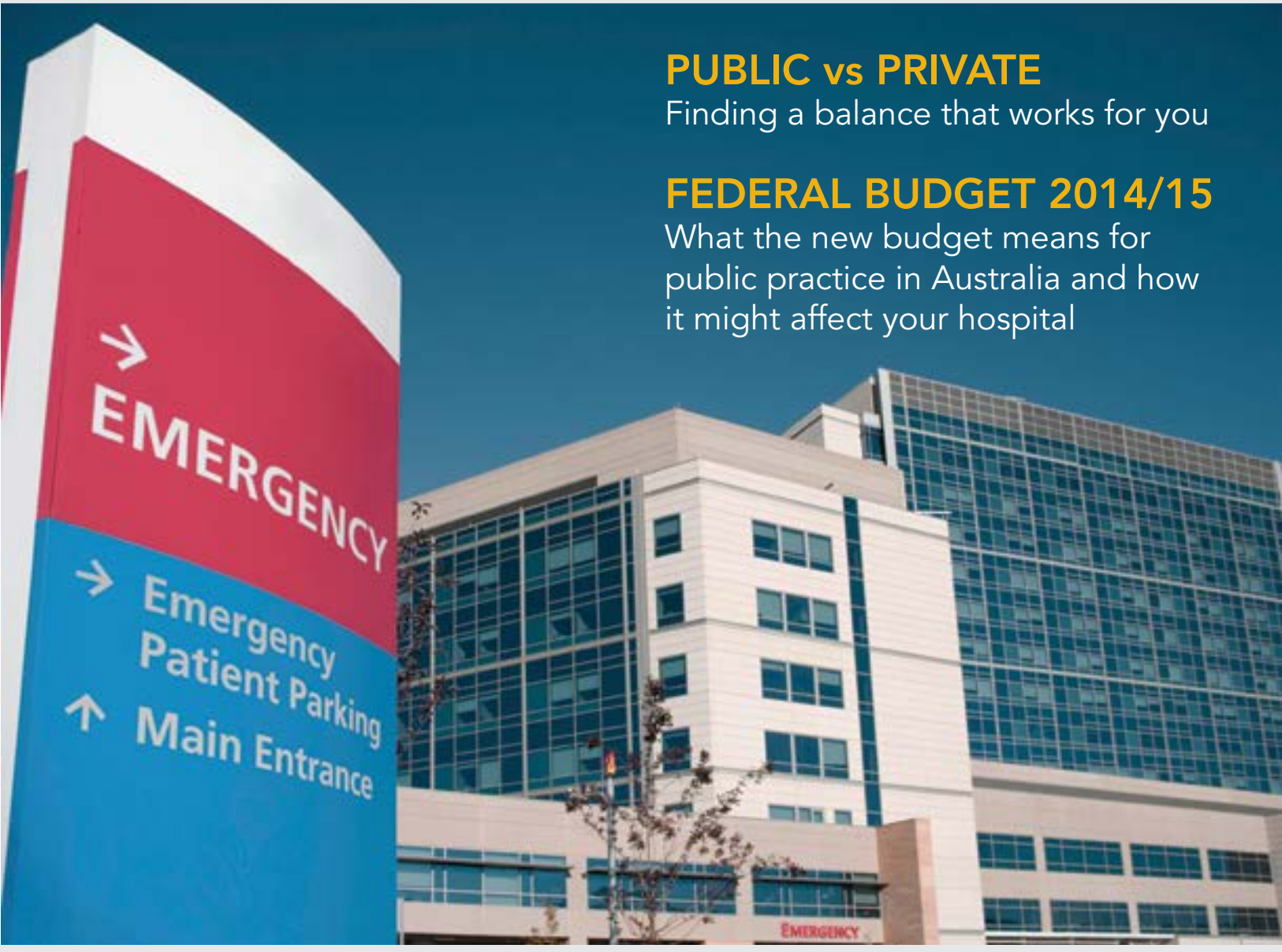
AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • AUGUST 2014



