have worldwide ramifications, with this providing a strong impetus to accelerate job substitution and expanded scopes of practice.

The American Association of Nurse Anesthetists has a strong advocacy arm and is running a program entitled 'CRNAs: The Future of Anesthesia Care Today'.

The American Society of Anesthesiologists' response is similar, with a program entitled 'When seconds count. Physician Anesthesiologists Save Lives.'

LEGISLATIVE CONFERENCE

It was with pleasure that I attended this meeting on behalf of the Society, which is designed to prepare members to advocate with their representatives on Capitol Hill.

The three key issues for the meeting in 2015 were as follows:

1. Taking action to protect the nation's veterans
2. Improving rural health care access
3. Ensuring access to life-saving colonoscopy screenings

The first two days of the meeting included a series of workshops, panels and presentations by American Society office bearers as well as Congressmen and Senators.

The Hill visit briefing and the mock Hill visit presentation were by far the most valuable sessions.

One of the most urgent issues addressed by the conference was the Department of Veterans Affair's Office of Nursing Services Hand Book.

The approach and key message taken by the Americans was as follows:

> *This new policy document would abandon VA's proven mode of team-based anaesthesia care. The new policy would abandon the VAs proven model of physician led, team-based surgical anaesthesia care and replace it with a nurse –only model of care.*
>
> *Veterans receiving care within the VA are some of the sickest of patients. Many Veterans are older with multiple medical conditions, putting them at greater risk of complications during surgery. When an emergency or complication occurs and seconds count, Veterans deserve to have a physician anesthesiologist leading their care team.*
>
> *Independent peer-reviewed studies show patients have better outcomes when physicians are involved in the anaesthesia care.*
>
> *The VA Chiefs of Anaesthesiology, Veterans Service Organisations and a bipartisan group of more than 60 lawmakers have expressed concerns to the highest leadership levels the VA about the proposed policy change.*

I was very fortunate to accompany the Missouri Delegation to a variety of Senate, as well as Congressional, offices to meet with the Senators and their delegates and Congressional staffers.

It was reassuring to see how actively, thoughtfully and forcefully the American Society is tackling this very important issue.

There is a growing sense that the legislation supporting this new handbook might well fail to progress, but this is to a large extent dependent on the level of public comment that the legislation provokes when it is made available. It will be vital that the American Society of Anesthesiologists and its supporters have access to the mechanisms to make comment and avail themselves of these.

Dr Guy Christie-Taylor
ASA President

FEATURE

RESPONSE TO 'HOSPITAL SAFETY'

In the April edition of *Australian Anaesthetist*, we featured an article by Dr Drew Wenck, entitled 'Hospital Safety: is ACHS accredication the right path?'. Following the publication of Drew's article, we recieved a number of responses, both positive and critical. The ACSQHC and ACHS have formally responded to Drew's comments, featured below, and Drew has been given the opportunity to reply to them.

We hope that the following responses provide insight and clarity to an ongoing topic of conversation in the anaesthetic community.

Dr Sharon Tivey
Medical Editor

ACHS RESPONSE

I refer to the Feature article published in your journal (April 2015) titled 'Hospital Safety: Is ACHS Accreditation the Right Path'.

I wish to bring to members attention significant inaccuracies in the article and also note that, regardless of the ASA's caveat that the author's opinion is not representative of the ASA, I still expect a professional society to take the trouble to confirm, prior to printing, that at least some of the facts stated are correct – facts not opinions. I am uncertain as to whether the ASA adopts a peer review process prior to accepting an article for publication but, if it does not, I recommend this approach, as peer review methods are shown to maintain standards of quality and enhance the publications academic credibility.

FACT: The Australian Council on Healthcare Standards (ACHS) did not write, mandate or make compulsory the 10 National Standards. The author has confused ACHS with the Australian Commission on Safety and Quality in Health Care (ACSQHC).

FACT: The ACSQHC was created by Health Ministers in 2006, and funded by all governments on a cost sharing basis, to lead and coordinate healthcare safety and quality improvements in Australia. The National Standards were endorsed and mandated by Health Ministers from each jurisdiction. The jurisdictional Departments of Health are the regulators.

The ACSQHC has an ongoing program of significant national activity with outcomes that aim to demonstrate direct patient benefit as well as creating essential underpinnings for ongoing improvement.

FACT: Since its establishment in 1974 the ACHS has built an enviable reputation as an independent, not-for-profit organisation. For more than 40 years it has been dedicated to improving the quality of healthcare in Australia and internationally through standards development, review of organisational performance, accreditation surveys and thus, supporting healthcare services to continuously improve.

In 2005, following increasing international recognition as an authority on healthcare quality improvement systems, ACHS established ACHS International (ACHSI) as a wholly owned, subsidiary company of ACHS. In 2015, ACHSI is successfully exporting accreditation programs and education to 18 countries.

In response to specific issues raised in the article:

- A 'cramming' approach taken by hospitals prior to an accreditation survey.
  This may have been the approach adopted by the author prior to his anatomy finals and may well have been an approach adopted by health services in the past; however, the standards and the accreditation survey process used by ACHS seeks to ensure evidence of continuous improvement and ongoing effort. Cramming would be easily recognised by our experienced peer surveyors.
- The absence of any senior medical staff at the 'ACHS preliminary audit' and the inclusion of medical staff in the ACHS process.
  The 'preliminary audit' to which the author refers to was in fact an Advanced Completion (AC) review. This occurs as a follow-up review post an Organisation Wide Survey (OWS) where High Priority Recommendations need to be addressed within a 90-day period. Medical Staff were well represented throughout the OWS.
  The ACHS always includes medical staff in its accreditation processes. It also has significant medical representation on its Council, Board, Standards Committee and in the development and review of clinical indicators.
- Multiple check lists/data points.
  The standards do not mandate how an organisation chooses to demonstrate that the Standard has been met. The organisations clinical governance framework or quality plan will confirm the systems and processes to ensure safe care and discuss how these systems will be monitored so as to continuously improve. By way of example, if an organisation adopts the Surgical Safety Checklist (referred to by the author) which was developed by the World Health Organisation and endorsed by Australian Health Ministers in 2009, then the surveyors would look for evidence that there is compliance with this pro-

cess – i.e. how does the organisation know that it is being used, how well it is being used and whether any improvement is required.

There are many other issues that the author has referred to, including occupancy levels, NEAT (which, by the way, is not a financial target it is an access target – agreed to by clinician experts and has had incentive payments attached as per the National Partnership Agreement on Improving Public Hospital Services), Root Cause Analysis and MET. It appears the author's grievance here is predominantly with the organisation's prescribed auditing process. As per above, the volume and frequency of audits is determined by the healthcare organisation and not mandated by the ACHS or ACSQHC.

It is disappointing that the author even appears to challenge the recording of adverse blood and blood product reactions. This is despite global recognition regarding the need for effective haemovigilance and improvement of patient safety.

The ACHS has always had great respect for the views, opinions and feedback received from senior medical staff and all health professionals. Feedback is how we improve and if the author is correct in that 'clinicians view the standards with derision hence their disengagement' then we need to look at how we can turn these views around so that the standards are embraced as best representing the minimum level of care that we would expect of any health service for our families and friends.

Dr Christine Dennis

Chief Executive Officer, ACHS

DR DREW WENCK'S RESPONSE TO ACHS

In response to Dr Christine Dennis from ACHS

I clearly stated that the ACHS accredits hospitals to their adherence to the National Standards. This is in the first two sentences of my article. At the end of the second paragraph I did call them the ACHS standards. However, if you accredit hospitals to a standard, ipso facto you interpret that standard and define a passing mark. The fact that another body mandates them is not relevant to what happens at the hospital level. In the minds of the doctors and nurses, they become your standards. A poster published on the standards called the EQUIPNATIONAL Table clearly states these are the National Safety and Quality Health Service Standards but have the ACHS logo imbedded. Indeed the S in ACHS stands for 'Standards'! If you want to split hairs and ignore the major thrust of the argument then you have succeeded.

Dr Dennis also states that, since 1974, the ACHS has built an enviable reputation. I am sorry but that reputation has not reached the senior doctors that I know. Rather than self-praise, Dr Dennis needs to provide evidence that the hospitals the ACHS accredits have been made safer. The fact that the Emperor's clothes have been exported to other countries is not evidence.

The response to my charge of cramming is interesting. Let me quote directly from Dr Dennis's response "High Priority Recommendations need to be addressed within 90 days" This is what creates cramming. It is scrambling to cross the line on a particular standard in terms of documentation and process. There is a huge flurry of activity up to accreditation, if the standards were imbedded this would not occur. It would be business as usual. The accreditors are well aware of this, hence, at a preliminary meeting they stated "don't take your foot off the accelerator".

It is interesting that Dr Dennis thinks senior medical staff are included and engaged in ACHS accreditation. I challenge the ACHS to do an opinion survey focussing on senior doctors. I think it will show a lack of engagement and outright derision of the process.

Dr Dennis's comments on auditing are also interesting. To show compliance you must audit the results. To say that the ACHS doesn't mandate the frequency is again splitting hairs. The surveyors frequently state, when looking at audits, that they need to be more complete or of a greater frequency. The ACHS may not 'mandate' the audit but still requires them.

I must also protest to Dr Dennis's disappointment that I appear to challenge the value of recording of adverse blood reactions. Let me be clear. What I challenge is the recording of minor reactions and the inevitable creation of a huge database that no one has the time to interrogate. This was clearly stated "Standard 7… mandates all transfusion reactions must be audited". This just wastes everyone's time.

Dr Drew Wenck

VOICING OUR FUSTRATIONS

Thank you very much [Dr Wenck] for your article in the latest *Australian Anaesthetist* "Hospital Safety: Is ACHS accreditation the right path?".

You have summarised the frustration (bordering on contempt) for many of the obligations of accreditation with which we are burdened – all for little or no patient benefit. Lively discussion of many important issues around accreditation was stimulated in several hospitals in the ACT. I hope that was your intention.

Dr Vida Viliunas

Canberra, ACT

FEATURE

ACSQHC RESPONSE

The Australian Commission on Safety and Quality in Health Care (ACSQHC) writes in response to the opinion piece published in the April 2015 edition of Australian Anesthetist. The article reflects a number of misunderstandings about the National Safety and Quality Health Service (NSQHS) Standards and accreditation, which ACSQHC is anxious to correct.

The Commission was established as an independent statutory authority under the National Health Reform Act 2011 to lead and coordinate national improvements in the safety and quality of healthcare. As part of that role, ACSQHC, not the Australian Council on Healthcare Standards (ACHS), developed the 10 NSQHS Standards.

The NSQHS Standards are mandatory for all Australian public and private hospitals and day procedure services. Introduced in 2013, ACSQHC continues to support their use by developing and promoting resources that facilitate their implementation. The primary aim of the Standards is to protect the public from harm. Prior to their implementation, preventable adverse events occurred partly because safety standards and accreditation processes were inconsistent and inappropriate to support safe patient care. While inherently difficult to measure, the adverse event rate is estimated to be 8% to 12% of hospital separations: the Standards work to reduce that rate. The Standards represent the minimal clinical care required to improve patient safety: they are not arduous, but mandate routine care.

The ACHS is an independent, not-for-profit organisation which accredits health services and in their accreditation role acts as an agent of ACSQHC. The ACHS did not develop the 10 mandatory NSQHS Standards, but have developed five additional standards which remain voluntary in all states and territories, with the exception of Queensland and the Northern Territory which require 15 mandatory Standards.

The patient journey described by the author accurately depicts the data collection processes required to meet accreditation, but also, and more importantly, to enhance effective patient care. Recording patient notes for clinical handover is an example of basic patient care which the author criticises as arduous and time consuming. Prior to the Standards, handover processes were highly variable and unreliable. Breakdown in the transfer of information was a critical contributing factor in serious adverse events and a major preventable cause of harm.

Antibiotics prescribed to patients are recorded for the purpose of antimicrobial stewardship. These records are used by healthcare institutions to reduce the inappropriate use of antimicrobials, improve patient outcomes and reduce adverse consequences, including antimicrobial resistance, toxicity and unnecessary costs. Along with infection control, hand hygiene and surveillance activities, it is a key strategy in local and national programs to prevent antimicrobial resistance. These programs have also been shown to reduce morbidity and mortality and healthcare costs.

Other data collected during the patient journey captures information critical to individual patient care, but also drives learning and improvement at the local facility level. The investigation of SAC 1 & 2 incidents through Root Cause Analyses (RCA) is conducted for medicolegal reasons and to ensure that health services continue to improve and learn from mistakes. The National Emergency Access Target (NEAT), as detailed by the author, is not data required by the Standards, but is a benchmark set by government to measure and compare hospital performance.

The alternate 'system' to achieve better patient care put forward by the author is largely concerned with hospital resources and local management. Resourcing issues such as the unavailability of beds in appropriate wards and nurse shortages should be raised with hospital administration. Of course, ACSQHC recognises that the proper resourcing of health services is important. However, while resourcing remains a challenge, issues of safety and quality should not be deprioritised.

The issue of 'cramming', as raised by the author, is concerning. However, cramming is not an indication that the Standards are too arduous. Rather, any hospital's necessity to cram in the face of an audit raises questions as to whether acceptable patient care is routine – a serious matter for hospital administration. Embedding the Standards and successful patient safety initiatives into routine care eliminates the need to cram and ensures that a hospital is providing safe, quality care around the clock.

The Standards remain a work in progress. Their continued development is informed by evidence and active engagement with states and territories, clinicians and consumers. Their usefulness in improving patient outcomes is best achieved when the Standards are integrated into routine care and when processes are not completed for the sake of accreditation, but to ensure the safety and quality of patient care.

Dr Robert Herkes

Clinical Director, ACSQHC

DR DREW WENCK'S RESPONSE TO ACSQHC

In response to Dr Robert Herkes from ACSQHC

I have already responded to who created the standards.

The rest of the response by Dr Herkes, I believe, has completely missed the point. The standards of themselves are all reasonable but do not address the

fundamentals of how a hospital delivers care. My fictional patient still died, despite all the standards being adhered to. The ACSQHC and the ACHS must look beyond their standards and address the thorny issues of occupancy, staffing and the impacts of rules like NEAT. Although my patient was fictional, the troubles that befell her are drawn from real coroner's cases. I see nothing in the National Standards that will prevent the same set of circumstances.

Dr Drew Wenck

FROM THE PRESIDENT

On behalf of the Australian Society of Anaesthetists

The highest priority for an anaesthetist has always been, and will continue to be, the safety and wellbeing of their patient. The speciality has played a vital role in the promotion, as well as implementation of patient safety advances.

The ASA would like to thank the contributors of the recent Feature on Hospital Safety for the views and opinions expressed and for providing the opportunity for members to be challenged to consider the complexities and controversies that attend such an important public health matter.

The views expressed are those of the author and the respective organisations and are not those of the ASA. The ASA seeks to represent its members and to facilitate their capacity to practise to the full extent of their training and as independent professionals.

The ASA has no doubt that its members seek, at all times, to advocate for their patients and to ensure that, not only is their own practice to the highest standard, but that the environment in which they undertake that work is as safe and appropriate as possible. It would anticipate that members interact with a variety of systems and processes to achieve this and that ACHS and ACSQHC are elements in that interaction.

The ASA continues to urge its membership to relentlessly pursue any and all avenues to improve patient safety and to engage fully with all partners and organisations that offer tools and mechanisms to maintain and improve safety and standards.

The ASA as an organisation is absolutely committed to interacting and engaging positively with all organisations with a shared and common goal of improving patient safety.

Once again, I would like to thank all of those who have contributed to this important discussion.

Dr Guy Christie-Taylor

ASA President

FEATURE

CLINICAL AND ADMIN SILOS: BREAKING DOWN THE BARRIERS

Healthcare provision is broken – the dire situation neatly parodied in a sadly comical video entitled 'If Air Travel Worked like Health Care'[1] – writes Adelaide anaesthetist, past ASA Federal Councillor and Director of Perioperative Solutions, Dr Douglas Fahlbusch.

The key challenge is the siloed nature of the industry, which has increased as clinical and administrative expertise have each developed in relative isolation. Recent increases in lifespan, obesity, patient and operative complexity and patient (consumer) demand are simultaneously adding pressure on already stretched healthcare resources.

Improving workflows, and the flow of information, will help to reduce the barriers between different areas of healthcare, resulting in efficient and better quality healthcare.

Anaesthetists and surgeons may be more aware of this than many single-system practitioners and administrators, given the cross-functional nature of perioperative practice. However, the complex interrelationships are not immediately apparent to the individuals within each silo, nor are the interdependencies (Figure 1)[2]. Opportunities for efficiency through the use of external information and/or through incorporating measures to address the time-dependency of many tasks tend to be overlooked. Analysis is often confined to the immediate environment within a facility. This can lead to unnecessary stress and resource consumption at certain points in the pathway.

So, how do we break down the barriers between clinical and administrative silos? In concept, this is simple: connect people, simplify workflows and support people involved in the processes – the patient, medical personnel and nursing and administrative staff. Support can be as simple as automating the completion of repetitive tasks, or as complex as supporting decision-making with better information that integrates patient,

healthcare entity and compliance requirements.

Known problems within existing healthcare-delivery models include:

- having incomplete access to often partial information,
- historical systems complicating or interfering with workflows,
- unmet needs in relation to mobility of access and user configurability.

Workflow improvements must therefore consider:

- **The flow of work.** Often this physically follows the patient's treatment path, without addressing staff requirements.
- **Team roles.** While cross-checking is essential, it is important to avoid 'reworking' or the duplication of tasks. Most organisations employ indispensable team members who work to avoid multiple small inefficiencies which would otherwise frustrate workflows and hinder the work of other team members. Their input is essential.
- **Processes.** Ones that make up the workflow, including known variations and feedback mechanisms when the workflow is interrupted in some way.

Introducing a new workflow to an organisation is always challenging. Arguably, this is particularly so for healthcare organisations. One size does not fit all. Hospitals can be characterised as complex, adaptive systems – that is, workflows are complex, altering or adapting each time a workflow is invoked. Comparisons are often made to manufacturing, where, by contrast, there is a relative predictability in the items required and the order in which they are processed or packaged.

Furthermore, the transfer of a successful workflow improvement from one healthcare organisation to another does not guarantee a second success. Healthcare organisations are unique, having developed independent histories,

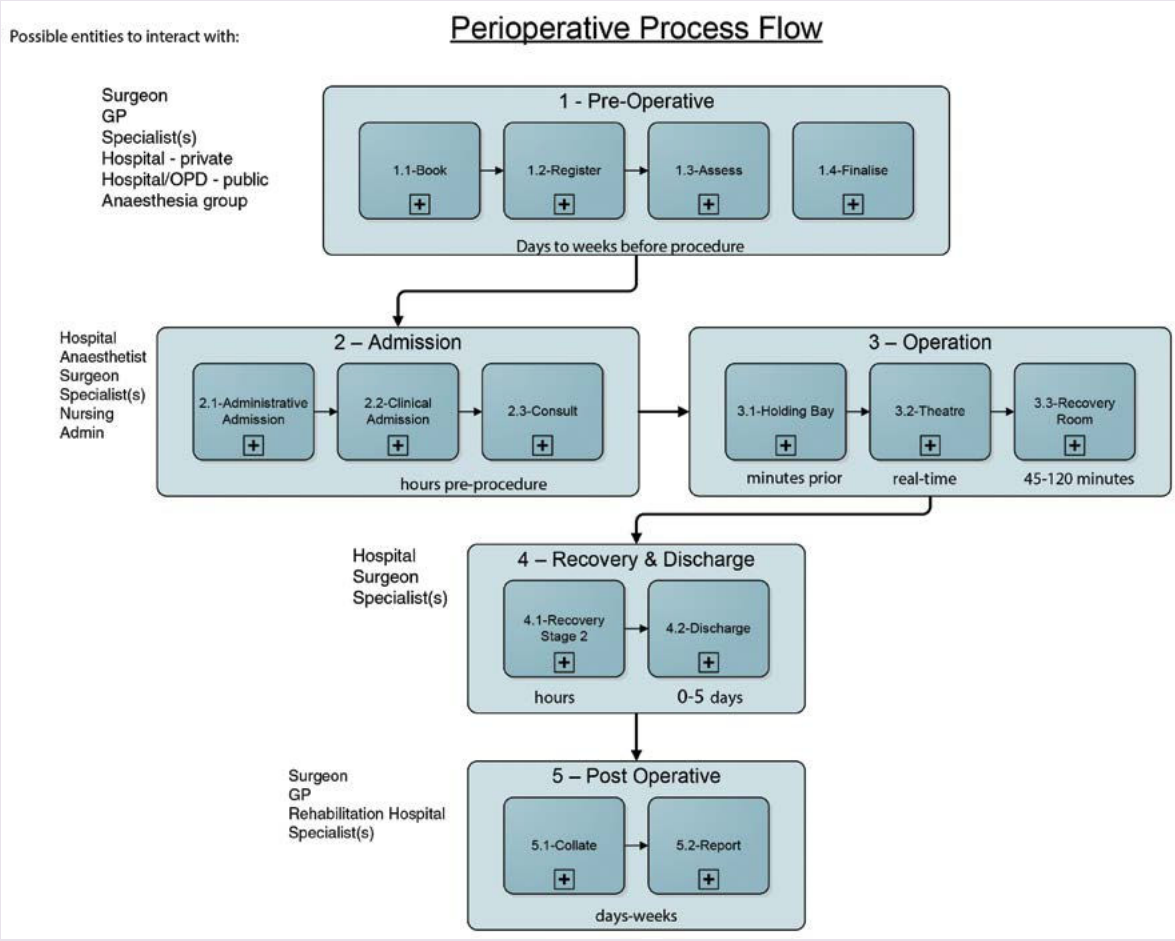


Figure 1: Perioperative Process Flow showing the complex interrelationships and time-dependencies within perioperative practice.

FEATURE

cultures and processes over time. Workflow improvements need to be customised for each organisation by the users of those processes in order for them to be successful and sustained.

If improvements in workflows are sought for a healthcare facility, a recommended approach is to first conduct a **Scoping Study**. This helps the provider and the facility to define the area(s) of most need and the area(s) of most benefit. Both parties can then proceed to one or both of:

- Product selection. Depending on the size and sophistication of the facility, new or updated product(s) may be warranted. The categorisation guide below is useful in defining the areas of need.
- Service selection. Depending on the facility, assistance with design, training and/or implementation may be required.

The scoping study typically identifies desired outcomes classified as[3]:

- Patient preferences, satisfaction and needs.
- Staff priorities, capacities and development needs.
- Visiting clinician priorities, capacities and development needs.
- Internal operations, organisation and processes (workflow).
- Clinical care and quality goals.
- Regulatory and legal reporting requirements.
- Business and financial goals.
- Information technology capabilities and equipment.

Outcomes identified after the scoping study should be assessed to ensure that they are:

- **Specific.** Well-defined, clear to anyone, e.g. reduce admission waiting times by half; reduce readmissions by 30%; reduce adverse events by 50%; reduce staff turnover by 10%; increase staff/visiting doctor/patient engagement scores by 15%.
- **Measurable.** The objectives must be quantified (as above).
- **Attainable.** Outcomes need to be realistic and be able to be achieved within a defined timeframe.
- **Relevant.** In line with the objectives of the facility and its environment.
- **Time sensitive.** It is important to set a deadline to drive the changes required.

Information technology products for perioperative healthcare can be categorised as:

- **Portals.** These enable access to a common pool of data with different viewing and data-entry permissions and criteria. Examples include patient, doctor, nurse and clerk portals.
- **Decision support.** Suggestions for pre-, intra- and postoperative care can be generated based on surgery type and patient factors. More efficient utilisation of resources occurs by up- and down-grading materials and staff appropriately. Note that this is therefore a therapeutic device, and requires approval by the Therapeutic Goods Administration.
- **Data aggregators.** This can be a dashboard display showing where patients are up to in the preoperative process, or software that collates pathology results. It can even be combined with near-realtime physiology data from monitoring devices.
- **Analysis.** Typical uses include external ones, such as compliance with federal requirements, for quality indicators and internal uses, such as for patient feedback and to address process delays.

It is worth noting that multiple products providing these functions are in use in hundreds, if not thousands, of hospitals around the US. They service many millions of patient episodes per annum. This usage both dwarfs the Australian market and provides useful information to guide implementation. Many of these products are currently being regionalised to suit the Australian market, and will provide exciting opportunities to lower risk and cost in perioperative processes.

Health professionals working across functional areas within the healthcare system, such as anaesthetists, are ideally placed to instigate improvements in workflows. Inevitably, many of these such improvements will be achieved through the use of IT. The twin goals of improving outcomes and reducing costs are achievable[4]. Longer-term benefits include building a sustainable healthcare system that delivers more services to more people, at the appropriate time.

Declaration of conflict of interest

The author is a director of Perioperative Solutions Pty Ltd, a provider of healthcare facility workflow analysis, change recommendations and implementation. Dr Fahlbusch has postgraduate training in business.

References

1. If Air Travel Worked Like Health Care. From www.youtube.com/watch?v=uXyp3BW5QII. Accessed May 2015.
2. Perioperative Process Flow. Further detail available from an unpublished analysis by the author
3. Electronic clinical quality improvement (eCQI). From https://ecqi.healthit.gov. Accessed May 2015.
4. Kaplan R & Porter M. The Big Idea: How to Solve the Cost Crisis in Health Care. HBR Sep 2011.

ADVANTAGE PROGRAM

The ASA has a number of corporate arrangements in place to provide members with discounts on products and services. The full list of suppliers can be found in the 'Membership' section of the ASA website. We are delighted to announce that Avis Budget Rental Cars have joined the program. Members are now entitled to discounts on their car rental services throughout Australia.

Members of the ASA can now receive discounts on car rental services in Australia. Members are able to access an 8% discount off the best possible rate at the time of purchase. This discount applies to the time and kilometre component for all Australian car rentals reserved via the ASA member-only online booking tool.

Members also have the ability to earn Qantas Frequent Flyer points on eligible Avis Budget care rental products, subject to the terms and conditions of the Qantas Frequent Flyer program. Budget car rental also gives you the ability to earn Flybuys points. Terms and conditions apply for both the Qantas and Flybuys programs.

The online booking tool can only be accessed through the members' section of the ASA website, under the 'Membership' tab. Simply click on the 'ASA Advantage Program' drop-down button and select 'Travel'.

If you have misplaced your login details, please contact the Membership team to ensure you are accessing all the latest deals.

By using either the Avis or Budget rental car services through the ASA, you are also supporting the Society, as each transaction you make provides a 2% commission to the Society. This contribution helps the ASA to continue to support, represent and educate its members.

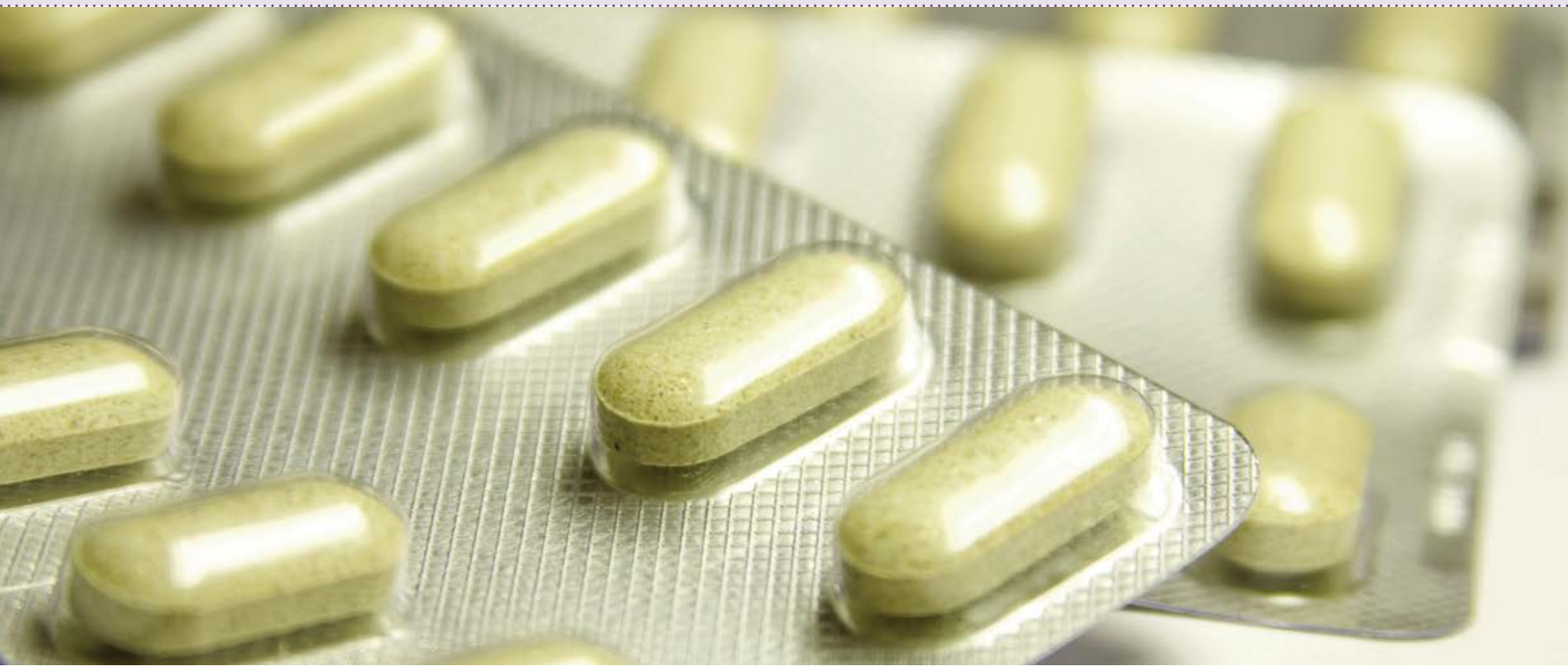
CONTACT US

The Society is continually looking for ways to enhance the ASA Advantage Program and we welcome any ideas you have for potential suppliers. Please email advertising@asa.org.au with your suggestions.

Visit www.asa.org.au and sign into the ASA Members Area to access your exclusive discounted rates from Avis and Budget.

AVIS® Budget®

FEATURE



PRESCRIBING OPIOIDS ON DISCHARGE—WHAT'S THE RISK?