PUBLIC vs PRIVATE
Finding a balance that works for you

FEDERAL BUDGET 2014/15
What the new budget means for public practice in Australia and how it might affect your hospital

PRACTICE, PRECISION AND PROFESSIONALISM
Preview this year's National Scientific Congress on the Gold Coast

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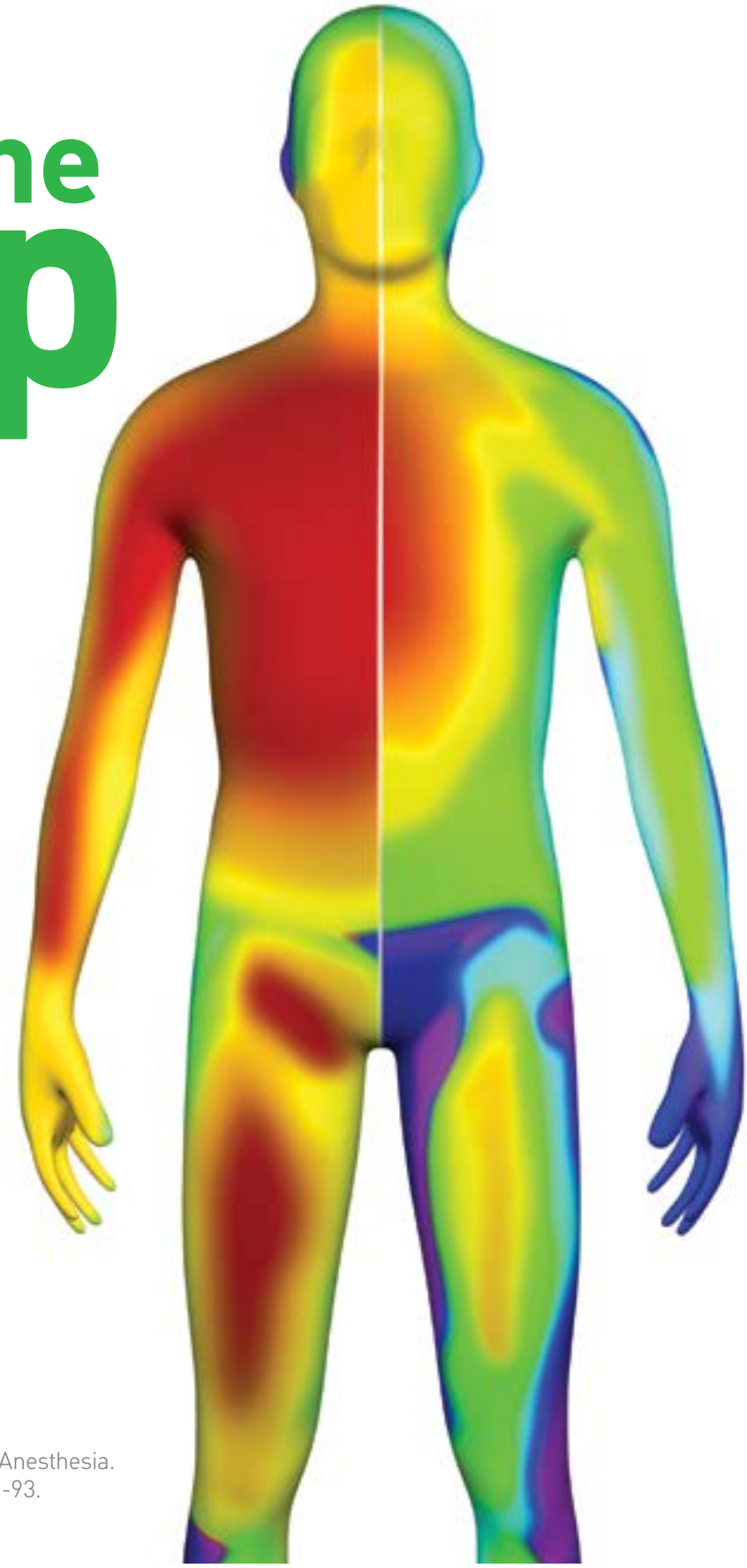

Perioperative hypothermia is unnecessary.