South Australian anaesthetist Dr Christine Huxtable and Colin Brown, Manager of SA Health Drugs of Dependence Unit, discuss the dangers of routine opioid prescription for postoperative pain.

The number of patients discharged from hospital with opioid medication to manage acute pain is rising. The financial imperative to 'discharge patients earlier' has resulted in the range of patients and procedures considered suitable for day surgery increasing exponentially, and 'fast-track protocols', which facilitate earlier discharge, being developed in almost every surgical discipline[1].

Although opioid analgesics are not routinely prescribed to all patients for discharge, to manage moderate-to-severe postoperative pain and optimise recovery and rehabilitation, some patients will require opioid medication when they go home, and they often expect it.

Of the opioid side-effects, opioid-induced ventilatory impairment or opioid-induced respiratory depression is the most feared and potentially most harmful. *Anesthesiology* recently published a review of American Society of Anesthesiologists closed claims related to postoperative respiratory depression in hospital inpatients[2]. Most of these resulted in patient death or severe brain damage.

Although we like to think that we can identify 'at-risk' patients, this study suggests otherwise. Only 25% of patients were identified as having, or being at high risk of having, sleep apnoea; and the opioids were administered by all routes, including oral. The most consistent risk factors were the use of opioids within 24 hours of a surgical procedure (87% of events occurring on the day or night of the surgical procedure), the concurrent use of non-opioid sedating medication (38%) and the prescription of opioids or non-opioid sedating drugs by more than one physician (34%). The only potential modifier of risk was monitoring. Of the 'respiratory catastrophes' after routine surgery, "case reviewers judged that 97% of claims probably or possibly could have been prevented by better monitoring"[2].

Despite this, we continue to discharge our patients with scripts for oral opioid analgesics, often on the day of surgery, to a home where monitoring may be good or may be non-existent. The age-based doses we send them home with

are an educated guess at best and will, by definition, be much greater than what some of our patients need. At home, patients have free access to other opioid and non-opioid sedating drugs, licit and illicit: alcohol, marijuana, antihistamines and sleeping tablets, herbal or prescription. Notwithstanding these compounding risk factors, there is very little reported about postoperative opioid-induced ventilatory impairment at home following surgery.

Evidence, however, is accumulating about patient harm from:

- inadvertent prolonged opioid use,
- increased falls,
- drug interactions,
- the non-medical use of prescription opioids,
- the indiscriminate sharing of drugs and
- opioid impairment of driving ability.

When we prescribe new opioids on discharge following surgery, we presume that our patients will use them to manage acute postsurgical pain and cease their use when the new pain stops. There are, however, a proportion of patients who continue to use these opioids for a much longer period than expected. Large, computer-based patient databases have allowed patients and their drug use to be monitored for a prolonged period after surgery and studies have now been published: 3% to 6% of initially opioid-naïve patients, sent home on opioids following 'major elective surgery', were still using them between three and six months later[3,4]; 2.3% of patients at two years following total hip replacement and 1.4% of patients five years following total knee replacement[5–7] were still using 'new' opioids prescribed postoperatively.

This prolonged use did not necessarily relate to either the intensity or the duration of the postoperative pain. It was best predicted by psychological factors, including depression. Years after their surgical procedure, patients may have been self-medicating their chronic pain or depression with the opioids prescribed by their anaesthetist postoperatively. For the minority still experiencing pain even at three months, their pain was by definition not acute and the evidence for benefit from treating it with opioid medication scant.

It seems that it may be the prescription of opioids alone, even if a patient doesn't have significant postoperative pain, which leads to long-term opioid use. In 2012, Alam et al looked at almost 400,000 patients who had had 'minor surgery'[8]. 'Minor surgery' was described as that "for which opioid analgesia on discharge was unlikely to have been necessary", such as cataract surgery. Despite this, they identified over 27,000 of these patients who were prescribed opioids to take home. They then looked at opioid prescriptions for these patients 12 months later. Ten percent of the patients who had been prescribed postoperative opioids had an opioid script written for them within one month of the anniversary date, compared with only 7.5% of those who had avoided a postoperative opioid script. Patients were almost 50% more likely to be using opioids 12 months following their surgery if they had been prescribed them on discharge. Many of these patients had moved on from codeine to more potent opioids over the year.

Discharge opioids may create an 'opioid pool' in the community. Many patients prescribed opioids have leftover tablets and most keep them[9–11]. This matters because people are very happy to restart their prescription medication 'years later' if they think they need it again or to share it with their friends or family. When surveyed, up to 20% of older Australians admitted to 'borrowing' the odd prescription medication and the class of drug that they were most happy to share was the pain medications, which included opioids[12]. They shared them with no doctor or pharmacist advice and no consideration of potential drug interactions.

The problem is not confined to friends sharing leftover painkillers. Over 70,000 children went to US hospitals in 2012 because of accidental medication exposure[13]. Opioid analgesics were not only the most common prescription medication involved, with over 30,000 presentations, they also resulted in the most severe injuries and the greatest number of hospital admissions.

The contribution of discharge opioids to the community pool is of course in addition to the existing quantity of opioids made available to the community for chronic (non-postoperative) treatment. In South Australia alone, approximately 8500 patients are regularly prescribed opioids for the management of persistent chronic pain.

Patients should be warned about the risks associated with postoperative opioid analgesia and driving, in particular. There is evidence that patients' subjective assessments of driving ability do not robustly correlate to actual driving performance following opioid consumption[14]. Ensuring patients are aware of the impact opioid analgesia may have on driving performance should be a shared responsibility across the treatment team—in particular, clinical pharmacists may be useful in this regard. Of course, patients have the ultimate responsibility not to drive if impaired by their pain relief, whether or not in combination with other drugs or alcohol. Significant legal consequences, both civil and criminal, may flow from driving under the influence of opioids.

Some Australian and international resources exist that may assist health practitioners assess and warn patients of the risks associated with opioids and driving. Some are more practical than others. And all might usefully inform the development of concise local policy guideline reference documents that can be used by clinicians at point of treatment. Two Australian resources that might be particularly helpful are:

- The National Transport Commission's *Assessing Fitness to Drive* and
- Drug and Alcohol Services SA's

FEATURE

Prescribing Drugs and Driving.

Prescribers should ask, and keep a healthy scepticism, about the quantity of over-the-counter codeine pain relievers that their patients consume. These preparations on their own or in combination may significantly impact driving ability.

The Mayo Clinic, in collaboration with two other health services in Minnesota, set up the Institute for Clinical Systems Improvement. They've recently published guidelines on opioid-prescribing for acute pain[15]. They recommend to:

- Avoid prescribing more than three days' supply or 20 pills of low-dose, short-acting opioids (i.e. restrict the total dose).
- Never prescribe long-acting or extended-release opioid preparations for acute episodes of pain.
- Educate your patients on opioid risks and benefits and review safe driving, work, storage and disposal.

To identify an at-risk patient, they suggest an ABCDPQRS approach:

- **A**lcohol use: alcohol in combination with opioids results in the greatest elevation of driving and perhaps other risk.
- **B**enzodiazepines and other drug use: non-opioid sedatives including the benzodiazepines, seem to be synergistic with opioids in their sedative effects.
- **C**learance and metabolism of the drug: beware renal failure and rapid codeine metabolisers.
- **D**elirium, dementia and falls risk, all increased by opioids.
- **P**sychiatric comorbidities: depression, anxiety and catastrophising all increase the risk of perpetual opioid use.
- **Q**uery other prescriptions: check you're the only doctor prescribing.
- **R**espiratory insufficiency and sleep apnoea are still risk factors for opioid-induced ventilatory impairment.
- **S**afe driving, work, storage and disposal.

To help manage the risks of discharge opioids, the Royal Adelaide Hospital developed an information sheet for patients prescribed oxycodone on discharge, which can be used for any opioid. The sheet was further developed by SA Health into an Opioids for Acute Pain resource kit that is freely available to download on its website at http://bit.ly/1d2vekf.

Australia's National Pharmaceutical Drug Misuse Framework for Action calls for the implementation of a national real-time prescription-monitoring network available to doctors, pharmacists and medicines regulators. Under the network, prescription information would be available to doctors to allow better decision-making when forecasting postoperative opioid requirements. This would allow for more detailed assessment of patient-specific risks to enable appropriate warnings about treatment to be given, for example covering the impact opioid consumption has on driving.

References

1. Macintyre PE, Huxtable CA, Flint SLP, Dobbins M. Costs and consequences: a review of discharge opioid prescribing for ongoing management of acute pain. Anaesth Intensive Care 2014; 42:558–574.
2. Lee AL, Caplan RA, Stephens LS, Posner KL, Terman GW, Voepel-Lewis T et al. Postoperative opioid-induced respiratory depression: a closed claims analysis. Anesthesiology 2015; 122:659-665.
3. Clarke H, Soneji N, Ko DT, Yun L, Wijeysundera DN. Rates and risk factors for prolonged opioid use after major surgery: population based cohort study. BMJ 2014; 348:g1251.
4. Carroll I, Barelka P, Wang CK, Wang BM, Gillespie MJ, McCue R et al. A pilot cohort study of the determinants of longitudinal opioid use after surgery. Anesth and Analg 2012; 115:694-702.
5. Singh JA, Lewallen DG. Predictors of pain and use of pain medications following primary Total Hip Arthroplasty (THA): 5,707 THAs at 2-years and 3,289 THAs at 5-years. BMC Musculoskelet Disord 2010; 11:90.
6. Singh JA, Lewallen DG. Predictors of use of pain medications for persistent knee pain after primary Total Knee Arthroplasty: a cohort study using an institutional joint registry. Arthritis Res Ther 2012; 14:R248.
7. Singh JA, Lewallen DG. Predictors of pain medication use for arthroplasty pain after revision total knee arthroplasty. Rheumatology (Oxford) 2014; 53:1752-1758.
8. Alam A, Gomes T, Zheng H, Mamdani MM, Juurlink DN, Bell CM. (2012). Long-term analgesic use after low-risk surgery: a retrospective cohort study. Arch Intern Med 2012; 172:425-430.
9. Harris K, Curtis J, Larsen B, Calder S, Duffy K, Bowen G et al. Opioid pain medication use after dermatologic surgery: a prospective observational study of 212 dermatologic surgery patients. JAMA Dermatol 2013; 149:317-321.
10. Bates C, Laciak R, Southwick A, Bishoff J. Overprescription of postoperative narcotics: a look at postoperative pain medication delivery, consumption and disposal in urological practice. J Urol 2011; 185:551-555.
11. Rodgers J, Cunningham K, Fitzgerald K, Finnerty E. Opioid consumption following outpatient upper extremity surgery. J Hand Surg Am 2012; 37:645-650.
12. Ellis J, Mullan J. Prescription medication borrowing and sharing – risk factors and management. Aust Fam Physician 2009; 38:816-819.
13. Burghardt LC, Ayers JW, Brownstein JS, Bronstein AC, Ewald MB, Bourgeois FT. Adult prescription drug use and pediatric medication exposures and poisonings. Pediatrics 2013; 132:18-27.
14. Verster JC, Roth T. Drivers can poorly predict their own driving impairment: a comparison between measurements of subjective and objective driving quality Psychopharmacology (Berl) 2012; 219:775-781.
15. Institute for Clinical Systems Improvement. From www.icsi.org. Accessed June 2015.

The views expressed in this article are those of the authors' and do not necessarily represent the views of SA Health or the ASA.

2015 AMA NATIONAL CONFERENCE

This year's Australian Medical Association (AMA) National Conference was held in Brisbane from 29 to 31 May, reports AMA Anaesthesia Specialty Representative, Dr Andrew Mulcahy. The National Conference is one of the most important events on the AMA calendar, with delegates representing more than 30,000 doctors coming together to discuss important policy issues, hear from politicians who control the national health agenda and develop new policies to shape the future of healthcare in Australia.

The AMA National Conference is an annual event and serves as an important arena for the discussion and development of AMA policy. The conference brings together practitioners, academics, operators, students, trainee doctors and media from across the country and internationally to discuss and debate the latest challenges in health, from climate change, family violence and the treatment of asylum seekers to general practice funding and training, the outlook for public hospitals and the pitfalls of defensive medicine. While there were no elections for AMA office bearer positions this year (they generally occur every second year), the program is usually based on a theme, with this year's being "Medicare – Mid-life Crisis?" Given the ongoing debate in Canberra over the Government's proposed Medicare changes – including the infamous GP co-payment model – the theme was timely and appropriate. Policy sessions at the conference explored the core areas and ideals that underpin the medical profession and the health system. As well as hearing from the high-profile AMA President, Assoc. Prof. Brian Owler, who opened the conference, the conference also welcomed the Minister for Health, Sussan Ley, and her Opposition counterpart, Catherine King, among other prominent speakers. A special guest this year was Julia Gillard who addressed the Leadership Development Dinner held during the conference.

Each specialty (including general practice) is represented at the AMA National Conference by an allotted number of official delegates, with the

FEATURE

number of delegates being based on the number of AMA members in each specialty. There are also delegates appointed on a regional basis (each state and territory) to represent other special interest groups (salaried doctors, Doctors in training) and members of Federal Council. These 150+ delegates were joined at the conference by official observers, medical students, overseas guests (including representatives of the World, British, Chinese, Singapore, American, Myanmar and New Zealand Medical Associations) and, finally, a large contingent of media.

Anaesthesia was represented by three official delegates: Drs. Guy Christie-Taylor (SA), Jim Bradley (Qld) and Mark Hurley (Vic). In addition, other anaesthetists present in an official capacity included Dr Elizabeth Feeney (Chair of the AMA Board and NSW delegate), Dr Andrew Mulcahy (Anaesthesia specialty representative on Federal Council), A/Prof Ross Kerridge (NSW delegate) and Dr Roderick McRae (Salaried Doctors).

In his opening address, Brian Owler, outlined the AMA's opposition to the Federal Government's so-called GP co-payment introduced over the previous year before its eventual abandonment. He also emphasised the importance of general practice and primary care for the future of the health system in Australia, and touching on more controversial issues, condemned the Federal Government's decision to fund the proposed new Curtin Medical School in WA as well as proposed changes to legislation dealing with asylum seekers and their medical treatment in off-shore detention centres. The President also made mention of the important role for the AMA in leading the debate on the health effects of climate change, workplace bullying and sexual harassment and the impact on gaps of the current freeze on Medicare rebates.

The address by the Health Minister Sussan Ley, was well received with the Minister explaining to the conference that, as a member for a rural electorate, she is passionate about rural health. She emphasised the breadth of the problem of ensuring sustainability in health financing with Medicare alone costing the Australian taxpayers $21 billion per annum. She also emphasised some of the problems with the open-ended nature of hospital funding and highlighted the disappointing statistic that 'avoidable' admissions to hospital make up 7% of all admissions and cost $3 billion per year. The Minister went on to talk up the forthcoming review of the Medicare Benefits Schedule (MBS) (the MBS Review Taskforce) stating that, for a successful outcome, there needs to be support from the the profession.

> [The] Conference is a vastly different affair to our annual NSC. It is unashamedly and blatantly political, often with the excitement of a Presidential election

The review will be in three parts, which will include a review of primary care services and Medicare compliance, along with a review of all items in the MBS. Thirty million dollars has been allocated over the next two years for the review. Questions from the audience focussed on stakeholder engagement and how it might work (details yet to be released) with a general feeling from some that the review will take much longer than expected and that it may simply be a means to cost-cutting. Finally, the Minister discussed the Federal Government's approach to the e-Health project (formerly the Patient Controlled Electronic Health Record [PCEHR]). She indicated that significant changes were being made, including making the system opt-out instead of the previous opt-in format. Overall, successful implementation of the e-Health project could generate $2.5 billion in savings (in ten years' time) and a further $1.5 billion for the State governments.

In her presentation to the conference, the Opposition spokesperson for Health commended the AMA on their stance on domestic violence and sexual harassment. She voiced her concerns about the current Government's cost-cutting measures with particular emphasis on the cuts in real terms to hospital funding and the shifting of this burden onto the States.

The conference program itself provided three days of intense discussions and presentations with a wide range of issues covered. The important policy sessions included the following:

- Funding quality general practice – is it time for change?
- Quality public hospital services: funding capacity for performance.
- Waste not, want not: ethics, stewardship and patient care.
- General practice training – the future is in our hands.
- Key AMA public health advocacy – local and global.

The session on 'Funding for General Practice' opened with the question "Is Fee-for-Service (FFS) the best model?", and provided a close examination of the current models of FFS and practice-incentive payments before moving onto discussions of alternative funding arrangements including variations on fund-holding arrangements with fees paid to doctors for providing holistic care for patients with chronic illness. One of the leading arguments for change is coming from a desire to improve primary care services for those in the community with chronic illness. However, the advantages of FFS include providing for consumer choice, ensuring that any funding follows the patient, ensuring that only services

that are actually provided are paid for and preserving the doctor–patient relationship and patient-centred care.

On the last day, a 'Soap-Box session' was held, where delegates could address the conference on any area of policy or issue of concern. ASA President, Dr Guy Christie-Taylor, was able to avail himself of this opportunity to highlight to the conference the potential threat of alternate providers, not only in anaesthesia but in many other specialties as well. Guy explained the rationale often put forward by health economists without considering the real-world workforce situation in Australia and the potential dangers for the quality and standards of healthcare for the community. This was well received by the conference.

The AMA National Conference is a vastly different affair to our annual NSC. It is unashamedly and blatantly political, often with the excitement of a Presidential election, but is squarely focussed on developing policy for the Australian health system. An interesting selection of speakers, from academics to clinicians to politicians, make for an exciting conference with plenty of opportunity for networking at the associated social functions. This year's conference lived up to all expectations.

AMA President A/Prof Brian Owler delivering the opening address


ASA President, Dr Guy Christie-Taylor, addressing the conference


Federal Minister for Health, Sussan Ley, and A/Prof Owler

Federal Minister for Health, Sussan Ley


Opposition Spokesperson on Health, Catherine King


AMA Presidents, past and present

Woman in Medicine Award recipient for 2015, Dr Jo Flynn, Chair of the MBA


Prof Geoff Dobb, [unknown], AssocProf Ross Kerridge, Drs Liz Feeney, Guy Christie-Taylor, Mark Hurley, John Murray and Rod McRae

Dr Christie-Taylor receiving his signed edition of Julia Gillard's *My Story*

FEATURE

TREATMENT LIMITATIONS IN THE PERIOPERATIVE SETTING

As anaesthetists in training, we have the great opportunity to observe a spectrum of anaesthetic practice and perhaps no area is more polarising than that of end-of-life care in the perioperative setting, writes GASACT Chair, Dr Ben Piper.

What we are to do with an advanced care directive (ACD) or not for resuscitation order (NFR) is a vexed question. There are many opinions; however, there are few answers. As in all areas of medicine where there are shades of grey, perhaps it is not the answers that we need but a consistent approach or framework to engage with these problems. Perhaps, it is time for a national approach...

With increasing frequency, patients are presenting for elective and urgent surgery with 'orders' or 'directives' in places that limit specified therapies. The unique challenge of the perioperative environment is the acute and often transient alterations in physiology that occur due to routine surgical or anaesthetic intervention. Such physiological insults may be readily reversible and be very different from changes that occur due to disease progression. To balance the patient's wishes and respect their right to self-determination, while simultaneously placing them in a state of iatrogenic compromise, is a complex task.

To demonstrate this complexity, a simulation of such events indicated a wide range of responses to situations involving treatment limitations when critical incidents arose[1]. This study demonstrated that only 75% of anaesthetists were aware of the order, only 57% discussed this with the patient and only 10% discussed this with the surgical team. Of those that were aware of the order, 27% suspended the order; whereas 30% engaged in a 'goal directed order'. Ninety percent continued resuscitation efforts until the simulation was ceased in spite of knowledge of the order.

Most Australian states and territories are actively participating in improving end-of-

ADVANCED CARE DIRECTIVE

A document that describes one's future preferences for medical treatment in anticipation of a time when one is unable to express those preferences because of illness or injury.

life care planning, with the impetus from both the ethically grounded reduction in patient suffering and improved autonomy, as well as the morally accountable reduction in cost burden in the acute care setting. To reduce expenditure on costly services that may promote suffering and be against patients expressed wishes seems like reasonable health policy.

Prior to the 1990s, the automatic rescinding of an ACD or NFR in the perioperative setting was common practice. However, there has been an evolution, albiet slow, towards a more considered and patient-centred process. There have been legal cases of considerable note such as the 2009 NSW Supreme Court ruling on *Mr A*. The result of this placed the medical practitioner in a position where life-sustaining therapy may be discontinued or not instigated on the basis of an ACD. To confound matters further, there is the potential for the provision of life sustaining treatment (e.g. CPR) against the explicit wishes of an ACD to be considered a battery: "It would be a battery to administer medical treatment to the person of a kind prohibited by the advance care directive" (Justice McDougall, NSW Supreme Court 2009).

When we consider what patients expect, Burkle et al[2] found that, of patients seen in the preadmission setting with active ACDs, 57% considered it reasonable to rescind the ACD; however, 24% considered that it should remain.

The article was published on the 20th anniversary of the American Society of Anesthesiologists releasing guidelines stating that automatic rescinding of DNR conflicts with patient autonomy. Twenty years later, 30% of doctors surveyed would still rescind the NFR order in the perioperative setting; however, this was significantly reduced for anaesthetists at just 18%. This suggests that the guideline has had an effective role in changing the way in which ACDs are considered in the perioperative environment.

At the current time, there are no Australian guidelines that are directed at the perioperative setting. Of the hospital-based guidelines available in Australia, 94% make no reference to the perioperative period[3]. Good examples of guidelines that have been introduced in the perioperative setting can be seen in both Canada and the US. What these guidelines permit is a framework to discuss and consider these increasingly common and complex circumstances.

A guideline will not reduce the spectrum of practice that we trainees observe in the management of ACDs, and nor should it. The guidance should encourage an individualised approach that pays respect to the current situation and the patient's wishes under such circumstances. It should aim to give anaesthetists confidence in what is considered reasonable in the uniquely challenging perioperative management of end-stage diseases in this vulnerable population.

WHAT WE KNOW

- ACDs are legal documents that have major significance to the anaesthetic profession.
- There will be an increased frequency of patients presenting for surgical and diagnostic procedures in advanced stages of disease with ACDs in place.
- Precedent exists for withholding life-sustaining therapy or having that therapy discontinued on the basis of an ACD.

CHALLENGES AHEAD

- Currently, there are six states and territories with legislation that cover ACDs and each varies in detail. Is it feasible to have national guidance on an issue that is fragmented in this way? Is there enough common ground to make such guidance useful?
- Improving the timely dialogue between patient, proceduralist and anaesthestist is an ongoing challenge with the emergence of high-volume short-stay operating practices.

References

1. Waisel DB, Simon R,Truog RD, Baboolal H, Raemer DB. Anesthesiologist management of perioperative do-not-resuscitate orders: a simulation-based experiment. Simul Healthc 2009;4: 70-76.
2. Burkle CM, Swetz KM, Armstong MH, Keegan MT. Patient and doctor attitudes and beliefs concerning perioperative do not resuscitate orders: anesthesiologists' growing compliance with patient autonomy and self determination guidelines. BMC Anesthesiol 2013;15:doi: 10.1186/1471-2253-13-2.
3. Sidhu NS, ME Dunkley, Egan MS."Not-for-resuscitation" orders in Australian public hospitals: policies, standardised order forms and patient information leaflets. Med J Aust 2007;186: 72-75.

CONTACT THE AUTHOR

To get in touch with Dr Ben Piper, please email gasact@asa.org.au

FEATURE

CSC 2015 INVITED SPEAKER ABSTRACTS

PROFESSOR JOHN B. WEST
SAN DIEGO, CA, USA

Professor of Medicine and Physiology, University of California, San Diego, CA, USA

KESTER BROWN ORATION – SEVERE HYPOXIA: LESSONS FROM THE SUMMIT OF MT. EVEREST

It is a remarkable coincidence that the highest point in the world is very close to the limit of human tolerance to hypoxia. During the 1981 American Medical Research Expedition to Everest, we were able to make the first measurements of human physiology on the summit. Incidentally, although this was 34 years ago, nobody has repeated the measurements since. The most striking finding was the enormous degree of hyperventilation which is necessary to maintain the alveolar PO_2 at a viable level. Alveolar gas samples showed that the PCO_2 was only 7 to 8 mmHg. This represents about a five-fold increase in resting alveolar ventilation. The alveolar PO_2 was about 35 mmHg, but the arterial value, which we could not measure directly but inferred from other data, was around 30 mmHg. The extremely low PCO_2 was associated with an arterial pH of about 7.7 to 7.8. Thus, the successful climber has extreme arterial hypoxaemia and a poorly compensated severe degree of respiratory alkalosis. The reason why there was such inadequate renal compensation for the alkalosis is not understood but may be related to the marked volume depletion that is characteristic of extreme altitude. Other measurements showed that the maximal oxygen consumption on the summit was about one liter per minute, a miserably low value, but just sufficient to explain how some climbers can reach the summit without supplementary oxygen. It is remarkable that young normal subjects can tolerate such an extreme derangement of their normal physiology and return to tell the tale.

RESPIRATORY UPDATE – THE LUNG IN NORMAL GRAVITY AND IN SPACE FLIGHT

Gravity has important effects on the physiology of the lung. Bloodflow is very unevenly distributed in the normal upright lung with the apex being just perfused under resting conditions. The cause of the uneven distribution is the weight of the column of blood in the pulmonary vessels that causes large pressure differences in the low-pressure pulmonary circulation. Ventilation is also greater in the lower regions of the upright lung than the upper zones. Here the reason is the weight of the lung that distorts it like a slinky spring. The lower regions therefore, have a small resting volume but a relatively large increase in volume with inspiration. These differences of ventilation and bloodflow cause differences in the ventilation-perfusion ratio thus, causing large regional differences in pulmonary gas exchange. For example, the relatively high ventilation-perfusion ratio at the apex causes a high PO_2 which is believed to explain the localisation of adult pulmonary tuberculosis in this region. The distortion of the lung by its weight also causes larger alveoli and larger mechanical stresses at the apex and this may be a factor in the distribution of centriacinar emphysema.

We had the opportunity to make extensive measurements of pulmonary function in astronauts during space flight using the SpaceLab carried up by the shuttle. The topographical distributions of bloodflow and ventilation became more uniform but there was some residual inequality. The absence of gravity increased the volume of blood in the lungs because blood moved from the dependent regions of the body where it normally pools. The result was an

SESSION TIMES

Respiratory update: effects of gravity on the lung
Saturday 12 September, Auditorium 1 & 2, 0945–1045

Kester Brown Lecture – Severe hypoxia: lessons from the summit of Mount Everest
Saturday 12 September, Auditorium 1 & 2, 1400–1530

GASACT Workshop – Physiology of pulmonary capillaries
Sunday 13 September, Auditorium 2, 1045–1245

Early history of high altitude physiology
Monday 14 September, Waterfront 1, 1030–1200

increase in pulmonary diffusing capacity during the flight, but this rapidly returned to the pre-flight value upon return to earth. Lung volumes were altered with the functional residual capacity being between the values for upright and supine subjects at 1 G. Residual volume was decreased possibly because all the alveoli assumed the same size in space. Changes in the deposition of aerosol occur in weightlessness and there was a change in the distribution of gases of very low and very high molecular weight that is so far unexplained. In summary, measurements made in the absence of gravity helped to explain the effects of normal gravity on the lung.

HISTORY OF ANESTHESIA SPECIAL INTEREST GROUP – EARLY HISTORY OF HIGH ALTITUDE PHYSIOLOGY

High altitude physiology may be said to have begun when Evangelista Torricelli made his immortal statement "We live submerged at the bottom of an ocean of the element air, which by unquestioned experiments is known to have weight". He wrote this in a letter describing the construction of the first mercury barometer. Shortly after, Blaise Pascal persuaded his brother-in-law to carry a Torricellian barometer to the top of the Puy de Dôme in central France thus demonstrating that barometric pressure decreases with altitude. The first air pump was built soon afterwards by Otto von Guericke who was concerned about the air tightness of wine barrels. He also performed the famous experiment in which two metal hemispheres were placed together to form an airtight joint and air was pumped out to give a partial vacuum. Two teams of horses were unable to separate the hemispheres thus demonstrating the enormous forces that could be developed by the atmosphere. Robert Boyle learned of Guericke's experiment and decided to make an air pump that could be used for physiological measurements. This was done by his colleague, Robert Hooke, who was a mechanical genius. Boyle's extensive series of experiments were described in his book *New experiments physico-mechanicall, touching the spring of the air and its effects*. This can be considered the first physiological treatise on high altitude physiology. A few years later, the Montgolfier brothers invented the hot-air balloon which was subsequently replaced by ballons using hydrogen. Early balloonists described the effects of rapid ascent to high altitude which was sometimes lethal. Finally in 1878, Paul Bert published his superb treatise "La pression barométrique" in which he proved that the deleterious effects of exposure to high altitude were caused by the low PO_2. As a consequence, he is often referred to as the father of high altitude physiology.

FEATURE

PROFESSOR BOBBIEJEAN SWEITZER
CHICAGO, IL, USA

Professor of Anesthesia and Critical Care, Professor of Medicine and Director of the Anestheisa Perioperative Medicine Clinic, University of Chicago, IL, USA

Inadequate preoperative patient evaluation and preparation have been shown to increase complications, costs, delays and cancellations of surgery and mortality. In several reports and studies originating in New Zealand and Australia, failure to appropriately assess and prepare patients for anaesthesia results in mortality and morbidity that may be preventable more than half of the time. Poor preoperative care was implicated in 53 of the 135 deaths attributable to anaesthesia in an Australian triennial report. The Victorian Consultative Committee on anaesthesia-related mortality indicated that problems with preoperative assessment were present in 18 out of 43 deaths in Victoria. An analysis of the first 2000 reports to the Australian Incident Monitoring Study showed a sixfold increase in mortality in patients who had inadequate preoperative assessment, compared to those who had been thoroughly evaluated. Kluger stated in his conclusions in a study published in *Anaesthesia*, "anaesthetists must recognise they are responsible for the overall clinical management of the patient rather than simply providing a technical service. The ability to diagnose, evaluate and manage medical problems is no longer the sole responsibility of physicians, especially when there are implications for anaesthesia".