Normal core body temperature (normothermia) is 37.0°C (+/- 0.5°C). If core body temperature drops, vasoconstriction and shivering are triggered at particular temperature thresholds to generate heat. In addition, if the temperature becomes elevated/rises, the cooling mechanisms, vasodilation and sweating, are also triggered at threshold levels.[1]

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

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

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

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

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FEATURES

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INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The December issue features of *Australian Anaesthetist* will focus on post-NSC round-up and ASURA. If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 12 September 2014.
- Final article is due no later than 10 October 2014.

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

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ASA EDITORIAL FROM THE PRESIDENT

DR RICHARD GRUTZNER, ASA PRESIDENT

Welcome to the latest edition of *Australian Anaesthetist*. In this edition we have focused on public practice, with commentary from a variety of members on different practice models and a review of issues facing public anaesthesia practice around the country.

Dr Michael Challis from Tasmania discusses many of the issues faced by practitioners starting out in practice. Deciding on the mix of public and private practice is a critical first step. Historically most Australian anaesthetists start out with a significant proportion of the week spent in public practice. This enables consolidation of the skills acquired during registrar training in the setting of a supportive departmental structure. It also enables participation in teaching and research. This is valuable not only for the individual anaesthetists but also for the trainees who can benefit from the experience of colleagues who have been through the final examination more recently. Dr Challis also discusses some of the issues around private practice, including how one might charge patients for one's professional services. Former ASA President, Dr Greg Deacon, has been quoted as saying "charge what you're worth and be worth what you charge". What you charge for professional services must be seen in the context of the total package offered to surgeons/proceduralist and their patients. If an anaesthetist is punctual, performs high quality pre-anaesthesia consultations, is empathetic with the patients, is technically skilled, organised and provides high quality safe anaesthesia with a focus on management of pain, nausea and vomiting, and provides quality post-operative care patients will generally be happy to pay for this service. Conversely the practitioner who is disinterested and provides poor quality anaesthesia will meet resistance from patients in relation to out of any pocket costs.

Another pertinent quote comes from a distinguished Victorian anaesthetist, Dr Andrew Bacon, who said in relation to patients and their families that "they don't care how much you know until they know how much you care". This is sage advice that I have personally tried to adopt during my thirty years in anaesthesia. This advice is still as relevant now as it was in 1985 and anaesthetists entering any form of anaesthesia practice in 2014 would be well served keeping it in mind.

Something that has changed in the last thirty years is the ability of recent anaesthesia graduates to secure suitable employment in the public hospital sector either as full time staff specialists or as VMOs with a significant number of weekly sessions. I have written on other occasions that the reasons for this are complex and multi-factorial. There has been an increase in the number of anaesthesia graduates over the last ten years which is entirely appropriate given the predicted increase in demand for services related to a growing and ageing population with high expectations of access to sophisticated medical care. Other factors such as the feminisation of the workforce and generational change have also been predicted to increase the demand for anaesthetists. A further assumption has been that resources would be provided by state governments to meet this demand for care in the public hospital system. We have seen a failure of the matching of resources with the increase in demand. We have seen the development of increasing waiting lists for elective surgery and the new phenomenon of the hidden waiting list. Patients on either the formal or hidden waiting list do not need a single nurse, operating theatre session, prosthesis, surgeon or anaesthetist. In many parts of the country and particularly in Victoria there have been significant budget cuts resulting in reduced elective surgical throughput. This has translated directly into cancellation of elective surgical sessions with an associated reduction of employment opportunities for anaesthetists. Not surprisingly the perception amongst young anaesthetists is that the workforce situation has been most dire in Victoria.