Medical diseases and syndromes that influence anesthetic perioperative management require the anaesthetist to be clinically knowledgeable and current in many aspects of medicine. New and updated preoperative evaluation consensus and evidence-based guidelines published by multiple medical specialties can guide the preparation of patients for anaesthesia and surgery. The anaesthetist is the perioperative specialist and is uniquely positioned to evaluate the risks associated with anaesthesia or surgery, discuss these risks with patients, and manage them perioperatively (in collaboration with the surgical team, specialists and sometimes the referring physician).

Patients require appropriate preoperative diagnostic and laboratory studies consistent with their medical history, the proposed surgical procedure and possible intraoperative blood loss. Routine preoperative testing is costly, is often clinically inappropriate, and cannot be justified. Focused, patient-specific evaluations lower overall risk. Simply evaluating patients and assessing risk without a focus on optimisation and care through the entire perioperative period is a suboptimal approach. Protocol driven management and quality improvement initiatives are as important as appropriate education and training of personnel.

Major surgery is often associated with significant physiologic stress and, frequently, with adverse outcomes, both short- and long-term. Approximately 15% of patients having in-patient, non-cardiac surgery are at risk for serious complications including disability or death. Worldwide, 200 to 250 million patients have surgery each year; many of them aged with severe comorbidities and advanced disease. Considering a 1% risk of death with a 5% risk of complications, up to 2.5 million patients will die and 12.5 million will have costly adverse events. We must identify those at risk and intervene earlier in order to lower risk, or at least inform patients of their chances for a meaningful outcome. A little over 12% of patients account for 80% of postoperative deaths. Although mortality rates vary widely across hospitals and countries, evidence suggests that high-risk patients are often not identified preoperatively, and proven strategies to lower risk are not implemented. Risk assessment can lead to changes in medical management, planned anaesthesia and surgery, postoperative care, or recommendations to avoid surgery.

HIGH-RISK PATIENTS AND CONDITIONS

Elderly patients

Advanced age is a strong predictor of postoperative mortality and morbidity resulting from cardiovascular, pulmonary and infectious causes. Elderly patients older than 75 years have up to twice the risk of serious morbidity and three to seven times the risk of dying compared to younger patients. The frail elderly and those undergoing cancer procedures are at particular risk. Frailty independently predicts postoperative complications, length-of-stay, and need for discharge to an assisted-living facility. Determination of a frailty score supplements other risk models. Impaired cognition, low albumin,

SESSION TIMES

Cardiac update: preop assessment and management of the patient at risk for perioperative ischaemia
Saturday 12 September, Auditorium 1 & 2, 0830–0930

Which patients are too high-risk for ambulatory surgery?
Saturday 12 September, Waterfront 2, 1600–1730

Preoperative identification, evaluation and optimisation of the highest risk patients
Sunday 13 September, Auditorium 1, 0830–1030

Preoperative considerations for patients with cancer
Monday 14 September, Auditorium 1, 1300–1500

previous falls, low haematocrit, functional dependence and multiple comorbidities are associated with a six-month mortality prediction and inability for discharge home postoperatively.

Cardiac disease

The goals in the pre-anaesthetic evaluation of patients with ischaemic heart disease are to identify the risk of heart disease based on clinical risk factors, identify the presence and severity of heart disease by symptoms, physical findings or diagnostic tests; determine the need for preoperative interventions; and modify the risk of perioperative adverse events. The Revised Cardiac Risk Index has been extensively validated for predicting perioperative cardiac risk in noncardiac surgery. Heart failure increases perioperative mortality three- to fivefold and is associated with a substantially higher risk than coronary artery disease (30-day mortality rate 9.3% versus 2.9%, respectively). Heart failure may be present in up to 20% of elderly surgical individuals. Patients with atrial fibrillation have twice the risk compared to patients with ischaemic disease in the perioperative period. Few patients derive benefit from preoperative revascularisation. Successful preoperative care of patients with cardiac disease is through medical management and meticulous perioperative care.

Cancer patients

Patients with a history of cancer are often elderly and have comorbidities unrelated to their cancer. They also may have complications related to the disease or the treatment. However, there may be little time for assessment and interventions before the perceived time-sensitive procedure.

SUMMARY

Optimal preoperative patient preparation is essential if risks are to be lowered. Further research and development of evidence-based protocols are needed. It is likely that optimal results will require a multidisciplinary approach with involvement of care providers with various clinical skills. Ideally, patients will be managed from several days to weeks before surgery, through a similar timeline postoperatively. Many patients should be evaluated before a date of surgery is even set. Importantly, patients must be highly invested in their care. Better data on outcomes of all surgical procedures are needed to drive the development of more effective systems of care. A starting point is to use a combination of age, type of procedure, comorbid conditions and biomarkers to stratify patients into categories of risk. Low-risk patients or those having low-risk procedures can proceed without special preparation. Most ambulatory procedures are relatively low-risk, but increasingly, the patients are high-risk. High-risk patients should be evaluated by a specialist in preoperative medicine and undergo advanced testing and prehabilitation, if needed, before proceeding to surgery in specialised centers.

FEATURE

PROFESSOR MARTIN SMITH
LONDON, UNITED KINGDOM

Consultant and Honorary Professor in Neuroanaesthesia and Neurocritical Care, the National Hospital for Neurology and Neurosurgery, Queen Square, University College London Hospitals, London, United Kingdom

NEUROANAESTHESIA UPDATE

The goals of the anaesthetic management of patients presenting for emergency craniotomy include facilitation of early decompression in those with an expanding mass lesion and/or risk of imminent brain herniation, prevention or treatment of intracranial hypertension, maintenance of adequate cerebral perfusion, provision of optimal operating conditions, and avoidance of secondary insults such as hypoxaemia, hypotension, hypo- and hypercarbia, and hyper- and hypoglycaemia.

Increases in intracranial pressure (ICP) after acute brain injury are related to brain swelling, expansion of intracranial mass lesions, or obstruction to cerebrospinal fluid outflow (acute hydrocephalus). Untreated, intracranial hypertension can have devastating consequences, and its control before, during and after emergency intracranial neurosurgery is a key determinant of outcome. ICP can be reduced by a moderate head-up position (to 30º), maintenance of normocapnia, administration of hyperosmolar solutions, diuretics, propofol or barbiturates, and surgical interventions. Steroids have no place in the management of raised ICP after head trauma or haemorrhagic stroke, but may be useful in reducing oedema in the rare patient presenting with a rapidly expanding brain tumour.

Airway management is complicated by a number of factors including uncertainty of cervical spine status in trauma patients, full stomach, intracranial hypertension and uncertain volume status. The choice of technique for tracheal intubation is determined by urgency, individual expertise and available resources. A rapid-sequence induction with cricoid pressure (with manual in-line stabilisation in trauma patients) is recommended in patients with an uncomplicated airway. Sodium thiopental or propofol decrease cerebral metabolic rate and attenuate ICP responses to intubation, but risk cardiovascular instability during induction of anaesthesia. While ketamine has traditionally been avoided because of a risk of increased ICP, recent data suggests that this risk is overstated and that the beneficial effects of ketamine on systemic blood pressure ensure maintenance of cerebral perfusion pressure in haemodynamically unstable patients. The choice of muscle relaxant for rapid-sequence induction is succinylcholine or rocuronium. While succinylcholine may transiently increase ICP, the clinical significance of this is questionable and in any case offset by the concurrent use of propofol or thiopental. Rapid control of the airway is essential to minimise the risks to the brain of hypoxaemia and hypercarbia, so a familiar technique is best.

Volatile anaesthetic agents reduce cerebral metabolic rate but at higher concentrations cause cerebral vasodilatation and raised ICP, and impair carbon dioxide reactivity. Cerebral vasodilatory effects are minimal at concentrations less than 1 MAC, so volatile agents can be safely used at low concentrations. Nitrous oxide should always be avoided because it stimulates cerebral metabolism, resulting in vasodilation and increased ICP. Propofol reduces cerebral metabolic rate and ICP, and does not adversely affect cerebral autoregulation. Total intravenous anaesthesia using propofol, usually in combination with an ultra-short-acting opioid such as remifentanil, is often a good choice. No studies have demonstrated an outcome advantage of one technique – inhalation or total intravenous anaesthesia – over the other, including on early postoperative recovery profiles. While there remains significant interest in the concept of intravenous and volatile anaesthetics as neuroprotectants, recent clinical studies have not demonstrated efficacy in this regard.

Meticulous haemodynamic management is a cornerstone of anaesthesia for emergency craniotomy to ensure maintenance of adequate cerebral perfusion throughout. Systolic blood pressure should be maintained >90 mmHg, but intraoperative hypotension is common and associated with worse outcome. Euvolaemia is the target for fluid therapy, but intraoperative fluid and electrolyte balance is dramatically affected by osmotic agents and diuretics administered to decrease ICP. Isotonic crystalloids are the replacement fluids of choice, and 0.9% saline is widely used. Normoglycaemia, normothermia and prevention of anaemia are also crucial intraoperative management targets.

This lecture will review the physiology and pharmacology of the anaesthesia management of emergency craniotomy,

SESSION TIMES

Neuroanaesthesia update
Saturday 12 September, Auditorium 1 & 2, 1130–1230

PBLD 02 – Perioperative stroke following non-cardiac surgery
Saturday 12 September, Meeting Room 2, 1600–1700

Trauma: Rescuing the brain – the role of the anaesthetist
Monday 14 September, Auditorium 1, 1030–1200

PBLD 20 – Acute subarachnoid haemorrhage
Tuesday 15 September, Meeting Room 2, 0845–0945

and discuss the importance of monitoring and managing systemic and intracranial haemodynamic variables, fluid and electrolyte balance, and glycaemic and temperature control.

RESCUING THE INJURED BRAIN: THE ROLE OF THE ANAESTHETIST IN IMPACTING OUTCOME AFTER TRAUMATIC BRAIN INJURY

Traumatic brain injury (TBI) is a leading cause of death and disability, and a contributing factor in almost one third of trauma-related deaths. The mortality of severe TBI is around 23% and more than 60% of survivors have residual deficits, including cognitive impairment and behavioral problems, which affect their functional status and quality of life. The epidemiology of TBI in high-income countries is changing as the reduction in high-velocity motor vehicle accidents is offset by an increase in fall-related injuries in an ageing population.

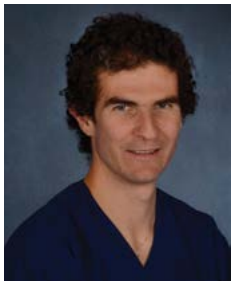
TBI is a heterogeneous diagnosis, encompassing diffuse axonal injury, focal contusions and space-occupying haematomas. If the initial (primary) injury is not immediately fatal, it is exacerbated by secondary injury that develops over the subsequent minutes, hours and days. The distinction between primary and secondary injury is relatively artificial since the pathophysiological changes after TBI are a continuum. Primary injury activates an auto-destructive cascade of ionic, metabolic, immunological and inflammatory changes that result in further neuronal damage or death and render the brain more susceptible to systemic insults. The burden of secondary injury, which is essentially hypoxic/ischaemic in nature, is directly related to outcome after TBI. Multiple pharmacological neuroprotective agents, including calcium channel blockers, statins, anti-inflammatory agents, free radical scavengers, magnesium, excitatory amino-acid antagonists, erythropoietin, corticosteroids and progesterone, have produced promising results in animal studies but none have translated into the clinic. Currently, the reliance on optimising systemic and cerebral physiology is the most important neuroprotective strategy after TBI.

Resuscitation and early management is a crucial stage at which mortality and morbidity can be influenced. The prevention or immediate correction of hypoxaemia and hypotension, and rapid diagnosis and evacuation of an expanding intracranial haematoma and treatment of raised intracranial pressure (ICP) minimise secondary brain injury and are key determinants of outcome. A particular challenge in multi-trauma patients is balancing the competing interests of hypotensive resuscitation which, on the one hand, limits on-going blood loss and speeds the time to resuscitation but, on the other, risks worsening associated brain injury. It is recommended that systolic blood pressure be maintained >90 mmHg at all times in any patient with TBI to minimise the risk of cerebral ischaemia so, if a lower blood pressure is required to treat life-threatening haemorrhage, the duration of hypotension should be as short as possible. Other physiological variables should be optimised during hypotensive resuscitation to maximise cerebral oxygen delivery; in particular hypocarbia must be avoided.

Head-injured patients may present for intracranial surgery, including evacuation of an expanding mass lesion, insertion of a ventricular drain or decompressive craniectomy, as well as for interventions for extracranial injuries. The intraoperative period provides an opportunity to continue and refine resuscitation started in the emergency department or ICU, but may also predispose to new-onset secondary insults. These include intraoperative hypotension, arterial blood gas abnormalities, hyperglycaemia, blood loss, large fluid shifts and the systemic and cerebral effects of anaesthetic agents. There is no specific evidence to guide the intraoperative management of TBI, but simple things are important. Targeting the 'five Ns' – normotension, normoxia, normocapnea, normoglycaemia and normothermia – is key. Intraoperative blood loss can be associated with coagulopathy and anaemia, both of which are especially detrimental in the context of TBI. Blood loss should be replaced with packed red cells if intraoperative haemoglobin falls below 90 g/l, and fresh frozen plasma used cautiously in patients with coagulopathy.

This lecture will discuss the role of the anaesthetist in the perioperative management of severe TBI, with particular reference to optimisation of systemic physiological variables including blood pressure, arterial blood gases, fluid balance, and glycaemia and temperature control, and ICP management.

FEATURE



DR KELLY BYRNE
HAMILTON, NEW ZEALAND

Consultant Anaesthetist, Waikato Hospital, Hamilton, New Zealand

REGIONAL ANAESTHESIA – OPTIMAL ANALGESIA FOR TOTAL KNEE REPLACEMENT

Total knee arthroplasty is one of the most common procedures performed worldwide. In 2011, it was the fourth most common surgical procedure in the US, with 718,000 total knee joint replacements performed in that calendar year. Despite the frequency of this procedure, there is no widely accepted analgesic regimen in place for total knee replacement.

Australasia, Canada and the UK have largely moved away from the routine use of epidural analgesia for total knee joint replacements, while practice in the US is so diverse that it is hard to generalise. A driving force behind this change in practice is the 'Enhanced recovery from surgery' craze that is currently sweeping the globe.

The best current evidence supports the use of a single shot femoral nerve block in total knee joint replacement, although there is now a strong body of emerging evidence supporting high volume local anaesthetic infiltration of the joint as an effective alternative. The evidence basis behind these two techniques will be examined in detail and the challenges to the anaesthetist of this potential change in practice will be examined.

Other topics that will be covered during this presentation include the place of the adductor canal block in anaesthetic practice, and emerging advances in local anaesthetics, including liposomal bupivacaine and the still experimental, permanently charged lignocaine analogues that are able to access the nerve through the TRPV1 channel.

A DAY IN THE LIFE OF AN ANAESTHETIST: A MEDICOLEGAL PERSPECTIVE

We spend a lot of time discussing and practicing for stressful clinical events such as not being able to intubate or ventilate the patient. However, these events are rare and most of us will probably never encounter them in clinical practice. We spend almost no time considering the medicolegal implications of our practice, or discussing ways of dealing with patient complaints, which are very common clinical scenarios of which most of us will encounter during our working lifetime.

Fear of medicolegal problems has been rated amongst the top three concerns of anaesthetists and it is invariably a stressful event for those of us who have to face it. Our practice environment is constantly changing and there appears to be an increasing number of complaints made against doctors. Data from the US suggests that the presence or absence of negligence does not relate to whether or not a complaint is made.

This presentation aims to cover the common medicolegal events that we encounter in our daily practice. It will explore, in detail, some of the issues related to consent and discuss some of the important cases in Australia and New Zealand that relate to consent. It will aim to provide a perspective on what you can do in your daily practice to reduce your exposure to potential medicolegal problems, and what your lawyer will be interested in if you have to defend a claim.

Other medicolegal aspects of our daily job, such as the implications of writing a reference for someone, the obligations under the law in relating to the impaired colleague and the medicolegal standing of practice guidelines will also be covered.

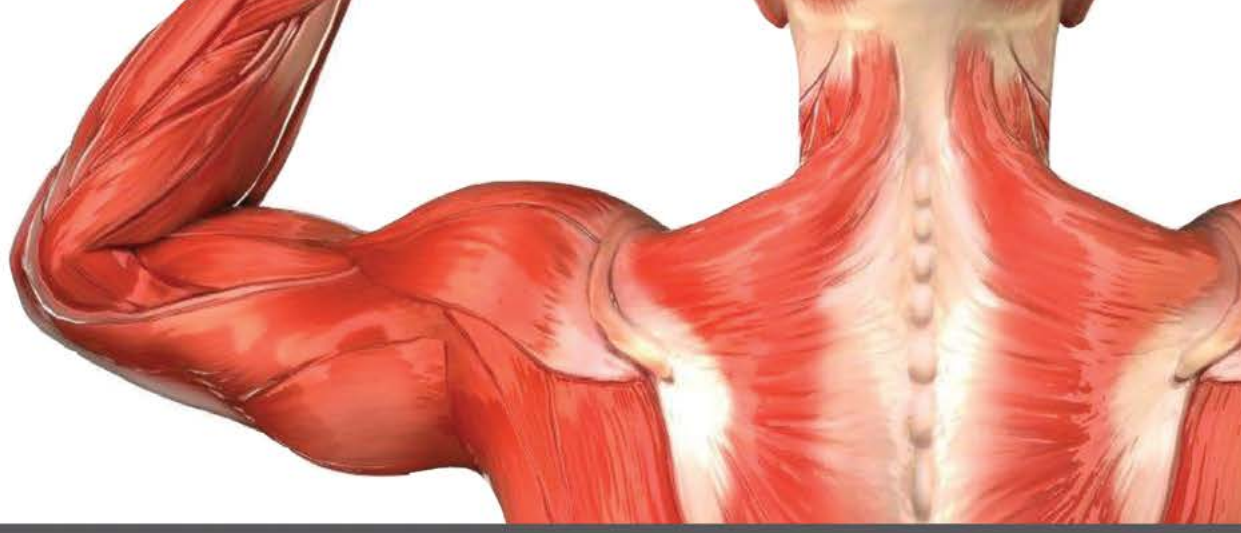
SESSION TIMES

Optimal analgesia for total knee replacement
Saturday 12 September, Waterfront 3, 1600–1730

Workshops – Basic and Advanced transthoracic echocardiography
Sunday 13 September, Waterfront 1, 1100–1230 & 1330–1500

A day in the life of an anaesthetists: a medicolegal perspective
Monday 14 September, Auditorium 1, 0815–1000

PBLD 11 – Nerve blocks for the decrepit
Monday 14 September, Meeting Room 2, 1030–1130



Anatomy and Ultrasound for Peripheral Nerve Blockade Workshop

Overview

This one-day hands-on practical course provides anaesthetists and trainees with the opportunity to learn new skills and theoretical knowledge to enhance their practice of regional anaesthesia.

The anatomy laboratory at the University of Queensland is purpose built for the education of medical and allied health staff where participants will receive guidance from experts in regional anaesthesia.

In addition to a comprehensive theoretical component, practical sessions include:

- Head, neck and eye block
- Tap blocks
- Lumbar, thoracic and paravertebral
- Sciatic and lower limb
- Upper limb
- Needling and ultrasound

Participants of the workshop will gain new knowledge and the confidence to perform regional anaesthesia in their clinical setting. Workstations are conducted in small groups, limited to six to allow adequate time for practice at each workstation. This event has been established since 2005 with positive feedback from previous participants.

REGISTER ONLINE!

To register online, visit www.asa.org.au and click on the Upcoming Events page under the Education & Events tab OR email events@asa.org.au for assistance.

Registrations close on 30 October 2015. Due to limited space, an early registration his highly recommended.

When

- Saturday 21 November 2015

Time

- 7:00am to 5:15pm

Tuition

- AU $750 ex. GST Early Bird on or before 1 September
- AU $795 ex. GST Standard after 1 September

Includes education material and trainer costs:

- University of Queensland specimen preparation and lab usage
- Certificate of attendance
- Workshop materials (including safety gear)
- Morning tea, lunch and afternoon tea

Venue

Gross Anatomy Facility – Otto Hirschfeld Building
University of Queensland, St Lucia, Brisbane

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

AESCULAP ACADEMY

ASA
Australian Society of Anaesthetists

FEATURE

ACCOCIATE PROFESSOR ALICIA DENNIS
MELBOURNE, VICTORIA

Assoc/Prof, University of Melbourne; Director of Anaesthesia Research and Staff Specialist Anaesthetist, The Royal Women's Hosptial, Parkville, Victoria

PREECLAMPSIA UPDATE – THE UNIFIED THEORY OF PREECLAMPSIA

Hypertension in pregnant women is a global health problem affecting millions of women each year. Approximately 20% of women who are left untreated will die. In October 2014, a new, unified theory of preeclampsia was published[1]. It took into account the definitions of hypertension in pregnancy, the differing classifications based on gestation and severity, and the risk factors, as well as recent haemodynamic work over the last five years, which has demonstrated a hyperdynamic cardiovascular system state[2,3].

This new theory enables an explanation of the condition and proposes that the development of new onset hypertension in pregnant women is an adaptive, rather than maladaptive, response to the presence of the growing fetus. Pregnancy is uncomplicated in women who can maintain a balanced oxygen supply for the growth and oxygen demands of the developing foetus; pregnancy is complicated by hypertension in women who are unable to maintain a balanced response[1]. This adaptive response to an inbalance in maternal oxygen supply and foetal oxygen demand progresses in a stepwise fashion from a subclinical condition of increased bloodflow, to then uncomplicated hypertension (gestational hypertension), to complicated hypertension (preeclampsia) and then finally to decompensated hypertension.

Conditions that lead to the development of hypertension in the pregnant woman can be subdivided into those that originate in the maternal cardiovascular system (pre-placental conditions – reduced oxygen content and reduced oxygen delivery), those that originate in the placenta (placental conditions – abnormal structure and/or function) and those that originate in the foetus (post-placental conditions – multiple foetuses, macrosomic foetuses). Each combination of women and foetus may have one or more conditions present and this may change from pregnancy to pregnancy in the same woman, may change with gestation in the same woman, and may differ from woman to woman; thereby explaining the heterogeneity of the observations in women with the condition.

The theory also enables a framework for research that focuses on the broad categories of pre-placental, placental and post-placental conditions and allows a systematic approach to the prevention and treatment of new onset hypertension in pregnant women.

References:

1. Dennis AT, Castro JM. Hypertension and haemodynamics in pregnant women - is a unified theory of pre-eclampsia possible? Anaesthesia 2014;69 1183-1189.
2. Dennis AT, Castro JM, Simmons SW, Permezel M, Royse CF. Haemodynamics in women with untreated pre-eclampsia. Anaesthesia 2012;67:1105-1118.
3. Dennis AT, Dyer RA, Gibbs M, Nel L, Castro JM, Swanevelder JL. Transthoracic echocardiographic assessment of haemodynamics in severe pre-eclampsia and HIV in South Africa. Anaesthesia 2015.

SCIENCE, SEX AND SOCIETY – WHY MATERNAL MORTALITY IS STILL A GLOBAL HEALTH ISSUE

The World Health Organization estimated that, in 2013, approximately 289,000 maternal deaths occurred, with the lifetime risk of a woman dying during pregnancy of childbirth in Africa being as high as 1 in 40 women. Maternal mortality is often a preventable problem, however access to health services, skilled help, appropriate infrastructure, hygiene and essential medicines and blood, mean that the burden of maternal mortality predominantly exists in developing countries. Maternal morbidity, a problem that exists in both low and high infrastructure countries, is due to the complications that women experience due to pregnancy related illnesses. It is estimated that approximately 20 million women annually experience these problems. Whilst some gains have been made in reducing maternal mortality, and possibly morbidity, with the introduction of the Millennium Development Goals, there is still a significant amount of work to be done before health outcomes for pregnant women are acceptable[1–3].

Underpinning any advancement in this area is the need to achieve gender equity; where all people, regardless of gender, are given what they need to enjoy a full and healthy life. Maternal mortality is a gender specific problem. The relatively limited application of scientific research to pregnant women and society's often historically burdened mystical views of pregnancy, girls and women means that a multipronged approach is necessary to breaking down this triad of scientific, sexual and sociological barriers.

Global health strategies to reduce

SESSION TIMES

Preeclampsia update – the unified theory of preeclampsia
Saturday 12 September, Auditorium 1 & 2, 1600–1730

Science, sex and society – why maternal mortality is still a glabal health issue
Monday 14 September, Auditorium 1, 0815–1000

Obstetric Haemorrhage; still a long way to go
Monday 14 September, Waterfront 2, 1300–1500

PBLD 21 – Pushing up the pressure – preeclampsia revisited
Tuesday 15 September, Meeting Room 1, 2 or 3, 0845–0945

maternal mortality involve addressing specific issue such as violence against women, access to safe contraceptive services for women and universal education, incorporating the necessary infrastructure of clean water, and sanitation services, for girls[4]. The future will be improved by allowing all girls to gain an education and for all women to value the one they have received. Specific to our profession, anaesthetists can be advocates for positive change by maintaining critical scientific thinking in the management of pregnant women and insisting that we are part of the multidisciplinary team so that pregnant women have choice and safety for their birth.

References:

1. United Nations. The Millenium Development Goals Report New York, 2014, ISBN 978-92-1-101308-5.
2. Australian Institute of Health and Welfare : Humphrey MD, Bonello MR, Chughtai A, Macaldowie A, Harris K & Chambers GM 2015. Maternal deaths in Australia 2008–2012. Maternal deaths series no. 5. Cat. no. PER 70. Canberra: AIHW
3. Knight M, Kenyon S, Brocklehurst P, Neilson J, Shakespeare J, Kurinczuk JJEoboM. Saving Lives, Improving Mothers' Care - Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–12. Oxford: National Perinatal Epidemiology Unit, University of Oxford. 2014.
4. UN Women. The Beijing Declaration and Platform for Action Turns 20 Report - Summary Report of the Secretary-General on the 20-year review and appraisal of the implementation of the Beijing Declaration and Platform for Action and the outcomes of the twenty-third special session of the General Assembly (E/CN.6/2015/3). 2015.

OBSTETRIC HAEMORRHAGE; STILL A LONG WAY TO GO

Obstetric haemorrhage remains a leading cause of maternal mortality globally[1]. It is defined as significant bleeding in the setting of pregnancy and importantly includes antepartum haemorrhage, which accounts for 24% of all haemorrhage deaths[1]. According to the World Health Organization, after pre-existing conditions exacerbated by pregnancy such as diabetes, malaria, HIV and obesity, which account for 28% of maternal deaths, severe bleeding is the second most common cause of maternal death (27% or approximately 78,000 maternal deaths per year). The vast majority of these deaths occur in poorer countries with low infrastructure. Furthermore in these settings most deaths due to haemorrhage are thought to be preventable.

Essential interventions to reduce maternal death, and specifically those due to haemorrhage, include provision of safe contraception and safe termination of pregnancy services for women[2], regular antenatal care and quality care before, during and after childbirth, including skilled care at birth, safe blood supplies, access to essential medicines such as antibiotics and oxytocin, safe anaesthesia and safe surgery[1].

Essential strategies to reduce maternal mortality from haemorrhage at a global level include addressing issues of gender inequity. This includes removing barriers to women accessing health services and removing barriers to girls accessing educational facilities.

In countries with low maternal mortality from haemorrhage, morbidity from haemorrhage remains high and includes complications of blood transfusions and hysterectomy[3,4]. In this setting, haemorrhage should be prevented with optimal antepartum, intrapartum and postpartum care. High-risk groups include women greater than 40 years of age, women with increased body mass index, women with abnormal placentation, women living in poverty and women living large distances from medical services. Early recognition of the critically ill woman is essential so that senior clinical and multidisciplinary team members can be organised quickly. Ongoing education and vigilance is necessary to prevent complacency in low mortality settings.

In the area of obstetric haemorrhage, there is still a long way to go to reduce the mortality and morbidity from this condition. As anaesthetists, we can be advocates for positive change and we must always remember that the standard we walk past is the standard we accept – let's make our journey one that our patients, our colleagues and ourselves can be proud of.

References:

1. Say, L., D. Chou, A. Gemmill, O. Tuncalp, AB. Moller, J. Daniels et al 2014. "Global causes of maternal death: a WHO systematic analysis." Lancet Glob Health 2(6): e323-333.
2. World Health Organization. 2014 Ensuring human rights in the provision of contraceptive information and services:guidance and recommendations ISBN 978 92 4 150674 8.
3. Australian Institute of Health and Welfare : Humphrey MD, Bonello MR, Chughtai A, Macaldowie A, Harris K, Chambers GM 2015. Maternal deaths in Australia 2008–2012. Maternal deaths series no. 5. Cat. no. PER 70. Canberra: AIHW.
4. Knight, M., S. Kenyon, P. Brocklehurst, J. Neilson, J. Shakespeare and JJE.M. Kurinczuk 2014. "Saving Lives, Improving Mothers' Care - Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–12. Oxford: National Perinatal Epidemiology Unit, University of Oxford".

FEATURE

PROFESSOR DEBRA SCHWINN
IOWA CITY, IA, USA

Dean of the University of Iowa Roy J. and Lucille A. Carver College of Medicine, Iowa City, IA, USA

GENETIC VARIABILITY – WHY DO SIMILAR PATIENTS HAVE DIFFERENT OUTCOMES?

Clinical genetics is part of mainstream medicine, now called precision (personalized) medicine. Genomics has led to new recognition that solid tumors actually consist of hundreds of cancer cells. Using single cell whole genome sequencing, metastases are now suspected to be minority cancer cells with different genetic mutations, not killed by a chemotherapeutic targeted to a majority cancer mutation type. In spite of such striking evidence of the power of genomic medicine, some suggest genetics is not relevant to anaesthesia. Nothing could be further from the truth. Perhaps we have not asked the right questions as a specialty to reveal the relevance.

Genomics

After sequencing the entire human DNA in the 2000, scientists turned to massively sequencing DNA from individual patients with and without disease. Next, large arrays of thousands of single stranded RNA molecules from cells or animal/human tissues were compared before/after conditions, and changes in RNA quantitated. Large-scale protein analysis is more difficult since it involves the use of mass spectroscopy, which is more labor intensive; this field is called proteomics. Following suit, identification of hundreds of small molecules and metabolites in cells, using biochemistry approaches, is called metabolomics. From these genomic methods, genetic fingerprints of tumors and diseases have begun to emerge.

Clinical Genetic Study Approaches

DNA sequence variation (single nucleotide polymorphisms or insertion/deletion sequences) may lead to alterations in protein sequence and function, therefore forming the basis of variability in disease expression and therapeutic efficacy. Genome-wide association studies (GWAS) identify thousands of short DNA sequences (markers) found throughout the entire human genome. More recently studies have focused on fairly large fragments of DNA that travel together, called haplotypes. It is interesting to note that mitochondria, powerhouses of cells, contain their own DNA. Mitochondrial DNA encodes only 13 genes, is circular, single-stranded, and is inherited from maternal mitochondrial DNA (as opposed to genomic double-stranded DNA inherited from both mother and father). Because of the importance of mitochondria in cellular metabolism as well as producing free radicals with ischaemia/reperfusion injury, it is increasingly apparent that variation in genomic and mitochondrial DNA is critical in determining how an individual patient may respond to injury.

Epigenetics describes the many ways DNA transcription can be modified/regulated without altering the DNA base pair sequences themselves. Adding complexity to gene regulation is the recent discovery of microRNAs (miRNAs); these small, 18-25 nucleotides long non-coding RNAs modulate gene expression levels via binding mature miRNAs to complementary mRNAs. This binding negatively regulates expression of specific genes by either degrading the bound target miRNA or directly inhibiting translation. Specific miRNAs have been implicated in diseases, including playing a critical role in controlling cardiac stress responses.

ICU care: diagnosing presence of disease causing agents

Genomics is crucial in the ICU where bacteria and viruses can be identified rapidly, including identification of specific strains. While normal flora must be taken into account, drug-resistant and highly virulent strains of bacteria can be identified now fairly rapidly, enabling definitive treatment to be initiated within hours of specimen testing. Diagnostic cultures are still used for confirmation, but in many cases a more definitive anti-microbial agent can be started immediately. This decreases drug resistance within hospitals (by decreasing the use of broad-spectrum antibacterial agents) and helps to track strains present within outbreaks.

Genetic of Coagulation

Genetic testing is particularly useful in drugs targeting the coagulation pathway. Examples include prediction of starting dose for highly toxic drugs such as warfarin (coumadin) and use/efficacy of anti-platelet drugs such as clopidogrel. For warfarin, some genotypes important for warfarin metabolism and vitamin K activity have been shown to be important in improving prediction

SESSION TIMES

Genetic variability: why do similar patients have different outcomes?
Sunday 13 September, Auditorium 1, 0830–1030

Translating today's research into your practice
Tuesday 15 September, Auditorium 1, 1130–1300

What do changes in the medical curriculum mean for anaesthetic training?
Monday 14 September, Waterfront 2, 1030–1200

of therapeutic warfarin dose and overall anticoagulation management. Because improved prediction has great potential to limit warfarin side effects such as excessive bleeding and emergency room visits, genetic testing is increasingly routine as warfarin is initiated. For the antiplatelet drug clopidogrel, therapeutic efficacy is the target. Clopidigrel is a pro-drug, and some individuals cannot metabolise the pro-drug to active drug due to genetic variability in metabolising enzymes, and hence do not respond with expected anti-platelet activity. Clopidogrel use is so common in unstable angina or coronary stent placement, that the FDA recently put a black box warning so clinicians would be aware to prescribe alternative anti-platelet drugs to the subset of patients who are non-responders.

Another important genetic variant in coagulation is Factor V Leiden. Factor V Leiden is resistant to inactivation by Protein C in the clotting cascade (it is degraded more slowly that normal wild-type Factor V). This results in increased thrombin generation and an enhanced incidence of deep venous thrombosis (DVT). Factor V Leiden is quite common, occurring in up to 10% of those of European descent. In the U.S., 4-7% of the general population is heterogeneous for Factor V Leiden, which makes them 5 times more prone to DVT at baseline and up to 35-times more prone to DVT when taking exogenous estrogens. It is striking that while most patients are given DVT prophylaxis in the perioperative period, identification of patients at highest risk (e.g. those with Factor V Leiden) is not routinely performed neither in studies nor in clinical medicine.

Conclusion

Clinical genetics has become part of mainstream medicine in many settings relevant to anesthesiologists. This brief review has highlighted key areas of perioperative medicine where genetic is relevant.

WHAT DO CHANGES IN MEDICAL SCHOOL CURRICULA MEAN FOR ANESTHESIA TRAINING?

Medical education innovation is occurring rapidly alongside changes in healthcare delivery. Recognition of new teaching methods that target adult learning strategies, team based care and interprofessional education (IPE), and emerging clinical sciences are all embedded in modern medical school curricula. The continuum of medical education has also expanded from undergraduate medical education (UME) to graduate medical education (GME) to continuing medical education (CME) and beyond. The common thread throughout all of these education innovations is creation of curious, life-long, self-directed learners via active problem-solving approaches to education. We can learn from these new approaches in our anesthesia education programs.

Brave new world

For years, medical knowledge has been taught in cloistered spaces, usually within the confines of formalised graduate medical or health science education programs in universities. This is rapidly changing. Over the last ten years the Kahn academy and other e-learning platforms have facilitated learning medical and biomedical 'facts' by anyone. Now, with the help of computerised anatomy tools (e.g. Cyber-Anatomy, https://www.cyber-anatomy.com), virtual anatomy learning is possible from anywhere in the world, by anyone. As a result, medical learning not only exists along the classical continuum of medical education and practice, it is rapidly being disseminated at all levels in our education system.

This brave new world of education has potentially wonderful ramifications for anaesthesia training. Before 'trying' a nerve block as part of patient care, detailed anatomy modules can be completed, questions answered, and various forms of visualisation and virtual interaction accomplished -- with the entire process occurring at a computer near the patient. This is useful for residents/registrars and anaesthesia fellows, as well as faculty who infrequently perform regional anesthesia. Furthermore, quality and patient safety (Q&S) science can be embedded simultaneously if the nerve block quality, efficacy during surgery and patient satisfaction is incorporated into standardised clinical documentation.

Knowing facts, however, does not directly translate into an ability to perform as a physician and practice medicine safely, particularly in challenging clinical settings. Physicians creatively analyse patient symptoms and, by asking a series of thoughtful questions, ultimately identify difficult and/or non-obvious diagnoses.

FEATURE

This process requires critical thinking skills layered on top of facts. Enter the flipped classroom, a pedagogical model where a typical lecture and homework sequence is reversed. Homework is given and expected to be reviewed/completed (e.g. short video, review article, questions/problems) prior to class. When all students are familiar with concepts as they enter class, deep discussions are possible that further embed the material. Furthermore, such discussions allow the teacher to identify and correct misunderstandings. Using these concepts, asynchronous learning can be completed prior to the scheduled clinical day, allowing discussions with multiple small groups of residents/registrars rather than requiring all trainees present for a classic lecture; this ultimately enhances flexibility for teaching concepts during clinical activities.

Finally, clinical care going forward will increasingly be delivered in teams. Medical students now often train in clinical setting with other health professionals. The next step in preparing students for team-based care is to have such care modeled throughout our healthcare system. One aspect of embedding IPE into clinical practice that is particularly relevant to anaesthesia is the process of patient hand-offs. After procedures, anesthesia practitioners transfer care of patients to a range of practitioners and information needs to be tailored to the individual receiving the patient. While standardised methods of hand-offs are encouraged, thinking through the most appropriate provider specific information (and emphasis) is important and provides an expedient way to embed teaching of interprofessional team-based care.

Continuous learning

Perhaps the most exciting aspect of the current medical knowledge explosion is availability of continuous learning for medical practitioners. In-depth, iterative self-study can be achieved through programs such as OpenAnesthesia (http://www.openanesthesia.org), the first adaptive learning system in anaesthesia. The next generation of online learning technology is individualisation of content. Such adaptive programs target learner's strengths and weaknesses, specifically reviewing and reinforcing correct answers while providing more practice long-term in areas of weakness, so that success is built over time.

New emerging clinical science, such Q&S science or clinical informatics, provides an avenue for even the busiest practitioner to learn new skills at any point in their career. Since medical care today often requires understanding diverse fields outside medicine, combined degree programs can be advantageous. Consider a medical student committed to rural medicine with a Master's Degree in clinical informatics; such an individual will likely transform their local access hospital, township/region, state and country. Indeed, some anaesthesia residency/registrar training programs already incorporate a formal Q&S rotation led by hospital epidemiology and the Chief Medical Officer.

Conclusion

Medical knowledge acquisition is rapidly changing, allowing flexibility, and new creativity across the health care learner spectrum. These ideas can, and should, be creatively and easily applied to anesthesia training.

COME & VISIT THE ASA TEAM AT THE CSC 2015.

- Update your details
- Grab a treat
- Sign up your friends
- GET involved with the Society

ASA

Australian Society of Anaesthetists

FEATURE

ANAESTHESIA AND THE SPECIALIST MEDICAL WORK-FORCE: 2015 SNAPSHOT

Members continue to express concern about the anaesthesia workforce in Australia, both present and future. Following a meeting held between the AMA, ANZCA and the ASA early in 2015, the Department of Health is examining vocational training in anaesthesia. The background to this work will be the data collected by the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA), and the reports of the Medical Training Review Panel (MTRP) and Health Workforce Australia (HWA).

In the following document, Dr James Bradley discusses the latest reports on undergraduate and postgraduate medical training in Australia, outlines the demographics of the current Australian medical workforce focussing on anaesthesia, and compares the current anaesthesia workforce with the predictions of HWA for 2018.

In mid-2014, the MTRP released its 17th report of this kind, which addressed findings from as recently as the end of 2013. As in previous years, university and postgraduate training, trainee and college fellow demographics, examination results along with some matters concerning overseas trained medical practitioners are sequentially examined. Sources of information include the medical deans, the colleges, state and territory health departments and the Australian Medical Council (AMC).

Initially formed under legislation in 1996, the MTRP is, post the 2013 Federal Budget, again the responsibility of the Department of Health, with HWA having been recently subsumed. MTRP reports to the Federal Health Minister, and has advised of "the continued increase in medical training that has occurred, particularly since 2007" and that "the boost to the health workforce is key to addressing shortages in many parts of Australia". Furthermore, the MTRP "brings knowledge of the various levels of training and different insights into the way medical education and training can deal with the challenges of increasing numbers of students and trainees, and produce the workforce trained in the areas needed

and equipped with the skills necessary for the future". These statements echo the previous year's comment that "[the MTRP] will be working… to better understand Australia's medical workforce supply and how to tailor medical education and training to ensure that the workforce is able to meet the future needs of Australians".

The 17th MTRP report and its large number of tables can be accessed at http://bit.ly/1Glsts0.

UNIVERSITY MEDICAL TRAINING

In relation to university medical training, the MTRP (Figure 1) confirms a doubling of the number of medical graduates over the decade to 2010, with a further increase to 3284 in 2012 increasing ultimately to 3732 in 2015 and, based on enrolments, stabilising (3,796) in 2018. This is underwritten by the 3669 students who commenced medical studies in 2013, with the percentage of international students remaining at about 15% (618 for 2018). With the number of commencing students now stabilising, a total of about 17,000 medical students spread over courses of different durations was expected to be the norm for the next few years, with about 3700 graduating each year.

However, in May 2015, a new medical school was announced for Curtin University (WA), to join in the 19 medical schools already in operation, with public funding for 550 places, and both La Trobe and Charles Sturt Universities are seeking approval to open medical schools. In the latter cases, claims that the large majority of students would come from regional backgrounds are being used for justification on the grounds that these students would be more likely to practise 'in the bush'.

MTRP reports that approximately 80% of all medical students (13,315 of 16,994 for 2013) continue to be Commonwealth-supported –70% via the Higher Education Contribution Scheme (HECS), about 25% via the Bonded Medical Places Scheme (BMPS), and a small and decreasing number (416 places in 2013) via the Medical Rural Bonded Scholarship Scheme (MRBSS). These two latter require a return of service, with MRBSS recipients being required to work in "remoteness areas" after completing vocational training. Approximately 21% of students are fee-paying and about half of commencing students are female. A small number (261) of students report that they are of Aboriginal or Torres Strait Islander origin, with about one quarter of all domestic students having a rural background.

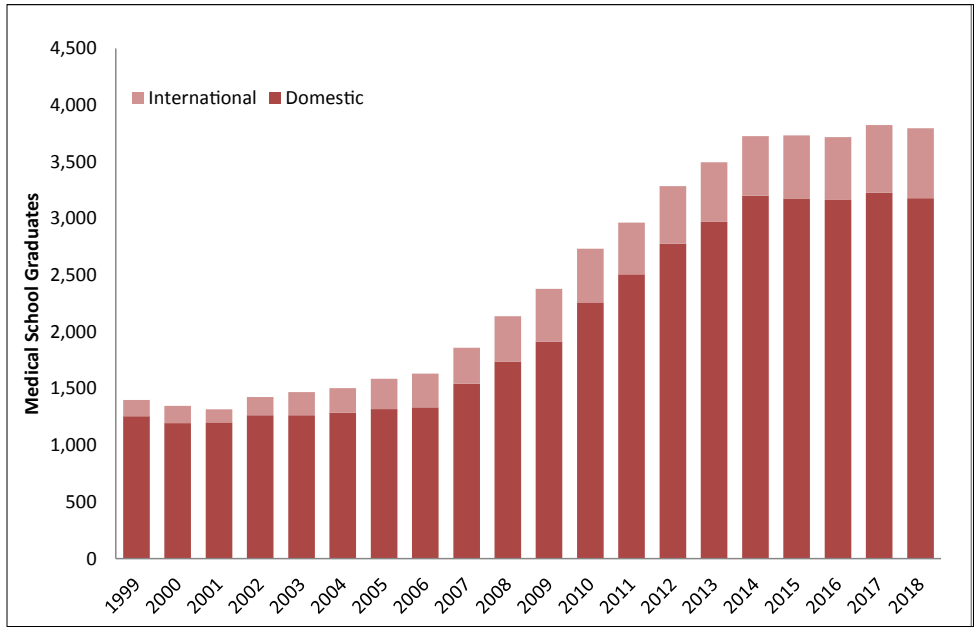


Figure 1: Domestic and international medical graduates, 1999–2012. Source: Medical Deans Australia and New Zealand Inc. Reproduced from Medical Training Review Panel Seventeenth Report; Figure 3, p. 4.

PREVOCATIONAL MEDICAL TRAINING

All graduates need to satisfactorily complete the first postgraduate year (PGY1) to achieve unconditional general medical registration with the MBA. Some new registrants will enter vocational medical training at this stage, though most will undertake a second or even third year of prevocational training. The MTRP advises that a small number will leave the medical workforce at this stage or continue to work in roles such as Career Medical Officers (CMOs).

VOCATIONAL MEDICAL TRAINING

Vocational medical training involves entry into specialist training through colleges or, in the case of general practice, the so-called General Practice Education and Training Ltd (GPET). These paths are accredited by the AMC. The report states that states and territories have different arrangements for managing vocational training and that they work with the colleges to offer training posts to be accredited as well as addressing supervision in public hospitals, state-wide training programs and the need for generalists or subspecialists.

Vocational training in anaesthesia is undertaken through ANZCA's curriculum, incorporating five years of approved training (two years of basic training [BT],

FEATURE

and two years of advanced training [AT], plus one year of provisional fellowship) following an initial two-year prevocational training period.

Across all specialties, MTRP reports that the number of vocational medical trainees has increased by 250% since 2000. There were 16,740 vocational trainees in 2012 and 17,888 in 2013. It would seem probable that the total number of vocational trainees would stabilise at about 17,000, with about 3000 'new fellows' across all specialties entering the post-training workforce each year.

It seems probable that the total number of vocational trainees would stabilise at about 17,000, with about 3000 'new fellows' across all specialties entering the post-training workforce each year

In regards to vocational training in anaesthesia, the MTRP states that the total number of basic trainees (BTs) increased from 410 in 2008 to 615 in 2012 but that it has then dropped, to 555 in 2013. First-year basic trainee numbers increased to 314 in 2012, but dropped to 215 in 2013, with 45.8% of total basic trainees being female.

There were 657 advanced trainees in anaesthesia in 2013, up from 609 in 2012, and 463 trainees in 2008. Advanced trainees in anaesthesia represent 5.5% of the 'AT' workforce.

The total number of anaesthesia trainees in 2013 was 1212 and at 31 December 2014 1188, slight decreases from the 1224 in 2012. The decrease from 2011 in first-year BT positions is noted and may help to explain this apparent stabilisation.

Two hundred and eighty sat the FANZCA fellowship examination in 2012, with 229 (81.8%) being successful. Of that 229, the report states that 50 (21.8%) were overseas-trained specialists.

The greatest increases in new fellows from 2008 to 2012 were in general practice (FRACGP and FACRRM) and adult medicine (FRACP) (more than 50%) and emergency medicine, with modest increases in surgery and obstetrics / gynaecology, and stable numbers in anaesthesia and intensive care. There were 3134 new fellows of medical colleges in 2012, an increase of 38.7% from the 2259 in 2008. In 2012, new fellows in anaesthesia comprised 7.3% of the new specialist workforce. The overall gender disposition was 44.5% female, and 676 (21.6%) were overseas-trained specialists.

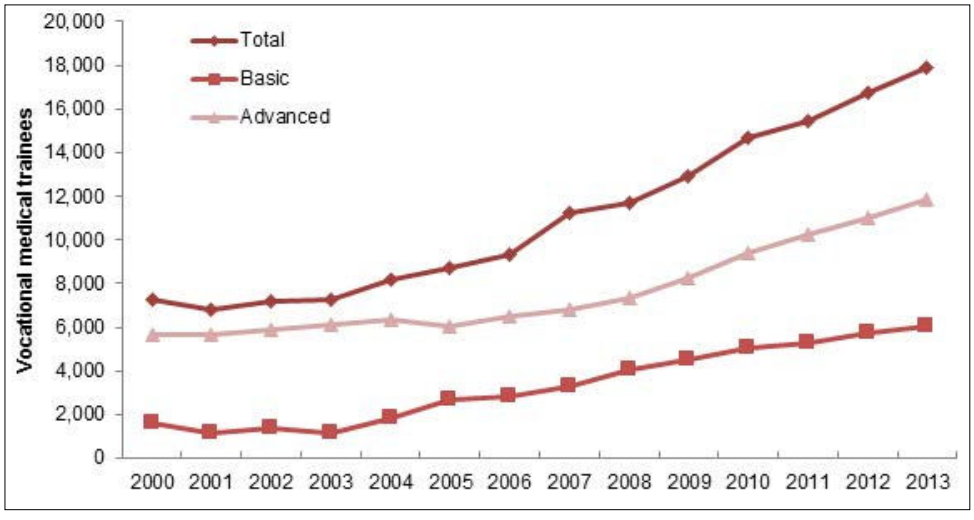


Figure 2: Vocational medical trainees, 2000–2013. Source: Medical colleges and GPET. From Medical Training Review Panel 17th Report.

The MTRP reports that of the 229 new fellows in anaesthesia, 50 (or 21.8%) trained overseas, compared with 71 in 2011.

Relative under-employment of anaesthetists and a potential loss of skills are likely consequences of any ongoing surplus.

Figures obtained this year directly by the ASA from AHPRA (which are in advance of updated MTRP reports) state that 253 new specialist anaesthetist were registered in 2013 and 228 in 2014.

These should be viewed in the context of new figures relating to retirement from the specialty are outlined.

THE CURRENT SPECIALIST ANAESTHESIA WORKFORCE

The published reports of the MBA state that 4350 and 4485 anaesthesia specialists were registered on 31 December 2013 and 31 December 2014 respectively. ANZCA reported 4163 Australian fellows as of 31 December 2014. A reasonable interpretation would be that approximately 300 'non-FANZCAs' are registered as specialists in anaesthesia.

The distribution of the fellows (i.e. FANZCA) across the states and territories continues to closely mirror the distribution of the population as a whole, at 31% for New South Wales, 25% for Victoria, 21% for Queensland, down to 1.6% for the ACT. There seems to be a continuing slight 'overpopulation' of specialist anaesthetists in South Australia and Tasmania and an under-population in the Northern Territory.

In 2012, in total, there were 51,967 fellows of medical colleges with 34.6% of these being female: anaesthetists constitute about 8% of the College fellow population.

Overseas-trained medical practitioners are, as in the 16th MTRP report, stated to form "a key part of the medical workforce in Australia, not only in rural and remote areas, but in all areas of Australia".

A total of 3090 visas were granted to overseas-trained medical practitioners in 2012–13, the lowest number since 2008–09. As previously, almost half of the visas granted were for UK and Irish practitioners, and almost one third were for those from the Indian subcontinent plus Sri Lanka, Malaysia and Singapore.

This of course begs the question: did we have an excess of new fellows in 2008, and has this excess simply continued?

The MTRP report also provides detail in relation to the process of assessment for these practitioners, the pathway to recognition as a specialist, and to the caveats related to employment in Districts of Workforce Shortage (DWS). Queensland has the highest number of overseas-trained doctors in absolute terms (2855) practising across all regions (with about 400 in remote and very remote areas). The picture in Western Australia is similar. However, the greatest number of overseas-trained doctors are to be found in Australia's major cities

With respect to anaesthesia, the report states that the assessment of 'Area of Need' anaesthetists is undertaken according to ANZCA policy.

It is to be noted that MTRP is silent with regards anaesthesia services provided by non-specialist anaesthetists. This is not within its remit, and the ASA is unaware if what mechanisms of any might define the workload of non-specialists. The ASA position in relation to non-specialist providers remains unchanged: the position is supportive, and underwritten by ASA position statement PS05.

PROJECTIONS: THE FUTURE SPECIALIST ANAESTHESIA WORKFORCE

It has been the expectation of the ASA that the HWA reports were likely to underwrite the orientation, perspectives and initiatives of government and other agencies in relation to the future health workforce, in particular the medical specialty workforce, including anaesthesia.

To recap, HW2025 examined a number of 'scenarios' which might ameliorate or worsen perceived problems with the current and future workforce in all major medical specialties. These 'scenarios' included the 'comparison scenario' (i.e. no changes), service and workforce reform, 'registrar work value', 'medium self-sufficiency' (through restricting medical specialist immigration) and the capping of working hours. HW2025 modelled each scenario in turn, but did not, as far as can be ascertained, consider combinations of scenarios.

HW2025 in reporting garnered and summarised 'stakeholder views'. The 'jurisdictional' stakeholder views were that there were problems recruiting specialists in regional areas, and that regional areas were often reliant on private sector specialists and international medical graduates. The 'College stakeholder'(i.e. ANZCA) view incorporated a trend to earlier retirement, an expanded training capacity available within the private sector, and the possibility that the training curriculum introduced in 2013 could have an effect (the latter negative).

As previously noted, the views of the ASA were not sought.

The MBA reports that were 4595 registered specialists in anaesthesia in Australia as of 31 March 2015… exceed[ing] all HW2025 demand projections three years early

HW2025, in summary, , raised no 'serious' or 'significant' concerns about the "workforce dynamics" of anaesthesia, reporting that as of 2012, anaesthesia had a practitioner-replacement rate of 'minimal' concern, an average practitioner age of 'modest' concern, and a dependence on overseas trained specialists and duration of vocational training of 'some' concern. It further predicted a "slippage" of all dynamics out to 2025, but not to a level of 'significant' concern. It also identified problems in recruiting anaesthesia specialists to regional areas. 'Inflows' for modelling purposes were, for a number of reasons, taken as 197 (the number of new fellows in 2009) dropping to about 170 from 2018, plus 40 (the number of international specialist anaesthetists entering each year, except for the 'medium self-sufficiency scenario'where the number was assumed to be 20), for a total 197 to 208 new specialists in 2018.

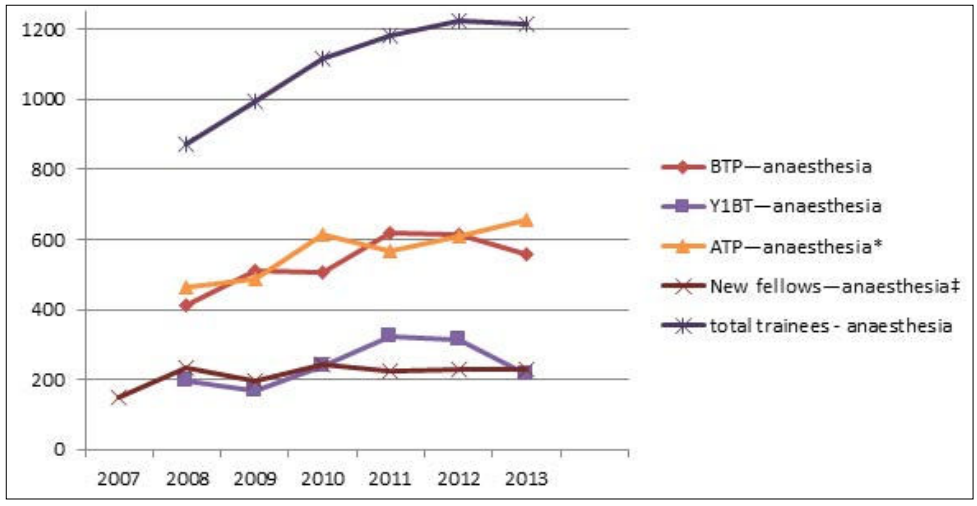


Figure 3: Number of basic and advanced trainee positions and new fellows in anaesthesia and pain medicine from 2007–2012. BT=basic training positions in anaesthesia, Y1BT=first year basic trainees in anaesthesia, AT=advanced training positions in anaesthesia or pain medicine.

FEATURE

A further deficiency in all reports to date (beyond a lack of data regarding anaesthesia services provided by non-specialist anaesthetists) concerns 'retirement' from the specialty. MTRP has so far been silent in this regard, but figures obtained this year from AHPRA by the ASA show that in 2013 and 2014, 61 and 102 practitioners respectively left the specialist anaesthetist register, resulting in a net gain of specialists of 192 in 2013 and 126 in 2014

Published national data now however enables comparison of actual anaesthesia specialist registrations with the predictions of HW2025:

- The MBA reports that were 4595 registered specialists in anaesthesia in Australia as of 31 March 2015.
- HW2025 established 2018 as a 'waypoint' for comparing supply versus demand:
- It estimated 'anaesthetist supply' as 4763 (the 'worst case' scenario: with restriction of specialist immigration and no other changes) to 5026.
- It estimated 'anaesthetist demand' for 2018 as 4092 ('best case' scenario: achieved through service and workforce reform) to 4505.
- Accordingly, the number of currently registered specialist anaesthetists exceeds the HW2025 demand projection scenarios for 2018 three years early.

WHERE NOW?

Questions asked previously by the ASA can now be addressed with the benefit of the further information emerging, with the possibility of some answers – or further questions:

- Do we have an excess of anaesthesia vocational trainees? While until recently the ASA had believed that there had been a very significant increase in anaesthesia trainee numbers in the last few years, the MTRP in fact reports stable numbers of new fellows in anaesthesia from 2008 to 2012. This begs new questions: did we have an excess of new fellows in 2008, and has this excess simply been maintained?
- Is there evidence that the average practitioner age and the 'replacement rate' are of concern? While HW2025 makes these assertions, there is not, yet in the view of the ASA, a clear answer. This year, for the first time we have details of the numbers of specialists in anaesthesia entering and leaving the national register, with net gains of 192 in 2013 and 126 in 2014 occurring. Of immediate value will be the application of knowledge of the age distribution of practitioners, given that age-based retirement should be relatively predictable.
- Given that the 2013 ASA member survey indicated that only 12% of anaesthetists (perhaps 400) practice in areas with a population of less than 100,000 and that only 0.8% (perhaps 30 anaesthetists) practice in rural or remote areas, is it realistic to believe that overseas-trained specialists are all or part of the solution to service provision in areas where the case-mix and caseload, not to mention support or lack of support for the provision of procedural services, is intractably problematic? In other words, noting that the 'problem states' are Queensland and Western Australia and noting their demographics, why can't service provision at a sufficient level be achieved through appropriate collaboration with the existing anaesthesia workforce, including 'rural generalists' (who are in many cases the 'GP anaesthetists')?
- Is shortening the duration of vocational training, canvassed by HW2025 as an area for possible reform, a question of any relevance? This topic is the province of ANZCA, but ASA member surveys suggest that, given the relatively fewer hours worked and a reduced exposure to case numbers, any reduction in training time would be unlikely.
- HW2025 canvassed the 'work value' of advanced trainees in relation to meeting the clinical workload. It seems anecdotally that, in some jurisdictions, new fellows are staying on as 'senior registrars', likely with a view to future appointment to teaching hospitals as well as for skills 'consolidation'. Is this phenomenon real, and if so, are we already seeing the benefits of the 'registrar work value' scenario?
- If it is determined that there is an excess of specialists in anaesthesia, do measures which address the number of visas issued for overseas-trained doctors/specialists in anaesthesia offer the best initial means for modulating the specialist supply?

Table 1
New fellows by selected specialty: 2008 compared with 2012

Medical specialty	2008	2012
Adult medicine	303	456
Anaesthesia	234	229
Anaesthesia - Pain medicine	11	19
Emergency medicine	95	135
General practice		
RACGP	819	1216
ACRRM	22	63
Intensive care	62	63
Obstetrics and Gynaecology	63	81
Psychiatry	147	136
Surgery	171	217

Source: Medical colleges. Reproduced from Medical Training Review Panel 17th Report; Table 4.40, p. 88.

Relative under-employment of anaesthetists and a potential loss of skills are likely consequences of any ongoing surplus. The MTRP's assertion that "the boost to the health workforce is key to addressing shortages in many parts of Australia" would seem shallow in relation to anaesthesia and the potential consequences of this oversupply.

All figures and tables in this article are based on content of the Medical Training Review Panel 17th Report©, Commonwealth of Australia 2014, and on information received from AHPRA and the Medical Board of Australia.