In this edition of *Australian Anaesthetist*, Vice President Dr Guy Christie-Taylor analyses the federal budget and its impact on health expenditure, particularly focused on his home state of South Australia. We also hear of similar cuts in expenditure in New South Wales,

Queensland, Tasmania and Western Australia. If these cuts are implemented, it is likely that austerity may become the new "normal". As we have seen already in Victoria, austere times are associated with reduced elective surgical throughput and therefore, a decreased demand for medical procedural specialists including anaesthetists. The picture painted by Dr Christie-Taylor's analysis is concerning, not just for South Australia, but for the entire country.

We have seen a failure of the matching of resources with the increase in demand

At the moment the ability to reduce the number of anaesthesia trainees is limited as ANZCA accredits departments of anaesthesia, not individual training posts. The National Medical Training Advisory Network (NMTAN) under the auspices of Health Workforce Australia (HWA) was seen as a potential way to control the number of training positions, however the future of this body is under a cloud following reductions in funding to HWA in the recent federal budget. We have no knowledge as to how this is progressing, but there is a cynical view that some governments may see an over-supply of medical specialists as advantageous. In the absence of any progress with NMTAN, it is difficult to see how the employment situation for young anaesthetists can improve. In a previous editorial of *Australian Anaesthetist* I wrote about the moral and ethical dimension to this problem. Anaesthesia trainees spend many years developing highly specific vocational skills with limited applicability in other areas of employment. The profession has a moral responsibility to ensure that there is strong likelihood of graduates achieving satisfactory employment outcomes. If governments are not able to meet the community demand for medical services we will need fewer trainees, not just in anaesthesia, but all medical disciplines. The brunt of the current workforce situation is being felt hardest by the youngest members of our profession. The ASA is very unhappy about this situation.

One of my great privileges as President of the ASA has been to represent the Society at meetings with the heads of other anaesthesia societies throughout the world. I have recently returned from the Common Issues Group (CIG) meeting of the American, Australian, British, Canadian, New Zealand and South African anaesthesia societies. Health Economics was one of the many topics we discussed during our two day meeting held in London and hosted by the Association of Anaesthetists of Great Britain and Ireland. Throughout the developed world there have been unsustainable increases in the proportion of GDP spent on healthcare and many of these developed countries are at the point at which expenditure increases above inflation can no longer be tolerated. The National Health System (NHS) in the United Kingdom has had real reductions in health expenditure over the years since the global financial crisis. The United States spends approximately 18% of GDP on health care compared with 8 to 10% in Australasia. Yet 45 million people have no health cover and health outcomes are no better than other countries which spend much less.

Public debate in the United States on sustainable health care is ongoing. So-called "Obamacare" is an attempt to provide coverage to some of the 45 million Americans who have no health cover and presently rely on the emergency departments of county and private hospitals for treatment of acute conditions. There is pressure across the entire health system to improve outcomes without additional expenditure. The American Society of Anesthesiologists is promoting projects such as the "Perioperative Surgical Home" and "Choose Wisely" to deliver more value per dollar of health expenditure. Similarly the European Society of Anesthesiologists is contemplating the ability of governments to continue to fund unlimited access to medical care and the need for increased efficiency. It is important that our Society closely monitors the consequences of the federal budget and the impact on the provision of elective surgical services in particular.

The profession has a moral responsibility to ensure that there is strong likelihood of graduates achieving satisfactory employment outcomes

Closer to home the workforce situation for anaesthesia graduates is also becoming difficult. New Zealand historically has produced more anaesthetists than required domestically, and the remainder have had the option to migrate to Australia to find suitable work. This route has slowed down considerably on account of workforce changes in Australia and there is now concern about the employment opportunities for local New Zealand graduates. With concerns about employment for New Zealand anaesthesia graduates the New Zealand Health Minister has requested that the National Committee of ANZCA and the New Zealand Society of Anaesthetists form a working party to advise him of the workforce situation for anaesthetists in New Zealand. The ability to control the number of training positions occurs in the context of a different regulatory environment, not being constrained to the same extent by the requirements of the Australian Consumer and Competition Commission. It is interesting that the workforce problem has been acknowledged and we will watch with interest the situation across the Tasman.