2015 AUSTRALIAN SOCIETY OF ANAESTHETIST ANNUAL GENERAL MEETING

Date: Monday September 14 2015
Time: 3.30pm
Location: Darwin Convention Centre, auditorium 1

Please join us at Darwin Convention Centre for the election of the Board of Directors, reports from key officer Bearers and the presentation of the Prizes, Awards and Grants.

Visit the Structure & Governance at the ASA website **www.asa.org.au** to view the previous minutes and relating documents.

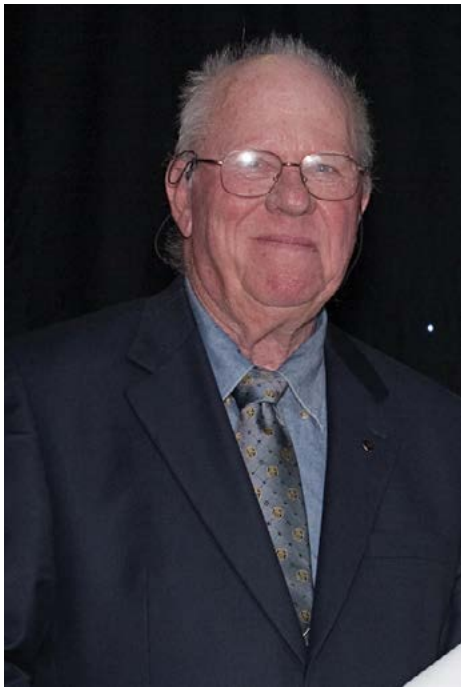
ASA
Australian Society of Anaesthetists

FEATURE

CONGRATULATIONS

Professor Ross B. Holland AM

Queen's Birthday Award recipient



As part of this year's Queen's Birthday Honours, long-serving ASA Member, Professor Ross Beresford Holland, was appointed to the Order of Australia in recognition of his enormous contribution to anaesthesia, healthcare standards and professional medical bodies, both here and internationally.

In 1952, Professor Holland graduated from the University of Sydney with a Bachelor of Medicine and Bachelor of Surgery and was admitted to the Fellowship of the, then, Faculty of Anaesthetists at the Royal Australasian College of Surgeons (now ANZCA) in May 1959.

In 1960, he was instrumental in founding the New South Wales Special Committee Investigating Deaths Under Anaesthesia (SCIDUA), the first body of its kind in the world, and was its initial Medical Secretary. He later became its Chairman and was the Committee's longest-ever serving member, only retiring from the organisation in September 2013. SCIDUA's creation was underpinned by Professor Holland's recognition of the importance of both analysing adverse events and granting anaesthetists the legal protection to report details of cases. The esteem with which he was held in the anaesthesia community, as well as his ability to work in conjunction with the State Coroner's office and NSW politicians, enhanced the reporting to, and recommendations of, the Committee. The SCIDUA was succeeded by equivalent committees in other states and Australia continues to lead the world in anaesthesia incident reporting and patient safety.

After accepting a post at Lidcombe Hospital in 1967, Professor Holland developed the Department of Anaesthesia such that it was approved for training of anaesthetists by the Royal College's Faculty of Anaesthetists. Similarly, he achieved training-hospital status for the Department of Anaesthesia at Westmead Hospital and retained Chairmanship of this Department through 1986.

In 1987, Professor Holland moved to Hong Kong, where he became the first Professor of Anaesthesiology at the University of Hong Kong, establishing similarly high standards of anaesthetic practice. He also held the title of Government Consultant in Anaesthetics.

Returning to Australia in 1990, he was appointed to the Chair of Anaesthesia and Intensive Care at the University of Newcastle and was Head of Department at the newly established John Hunter Hospital for three years.

Apart from a long-standing interest in the reduction of anaesthetic morbidity and mortality, he also has been involved in the development of improvements in anaesthesia and care for the developmentally disabled, as well as anaesthesia in non-hospital settings, such as dental clinics and stand-alone suites for electroconvulsive therapy for psychiatric patients.

Professor Holland has been involved in many aspects of the anaesthesia specialty and served as Dean at the Royal College's Faculty of Anaesthetists (equivalent to the Presidency of ANZCA). In 1993, his distinguished service was recognised with the presentation of ANZCA's Robert Orton Medal, the highest award given by the College. In 2006, he was the recipient of the Gold Medal of the Australian Council on Healthcare Standards for his individual contribution to improving the quality and safety of Australian health

services. In 2009, Professor Holland was presented with the ASA Gilbert Brown Award. The award is given to an individual who has made outstanding and particularly meritorious service to the Society and to anaesthesia in Australia.

He has also been a Member of Australian Cases Committee and the Medical Defence Union. Professor Holland served in Vietnam and in East Timor as part of Australian aid programs, and was decorated accordingly.

For years, he has maintained a keen interest in the history of anaesthesia and in historical artefacts of surgery and medicine. During his employment at Lidcombe Hospital, Professor Holland began a teaching collection of medical artefacts—as the collection grew, the Society for Preservation of the Artefacts of Surgery & Medicine was formed to protect it. Today, the Society's museum is operated on the old Gladesville Hospital site. Since his retirement from clinical practice in 2008, this interest has been upheld and, until 2015, Professor Holland acted as Chair of the ASA's History of Anaesthesia Library, Museum and Archives (HALMA) Committee.

In addition, he was Co-Chair of the Organising Committee for the 8th International Symposium for the History of Anaesthesia, which was held at the University of Sydney on 23 to 25 January 2013. This conference was very successful—a truly outstanding international occasion with delegates and speakers from the UK, USA, The Netherlands, Belgium, France, Russia and New Zealand.

In September 2013, Professor Holland presided over the opening of the ASA National Scientific Congress held at the National Convention Centre in Canberra.

Professor Ross Holland is a truly great contributor to our specialty and to the nation's community at large—his appointment in June as a Member (AM) in the General Division of the Order of Australia is certainly a well-deserved one.

REGULAR

FINANCE NEWS

PRIVATE SCHOOL FEES: 4 STRATEGIES TO EASE YOUR CASH-FLOW COMMITMENT

There are many reasons that compel people to begin investing, including funding their children's private education, writes Stuart Wemyss, a chartered accountant, financial planner and mortgage broker with ProSolution.

Private school fees can figure in the range of $10,000 to $30,000 per year and these are not the only expenses involved. Other additional costs to fees include computers, uniforms, extra-curricular activities and so on. The rule-of-thumb is to add a minimum of 10% onto the base fees to account for these hidden extras. As you can imagine, this education expense will put quite a dint in your cash flow if you don't plan for it in advance, particularly as most of us have more than one child. I have compared four strategies that aim to fund private school education and fees that people could consider implementing.

THE COST OF EDUCATION

I read an article a few years ago about the average increase in private school fees. It noted that between 2001 and 2012, the average fees from six elite Victorian private schools nearly doubled over that period (increased by 96%). That equates to an average increase of 8% p.a. The Australian Scholarship Group projects that, if you had a child today, their year 12 school education would cost you $67,149.

1. Develop a regular savings plan

One simple option is to open a high-yielding bank account and start marking regular contributions when your child is born. I've worked out that, to fund one child through private school education, you would need to save approximately $1,000 per month from the time they are born until they finished secondary school (i.e. over an 18-year period). In total, this requires you to save just over $280,000 (principal) over the 18-year period.

2. Buy a property and sell when schooling begins

Assuming your child is born in 2015, you will need approximately $310,000 in the year 2027 to fund their next six years of secondary school education. I project that if you purchase a $400,000 investment property and sell it in the year 2027 (after 12 years of ownership – just before the child starts secondary school), you will net cash proceeds of approximately $340,000 after paying for taxes and selling costs. This will be enough to fund the next six years of private secondary school fees.

In terms of the cash flow cost of the property, I have projected a strategy that will cost approximately $89,000 after tax to hold the property for 12 years – significantly less than Strategy 1.

3. Buy a property and borrow to fund education

Following on from the second strategy, an alternative is to not sell the investment property before the child starts school but instead retain it and borrow against the equity in the property to fund school fees. After the child finishes secondary school, the decision can be made to either sell the property and repay the school loan or hold onto the property for a little longer. By the time the child finishes secondary school (year 2033), I estimate that the property will be worth $1.35 million and there will be two loans secured by it. The first loan is the tax-deductible investment loan of $431k (used to purchase the property) and the school fee loan of $348k (so the loan-to-value ratio is just under 58%). If the investor sold the property after the child finished secondary school, they would net approximately $330,000 in cash after repaying both loans, selling costs and taxes.

In terms of the cash-flow cost of this strategy, you will need to pay interest in

respect to the loan used to fund private school fees. As you draw down the loan each year, the interest cost increases. The cash-flow cost of this strategy over the 18-year period totals $167,000 which is significantly more than Strategy 2 (i.e. $89,000). However, taking into account the cash sale proceeds (when the property is sold) of $330,000, the strategy is actually profitable by approximately $163,000 ($330k less $167k).

4. Regular geared investments in to the stock market

The fourth alternative strategy that I compared was a regular share market investment plan with gearing. The advantage of investing in the stock market (compared to property) is that you can invest regularly in smaller amounts. In addition, you can establish regular gearing. Using this strategy, I assumed that you would invest an amount of $560 per month of your own money into a managed fund beginning when your child is born. In addition, each month you would borrow the same amount ($560) to also contribute into the investment. When your child starts secondary school you would need to sell down your investments gradually to fund the fees. Once the child completes their schooling, you would sell any remaining investments and repay the loan.

In terms of cash-flow, this strategy costs you $560 per month (plus inflation) for 18 years – which totals approximately $160,000. The after-tax investment returns from the managed funds over the 18-year period will be approximately $13,000; so the net after tax cost of this strategy is close to $147,000.

In terms of a suitable managed fund, I would typically recommend a low-cost, passive-style investment such as an index fund.

HOW DO EDUCATION SAVINGS PRODUCTS STACK UP?

You may be aware that there are some providers that sell products aimed at helping you save for education. According to an article by Choice magazine, there are only two education savings plan providers – Australian Scholarship Group and Lifeplan. These plans are operated as a 'scholarship plan', which entitles the provider to recover the tax paid on investment earnings whenever those earnings are used to pay eligible education expenses. I have reviewed the above products and, on the whole, I don't feel that they provide a superior alternative to the four strategies above. They appear a bit convoluted, lack flexibility and are more expensive.

AND THE WINNER IS...

It seems obvious when you lay them out like this, that the best option is buying an investment property, borrowing the school-fee costs and selling the property when your child finishes school (or later depending on affordability). However, the best solution for you depends on your comfort level with debt, your investment preferences, level of existing investments and your cash-flow position (amongst other things). There is however, one additional important point that I need to make. The quality of the asset you invest in will greatly determine your success. You cannot expect above-average returns from average-quality assets. If you want quality returns, invest in quality assets. It doesn't matter how perfect your strategy is – no strategy can make up for poor-quality assets.

This is an edited version of an original article written by Stuart Wemyss. To read the full article and analysis, go to www.prosolution.com.au/schoolfees.

For more information, please contact:

Web: www.prosolution.com.au

Stuart Wemyss
Email: *swemyss@prosolution.com.au*

Phone: +61 3 8624 4610

Stuart Wemyss is an independent and licenced chartered accountant, financial planner and mortgage broker with over 18 years' experience in financial services. He founded ProSolution Private Clients in 2002.

REGULAR

CAREERS IN ANAESTHESIA
PRACTICE MANAGERS

Australian Anaesthetist spoke with two Practice Managers about their roles in anaesthesia and what they can do for our members.

CHERYL WOOD

Business Manager, Associated Anaesthetists Group Ltd.

I was employed three years ago as Business Manager for the Associated Anaesthetists Group in East Melbourne, but I tend to use the titles 'Business' and 'Practice' Manager, interchangeably. For me, any delineation of the roles would be:

- When I am 'working *on* the business', I am the Business Manager.
  For example: compliance/governance, business planning, human resource management, financial and operations management etc.
- When I am 'working *in* the business', I am the Practice Manager.
  For example: staff supervision/training and workforce planning, day-to-day practice tasks, communicating with stakeholders as a representative/ manager of the business etc.

You could say that I have an eclectic professional background. My previous employment history has included roles such as Practice Manager of single-practitioner physician offices, Marketing Director for Life.Be.In.It. International, Management Consultant, Senior Policy Program Advisor with the Victorian Department of Human Services and Executive Officer of a primary healthcare organisation. So as you may expect, I was initially attracted to the Business Manager role as it was one which would draw upon my broad professional experience, transferable skills and MBA qualifications.

From my experience, and I think most would agree, practice management varies from practice to practice and often depends on the size of the organisation and responsibilities expected of the manager. A background in staff supervision and leadership is important for anyone considering such a role. My job is very hands-on, with responsibility for financial planning, management, reporting and staff payroll, and therefore some financial skills and experience are highly regarded.

I see the role of a practice manager as one who identifies the core competencies of a practice's staff and works to enhance those skills to not only manage day-to-day functions of the business, but also look critically at each individual's roles and identify opportunities for improvement within existing systems and processes. On a daily basis, a practice manager is faced with a variety of tasks and situations and they need to be able to prioritise, compartmentalise and multi-task. As a leader/supervisor and representative of the organisation, good relationship and communication skills are critical.

When commencing in my role, I initially focused on building the capacity of the organisation through HR strategies, with a view to building skills and resilience in my staff. I also focused on establishing rigorous and robust financial management and reporting systems and implementing changes with a view to shared accountability and ownership for tasks across the organisation. Now, three years in, my role is primarily focused on maintaining the organisational capacity and financial management systems. However, after a number of system changes, I am about to commence a workflow mapping exercise to understand where we need to be allocating our staff resources and associated staff professional development needs. I guess the only constant is change!

One of the most challenging aspects of my role is HR management, particularly managing workflow peaks and troughs. This can be challenging when you have to manage staff planned and unplanned leave, ensuring we have adequate resources to meet the day-to-day needs of the practice during peak periods while also avoiding being overstaffed during periods of low workflow – a delicate balance, one might say.

Whilst there are always challenges that come with any role, there are also positives. The most rewarding aspects of my day are when staff say they feel accomplished. After a period of peak workflow or under-resourcing due to staff leave, when a staff member proudly announces they have finally caught up or achieved a goal, it is an achievement the whole practice celebrates as a group. Such achievements are often communicated to our anaesthetists so they can appreciate how hard the staff work for them. It is also

rewarding when one of our anaesthetists attends or communicates with the office to acknowledge the hard work and dedication of the staff.

Academia is great at turning out skilled clinicians. However, many anaesthetists are unfamiliar with the 'business of anaesthetics'. To be professionally successful and to achieve a great working relationship with their practice manager and staff, anaesthetists should familiarise themselves with the specifics of anaesthetic billing and informed financial consent. They also need to focus on developing good soft skills such as business development, promoting themselves to potential referrers and developing an ability to have difficult (financial) discussions with patients. Practice managers are often a great source of knowledge for new anaesthetists wanting to develop these skills, and they should avail themselves of our knowledge.

If our anaesthetists were asked what I do all day, their answers would range from, "she answers the phone/email and responds to my requests, questions and concerns", through to "she manages the staff in the office and makes sure the bills and staff get paid, and the work gets done". Though I would like to think they would say "she makes the business of my anaesthetic practice easy. She answers any questions I have, gives me advice and provides reports and resources when I need them. She manages a great team of staff who make sure I am offered work from time-to-time, covers my planned and unplanned leave and ensures I am where I am supposed to be, when I am supposed to be there. Her staff also ensure patients are aware of their financial obligations preoperatively, which is great, because I am then free to focus on the clinical aspects of their surgery; and most importantly, she ensures I get remunerated at an appropriate rate for the work I do".

ROSLYN CAIN

Office Manager, Narcosia Anaesthesia

I am the Office Manager for Narcosia Anaesthesia, a long-established practice of 32 anaesthetists in Brisbane, Queensland. I have been with Narcosia for over eight years and in my current position for four.

Anaesthetic practices and Practice Managers' roles vary according to the requirements of each particular practice. Practice Managers have diverse backgrounds and my background was, for many years, as a dental assistant, working in general practice and with oral surgeons and orthodontists in the private and public sectors. I have also spent time working for the Kimberley Public Health Unit in Derby in remote Western Australia. Every position I've held has given me a chance to gain more knowledge and, although I have no formal qualifications or degrees in practice management, I have been a keen learner over the years and have used my on-the-job learning, applying my knowledge of anaesthesia to take on the challenges of this important role.

While our responsibilities within our practices vary, I am an active manager, overseeing the administrative aspects of the practice to ensure the business runs smoothly, is current and up to date with legislative requirements and, most importantly, that we have a happy workplace. My role within the practice also encompasses covering the surgical booking lists for the anaesthetists and patient billing. Looking at my role within our practice, I believe it is important as a manager to be proficient with the practice software, to be able to understand and cover all positions within the practice, and to be able to effectively manage and offer assistance and problem-solve when necessary.

The role itself can, of course, have its challenges, as with any job! One such challenge is that, unlike a surgeon or specialist, a patient does not tend to see their anaesthetist until they are about to go into surgery and have little or no understanding about anaesthesia or those administering it. This, combined with pre-surgery apprehension and the minefield of health funds, can quite often be frustrating for the patient. To be able to educate and to provide patients with an understanding and acceptance of the process is one the more rewarding aspects of the job.

Cheryl is quite right when she mentions that many anaesthetists are not familiar with the 'business of anaesthetics'. This often presents a steep learning curve and practice managers provide assistance and information to help anaesthetists understand the business side of their profession. It's another rewarding aspect of the job to see new anaesthetists become more confident interacting with staff and to watch their business acumen develop in conjunction with their clinical expertise.

As readers will agree, anaesthetic billing is 'unique' within the medical profession. Over the past eight years, I have witnessed the idea of informed financial consent become significantly more important within the practice environment. The difficulty of providing financial information to each patient that is as accurate as possible, while maintaining the fact that informed financial consent provides an estimate of likely fees (not a 'quote'), is a part of this ongoing evolution. In this aspect of practice, we often have to work together, educating each other, and conquering this challenge is another rewarding part of a practice manager's job.

It's important for anaesthetists and practice managers alike to know that the ASA offers assistance and advice to us as much as they look after

REGULAR

anaesthetist members. The ASA holds annual conferences specifically for practice managers as well as ensuring there are talks and workshops offered for the profession at other, larger conferences, such as the annual NSCs. These conferences not only offer a chance for the all-important networking with other practice managers, but also key speakers who provide us with valuable information to take back to our practices. Of all the aspects of the role, I would say that networking plays one of the larger parts in our profession. It is not uncommon for me to make contact with a fellow manager I met at an event, or to be contacted in return. It is a great way to bounce issues off each other and draw on experiences to solve issues that may arise on a day-to-day, or one off-basis. We have formed some great friendships and each conference is an opportunity to catch up with transnational colleagues.

BECOMING A REGISTERED PRACTICE MANAGER

For further information about becoming an ASA-registered Practice Manager, please contact membership@asa.org.au

2015 PRACTICE MANAGERS' CONFERENCE

On 22 May 2015, over 50 practice managers from around the country gathered at the Mercure Sydney for the annual ASA Practice Managers' Conference.

Led by Dr Mark Sinclair, Chair of the ASA Economics Advisory Committee, the program for the conference covered a variety of issues important to practice managers including Medicare and private health insurance, medicolegal considerations and an update from the ASA Policy Team, Chesney O'Donnell and Josephine Senoga, on how the ASA can assist in the way of advice and advocacy.

Of particular significance was a presentation by Commissioner, Sarah Court, from the Australian Competition and Consumer Commission who spoke regarding the potential pitfalls to look out for relating to practice management in Australia. Commissioner Court confirmed the ACCC's intent to focus on the medical industry in the coming year and also commented on the high level of quality and detail in the submissions received by the ACCC from the ASA.

Passionate participation and discussions from the practice managers throughout the conference once again proved the importance of such a forum for collaborative thought and leadership, particularly for practice managers often working in isolation.

The ASA would like to thank all of the conference speakers. Besides those mentioned above, we were fortunate to hear from Dominique Egan (TressCox Lawyers), Fiona Kolokas (Australian Association of Practice Management) and the afternoon session was led by Sue Edwards (Illawarra Anaesthetic Secreterial Service) and Ros Cain (Narcosia Anaesthetic Group).

The conference would not have been possible without the support of our 2015 sponsors; thank you again to Avant Mutual Group, Direct Control, MediTrust and Shexie.

Alaina Koroday

ASA Advertising and Events Executive

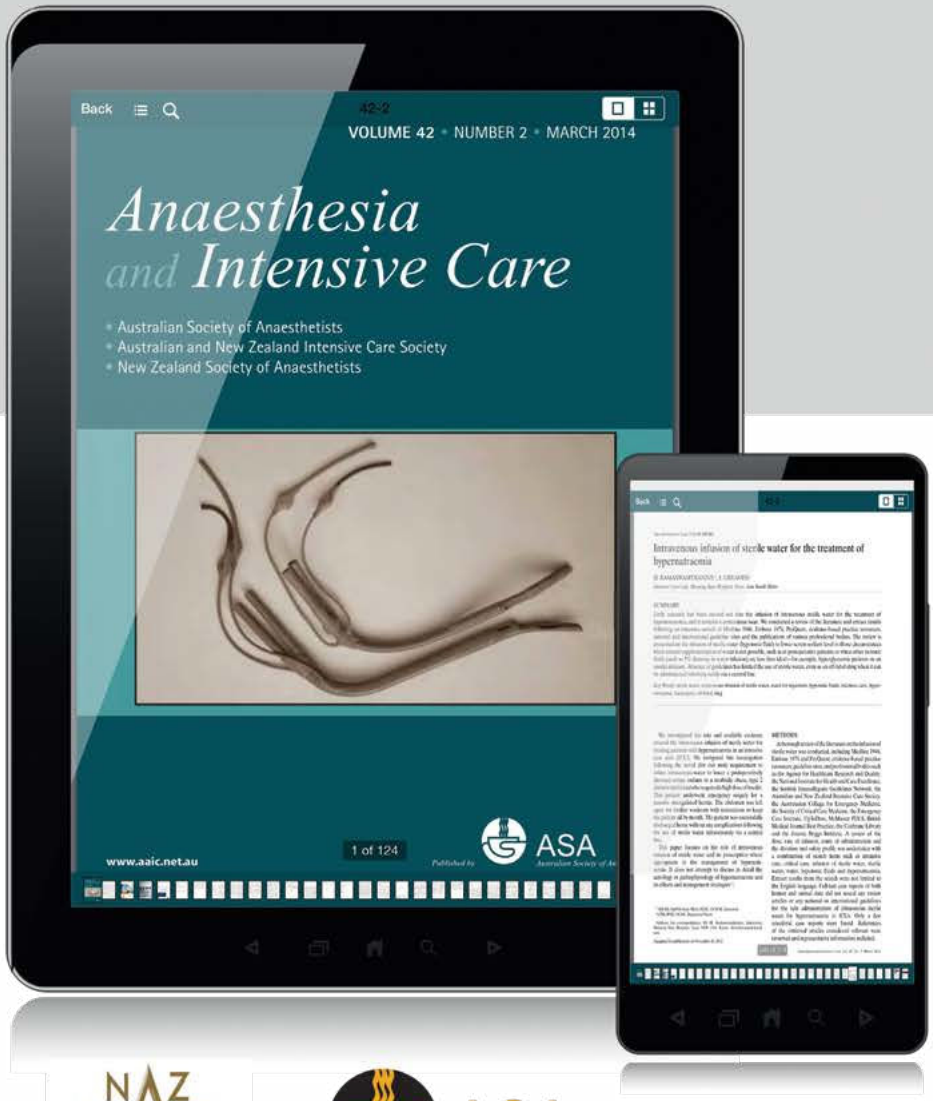
Editor's note

The next Practice Managers' Conference will be held in Perth in November 2015. Please contact events@asa.org.au if you have any queries.

Ensure you are getting the latest content as soon as it goes to print!

Download the AIC App*!

Please email aicsubscriptions@asa.org.au if you no longer wish to receive the hard copy!



ANDROID APP ON Google play

Download on the App Store

*Only available to ASA or NZSA membership and ANZICS or individual subscribers.

ANZICS

NZSA SALUS PER SCIENTIAM

ASA Australian Society of Anaesthetists

www.aaic.net.au | 1800 806 654 | aic@asa.org.au

REGULAR

WEBAIRS NEWS

Data from the incident reporting system webAIRS continues to be used in innovative and important ways, writes Dr Martin Culwick.

WEBAIRS AT THE CSC

WebAIRS data will be used for two sessions and two workshops at the ASA/NZSA Combined Scientific Congress in Darwin. The first session, 'Cognitive Tools for Crisis Management', will be held on Saturday, 12 September at 4:00 pm. It will feature discussion about immediate responses to anaesthetic crises, including new ideas about simplifying these responses, as well as a formal presentation of cognitive tools and aids used for crisis management.

The second session, planned for Monday, 14 September at 1:00 pm, will firstly look at webAIRS data relating to catastrophic events that might occur during otherwise routine cases. After that, renowned international speaker, Professor Keith Ruskin, will present on data from the Anesthesia Quality Institute database, which contains more than 25 million anaesthetic records and has an important role in the development and improvement of training programs. The final part of this session will be dedicated to discussion on how to display and maintain an organisational diagram to track anaesthetic crises and maintain a comprehensive repository of similar data. Bow-tie diagrams for risk assessment will be incorporated throughout this presentation.

LEARNING FROM DEFECTS

WebAIRS analysis using the 'Learning from Defects' tool created by Johns Hopkins Medicine has recently commenced and, at the 2015 ANZCA ASM in Adelaide, such analysis relating to airway obstruction was presented. The findings were as follows:

- There were four cases where a throat pack obstructed the airway—three were retained throat packs, and in one case the endotracheal tube was dislodged by the operator with the pack still in place. It is recommended that the throat pack be added to the surgical swab count in all cases. In addition, it is also suggested that a visual cue should be used to act as a reminder to the anaesthetist. For example, a label could be attached in a prominent part of the circuit that would always be seen prior to extubation. Many anaesthetists have also devised other suitable reminders but adding the pack to the swab count is useful and is an effective method for double-checking that the pack has been removed.
- There were nine instances where chewing gum was a potential hazard in association with anaesthesia. In four of the nine cases, the patient was anaesthetised prior to the discovery of the gum and in three cases the gum was removed in recovery. There was also a similar case where a patient was anaesthetised while chewing tobacco.
- There was a single case where a coin had been ingested and resulted in tracheal compression.
- Lastly, there were two cases that involved broken dentures. One of these resulted in airway obstruction, while the other was classified as a potential hazard.

PROGRAM IMPROVEMENTS

The updated webAIRS registration program was released in January 2015 and appears to be functioning well. Since last year a group of sites has been automatically forwarding denominator data. This currently includes deidentified data from 42,629 records collected from 20 May 2014 to 3 June 2015. Improvements to the morbidity and mortality meeting tool, the home page and the incident reporting page are also being developed.

For more information, please contact:

Dr Martin Culwick, or Administration Support

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.

Australian Society of Anaesthetists Member Achievements

GASACT Common Issues Group Scholarships awarded to:

Dr David Brian Rawson
Association of Anaesthetists of Great Britain and Ireland
GAT Annual Scientific Meeting: 17–19 June 2015, Manchester, UK

Dr Robert Easther
American Society of Anesthesiologists
United States Annual Meeting: 24–28 October 2015, San Diego, CA, USA

Dr Scott Popham
Canadian Anesthesiologists' Society
Annual Meeting: 19–22 June 2015, Ottawa, ON, Canada

Queen's Birthday Honours:

Professor Ross Beresford Holland, NSW, Member (AM) in the General Division
For significant service to medicine in the discipline of anaesthesia, as a clinician, to healthcare standards, and to professional medical bodies.

Dr Paul Graham Luckin, Qld, Member (AM) in the General Division
For significant service to the community through emergency medicine, and as an authority on survivability in search and rescue operations.

ASA
Australian Society of Anaesthetists

INSIDE YOUR SOCIETY

POLICY UPDATE

This month, Chesney O'Donnell and Josephine Senoga have been busy with a number of briefs and submissions.

3RD MABEL RESEARCH FORUM

The penultimate of Medicine in Australia: Balancing Employment and Life Forum, or more commonly known as MABEL was held in Melbourne between 23 and 24 April 2015. MABEL research focuses on the medical workforce. The motivation behind MABEL is to help improve the knowledge exchange between researchers and end-users which has been lacking in the past. The MABEL project began in 2008 and has an annual funding of $2.1m to $2.4m dollars, provided by the National Health and Medical Research Council (NHMRC). Surveys are utilised to help examine why interns and doctors make the labour supply decisions that they do. The aim is for nine waves of national longitudinal surveys to be conducted from a rough sample of 10,000 participants[1].

Representatives included Medical Deans of Australia Chair, Professor Judy Searle, Government Departments, hospitals and consumer groups such as the Consumers Health Forum of Australia. Some concerns were expressed regarding the future of the medical workforce. Suggestions were made that medical students graduating did not correspond with offers of internships and that the most disadvantaged are international students. With an under supply of doctors in rural regions, state governments are pressured to produce more doctors. International doctors may possibly take up the load of rural work. Debate revolved around the issue of maldistribution versus oversupply of doctors in certain specialities.

Nurse Endoscopy

Discussion shifted to the m ore topical subject of nursing and job substitution with Dr Brendan Murphy, CEO for Austin Health, supporting nurse endoscopy as a viable option. The most compelling argument was associated with increased colonoscopies and the screening for bowel cancer. The demand for scanning and nurse endoscopy has risen to 30% according to the National Bowel Cancer Screening Program (NBCSP). By 2020, public sector endoscopies will significantly increase by approximately 6738[2] colonoscopies under a full roll-out scenario. The Department of Health 2010 research, entitled 'Endoscopy in Victoria's Public Health Services' articulated that these large numbers are due to certain lifestyle conditions such as obesity, which are associated with gastro-intestinal comorbidities.

Welfare

Other areas of interest included medical practitioners' welfare. Former AMA President and current overseer of the Australian Institute of Health and Welfare, Dr Mukesh Haikerwal, argues that there are four corners of the health ecosystem in Australia; government, consumers, information communication technology and health professionals. Dr Haikerwal's work on medical practitioner welfare issues and research by *beyondblue* show that Australian doctors and medical students suffer higher levels of distress and depression than the general population. Further, research by Dr Danny Hills concerning workplace aggression in Australian clinical medical practice shows that clinicians reported experiencing verbal or written aggression at 70.6%[3] from a cross-sectional survey conducted with a sample of 9499 General Practitioners (GPs) and GP Registrars, Specialists, Hospital Non-specialists and Specialists in Training.