In order for any anaesthetist or medical practitioner to provide the highest quality

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care adequate volume of practice must be maintained. Participation in continuing professional development is another vital element. In order to maintain volumes of practice, anaesthetists, particularly recent graduates, need to be suitably employed. Amongst anaesthesia trainees we have heard concerns that the volume of practice in some clinical areas is being diluted amongst a larger number of trainees. This is regarded by the trainees themselves as having a detrimental effect on the quality of training. It may be that Directors of Anaesthesia, who essentially determine the number of anaesthesia graduates in Australia, need to have less positions for registrars and more positions for recent graduates. This will enable service provision to be met along with the need for employment and consolidation for recent graduates.

Another significant topic discussed at both the Common Issues Group and the Canadian Anesthesiologists Society meetings was revalidation. This is being handled in different ways in different parts of the world and in Australia we are moving towards revalidation in the short to medium term. Revalidation is the process by which doctors have to regularly show that they are up to date, and fit to practice medicine and maintain their registration. The Medical Board of Australia has "begun the conversation" on revalidation. It has said that any changes must be evidence based, multi-faceted, valid and cost effective. Regulation for regulation's sake would be unacceptable to the medical community and would not satisfy the above criteria. The ASA continues to engage with the Medical Board of Australia on behalf of our members.

Another related issue is the poorly performing practitioner. It would be naïve to believe that increased requirements associated with revalidation would in some way lift poorly performing practitioners above the minimum acceptable standards to continue in practice. There is information available already to recognise the poorly performing practitioner. They tend more likely to be older practitioners, professionally isolated and those about whom multiple complaints have been made. It could be argued that anaesthesia is a unique specialty, because due to the team nature of our work it is much harder to be isolated and none of us practice purely in isolation.

In order to maintain volumes of practice, anaesthetists, particularly recent graduates, need to be suitably employed

The Royal Australasian College of Surgeons (RACS) has a remediation process to assist the poorly performing practitioner in surgery. No such mechanism exists in the anaesthesia community and the only tool available to deal with the poorly performing practitioner is the rather blunt one of mandatory reporting. There may be a need for processes such as those in place at the RACS to be developed in anaesthesia.

I cannot complete my editorial without acknowledging the enormous contribution made by Dr Jeanette Thirlwell to medical publishing and to *Anaesthesia and Intensive Care* in particular. Over an extraordinary 42 years Jeanette has overseen the evolution of *Anaesthesia and Intensive Care* into one of the world's leading anaesthesia journals. The ASA is in her debt and it is fitting that the *Anaesthesia and Intensive Care* best paper prize at the National Scientific Congress has been re-named the "Jeanette Thirlwell *Anaesthesia and Intensive Care* Best Paper Award".

Finally, this is my last editorial for *Australian Anaesthetist*. It has been a great honour and privilege to be your President. We are part of an amazing specialty and the other committed anaesthetists I have worked with both in Australia and from around the world over the last two years have been inspiring. I trust you find this issue of *Australian Anaesthetist* informative and please feel free to contact me through the ASA with any comments or concerns.

FOLLOW THE PRESIDENT ON TWITTER

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

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

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ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

THE VALUE OF MAKING FRIENDS

All throughout our lives, we are constantly meeting people. It starts at preschool, although I often wonder if we can really remember that far back or if it's simply the result of being reminded of who were our friends at that time!

As we progress through primary and high school, we are constantly meeting people with whom we come to form friendships. In some cases, those friendships extend to university and into our working lives, as those individuals we gravitate towards can often share our interests. How often do you hear someone say "oh, we've been friends since high school"?