Other interesting statistical results

MABEL surveys from 2010-12 show that male interns are more likely to prefer surgery at 33% followed by internal medicine at 17%, general practice at 12% and anaesthesia at 11%. In contrast, female interns prefer general practice at 23%, followed by internal medicine at 16%, anaesthesia at 12% and paediatrics and child health at 12%. The median annual earnings of an intern is around $66,000 in comparison to GPs at $225,000[4]. Male specialists aged 40 to 49 years and female specialists aged 30 to 39 years are the most responsive to changes in hourly earnings. Government research shows that a great number of doctors (primarily GPs) are prepared to work "in the bush" provided they are substantially remunerated, requiring added incentives of at least 130% of annual earnings or around $237,000[5].

SIXTH AUSTRALASIAN WORKSHOP ON HEALTH ECONOMICS 2015

Sponsored by Monash University Business and Economics & the Centre for Health Economics as well as the Melbourne Institute of Applied Economics and Social Research, this workshop covered various specialties and themes revolving around the policy areas of applied health, labour and public health economics. The workshop was highly relevant in light of the ASA's dealings with MSAC, and the growing trend of government departments implementing health economic principles when developing public policy in light of the overall objectives of the Federal Government to diminish our current deficit. Fourteen papers were presented.

One paper in particular of special interest was by French PhD student, Ms Mathilde Péron[6], who analysed various case scenarios in France, the USA and Australia concerning national health insurance and doctor billings. The relationship between balance billing and supplementary health insurance in France is arguably similar in some ways to the out-of-pocket debate in Australia. France is seeing the rise of balance billing by doctors who wish to recoup more money from procedures. The concern is that this would affect the public sector and raise insurance costs for their members. Alternatively, there is the argument that this would not occur and that the free market would adjust itself accordingly and, as a result, improve the general quality of care.

Several questions arise when comparing France with Australia: does better coverage contribute to a rise in medical prices? Will there be the creation of a two-tier healthcare system resulting in class divisions where only the rich can afford these type of specialists? Will the public system lose valuable funding due to pressures to move to private healthcare? These questions drew some debate when contrasted with the data supplied by Private Health Insurance Ombudsman (PHIO) from 2013 to 2014 that 28% of patient complaints made to PHIO concerned misinformation from the insurers regarding their cover[7] which wasn't clearly explained.

MEDICARE BENEFITS SCHEDULE REVIEW TASKFORCE

The Minister for Health announced recently that the Federal government intends to pursue a wholesale review of MBS items over the next two years. This review will most likely have an impact on the specialty of anaesthesia. The establishment of a Medicare Benefits Schedule Review Taskforce for the a review of 5500 services listed on the MBS is intended to "better align [the MBS] with contemporary clinical evidence and the Primary Health Care Advisory Group which will investigate options to provide better primary care when and where people need it"[8]. (Minister Ley, 4 June 2015).

References

1. Lecture Presentation at the MABEL Forum 2015.
2. Department of Health 2010, Endoscopy in Victoria's Public Health Services, State Government of Victoria, Melbourne.
3. Hills, Danny "In harm's way: The impact of workplace aggression in Australian clinical medical practice" 2013, Monash University Theses, Identifier http://arrow.monash.edu.au/hdl/1959.1/909581.
4. 'MABEL Matters', No.9 May 2014.
5. Lecture Presentation at the MABEL Forum 2015
6. Dormont, Brigitte., Peron, Mathilde., "Does health insurance encourage the rise in medical prices? A test on balance billing in France" Laboratoire d'Economie de Dauphine WP n°9/December 2014.
7. Australian Government Private Health Insurance Ombudsman, Annual Report 2013-14, http://www.phio.org.au/downloads/file/PublicationItems/PHIOAR2014.pdf.
8. Health Minister Sussan Ley's Media Release, 4 June 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.

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

In this edition of *Australian Anaesthetist*, EAC Chair, Dr Mark Sinclair, reports on the (lack of) progression with MSAC, an update on indexing with private health insurers and the successful Practice Managers' Conference held in May this year.

MEDICAL SERVICES ADVISORY COMMITTEE (MSAC)

The final Public Summary Document (PSD) regarding MSAC Application 1183 (the introduction of two new Medicare items to cover the use of ultrasound in the practice of anaesthesia) has been released and is available on the MSAC website. As expected, the application was not supported by MSAC.

Members will recall that the ASA has significant concerns regarding MSAC's justification of their position. The ASA was allowed a one-paragraph response to be included in the final PSD which, as previously reported, is totally insufficient to detail our concerns. The paragraph therefore contains a link to a page on the publicly accessible section of the ASA website, on which the PSD and the ASA's detailed response can be viewed (News/Latest News section of www.asa.org.au). EAC will seek the opportunity to meet with MSAC representatives to discuss our concerns.

As previously reported, the detailed clinical and economic assessment of application 1308 (for three new Medicare items to cover local anaesthetic nerve blockade (LANB) for post-surgical analgesia) was released in early 2015. The assessment accepts that the evidence supports two MSAC criteria, namely, that LANB is safe and clinically effective. However, the third criterion that must be met is that of cost-effectiveness. Here, as expected, the evidence is less certain. As before, MSAC has stated repeatedly that cost-effectiveness will be given very strong emphasis in their deliberations. This will make the application process difficult, as it did for application 1183.

Again, as per application 1183, the ASA has concerns with certain aspects of the economic analysis of 1308. A teleconference was held in May with representatives of the Health Technology Assessment (HTA) body, which performed the analysis. HTA has taken some of our concerns on board. However, as with 1183, the ASA may need to separately engage the services of experts in health economics.

MSAC has also completed its review of cardiopulmonary bypass services. The issue of Medicare funding for perfusion services provided by doctors ('medical perfusionists') has been a point of discussion for some years. The committee involved in the review included representatives from ANZCA and the National Association of Medical Perfusionists of Australia (NAMPA), and Dr Nigel Symons representing the ASA. The likely outcome is that the MBS perfusion items will remain in place, but will be subject to an explanatory note involving ANZCA Position Statement 27 (Guidelines for Major Extracorporeal Perfusion), and also requiring "personal operation" of the equipment. The exact details of the explanatory note will obviously be essential. The ASA will continue to work with the medical perfusion profession on this issue.

Other issues requiring ongoing dealings with the Department of Health and MSAC include funding for the use of Botox by pain medicine physicians, for the treatment of chronic migraines (currently restricted to the services of specialist neurologists) and improved Medicare funding for pain medicine consultations.

Any significant developments in these areas will be communicated to members via the regular President's enews or on the ASA website.

PRIVATE HEALTH INSURANCE

As members will be aware, the date for indexation of Medicare and private health insurance rebates has changed from 1 November each year, to 1 July. However, the Medicare rebates have been frozen since November 2012 and at this stage the government intends to extend this freeze through to July 2018. The response from the health insurance industry has

been variable, with some applying a small indexation each July, and others following the same line as Medicare. By the time of publication, all July 2015 schedules will be viewable on the ASA website, by following the links News/Economic Update/ Anaesthesia Rebates and Fees.

The insurer HCF has made a significant change to its schedule of rebates. For the first time, a 'known-gap' product has been made available. There is also a separate 'no-gap' schedule available, with a slightly higher level of rebate. However, in order to access this slightly higher rebate, an anaesthetist must enter into a 'no-gap' agreement with HCF. Once registered with HCF as a 'no-gap' provider, an anaesthetist cannot choose to opt out and use the 'known-gap' billing system on a patient-by-patient basis. It is still possible for a registered 'no-gap' anaesthetist to bill at a level of their choice, but in this case the patient will receive only the MBS Fee as the rebate.

The ASA advises members to carefully consider the implications of entering such a 'no-gap' agreement. The table below serves as an example of the rebates that would be paid for the same anaesthesia service (a one hour anaesthetic for an inguinal hernia repair) under each of the two schedules.

The 'no-gap' rebate is clearly higher. However, under the 'known-gap' terms and conditions, if the anaesthetist's fee is over $342, the full 'known-gap' rebate will still be paid, provided the total out-of-pocket expense to the patient does not exceed $500. A reasonable patient co-payment, obtained after best possible informed financial consent practices are followed, will bring the total fee to well above the $368 provided by the 'no-gap' scheme.

	Pre-anaesth	Anaesth	Anaesth time	Total rebate
MBS item	17610	20830	23043	
MBS fee	$43.00	$79.20	$79.20	**$201.40**
HCF 'kg'	$73.00	$134.50	$134.50	**$342.00**
HCF 'ng'	$90.30	$138.85	$138.85	**$368.00**

kg=known gap, ng=no gap

An email was sent to all ASA members in late June, explaining in detail the new HCF schedules and the applicable terms and conditions. Members are welcome to contact the ASA with any queries, via email: policy@asa.org.au, or via telephone: 1800 806 654.

The insurer NIB has introduced new terms and conditions regarding its 'Medigap' schedule of benefits. Anaesthetists billing under this scheme are reminded that it is the sole remaining 'no-gap only' system and that billing under 'Medigap' means accepting the NIB rebate as the full fee. Utilising the 'Medigap' system also indicates automatic agreement with the new terms and conditions. This includes agreement to be subject to a detailed audit of patient accounts, upon request. The method employed by these proposed audits raises significant concern regarding patient privacy. The full 'Medigap' terms and conditions are available online (nib.com.au/providers/medigap/schedule-of-benefits). Again members are encouraged to contact the ASA if further information is required.

NIB also intends to list doctors' billing patterns on its website, including how often individual doctors utilise the 'Medigap' product. This is supposedly aimed at assisting patients, by informing them of what their doctor is likely to charge. However, anaesthetists' billing decisions are generally made on a case-by-case basis. The utilisation of 'Medigap', no matter how frequently, gives an individual patient no guarantee that they will be billed as 'no-gap'. The usefulness of listing such information is, therefore, questionable. EAC will seek to discuss these issues with NIB, and members will be kept up to date of any developments.

PERIOPERATIVE MEDICAL SERVICES

The ASA frequently receives queries from members regarding Medicare funding of consultation services. In particular, postoperative attendances on patients. The increasing number of anaesthetists providing follow-up care to their patients is, of course, a most positive development. However, the rules regarding Medicare funding must be taken into account. If such post-anaesthesia services are simply routine aftercare, no Medicare items apply. Referred attendance items in the range 17640 to 17655 only apply where attendance is required to provide a specific service; for example, to handle issues related to analgesia or fluid balance. Items for therapeutic and diagnostic procedures (eg. topping up a nerve block catheter) may also apply where such services are provided. Members are encouraged to contact the ASA if there is any uncertainty.

PRACTICE MANAGERS' CONFERENCE, MAY 2015

Another highly successful Practice Managers' Conference was held at the Mercure Hotel, Sydney, on 29 May 2015. These conferences have been an annual event for some years now and are very popular with our anaesthesia practice managers and staff. As well as updates from the EAC and the ASA Policy team, we were fortunate to receive interesting and highly relevant presentations from Dominique Egan (TressCox Lawyers), Fiona Kolokas (Australian Association of Practice Management) and Sarah Court (ACCC Commissioner). Our thanks go to Alaina Koroday (ASA Advertising and Events Executive) and to Chesney O'Donnell and Josephine Senoga (ASA Policy) for their input. We also thank the sponsors of the event: Shexie, Direct Control, Meditrust, and the Avant Mutual Group.

We are organising smaller meetings in cities such as Perth and Adelaide, as it can be difficult or impractical for practice managers from these areas to attend one-day meetings in the eastern states. Members are reminded that their practice managers can register for access to certain sections of the ASA website.

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

FROM THE OUTGOING PIAC CHAIR

Dr Jim Bradley

The Professional Issues Advisory Committee report in the April 2015 edition of *Australian Anaesthetist* outlined the committee's likely principal areas of activity for the coming year, writes Dr Jim Bradley.

It was foreshadowed that the anaesthesia workforce, 'revalidation', the Australian Council for Safety and Quality in Health Care (ACSQHC) and its national standards (NSHQS), and private hospital governance matters would require considerable attention and this is proving to be the case.

The Department of Health is currently examining the anaesthesia workforce and the most recent information available to the Society is assisting our current engagement in this process. The evolving position of the Society is that more than 200 anaesthetists are entering the national specialist register each year, that the annual net increase is in the order of 150 (though numbers are preliminary) and that a reduction in case-mix or caseload consequent to an 'oversupply' – if real – could threaten 'consolidation' of skills and induce de facto subspecialisation, i.e. a loss of 'generalist' skills.

The likelihood of 'revalidation' of practitioners by the Medical Board of Australia (MBA) and the consequent professional and financial consequences are matters with which most members are by now familiar. Our response to a likely consultation paper from the MBA would address the evidence base, cost effectiveness and validity of such a process.

As the ACSQHS beds down its HSHQS standards, anaesthetists are now seeing conflict between documents driven by the reporting requirements of healthcare facilities against the NSHQS and our own professional position statements. The Society's position is to advocate that healthcare facilities, when establishing guidelines or protocols, accurately reflect, in particular the wording and intent, of ANZCA documents.

Finally, private hospital governance matters are increasingly complex and have been seen to disadvantage a number of our members this year. Consequences have included both limitation and withdrawal of clinical privileges. The Society has now had considerable experience in assisting members in these matters and is always willing to assist promptly and constructively.

In closing, I am stepping down from PIAC, and would like to thank all its members, past and present, for their generous commitment and considered contribution over the five years in which I had been the Chair. I would also like to welcome on your behalf Dr Antonio Grossi as incoming Chair. Among his other ASA contributions, Antonio is a past Victorian ASA Federal Councillor as well as a long-standing member of PIAC.

FROM THE INCOMING PIAC CHAIR

Dr Antonio Grossi

I would like to introduce myself as the new chair of PIAC, writes Dr Antonio Grossi.

Under Dr Jim Bradley's chairmanship, the role and work of this committee has evolved substantially. Today PIAC's activities are pervasive at local, state, federal and international levels.

Current activities have included:

- Dealing with membership enquiries regarding accreditation and working conditions.
- Interfacing with private and public hospital groups.
- Considering how revalidation will impact members.
- Continuing to support member education, research and training.
- Compliance with clinical care standards and the role of perioperative medicine.
- Contribution to development of professional standards and maintaining ASA position statements.
- Consultation and submissions to the AHPRA/MBA.
- Continuing engagement with the welfare of anaesthetists with a particular focus on substance abuse and suicide prevention.
- Representing anaesthetists at federal government bodies.
- Providing anaesthetists' perspective at New Health Reform Workshops.
- Monitoring workforce issues through membership surveys and considering the implications of these to all aspects of professional practice.
- Joint submissions with the ASA, AMA and ANZCA to NMTAN in relation to anaesthesia workforce issues.
- Exploring ways to assist members with employment in areas of need.

Looking forward, workforce issues and revalidation will certainly impact members' professional lives and PIAC will continue to support members through any changes that may or may not occur. Maintaining a safe and high standard of care for our patients is a professional obligation and must be preserved. Anaesthetists' professional autonomy may be eroded by health budget rationalisations, increasing corporatisation of medicine and increasing non-evidence based regulation. However, by engaging with stakeholders and being proactive in the delivery of quality healthcare services, PIAC will continue to provide advocacy and support for members.

This enormous task would not be possible without the contribution of several talented and dedicated anaesthetists who serve on PIAC. The network and collective experience of these individuals provides a great resource for the society and its members. Collaborating with these people is a privilege. In particular, PIAC will continue to work closely and synergistically with ANZCA on these professional issues.

Finally, I would like to acknowledge the personal and professional contribution that Dr Jim Bradley has made in developing PIAC. He has been both an inspiration and a mentor. In his new role in the ASA as 'Special Affairs Advisor', Jim will continue to contribute and be an ongoing resource to PIAC.

INSIDE YOUR SOCIETY

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

THE DELIVERY OF SAFE ANAESTHESIA—THE MICRONESIAN STORY

The ASA has spearheaded the development of safe anaesthesia across the Micronesian archipelago since 1994, writes anaesthetist, Arthur Vartis. This has largely been through the Micronesia Anaesthetic Refresher Course (MARC) and the establishment of the Micronesia Anesthesiology Society (MAS). These important initiatives have transformed the delivery of safe anaesthesia in a region which, prior to 1994, was largely provided by health workers outside of medicine.

The word Micronesia comes from the Greek word meaning "small islands". These coral cays and volcanic remnants form an archipelago of over 2000 islands that stretch an eighth of the Earth's circumference across the northern tropical pacific. There is so much water and so little land mass that rarely do they feature on most maps.

The Micronesia archipelago is a loose association of five sovereign states. All are heavily dependent on overseas aid, particularly from the United States. The US regards the Micronesian islands as vital to its geostrategic interests. Some are formal American territories, the most important of which is Guam.

During WWII the Micronesian islands were used as strategic stepping stones by Imperial Japan's conquest across the Pacific, and then subsequently by America's defensive response. As a result, some of the fiercest battles occurred across these small islands. One of the legacies of WWII has been the bonanza of wrecks from both the Japanese and American military hardware that were left scattered across the reefs. This has led to an important tourism industry, albeit still catering to the hard core diving enthusiast.

Most employment is within the public sector, with an average per capita GDP of about US$2,000. Unemployment, particularly youth unemployment, remains high. Most families rely on subsistence fishing within a very strong family network. Religion plays a strong role within the community. The population is almost entirely Christian, a legacy of early Spanish colonialism.

Anaesthesia services vary tremendously across Micronesia. Some states have very limited resources in personnel, equipment and drugs. All rely on the input of nurse trained anaesthetists with some states totally dependent, with no medical anaesthetists. Drug supply is, at best, intermittent, resulting in a chronic shortage with many items past expiry. Without biomedical support, equipment cannot be maintained. Half of the operating theatres in the region are without capnography. Vaporisers have never been calibrated. Laboratory reagents are either unavailable or expired. In some states, regular electricity outages are the norm. Fortunately, pulse oximetry is readily available.

The level of medical services varies tremendously across Micronesia. Palau, in the western region, is the best resourced, with two medical anaesthetists, a ventilated ICU bed, CT scanning and a blood bank. In contrast, Pohnpei relies entirely on the services of a single anaesthetist, with no facilities for ICU or imaging other than basic radiology, whilst the provision of anaesthesia in the Marshals is entirely nursing based. Donor blood is largely fresh whole blood. Only one site hosts very limited laparoscopic surgery. The introduction of a western diet has seen the rising burden of diabetic related surgery, escalating the demands on a limited health budget. Micronesia remains heavily dependent on visiting teams predominantly from the US.

The limited number of anaesthetists across Micronesia has meant that it remains near impossible for anaesthetists to leave their island state for an extended period without seriously disrupting medical services. One of the consequences of this has been severe isolation and lack of ongoing medical education.

In 1994, the ASA addressed this need when the first MARC was organised by Drs Haydn Perndt and Christopher Sparks in Palau.

Since then, the ASA has regularly run this important and much needed course across the archipelago. This has been with the assistance at various times of the Pacific Society of Anaesthetists, the New Zealand Society of Anaesthetists, the Philippine Society of Anesthesiologists (PSA), the Japanese Society of Anesthesiologists (JSA) and, more recently, the World Federation of the Societies of Anaesthetists. The logistics in organising these meetings are considerable. In order to allow the Micronesian anaesthetists to attend, locums are often needed at each of the island states. The

significance of these meetings is not lost to the local government as evidenced by the formal welcome attendance by a senior government minister.

One of the offshoots from this has been the support for physicians from Micronesia to attend the Post Graduate Anaesthesia Training course in Fiji. This was a major development for anaesthesia in the region which, prior to 1994, was mainly performed by the nursing profession.

In 2005, MAS was formed. The Society fosters the continued education and promotion of anaesthesia throughout the archipelago.

In 2012, the ASA supported the MAS President, Dr Dennis Agapito, in attending the World Congress of Anesthesiologists in Argentina where formal membership into the World Federated Societies of Anesthesiology was formalised.

Over the past 22 years, the MARC has hosted conjoint Primary Trauma Care and Essential Pain Management courses.

The last meeting of the Society was held in Kosrae in April 2015. The theme was 'Safe Anaesthesia'. In attendance were representatives from the ASA and the JSA. Delegates included medical and nursing anaesthetists from the Marshall Islands, Palau, Pohnpei and Yap. Also in attendance were nursing and medical staff from Kosrae Hospital.

The meeting focused on skill sets and decision pathways that could provide a framework for the safe delivery of anaesthesia. Topics included spinal, obstetric and paediatric anaesthesia, airway management, perioperative management of diabetes, cardiac, anaphylaxis, basic and advanced life support, anaesthetic emergencies and trauma. There was also a session on the 'Safe Surgery Saves Lives' WHO initiative and safety check-list.

The MARC is a highly interactive course that focuses on two-way dialogue. This is facilitated through Problem Based Learning Scenarios, case presentations, workshops and simulated scenarios. This two-way dialogue has been very effective in targeting the course content and identifying skill-set and knowledge shortcomings amongst the delegates. The course deliberately steers away from didactic lectures and invites active participation by delegates as an integral component of the course.

The incremental effect that the MARC has had on the provision of safe anesthesia cannot be overstated.

Case presentations, in particular, often shed light in areas of deficiencies either in skill set or knowledge. In 2013, there were three independent case presentations of maternal intraoperative deaths associated with spinal caesarian section. The recurring theme was the widespread lack of use of a wedge to produce lateral tilt and a poor threshold for intervention in maternal hypotension. It was found that a number of delegates were unaware of the physiological basis of lateral tilt and tended to let systolic blood pressures fall well below 80 mmHg before intervening. This prompted a whole session on obstetric haemodynamics and the impact of spinal anaesthesia on the gravid mother. It was pleasing to find that at the 2015 Kosrae meeting, all but one delegate had adopted the regular use of lateral tilt and the trigger SBP had risen into the 90's. This was a good result.

This was the 16th meeting under the auspices of the MAS and represents the culmination of 22 years of work by the ASA in addressing the provision of anaesthesia throughout the region.

All of the anaesthetists work in areas of complete professional isolation. Their society underpinned by the continued relationship with the ASA provides the only forum within which the Micronesian anaesthetists can foster and promote the delivery of safe anaesthesia.

As stimulating as this week was for me professionally, the personal fulfilment was most enduring. There is a palpable sense of the changes that have resulted in this part of our neighbourhood.

The next meeting will occur in 2017 in The Marshalls. An opportunity exists to assist at this next meeting and I would recommend this to anyone interested in the provision of anaesthesia outside of Australia.

Training

MARC team

CONNECT

Connect with other anaethetists on this topic via twitter.

Tweet to @ASA_Australia with #ASA_ODEC to streamline your comments.

Follow the discussion at bit.ly/12RJssS

INSIDE YOUR SOCIETY

GROUP OF ASA CLINICAL TRAINEES UPDATE

SCHOLARSHIP REPORT FROM DR DAVE RAWSON

I was recently awarded a GASACT Common Interest Group scholarship. Three such scholarships are awarded annually to assist trainees in attending an international Common Interest Group meeting. Through the generous funding provided, I was able to travel to Manchester to attend the 2015 Group of Anaesthetists in Training (GAT) Annual Scientific Meeting. GAT is the trainee arm of the Association of Anaesthetists of Great Britain and Ireland (AAGBI).

Prior to the commencement of the conference proper, I was invited by the organisers of the event to attend the GAT committee strategic planning meeting. This is an annual meeting during which short- and medium-term goals are identified, discussed and recorded. It is attended by the present and incoming committee members as well as representatives from AAGBI. The three focus areas of discussion were education, wellbeing and communication. I sat with the education small group discussion where we looked at issues such as the growing importance of e-learning platforms, the content and structure of the ASM and how to encourage participation at conferences. It was interesting to listen to similarities and differences between here and the UK, especially in terms of the intersection in education provision between the College and the Society. I was glad to be able to contribute points of comparison about how things operate in Australia.

Much of the discussion points arose from a large, recently completed AAGBI membership survey, which included a trainee answered section by over 500 trainees. Interesting points to note were the importance trainees placed in the GAT ASM and GAT-coordinated seminars on topics such as leadership and transitioning to consultant work.

The participation of the AAGBI President and other board members was impressive. They were enthusiastic about promoting GAT's role in trainee representation. It seemed to produce a healthy environment for committee members from both organisations to work together and led to some spirited debate. This continued with a lively and enjoyable evening at the combined GAT and AAGBI dinner at a local restaurant.

The conference itself ran over two and a half days on the grounds of the University of Manchester. There were over 300 trainees in attendance from what seemed like all parts of Great Britain and Ireland. There was an air of excitement in the venue throughout, as though this was a conference that trainees were genuinely enthusiastic about attending, not only for the educational content but also for the chance to catch up with old colleagues and network with new people.

The presentations were a balance of clinical and non-clinical topics. It was a challenge navigating through the attractive options in the program to make the most of what was on offer. After an opening talk on the 'Future Shape of Training', which followed on nicely from the committee strategic meeting discussions, there was an interesting presentation about 'Medics as Managers'. Thist provided some valuable insights and advice from an anaesthetist who had assumed a leadership role within a trust. He advocated engagement, empowerment and some useful tips from "If Disney ran your hospital"! I found this quite topical, working as I am in a hospital in Western Australia where new management styles and structures are being adopted.

Other noteworthy presentations I was able to attend included:

- 'iWant Great Care': A talk on the success of an online feedback site established to facilitate public comment on doctor performance (the results were overwhelmingly positive… something of a surprise to most of the audience it seemed).
- 'Excellence': a presentation about defining and rewarding excellence instead of emphasising the reporting of underperformance.
- 'The Generation Game': intergen-erational relationships in the anaesthesia workplace. A fascinating

look at how our generational groupings inform our views on working hours, professionalism, work/life balance, learning styles and communication.

Having attended the 2014 ASA NSC on the Gold Coast, I had previously been entertained and informed by presentations from visiting English anaesthetists, William Harrop-Griffiths and David Bogod. I was therefore pleased to note that they were both presenting at this meeting. Dr Harrop-Griffiths gave a typically entertaining talk on patient safety and Dr Bogod spoke the following day on medico-legal issues, using some data and examples from his own obstetric practice.

A panel discussion session provided the opportunity to hear what a group of representatives from several different organisations thought about some of the hot-topic issues in UK anaesthesia. I was particularly interested in the questions from the trainee audience and responses from the panel about physician's assistants in anaesthesia and duration of training time. Both are points of contrast to the Australian system.

In addition to the GAT/AAGBI dinner, I also attended the main social event of the conference, a dinner-dance at the historic Midland Hotel. It was well attended and a lot of fun. At such events, and indeed throughout the conference, I made the most of the opportunity to make new friends and contacts. It was interesting to reflect on shared experiences and points of difference in training, and to discuss future plans and ambitions. I met some interesting, inspiring and very motivated people who I hope to maintain contact with as my career progresses.

I would like to thank the ASA for the opportunity to attend the conference. Their financial support enabled a unique opportunity and I'm humbled to have been selected for the scholarship. I know I've learnt a lot that I can bring back and share with other trainees. As a GASACT ambassador, I hope that, in my short time abroad, I have been able to help strengthen relations between the ASA and our overseas colleagues.

I would also like to thank the GAT committee and ASM organising committee for making me feel so welcome, both before and during the conference. I hope I can sustain the friendships and networks I have started to build. I certainly look forward to meeting again.

CONNECT

Connect with other anaethetists on this topic via twitter.

Tweet to @ASA_Australia with #ASA_GASACT to streamline your comments.

Follow the discussion at bit.ly/12RJssS

INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

NATIONAL

Dr Donald Maxwell

The Retired Anaesthetists Group has now been led by Professor David Gibb as National and NSW State Chairman since 2005. David has done a wonderful job of organising RAG in this period, having himself taken over from Dr Des O'Brien, who fathered the concept of RAG from its outset in the 1990s.

I have now been invited to take over from David as National Chair. My first task, of course, is to thank him for all the years he has led us and helped build RAG, with the significant support of the State Chairs.

For those of you who do not know me, I have been around for a long while. I trained at St Vincent's in Sydney and at the Nuffield Department in Oxford and qualified as FFARACS (1960) and FFARCS (1961). I have been involved with the ASA for many years (NSW Chairman, 1977 to 1978, and President, 1982 to 1984) and am an elected Life Member. I was also active with the College of Anaesthetists as a member of the NSW State Committee and Chairman (1970 to 1972) and have been Convenor of several National Meetings, including the Post World Congress of Anaesthetists Meeting in 1984 in Sydney, which formed part of the ASA's 50th birthday celebration. While I have been retired from active Anaesthesia since 2000, I have continued to be involved in its affairs and am a regular attendee at meetings.

RAG reunites, over lunches, lectures and social functions, those of us who have spent years together in professional and academic life, when we might otherwise lose all contact.

The retired anaesthetists are now a significant group of 369 members and have much to share and offer. They are part of the living history of anaesthesia.

I hope to continue, with the help of RAG members and State Chairs, to promote the interests of retired anaesthetists and to keep us together in our mature years. I look forward to seeing many of you at our coming CSC in Darwin in September, where I hope you can join me at the RAG luncheon.

SOUTH AUSTRALIA

Dr John A. Crowhurst

Our Group in SA meets for lunch on the second Monday of every odd month at the Kensington Hotel, where have our own private dining room and, from time-to-time, a guest speaker.

Our membership, comprised of colleagues from anaesthesia, intensive care and pain medicine now numbers more than 70, whilst attendance at meetings during 2015 has varied from 12 to over 30.

The guest speaker at our May meeting was Dr Denes Marantos, a well-known South Australian physician who presented 'The Paradox of Health', a fascinating insight into the not-so-obvious shortcomings of modern medicine. Some 34 were in attendance.

It is with great sorrow that we learned of Dr John Roberts's passing in March. John was an outstanding clinician and teacher who, after gaining his PhD at Oxford, practised at the Flinders Medical Centre from 1975 until his retirement. He was well known internationally for his work as Editor of *Anaesthesia and Intensive Care*, and his many contributions to the work of the ASA. The memory of John will continue with all of us who enjoy those now-famous Fox Creek wines, as he was one of the founders of that McLaren Vale estate. All of us here in SA extend to his wife, Lynn, and family, our sincerest condolences. An obituary can be found in the July issue of the *Anaesthesia and Intensive Care* journal.

Any retired or semi-retired colleagues in SA who have not joined the RAG are most welcome to do so, and any colleagues from other States are most welcome to join us on the second Monday of each odd month.

WESTERN AUSTRALIA

Dr Wally Thompson

Annual General Meeting

The first AGM of the RAG (WA) was held on 14 March during the 2015 Autumn Scientific Meeting of Anaesthesia, WA, which took place at the University Club. Fourteen members attended and there were six apologies. There was a review of the activities during the year and a brief discussion as to how future activities might be organised. It was resolved to continue in much the same vein and it was noted that there was a need to try and continually update the membership list.

RAG Gathering, April 2015

An informal and convivial gathering of members was held at the Café at the University Club on 30 April.

VICTORIA

Dr Patricia Mackay

The composition of the Victorian RAG Committee has expanded in response to a need for sufficient active members on the Committee and now consists of Patricia Mackay OAM (President), Rod Westhorpe OAM (Secretary), Christine Sweeney (Treasurer), Jean Allison and Michael Davies (Committee members) and David Crankshaw (Committee member—newly elected). We have an active membership of around 66.

The Victorian group has four meetings a year and recognises that meetings should not only address social issues and hobbies but should also have more scientific input, especially in relation to advances in our specialty. To this end, the most recent meeting was entitled 'Then and Now', which comprised a short description by Pat Mackay of anaesthetic practice in New Zealand, Melbourne and Oxford between 1948 and 1953. This was followed by a talk by Dr Peter Seal, Chairman of the Victorian section of the ASA, who gave a very comprehensive description of the enormous recent developments in anaesthetic techniques, equipment and pharmacology, as well as the time restraints that confront today's anaesthetists.

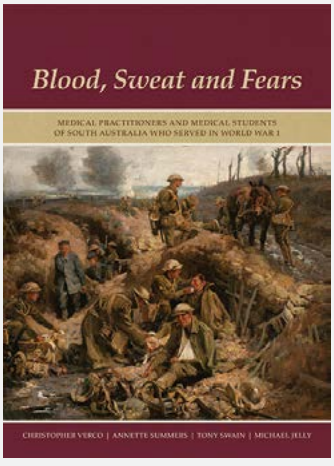
The club continues to enjoy the hospitality of the Lyceum Club and looks forward to a national RAG meeting in 2016, which will be held in Melbourne, in association with the AGM of the ASA.

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: (02) 8556 9700

BOOK REVIEW



Blood, Sweat and Fears: Medical Practitioners and Medical Students of South Australia who served in World War I. C. Verco, A. Summers, T. Swain & M. Jelly. Army Health Services Historical Research Group, Army Museum of South Australia Foundation, 2014; ISBN978-0-646-92750-3; pp. 230.

This attractively produced paperback contains one-page biographies with a monochrome photograph of over 200 medical practitioners or medical students from, or associated with, South Australia. The timely production is in recognition of the centenary of World War I.

Although, on first sight, the volume may appear to be limited to South Australian interest, many of the personnel described later worked in other parts of Australia and so is deserving of a wider audience. In addition, many of the doctors specialised in later years; for example, those who were associated with the Australian Society of Anaesthetists include Drs Gilbert Brown, Rupert Hornabrook, Kirke Godfrey, Alan Lamphee, Henry Prest and Glen Burnell.

Apart from the interesting and illuminating biographies, there are numerous snippets of medical history and advice from wartime included. For example:

> *Wanted Immediately [from J.R. Kaye, Lieutenant Colonel Div. san Officer WR Div. TF] Your co-operation, not grumbling …. clean tent-floors, and a clean camp surface, not polluted with urine or excrement. All refuse and filth rendered harmless by fire, burial or disinfection. Open tents, to let in the sunshine and fresh air and keep away the doctor.*

and

> *University of Sydney and the War… the University of Sydney, dealing with the proposals under consideration by the legislature…with the speeding up of the medical course…and the issuing of degrees…within a shorter period than prescribed, for the purpose of joining the Army Medical Service… The Faculty of medicine has had under careful consideration the suggestion that a preliminary qualification should be granted…and that afterward return to the University to complete their qualifications…*

Blood, Sweat and Fears also includes coloured photographs of the medals issued to Australians during World War I. Useful notes are given on the Army medical chain of evacuation, on hospital ships and the row at Adelaide Hospital in the 1890s over wages and conditions.

This is a valuable book for the historian and the library; it will assist many researchers and will also be a source of pride to the descendants of all those mentioned therein. It is also, of course, a fine exemplar to all those who attempt in the testing situations of wartime to render the best possible medical assistance to colleagues and others.

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

HARRY DALY MUSEUM

We are excited to announce that the Harry Daly Museum has opened its doors to the public for the first time since our relocation to North Sydney in 2013. Stage 1 of our new exhibition, 'Our Battle for Oblivion: The History of Anaesthesia and Pain Management', is now complete. Displays awaiting visitors include a physical representation of Dr Reg Cammack's history of anaesthesia timeline, as well as cases devoted to a range of topics, including uniquely Australian anaesthetic innovations, anaesthesia in the field, paediatric/obstetric anaesthesia and practice today. Featuring never-been-displayed objects, each analysed to the highest standard, this exhibition is a true delight to experience.

On Sunday 5 July, the Museum and Library hosted a seminar entitled 'Health and Medicine Museums are Good for You'. The seminar was run as a satellite event of the Australian and New Zealand Society of the History of Medicine 2015 Conference. The event was attended by over 36 health and medical museum professionals, as well as others with a keen interest in the history of medicine, representing over 23 organisations. The content of the seminar focused on the use of collections to engage audiences, especially in small or volunteer-managed museums. Speakers from different museums shared insight into a variety of topics, from displaying artefacts online and converting historic photograph collections into videos to relocating collections and turning bunches of "stuff" into community resources.

The Harry Daly Museum is now open by appointment on Thursdays and Fridays between 10 am and 4 pm. To book, please contact asa@asa.org.au. Please also search our collection on eHive (http://ehive.com/account/4493), find it on Trove or follow the links from the ASA website.

Anna Gebels
Curator, Harry Daly Museum

RICHARD BAILEY LIBRARY

The ASA has recently received a wonderful donation from Dr Rod Westhorpe of a professionally preserved copy of *The Illustrated London News of 9 January 1847*, describing the first use in England of an apparatus for inhaling sulphuric ether to make surgical operations painless, i.e. the first practical anaesthetic. The article includes a sketch of the apparatus used. The copy of the magazine has been housed in mylar in its own Solander case so that the microclimate in which it lives has reduced variation.

For the time being however, a special display in the Richard Bailey Library has been arranged that also tells the story of the first use of etherial inhalation in Van Dieman's Land (Tasmania) by W. R. Pugh in early June 1847. On display is his letter to the *Australian Medical Journal* describing his use of ether at St John's Hospital. Visitors to Launceston. Visitors today can see a life size bronze statue of Pugh on the steps of Prince's Square.

John Belisario, in Sydney, is believed to have used a similar piece of apparatus at around the same time. All these early experiments originated from the Morton's successful demonstration of ether anaesthesia in America on 16 October 1846, followed by other successes in England which gave rise to the report in the *Illustrated London News*. It seems that the magazine only arrived in Australia in May 1847, although there is some argument about the precise date.

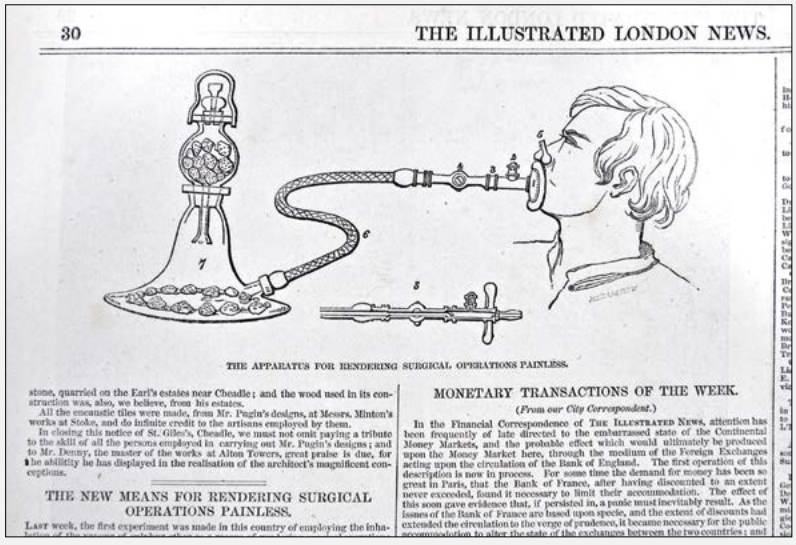
The Richard Bailey Library is also grateful to have received as a gift some anaesthetic titles, which we previously lacked, discarded from the library of ANZCA.

The Richard Bailey Library thanks the above donors for their generosity and is always delighted to discuss possible donations of importance in anaesthesia or mesmerism.

Peter Stanbury
Librarian, Richard Bailey Library

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 ASA head office (1800 806 654).



30 THE ILLUSTRATED LONDON NEWS.

THE APPARATUS FOR RENDERING SURGICAL OPERATIONS PAINLESS.

stone, quarried on the Earl's estates near Cheadle; and the wood used in its construction was, also, we believe, from his estates.

All the encaustic tiles were made, from Mr. Pugin's designs, at Messrs. Minton's works at Stoke, and do infinite credit to the artisans employed by them.

In closing this notice of St. Giles's, Cheadle, we must not omit paying a tribute to the skill of all the persons employed in carrying out Mr. Pugin's designs; and to Mr. Denny, the master of the works at Alton Towers, great praise is due, for the ability he has displayed in the realisation of the architect's magnificent conceptions.

THE NEW MEANS FOR RENDERING SURGICAL OPERATIONS PAINLESS.

Last week, the first experiment was made in this country of employing the inha-

MONETARY TRANSACTIONS OF THE WEEK.

(*From our City Correspondent.*)

In the Financial Correspondence of The Illustrated News, attention has been frequently of late directed to the embarrassed state of the Continental Money Markets, and the probable effect which would ultimately be produced upon the Money Market here, through the medium of the Foreign Exchanges acting upon the circulation of the Bank of England. The first operation of this description is now in process. For some time the demand for money has been so great in Paris, that the Bank of France, after having discounted to an extent never exceeded, found it necessary to limit their accommodation. The effect of this soon gave evidence that, if persisted in, a panic must inevitably result. As the issues of the Bank of France are based upon specie, and the extent of discounts had extended the circulation to the verge of prudence, it became necessary for the public accommodation to alter the state of the exchanges between the two countries; and

Clockwise from top left: inside the newly re-opened Harry Daly Museum; illustration of the first use of practical anaesthesia in England reported in the *Illustrated London News*, 1847; attendees at the 'Health and Medicine Museums are Good for You' seminar in July.

INSIDE YOUR SOCIETY

MEET YOUR ASA STATE CHAIRS

TASMANIA COMMITTEE

Dr Michael Challis

I live in Hobart with my wife, Hannah, and our four daughters. I have a 0.5 FTE public appointment at the Royal Hobart Hospital, and work roughly 50/50 in the public and private sectors. I have been the Tasmanian State Chair for a little over a year. I was Vice-Chair for only a short period of time before accepting this appointment, so it has been a steep learning curve, but one which has been both enjoyable and educational. I had no idea the ASA was so active and busy!

My areas of clinical interest include anaesthesia for neurosurgery, ENT surgery and difficult airway management, orthopaedics, regional anaesthesia, intra-operative cell salvage and acute pain management. I am also involved in the research arm of the Royal Hobart Hospital anaesthetic department.

Outside of work, I love spending time with my family, but also wish I had more time to spend indulging my passion for cycling. Unfortunately, work (and life) gets in the way all too often, but I do have a goal of cycling in France (around Tour de France time) before I reach a certain age—no doubt I'll wish I were at least 15 years younger when I finally get to do it!

QUEENSLAND COMMITTEE

Dr Jim Troup

I am currently employed as Deputy Director and Senior Staff Specialist at the Royal Brisbane and Women's Hospital in Herston, though I actually graduated from Monash University in Melbourne and spent my junior years in working in Darwin. After returning to Melbourne for anaesthetic training, I found myself missing the warmer northern weather and ended up in Brisbane as a full-time staff anaesthetist. I have been on the ASA Queensland State Committee as the full-time staff representative since 2005. My professional interests are in anaesthesia for neurosurgery, helping to run a large department and mentoring junior staff. I have been involved in the state mortality committee as a member then Chair of the Queensland Committee to Enquire into Perioperative Deaths, until this committee was disbanded in 2006. I am currently serving as Chair of the replacement Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee, which started the process of state-based mortality reviews again in 2012. My personal interests include reading science fiction, science and technology and fishing.

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin

I graduated from the University of London St Thomas's Hospital Medical School in 1983 and gained Fellowship of the (British) College of Anaesthetists in 1990, before it was awarded its Royal Charter in 1992.

Post-fellowship I gained my "BA" ("been abroad", that is!) by spending 14 months in Professor Bill Runciman's department at the Royal Adelaide Hospital, and so began my love affair with Adelaide. I returned to the UK to complete my specialist training at Guy's Hospital in London from 1992 to 1995.

In early 1995, I was doing the rounds of consultant interviews in the UK when my friend and colleague Steve Kinnear phoned me early one morning (before sunrise) asking if I would be interested in applying for a job in Adelaide. The public sector at that time was having difficulty recruiting and it was an opportunity that I found impossible to resist. Fortunately, I was able to persuade the Board of the Royal Adelaide to appoint me and allow my wife to come with me!

Almost 20 years to the day later, I can reflect on the luck that has put me here in the city of parks and churches. I can think of no better place to work and am grateful to my colleagues at the Royal Adelaide and Stace Anaesthetists for providing me with a varied, challenging but above all interesting life.

My interests continue in airway management and anaesthesia for upper gastrointestinal surgery. I firmly believe in representation through membership and that the ASA is THE body for anaesthetists in Australia.

When not working, I would like to play more golf, spend time on the SA south coast (where I fail to surf but derive great pleasure from continuing my futile attempts), want to kite board, ride my bicycle ridiculous distances, watch my boys playing rugby union, enjoy my four adult children and embark on walking holidays with my wife of 27 years. Not much to ask—why are there only 24 hours in a day and seven days in a week?

NEW SOUTH WALES COMMITTEE

Dr Michael Farr

I am a VMO anaesthetist living in Sydney. After gaining my MBBS in Adelaide in 1997, I worked as a JMO at the Royal Adelaide Hospital before moving to London mid-1999, where I lived for the next three and half years. In the UK, I worked in various roles (the majority in anaesthesia and intensive care) in both NHS and private hospital facilities, mostly in London.

I returned to Australia and commenced anaesthetic registrar training in Adelaide in 2003, before moving to Sydney in 2006. I was admitted to FANZCA at the end of my Provisional Fellowship year at the Prince of Wales and Sydney Children's Hospitals during 2007.

I currently practice anaesthesia in both public and private hospitals in Sydney and am a member of anaesthetic group Sydney Anaesthetics. I have been a sitting member on the ASA NSW Committee since 2009 and in June 2014 became NSW State Chair. I also sit as ASA observer at ANZCA NSW Regional Committee meetings and in March 2013 convened an ASA Scientific Meeting at the Hilton, Sydney.

Outside of anaesthesia, I'm a self-confessed 'foodie'. Apart from eating, my favourite pastimes include travel, skiing, and spending time with friends and family.

INSIDE YOUR SOCIETY

WESTERN AUSTRALIA COMMITTEE

Dr David Borshoff

I am now a full-time private anaesthetist, having recently finished 17 years as a sessional cardiac anaesthetist at Royal Perth Hospital. I have taken up the position of Director of Anaesthesia and Pain Medicine at the rapidly growing, 500-bed St John of God Murdoch Hospital, and am a local Western Australian graduate. I have spent time in both London and Cambridge (UK) hospitals during my post-fellowship years.

I am part of the Euroanaesthesia Patient Safety Course Faculty and maintain an interest in human factors, anaesthesia crisis management and aviation safety. I am the author of The Anaesthetic Crisis Manual, first published in 2011, which is modelled after airline-industry safety checklists to detail the management of anaesthetic crises in everyday practice. Aside from being a lapsed recreational pilot, I am also a wannabe musician, plus a husband and father of four (nearly) adult children.

VICTORIA COMMITTEE

Dr Peter Seal

I am an anaesthetist in both the public and private sectors, and an intensive care specialist as well, though I regard myself as a large 'A' Anaesthetist and small 'i' intensivist. I have established myself throughout my consultant career as a sole practitioner and have also served as an anaesthetic supervisor of training. In 2005, I was invited to join the Victorian State Committee of Management and has remained on it ever since. For much of that time, I was the Education Officer, and convened several ANZCA/ASA Combined Continuing Medical Education Meetings. I was elevated to the position of Chair in 2013. In addition, I was a member of the NSC 2010 Melbourne Organising Committee.

My wife Gerri is a chartered accountant and is also my practice manager. Together, we have three children: Andrew, who is 16 years old, Caitie, 14, and Ali, 10. We share a number of interests, particularly sport—as dedicated Geelong supporters in the AFL, we've all been pleased with the Cats' success in recent years. One of my great joys was in returning to play amateur football after successfully passing the Part 1 Examination! I am also a major fan of cricket in all its formats and, after quite a few seasons assisting my son and various junior teams, am contemplating donning the creams myself next summer in the veterans' league! Additionally, I am an avid runner and have completed 12 organised marathons, including three overseas. After participating in the London Marathon last April, I hope to join the illustrious Melbourne Marathon Spartans Club this October, if I'm able to pass the finish line there for the 10th time.

AUSTRALIAN CAPITAL TERRITORY COMMITTEE

Dr Mark Skacel

I am both an intensivist and anaesthetist who has lived and worked in Canberra since the last century, surviving many contract negotiations, roster disputes and changes of administration. Having a cool and experienced head for any industrial matter that arises is a value I believe I bring to the leadership of ACT ASA and was particularly significant during the 2013 Canberra NSC. My support of great organisations extends to the Essendon football club and Lions Rugby.

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

TASMANIA COMMITTEE

Dr Michael Challis, Chair

Our one-day winter Continuing Medical Education (CME) meeting will again be held at Freycinet National Park, on Saturday 29 August 2015. The meeting will focus on the intellectual and interpersonal sides of anaesthetic practice. There will be two fantastic workshops for registrants to choose from in the morning: the popular "Key 2 Me" process communication workshop, or alternatively an ANZCA-recognised ALS refresher course. We hope to attract some interest from interstate, and hopefully a number of you will take the opportunity to join us in this beautiful and pristine part of the world and get some CPD points at the same time. The course runs on Saturday only, and Sunday is free to enjoy the fabulous National Park areas.

We are also well into the planning phase for our 2016 Tasmanian Combined ASA/ANZCA Annual Scientific Meeting, with the theme of 'Anaesthesia in the Extreme'. We plan to cover topics related to extremes including thoracic anaesthesia and severe lung disease, 'extreme' airways, anaesthesia in the elderly, hyperbaric medicine, massive transfusion and retrieval medicine. We are extremely pleased to have Professor Peter Slinger from Toronto confirmed as our keynote speaker. We also have a fantastic array of well-known Australian speakers such as Associate Professor Reny Segal (Royal Melbourne Hospital and member of the Airway SIG Executive), Associate Professor David A. Scott (Director of Anaesthesia at St Vincent's Hospital in Melbourne, and ANZCA Vice President) and Associate Professor Craig French (Director of Intensive Care, Western Health, and co-chair of the Expert Working Group that wrote the latest *Patient Blood Management Guidelines*). The meeting is, yet again, shaping up to be a high-quality event and we hope to attract a significant number of interstate delegates.

On the industrial front, the implementation of the new Salaried Medical Practitioner's Award has gone smoothly.

The Tasmanian public health system has been outsourcing surgical work to private hospitals in a bid to reduce waiting lists and plans are underway to increase this. 'Public-in-private' lists seem to be happening across the country with increasing frequency and perhaps this might help to ease the workforce pressures that have been affecting many anaesthetists, particularly younger specialists. However, caution is required in taking on these lists. While the idea has merit, unfortunately several examples from across the country (including in Tasmania) have shown that the planning of these initiatives may have failed to include contingency plans for postoperative issues. I would encourage anyone considering taking on these 'public-in-private' lists to make sure you are satisfied that appropriate policies and plans are in place to ensure patient safety, and also to ensure that you understand the fine details of what you are signing up for.

AUSTRALIAN CAPITAL TERRITORY COMMITTEE

Dr Vida Viliunas, Vice Chair

Contracts

Contract negotiations continue at the Canberra Hospital with some improvement of engagement for staff specialists and visiting medical officers (VMOs).

Public in the private

Public hospital joints are being performed in John James Calvary Hospital. There have been concerns about level of care, patient 'ownership' and the bed implications for the high throughput of public patients in a private hospital.

GP sedationists

GPs continue to be appointed for endoscopy lists at Calvary in Bruce, despite there being a relative oversupply of anaesthetists.

Registrar membership

A successful GASACT dinner was well attended on 20 March. A concerted effort (see 'Masterclass', next page) is being made to recruit new members and to encourage them to see the benefits of membership, continuing into consultant life.

INSIDE YOUR SOCIETY

Subscriptions amongst registrars are high, though retention is less so.

July 2015 Masterclass

ASA ACT hosted a well attended 'Pulmonary Hypertension Masterclass: when the heart doctor meets the gas doctor'. A husband-and-wife (cardiac anaesthetist and cardiologist with a special interest in pulmonary hypertension) team will be presenting. The meeting is co-sponsored with Bayer.

Farewell

The ACT was sad to note the passing of local anaesthetist Dr Peter Yorke.

WESTERN AUSTRALIA COMMITTEE

Dr David Borshoff, Chair

We recently held the Autumn Scientific Meeting at the UWA University Club. The theme for this year was 'What's Hot'. There were excellent updates in paediatrics, malignant hyperthermia and total intravenous anaesthesia. We wish to thank all those involved who contributed to the meeting's success, but especially the convenor, Dr Lip Yang Ng, and the interstate speakers, Drs Ian McKenzie and Andrew Davidson.

For many of us, one of the highlights of the day was the Bunny Wilson Memorial Lecture, given by Dr Tim Pavy. The evergreen Dr Pavy is well known as an erudite raconteur, but was in particularly good form with his historically informative and wonderfully entertaining talk on 'The Journey Towards Death'!

Our AGM was held during the meeting and the following committee was elected: David Borshoff (Chairman), Phillip Soet (Vice Chairman), Andrew Miller, Angela Palumbo, Chris Cokis, Denise Yim, Dennis Millard, Divya Sharma, Ian Forsyth, Irina Kurowski, James Anderson, James Miller, Jeremy Buttsworth, Lip Ng, Mike Soares, Paul Kwei, Ralph Longhorn and Rob Storer.

We are looking forward to the Bunker Bay Updates on the 16 to 18 October 2015, to be organised by Sam Hillyard and Rockingham Hospital. The theme this year will be 'Modern Challenges and Daily Dilemmas'. This is always popular so people should book early to avoid disappointment.

We are planning a social night later in the year to welcome new members and catch up with the old. This promises to be a great night and details will be released soon.

Finally, a recent introduction to the WA anaesthetic community has been a combined St John of God Healthcare Group and ASA-supported Morbidity and Mortality meeting. The first was held on 23 March and will be held three to four times per year. A turnout of approximately 90 anaesthetists made for a very enjoyable evening with plenty of robust discussion.

From the feedback received, this appears to be a welcome addition to continued professional development in Western Australia.

NEW SOUTH WALES COMMITTEE

Dr Michael Farr, Chair

The majority of the ASA NSW Committee's recent efforts have been directed toward the following most pressing (and ongoing) workplace issues in NSW.

NSW industrial and workplace issues

Public VMO after-hours loading

ASA members may recall from our last 'Around Australia' report in April the unresolved issues regarding on-call, call-back and after-hours loading rates for VMO anaesthetists at one of our rural public hospitals. The dispute remains ongoing, as do our concerns. Amongst other issues, it appears that VMO anaesthetists at this hospital are now being forced to accept no loading for emergency theatre work between 0800 and 1800 on Saturdays, with this work being paid at the standard hourly rate. There was a further notice of intention to implement the same conditions on Sundays within the next twelve months. This arrangement is clearly unsatisfactory. Along with the AMA, the ASA continues to pursue this matter with the Ministry of Health. The outcome in this matter will likely have far-reaching implications. The ASA strongly advises all VMO anaesthetists in NSW to carefully examine any new VMO contracts and before signing and to carefully compare these with the PUBLIC HOSPITALS (VISITING MEDICAL OFFICERS SESSIONAL CONTRACTS) DETERMINATION 2014.

Public/Private Hospital Partnerships

The idea of public/private partnerships is not a new one. Despite some successes and failures, there remains no consistently accepted model regarding the role of anaesthetists and/or anaesthetics departments both in their development and ultimate day-to-day running (including on-call services and appropriate provision for anaesthetic registrars). There are many inherent difficulties and complexities associated with attempting to implement a model that provides appropriate standards of patient care whilst maintaining financial viability and staff satisfaction. Recent examples include the Chris O'Brien Lifehouse facility in Camperdown and the new Northern Beaches Hospital, currently under construction in Frenchs Forest (contract held by Healthscope). I note this to make our members aware of the ASA's ongoing involvement (along with the AMA), including listening to our members' concerns in an attempt to facilitate both fair and rewarding outcomes for anaesthetists and anaesthetic registrars at these facilities.

Continuing Professional Development

There was a CPD meeting on Tuesday 16 June, organised by ACECC and held at the Hilton, Sydney. This was extremely well attended and included international speaker Dr Anil Patel.

GASACT

Regarding events provided for trainees, it has been agreed that ANZCA will play the primary role in future Part Zero courses in NSW, while the ASA will do this with respect to the Part 3 course. That being said, we still expect there will be ongoing input from both organisations at the respective courses. A date for this year's NSW Part 3 course will be set shortly and is likely to again take place in Sydney in late November.

QUEENSLAND COMMITTEE

Dr Nicole Fairweather, Vice Chair

Queensland is currently the only state with anaesthesia Area of Need workforce-shortage positions—a stark contrast to other states, where local graduates are underemployed. I can only suggest that the structural employment changes forced upon the public hospitals were not beneficial, with many staff having either reduced their hours or left Queensland Health altogether. I can only hope that the climate improves and many staff return.

The Queensland Committee have offered their assistance to Dr Jeannette Young, the Chief Health Officer of the Department of Health, in order to assist in any workforce matters in the assessment of Area of Need applications by Hospital and Health Boards. This offer has been accepted. ANZCA already plays a role in this process and we hope to be able to aid local graduates to fill local positions.

The 2015 18th Annual Queensland Registrar Scientific Meeting was held at the ANZCA offices on 30 May. Six registrars presented at the meeting and the standard of these presentations was again very high. The judges (myself, Drs Sarah Earnshaw and Martin Heck) awarded the ASA Chairman's Choice Award of $500 to Dr Rebecca Kamp for her presentation entitled 'Evaluation of epidural extension at a tertiary referral hospital'.

This year's GASACT representatives are Dr Scott Popham and Dr Karla Pungsornruk. Scott and Karla have devised and presented a Mentoring program which the Queensland Committee plan to roll out in the coming year. This will facilitate the matching of our trainee members to our Ordinary members, many of whom may not otherwise have the opportunity to meet. This should be a unique way to interact with our trainees without them having concerns about confiding in someone with input into their assessments. I would encourage everyone to be involved, as I think that both Ordinary members as well as our trainees stand to benefit from such relationships.

Our last ever ASA Part Zero Course was held on 28 February at the Australian Medical Association (AMA) (Queensland) offices. We had 34 attendees: 17 introductory trainees and 17 Principal House/Resident Medical Officers. There were 18 applications for membership. All feedback from course participants was positive with many indicating that it was very informative and a day not to be missed. The lucky door prize was a place on the ANZCA Part 1 Exam preparation course, which was won by Dr Iain Walker-Brown from Hervey Bay/Maryborough Hospital. Moving forward, ANZCA will own and administer the Part Zero Course, and we will contribute toward it.

The Part 3 Course was held on Saturday 18 July. I am sure that those entering the consultant phase of their working lives were keen to hear from consultants speaking about working in public and private practice and how the ASA can help them. Attendees saw the return of popular speakers from last year, including a presentation from a solicitor who speaks to contract negotiation. Despite senior contracts disappearing from the landscape, they will remain a necessity for VMOs in the future. The lucky door prize was attendance at an excellent regional anaesthesia meeting—a great prize! Moving forward, the ASA will own and administer the Part 3 Course, with ANZCA contributing and advertising the event to its trainees on our behalf.

The combined ASA/ANZCA CME Committee has once again been busy this year under the Chairmanship of Dr David McCormack. The yearly combined meeting entitled 'ERAS: The Myths, Methods and Monitoring' was held on Saturday 27 June and was convened by Dr Helen Davies.

All Queenslanders would be aware that the Palaszczuk Government took power after the 31 January election. They have set about reversing many of the legislative and contractual changes that had been introduced by the previous government despite significant opposition by Queensland Health doctors, their unions and many of their representative bodies.

At this early stage it appears that Senior Medical Officers will be returned to collective bargaining agreements, but VMOs will remain on 'truly individual' contracts. It will require vigilance and engagement from both unions and representative bodies to ensure that VMOs are not disadvantaged in this process. Many VMOs of course joined a union during the contract dispute, whereas few were union members in the past, so it is a 'Brave New World' for everyone concerned. It would be interesting to watch those same Department of Health executives negotiate MOCA-4 (or its equivalent).

Of note, the Lady Cilento Children's Hospital opened in November last year, and remains plagued by public criticisms regarding its delivery of services and facilities. I am sure that the diligent work of staff is one of the only reasons that it has continued to function so smoothly and they should be congratulated for working in adverse conditions.

Queensland has several unique surgical delivery models which affect anaesthetists, including Surgery Connect, Mater Broker, Specialist Connect, public hospital incentive waiting lists and Mater Public at Private (for both neurosurgery and thoracic surgery), and I would urge all anaesthetists

INSIDE YOUR SOCIETY

to consider their value, negotiate what they believe to be a fair price for their services and not necessarily accept what has been agreed to on their behalf by surgical and administrative colleagues without regard to anaesthetic considerations. Contact your medical defence organisation as some do not indemnify you for Public Patients without specific endorsements on your policy. Involve the ASA if you think you need to—that is why our big family is here!

I have found the last two years as State Chair rewarding and fulfilling. It has been an honour and a privilege to get to know the folks in our organisation and I would encourage all members to at least engage with their State Committee, if not become an Elected Office Bearer.

I would like to thank the entire Committee for all their time and effort over the last year. Although it goes without saying, I will also mention that I could not have done any of this without the support of Ms Jennifer Burgess, who runs the show as our Secretariat, and we look forward to that professional relationship continuing for at least another two years.

Finally, at our AGM on 27 June, Dr Jim Troup was elected unopposed as the new State Chair. I will be continuing as Vice Chair to support Jim in all his efforts.

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin, Chair

I have had the pleasure of representing the ASA, in the absence of our President, at the ANZCA Annual Scientific Meeting, held in Adelaide in May. I would like to extend my thanks to Dr Genevieve Goulding, President of ANZCA, for extending this invitation to me and to the Convening Committee, headed by Dr Aileen Craig, for an excellent program. The highlight for me was seeing so many of our bright, motivated junior staff being awarded their Fellowship. It is heartening to know that our speciality rests in their hands in the years to come. I know that they will do us proud. Congratulations to them all!

I also attended the AMA (SA) Gala Dinner, which presented a wonderful opportunity to network with colleagues from a wide range of specialities in a most convivial environment. Congratulations to the organising committee for a great evening and to outgoing President Patricia Montanaro—plus a warm welcome to incoming President Janice Fletcher. I believe that the power of such relationships can never be underestimated.

The Biennial Darwin CME Meeting, 'New Answers to Old Questions', this year held in May, has become so popular that it has outgrown its original venue of the Royal Darwin Hospital and moved to the Sky City Casino. Again, it was a pleasure to meet so many old friends and new faces. It bodes well for the forthcoming ASA/NZSA CSC in September and I look forward to seeing many of you there. Don't forget that Professor John West will be coming to Adelaide after the conference—please ensure that you have booked your ticket for the dinner meeting on Thursday 17 September at Adelaide Oval. Places are limited and it will be strictly 'first in, best dressed'. Don't be disappointed by making a late decision! Prof West will also be presenting to the Department of Anaesthesia at the Royal Adelaide Hospital on the Monday morning (21 September), the Grand Round (also at the Royal Adelaide) on the Tuesday (22 September) at lunchtime and at the University of Adelaide on the Tuesday evening. He is also the invited speaker at the ANZ Thoracic Society meeting in Victor Harbor on the weekend prior (Saturday and Sunday, 19 to 20 September). If you can't make it to Darwin, there are plenty of opportunities to hear Prof West talk on a range of topics, from polio epidemics to respiratory physiology in space!

Corridor talk in the public sector has recently revolved around the State Government's 'Transforming Health' plan and the new Royal Adelaide Hospital. Both of these developments will present us with significant challenges in the months to come and the uncertainty surrounding how care is to be provided is concerning to all levels of healthcare workers. Exactly where the Enterprise Patient Administration System, a computerised medical records and daily workflow patient management system, will sit with these changes remains an unanswered question, and is just one of many issues that will have a destabilising effect on the South Australian healthcare workforce.

The next Combined ASA/ANZCA CME meeting will have taken place by the time this edition of Australian Anaesthetist goes to press. 'Anaesthesia Research Update' was the topic for July and I hope it will attract the same volume of attendees that we have come to expect in the recent past. The meeting will have been preceded by the SANT Committee AGM. Unfortunately, our previous arrangement for video hook-up to our remote sites is no longer available and our search for an alternative 'live' link has proven unsuccessful in a financially viable location. We will continue to seek out options, but sadly our best alternative is to secure a recording of the meeting for subsequent distribution to Darwin, the Riverland and Mt Gambier. Although this is far from ideal, it is our best solution at present.

On a brighter note, I would like to welcome Dr Felicity Stone as our new Northern Territory Representative on the SANT Committee and all our new members, both Ordinary and Trainee, to the ASA and thank the existing membership for their continued involvement, remembering that the Society will only ever be as strong as its membership base.

The support from the SANT Committee is, as always, greatly appreciated, as is that provided by Head Office in Sydney and the Secretariat in Adelaide, Tracey DiBartolo.

The ASA SANT Committee can be contacted via Tracey at the ASA SA office on 08 8361 0105 or tracey@amasa.org.au.

VICTORIA COMMITTEE

Dr Peter Seal, Chair

Cocktail evening, June 2015

On Tuesday 2 June, a cocktail evening celebrating our specialty took place at Taxi Kitchen in Federation Square. It provided a wonderful opportunity to acknowledge and congratulate the successful candidates from the recent Final Fellowship Part 2 Examinations, as well as new ANZCA Fellows who have graduated in the past 18 months. More than 50 attended this joyous occasion, including 21 of our younger colleagues who were still floating, fresh from their respective triumphs. Many of them were joined by their spouses and partners. Hopefully this will be the inaugural instalment of an annual event.

New Fellows' Forum, May 2015

The New Fellows' Forum was held on Tuesday 12 May at the Habitat Lounge in Fitzroy. It was an outstanding affair in which 31 participated, including seven Directors of Anaesthesia representing most of the major departments in Melbourne, plus 18 New Fellows all within three years of graduation. An absorbing discussion ensued, and it was fascinating to hear the views of some of the Directors. Certainly, there was much more of a feeling of optimism from the New Fellows this time round, compared with the previous two years, and their general consensus was that the crisis had eased somewhat since the beginning of the year and that currently there was a significant amount of work on offer. In particular, Dr Suzi Nou is to be praised for her superlative role in the planning and organisation of the event. In addition, she hosted and adeptly facilitated a compelling and comprehensive discourse on the night. Many thanks as well to Drs Michelle Horne and Zoe Keon-Cohen for their administrative and moral assistance.

GASACT 'Boot Camps'

In conjunction with the Urban Anaesthetics group, GASACT conducted an intensive day of Part 2 Examination practice on Saturday 18 April at the Peter MacCallum Cancer Centre. Drs Debra Leung and Greg Bulman contributed to the running of a thorough preparation for the approximately 40 candidates that were in attendance. Debra and Greg are planning to follow up with a repeat 'Boot Camp' in early 2016 and are hoping to cover the Medical Viva aspect of the assessment, an area for which previously there has been minimal instruction.

36th Annual ANZCA/ASA Combined CME Meeting, July 2015

The 36th Annual ANZCA/ASA Combined CME Meeting occurred on Saturday 25 July, at the Hotel Sofitel Melbourne on Collins St. It was entitled 'Art and Science, Tips and Tricks', was convened by Dr Michelle Horne, who put together several stimulating and popular sessions. Themes that were covered included perioperative medicine, paediatric anaesthesia, hot topics in adult anaesthesia, and academic anaesthesia.

ASA Rural Meeting, March 2016

It is planned that the Rural Meeting, after an absence of five years, will return in March 2016. Almost certainly the venue will once more be beautiful Creswick, just near historic Ballarat.

ASA NSC, Melbourne, September 2016

The structure of the academic program is continuing to take shape under the leadership of Scientific Convenor, Prof Colin Royse. The invited speakers have been locked in, while Workshop and Small Group Discussion sessions will be developed over the next few months.

Committee of Management Changes

Dr Antonio Grossi has been appointed Chair of PIAC, and we wish him well in this crucial role. Dr Jenny King takes over from him as the ANZCA Victorian Regional Committee Representative. Dr Andrew Schneider has relinquished his position on the Public Practice Advisory Committee, and his place has been accepted by Dr Suzi Nou. In addition, we are thrilled that Dr Zoe Keon-Cohen has become a mother for the first time after her baby son was born in early June.

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from April to August 2015.

TRAINEE MEMBERS

Dr Preeti Ananda Krishnan	SA
Dr Roland Bartholdy	QLD
Dr Joseph Michael Bauer	QLD
Dr Alicia Beasley	QLD
Dr Benjamin Daniel Biles	VIC
Dr Michael Booker	NSW
Dr Jeremy David Broad	VIC
Dr Joanna Elizabeth Burton	QLD
Dr Rebecca Caragata	QLD
Dr Julia Lee Carter	QLD
Dr Dorothy Chan	VIC
Dr Konika Chatterjee	QLD
Dr Phillip Collins	NSW
Dr Isabelle Cooper	VIC
Dr Timothy David Cooper	NSW
Dr Jane Jing Dang	VIC
Dr Henry Davidson	VIC
Dr Monica Joy Diczbalis	NSW
Dr Kathryn Donaghy	VIC
Dr Robert Gregory Esther	TAS
Dr Thomas Egan	NSW
Dr Nathan Bruce Flint	QLD
Dr Berni Frost	NSW
Dr Nicholas Gerbanas	QLD
Dr Biljana Germanoska	NSW
Dr Anthony Gray	ACT
Dr Michelle Haeusler	VIC
Dr Laura Jane Hamilton	WA
Dr Patrick Hamilton	VIC
Dr Megan Haysey	VIC
Dr Jessica Hegedus	QLD
Dr Timothy Ho	VIC
Dr Soheil Hosseini	VIC
Dr Nicole Hunt	VIC
Dr Zacchary Ivey	VIC
Dr David Janmaat	WA
Dr Matthew Jenke	VIC
Dr Alison Jones	QLD
Dr Melissa Jusaitis	SA
Dr Sophie Klaassen	ACT
Dr Yasmin Lennie	VIC
Dr Mateusz Piotr Lisik	NSW
Dr Thar-Nyan Lwin	QLD
Dr Bianca Macula	VIC
Dr Claire Jane Maxwell	QLD
Dr Alexander McCann	VIC
Dr Christopher John Moran	VIC
Dr Shweta Natarajan	QLD
Dr Michelle Nguyen	VIC
Dr Thi My Tien Nguyen	NSW
Dr Therese Nigro	VIC
Dr Emma Paver	QLD
Dr Curt Peterson	VIC
Dr Ramanan Rajendram	VIC
Dr John Robillard	VIC
Dr Patrick Rubie	QLD
Dr Emily Sing	VIC
Dr Robert Leslee Smith	QLD
Dr Timothy Stegeman	NSW
Dr Tiffany Shu Hin Tam	QLD
Dr Jessica Taylor	QLD
Dr Satya Surya Varanasi	NSW
Dr Christine Velayuthen	NSW
Dr Tharindu Vithanage	QLD
Dr Iain Cameron Walker-Brown	QLD
Dr Alice White	VIC
Dr Luke William Willshire	VIC
Dr Elliot Wilson	VIC
Dr Angela Lian Jeen Wong	VIC
Dr Christine Wu	VIC

ORDINARY MEMBERS

Dr Theodore Adraktas	VIC
Dr Bikash Agarwal	VIC
Dr Ioana Arhanghelschi	QLD
Dr Jeremy Luke Brammer	QLD
Dr Ravindra Cooray	SA
Dr Alister Ford	VIC
Dr Suet Ling Go	VIC
Dr Elizabeth Anne Gooch	QLD
Dr Paris Hills-Wright	SA
Dr Brian Hue	WA
Dr Kevin Robert Johnston	QLD
Dr Adebayo Taiwo Jolayemi	NSW
Dr Matthew Keating	WA
Dr Peter Koudos	VIC
Dr Phillipa Louise Lane	VIC
Dr Matthew Leach	NSW

Dr Anthony George Lentz	QLD
Dr Tho Ma	NSW
Dr Paul Robert Nicholas	NSW
Dr John Henry Pratt	WA
Dr Raje Rajasekaram	VIC
Dr Francesca Lee Rawlins	QLD
Dr Simon William Roberts	NT
Dr Andy Siswojo	VIC
Dr Natalie Anne Smith	NSW
Dr Emily Stinson	NSW
Dr Felicity Kate Stone	NT
Dr John Paul Woodall	SA

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Drs Ian Miller Painter, Henry Paul Dyer and Phyllis Lynette Liddle.

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

INSIDE YOUR SOCIETY

UPCOMING EVENTS

UPCOMING EVENTS

ASA & NZSA 2015 Combined Scientific Congress

Date: 12 to 15 September 2015

Venue: Darwin Convention Centre, Darwin, Northern Territory

Contact: Katie Fitzgerald, ASA, 1800 806 654 or events@asa.org.au

Website: www.csc2015.com

Anatomy and Ultrasound for Peripheral Nerve Blockade Workshop

Date: 21 November 2015

Venue: University of Queensland, St Lucia, Brisbane, Queensland

Contact: Alaina Koroday, ASA, 1800 806 654 or events@asa.org.au

Practice Managers' WA Conference

Date: 13 November 2015

Venue: TBA, Perth

Contact: Alaina Koroday, ASA, 1800 806 654 or events@asa.org.au

GASACT VIC Part 3 Course

Date: 14 November 2015

Venue: TBA

Contact: Alaina Koroday, ASA, 1800 806 654 or events@asa.org.au

GASACT NSW Part 3 Course

Date: November 2015

Venue: TBA

Contact: Alaina Koroday, ASA, 1800 806 654 or events@asa.org.au

GASACT WA Part 3 Course

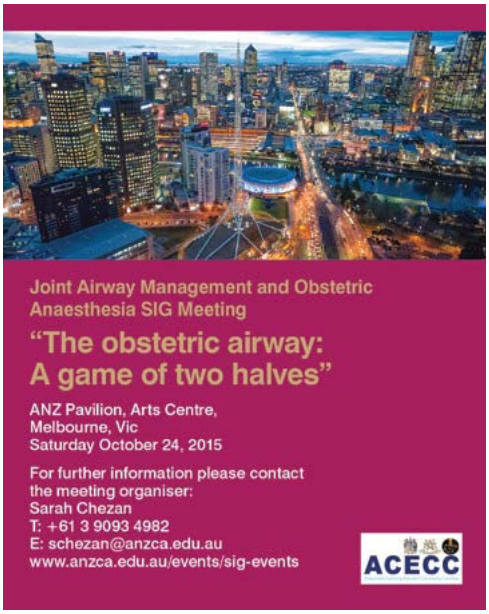
Date: November 2015

Venue: TBA

Contact: Alaina Koroday, ASA, 1800 806 654 or events@asa.org.au

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

ACECC
Anaesthesia Continuing Education Coordinating Committee



LIFESTYLE

OPINION: MINIMUM STANDARDS OF CARE

I read the article by Dr Drew Wenck ('Hospital Safety: Is ACHS accreditation the right path?') in the April 2015 edition of *Australian Anaesthetist* with much interest and considerable empathy, writes Dr Joanna Sutherland, VMO Anaesthetist at Coffs Harbour Health Campus and Conjoint Associate Professor for UNSW Rural Clinical School.

I agree with Dr Wenck that imposing an enormous compliance burden of "process" measures on hospitals, requiring legions of bureaucrats to fill in forms and tick boxes, will not of itself promote quality healthcare. I also agree with Dr Wenck that anaesthetists (and all doctors) need to be proactive in defining the performance standards we expect from hospitals, in order to provide our patients with optimal care.

It does appear that there has been some confusion over the identity of who sets the 15 National Standards. ACSQHC (the Australian Commission on Safety and Quality in Health Care – 'the Commission'), which is a federal government agency, produced the National Standards in 2011, in agreement with the State Health Ministers. In contrast, ACHS (Australian Council on Healthcare Standards) is a private, not-for-profit organisation and Australia's leading accreditation provider. Institutions (public and private hospitals, day procedure centres) all want to demonstrate to their funders, and to the public, that they are delivering quality healthcare. As we all recognise, the delivery of healthcare is a risky business and outcomes are not always aligned with intent, even though intentions are good. Enter the accreditation "experts"– ACHS, for a fee, helps organisations demonstrate compliance with standards (as set by medical colleges such as ANZCA and also other bodies such as ACSQHC) by producing clinical indicator sets. ACHS does not set standards of care. ACHS relies on expert assistance (from anaesthetists among others) to ensure that their indicator sets align with

professional standards (for our caseload, ANZCA standards in particular).

The frustration expressed by Dr Wenck in his article is not unique. Denmark has recently announced that, henceforth, all accreditation processes under the 10-year-old 'Danish Quality Model' will cease in its public hospital sector. The Health Minister referred to hospitals and staff as "drowning in paperwork" and has announced that the new system will include "national targets with…local solutions". But what does that mean?

the delivery of healthcare is a risky business and outcomes are not always aligned with intent, even though intentions are good

In many industries, a "performance-based" or "outcome-based" standard is defined, and then institutions are expected to demonstrate compliance with, this standard (i.e. produce the expected outcome) in whatever way they choose – often allowing for innovative use of technology or workforce. The building industry is a good example. Historically, standards were very **prescriptive** (e.g. for particular buildings, "all windows facing a boundary allotment must be… not less than 900 mm from that boundary"). In the 1990s, the building industry code was reformed to a **performance-based code** – which for the example given, now states that "a habitable room must be provided with windows so that natural light… provides a level of illuminance appropriate to the function… of the building". So the building designer can put the window wherever is desired, allowing for flexibility and innovation (not a 'one-size-fits-all' solution), provided the outcome meets the standard of functionality.

So, what would a performance-based standard, rather than a prescriptive standard, look like in healthcare? As an example, let's consider a hypothetical new standard "provision of an appropriate level of postoperative care for all surgical patients, aligned with need". Under the broad outcome of needs-based postoperative care could be the subset "maintenance of adequate oxygenation, and skilled rescue from adverse airway events and/or hypoxia", and the service level required to deliver this outcome (e.g. for a patient with sleep apnoea after major surgery: continuous pulse oximetry and a clinician with airway skills able to provide bag-mask ventilation, and available to respond immediately in the event of deterioration). Historically, we may have requested "high-dependency care" for some of these higher risk postoperative patients (an example of a *prescriptive* standard). In many institutions, this means a 1:4 (or other) nurse:patient ratio, often delivered in a particular ward (usually the High-Dependency Unit), but merely defining a minimum number of nursing staff does not necessarily provide patients with the skills required for appropriate care.

There should never be a reason to transfer an unstable patient to an inappropriate environment

Focus on a minimum nursing "headcount" reflects an old-fashioned and prescriptive model of care. Too few staff will clearly result in gaps in care and service, but a minimum number of registered nurses per shift will not necessarily guarantee quality care either, unless these staff have the particular skills required to perform the expected tasks – and actually do what is required of them. Use of technological solutions such as pulse oximetry with wireless ('bluetooth') communication to mobile clinical staff (such as is widely used in North American hospitals) may redefine our current understanding of a high-dependency environment. Until we are able to clearly articulate expected outcomes, minimum standards of care and performance requirements, we will have difficulty in participating fully in meaningful conversations about healthcare quality.

The description in Dr Wenck's article of the NEAT target (popularly, but inappropriately, described as a "4-hour rule") demonstrates apparent misunderstanding of the intent and application of this objective. The target refers to a *proportion* of patients who should be appropriately managed, with adequate resources, so as to avoid prolonged (and unsafe) stays in emergency departments.

Good minimum standards of care assist greatly to... identify and provide appropriate resources for patients

There should never be a reason to transfer an unstable patient to an inappropriate environment. Hospitals are required to provide adequate resources and institute whole-of-hospital redesign in order to meet this target, which has generally been shown to avoid 'access block' and improve patient outcomes. Dr Wenck's (fictional) hospital appears to be under-resourced for the caseload he describes. In real life, this scenario leads to anger and frustration.

As Dr Wenck observes, "senior medical staff are not fools" – I encourage him (and all other senior medical staff who, like me, share his views on the state of current hospital accreditation processes) to join in reform of the system. The best way to change any system is from within. Anaesthetists must work with the many groups (such as ANZCA, ACSQHC and the Agency for Clinical Innovation in NSW) who, together with various stakeholders, describe minimum standards of care for hospitalised patients. These groups always welcome and value the input of anaesthetists, who are the experts in provision of anaesthesia and perioperative care.

LIFESTYLE

Good minimum standards of care assist greatly in making the case with hospitals to identify and provide appropriate resources for patients.

We must also move to real measurement of outcomes (both intended and unintended) that are important to patients. How fantastic would it be if we had a system that informed us of the outcome of each and every patient who had come through our hospital processes? Who really understands the improvement in quality of life of all patients who have received a knee replacement in their hospital? Or the (unintended) mortality of their hospital cohort who presents for colorectal surgery? Without these outcome measures, it is very difficult to demonstrate any further improvement from our systems of care. If our outcomes are poorer than expected, we should be able to audit our service against the previously agreed minimum standards of care, to identify gaps in service and potential reasons for our discrepant results.

Australia is a relatively small country and our healthcare supports good life expectancies and quality of life generally. But unless, and until, we define minimum standards of care and measure and report publicly on the patient-level outcomes of all our healthcare interventions, we are "dancing in the dark". When we really know what it is we are actually achieving, "Oh the places we'll go" (with apologies to Dr Zeuss).

Author's note

On behalf of ANZCA, and with the ASA, I chaired the ACHS working party which developed the 2015 Anaesthesia and Perioperative Care Clinical Indicator Set (Version 6). I have also worked with ANZCA, the NSW Agency for Clinical Innovation and ACQSHC to develop minimum standards of care for procedural sedation, and for care of patients with hip fracture.

Editor's note

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

Unsafe surgery is a global health crisis.

You're up to a thousand times more likely to die or experience complications from an operation in a low-resource country than in a high-resource one.

Surgery should be life-saving, not life-threatening.

Visit www.lifebox.org or @safersurgery to find out more.

lifebox

Saving lives through safer surgery

Registered as a charity in England & Wales (1143018) Registered as a company limited by guarantee (7612518)

LIFESTYLE

JOINING A RETIRED LIFE

A friend once told me that the time to retire is when you get too busy to spend time going to work, remembers retired member, Dr Jean Allison.

In 1990, at the time I was due to retire from my position as a Consultant Anaesthetist, I was on the Advisory Board of the International Social Services (Hong Kong Branch), a member of the Natural History Society, Vice President of the Hong Kong History Society, a member of two Walking Groups and of three Clubs and on the Committee of the Hong Kong Branch of the British Medical Association. When we received a letter from Medicins sans Frontiers asking if we could supply a half-time doctor at Fu Day Refugee Centre, the rest of the Committee all looked at me and said "Jean, you have *got* to take this".

When it was time to give up my Hospital Quarters, I moved to a flat on the western end of Hong Kong Island (Fu Day was in the New Territories). The centre was in an old Army Barracks and the refugees were in double bunks (about a metre wide) in Nissen huts with communal facilities. I learnt that no-one in their right mind ever fell from a top bunk—if an unmarried woman gave such a history it was understood that I should do a pregnancy test; and if a man fell, I should find out what he had taken – heroin or marijuana. The clinic where I was to spend the next year and a bit was set up in a converted shipping container. Reassuringly, other agencies had similar accommodations too.

Later that same year, I went to the European Congress in Warsaw and met a lot of my Chinese friends who told me about their experiences on 4 June 1989 when the tanks moved into Tiananmen Square. It was incredible to know I had been so close to such a monumental event in history.

After the European Congress, I had the opportunity to visit Auschwitz and Birkenau. A Sydney woman in our party, Freda, had been in Birkenau when it was a concentration camp. She described seeing her parents for the last time as they were sent to the gas chambers. The barracks looked very like Fu Day, except that there was a stove in the middle with a flue that went to either end and provided some heating—not quite as necessary in tropical Hong Kong. Freda explained that, unlike Fu Day, where there were two in each bunk, there were five in Birkenau.

Back at Fu Day, I soon got used to general practice and made friends with

some of the staff. When Fu Day closed, about a year later, I was asked to work in a bigger centre at Pillar Point for a few weeks. It was about this time I was also asked to work part-time with my friend at the Prince Philip Dental Hospital, three mornings a week. I was quite in demand as I was also asked by Red Cross to help at the detention centres. To say I was busy would be an understatement. But these locations and the work I did gave me an enduring sympathy for asylum seekers and led me to lobby my local MP as a member of GetUp! last year.

I saw what happened to expatriates who had retired to their home country when they finished their appointment, and to those who stayed on too long. Armed with these observations, I tried to 'get it right' by returning to Australia before I was 66. I came back in 1993 and was totally unprepared for the culture shock I would suffer. The traffic frightened me, I could not buy the fruit and vegetables I was used to and instead of the views of sea and hills that I had when I walked with people aged from 7 to nearly 90, I had to learn to walk among trees with other retirees.

I had bought a house at Berwick and started a group who met to read poetry and prose together, like the one I had joined in Hong Kong. I am so pleased to report it is now in its 23rd year and still going strong!

In 1996 I moved to South Yarra to a house designed to be suitable for the disabled. Berwick was too far out and my sister was the only person I knew there who was younger than me.

I joined Toorak Uniting Church (which has been going for over 25 years) and was soon involved with activities there, joining the Drop-in Card Day, the Morning Group (which had started as a mothers' support group but had changed focus as the founders were by then in their 80s), the Church Council and the Fellowship Lunch. Now I run the Card Day and help organise the Fellowship Lunch, which involves making the sandwiches for attendees. I have been President of the Morning Group twice.

When Ralph Clark was asked to form a Retired Anaesthetists Group, he declined the job of President, so Peter Prideaux was elected. I have been on the committee since its inception. When I took my turn as President, I was recruited to the Victorian Committee of the ASA and have been invited to stay on the Committee since then. The best bit of being on the Committee has been being able to join the Organising Committee for the Melbourne Congress in 2009.

I continue to attend the Scientific Congresses held by the ASA as well as international ones. I feel as though it's a badge of honour to be able to say that I have attended all the World Congresses of the WFSA, except the second one in Toronto and the last one in Buenos Aires—possibly a unique record.

About five years ago, Peter Prideaux was invited to speak to the Australian Medical Association about our experience with the RAG, but as he was not a member of the Association, he asked me to volunteer to serve on the Committee of the Retired Doctors Special Interest Group. This is another committee I have been on since, organising interesting talks in various venues, as well as wine tours.

When I could still afford it, I did one of the things that staves off senile decay: I travelled. I enjoyed holidays with Alternative Travel Group and have walked with them along the Southern Tuscan Trail, in Umbria, from Sienna to Rome, in the Cevennes and through the Basque country. As part of my travels, in 2002, my sister Robin and I attended the centenary celebrations of our grandfather's ship *The Scotia* in Troon, where it sailed from, and in Glasgow, where the office of the Royal Scottish Geographical Society is situated. In 2004 we set off from Ushaia "in the footsteps of Bruce and Shackleton". William Speirs Bruce was the scientist who organised the Scottish Expediton to Antarctica and appointed Grandfather (Thomas Robertson) as Captain of *The Scotia*. Unfortunately, we hit a rock in South Georgia, and after patching the ship with a sheet of plastic and epoxy glue in Gritviken, we sailed back to Ushaia. At the WFSA Congress in Cape Town, David Wilkinson gave a talk on anaesthesia in Antarctica, and mentioned *The Scotia*. He repeated the talk for RAG when he visited Melbourne in 2011.

I joined the Friends of the Royal Botanic Gardens, Cranbourne, some time in the last century and have enjoyed taking part in planting activities, as well as many interesting lectures and dinners. Evidently I enjoy my time outside and part of my membership CV is also the Friends of Herring Island (a small island in the Yarra River). Membership with them means the first Sunday of every month spent weeding and planting. Since an unfortunate back injury, I have only been able to join them socially, but these memberships have been a joy and a wonderful way to stay active and outdoors.

I'm also a member of the Lyceum Club, a club for professional women.

Staying active is important, but keeping the mind agile is equally pertinent for me, and so I was pleased when a friend asked me to convene a circle to read poetry and prose, like the one at Berwick. It is now the Poetry Circle and has grown so big that it is split into two groups. Other circles bring me into the club several times a month.

As you can imagine, retiring to a quiet life was certainly not an option for me! Even in retirement I have kept myself well and truly occupied!

Image: Jean and Annemarie Evans in Hong Kong, 2014. Jean returned to the island for the 60th Anniversary of the Society of Anaesthetists, Hong Kong, and the 25th Anniversary of the Hong Kong College of Anaesthesiologists.

CONNECT WITH US ON TWITTER @ASA_AUSTRALIA

JOIN THE CONVERSATION

Connect with others, get the latest news #ASA_Australia.

ASA

Australian Society of Anaesthetists

ASA & NZSA 2015 Combined Scientific Congress

ASA & NZSA
2015 Combined
Scientific Congress

Darwin, Northern Territory
12-15 September 2015

INVITED SPEAKERS

PROFESSOR JOHN B. WEST
Distinguished Professor of Medicine and Physiology in San Diego, the author of the 'Respiratory Physiology' textbooks, he maintains an active research programme in pulmonary function. He will deliver the Kester Brown Lecture.

PROFESSOR DEBRA A. SCHWINN
Dean of the University of Iowa Roy J. and Lucille A. Carver College of Medicine. She specialises in cardiothoracic anaesthesia and research into the stress response.

A/PROF ALICIA DENNIS
Associate Professor at The University of Melbourne; staff specialist anaesthetist and the Director of Anaesthesia Research at The Royal Women's Hospital, Australia. She practices and leads extensive research in obstetric anaesthesia.

PROFESSOR BOBBIEJEAN SWEITZER
Department of Anesthesia and Critical Care, University of Chicago. Director, Society for Perioperative Assessment and Quality Improvement. Her main interest is preoperative patient preparation and perioperative medicine.

DR KELLY BYRNE
Consultant anaesthetist at Waikato Hospital in New Zealand. His main interests are regional and cardiac anaesthesia, ultrasound and echocardiography.

PROFESSOR MARTIN SMITH
Director of Neurosurgical Critical Care Services at the National Hospital for Neurology and Neurosurgery, University College London Hospitals Honorary Professor at University College London.

WWW.CSC2015.COM

New Zealand Society of Anaesthetists (Inc)

ASA
Australian Society of Anaesthetists

Dräger

Experience it for Yourself

Perseus® A500 and the Infinity Acute Care System

Find out what everyone is talking about.

www.draeger.com/myperseus
1800 372 437

Dräger. Technology for Life®