As a consequence, these friendships can prove to be a great asset in many aspects of our lives, both personally and professionally. I was reminded of the value of these friendships when I attended the Common Issues Group meeting in London during May.

The Common Issues Group meeting is an annual meeting staged between representatives of the American Society of Anesthesiologists, Association of Anaesthetists of Great Britain and Ireland (AAGBI), the Australian Society of Anaesthetists and the Canadian Anesthesiologists' Society. The group has been meeting since 1997. In 2013 invitations were extended to the Presidents of both the New Zealand Society of Anaesthetists and the South African Society of Anaesthetists. Our society was represented by President, Dr Richard Grutzner, Vice President, Dr Guy Christie Taylor, Immediate Past President, Dr Andrew Mulcahy and myself.

Throughout the meeting, topics of mutual interest and focus were discussed, ranging from International Relations, incorporating such things as Lifebox and the World Federation, through to patient safety, training and workforce issues; with the various bodies taking the lead in each discussion. From an Australian perspective, Dr Grutzner led the discussion concerning workforce. It was apparent from the discussions that this issue is present in all attending countries, with the US Vice President, Dr John Abenstein, reporting that in excess of 500 medical school graduates would be completing their training unable to secure a residency in any specialty. A direct result of the increased number of medical graduates in the US. Is there a lesson in this for those of us in Australia?

Importantly, the issue of anaesthetists' welfare promoted significant discussion. While Dr Grutzner was able to report on the work of the *Beyond Blue* Foundation in Australia and the work of the Welfare Special Interest Group, Dr Richard Griffiths of the AAGBI noted that their organisation was looking to develop a significant piece of work on this topic and was willing to share the findings with the member Societies, once completed.

Within the topic of Patient Safety, Dr William Harrop-Griffiths, President of the AAGBI and guest speaker at this year's National Scientific Congress, addressed the meeting on the issue of 'Never Events', noting that, sadly, these do occur. In elaborating, he mentioned that in the United Kingdom, even with the introduction of the Operating Checklist, there had been no change in the incidence of such events, which remains a concern. Interestingly, delegates who had been taken on hospital visits the previous day noted the adherence to the Checklist and how impressed they were with its use.

In terms of international relations, Ms Kristine Stave from Lifebox informed the meeting of the success and future direction of this initiative, one which has been strongly supported in Australia. In terms of numbers, over 7,000 pulse oximeters have been provided to some 90 countries as a direct result of donations. The Foundation is planning to continue with this aspect of its work while looking to investigate the implementation of a broader 'safer surgery' program in countries in need.

The meeting provided a unique forum for the exchange of information on issues common to membership organisations. This interaction has the capacity to influence the promotion and advancement of anaesthesia and to actively address matters which will influence patient safety and an individual's wellbeing. It is clearly an example of how important good friends really are.

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LETTERS TO AUSTRALIAN ANAESTHETIST

CV TIPS FOR TRAINEES

Thank you for the excellent article on *Polishing your CV* by Dr Viliunas. As someone who reviews CVs and does referee checks quite frequently I would like to add a couple of tips.

- In regards to referee contact details, please make sure you include a **mobile number** if possible. Many hospitals require verbal reference checks. Giving a department or hospital number is often fraught with delays, as it may mean leaving a voicemail or message to be contacted back later, which is often not done. If someone is happy to be your referee they are usually happy to be contacted directly.
- Ideally, make it a referee from within the last six to 12 months. Some health services require this. If there are two similar candidates, the one with easily contacted contemporaneous referees will be at an advantage.

Remember that whoever is checking the CV, either at interview stage or in making a decision on who to interview, is probably time poor, so making your CV easy to read and assess and your referees easily contactable is to your benefit.

Dr Anne Jaumees,

Sydney, New South Wales

THANK YOU

I just wanted to pass on my thanks for the series of articles done regarding the workforce issues in anaesthesia.

As a first-year consultant, getting work is far more difficult than I had imagined, and certainly not the situation when I joined anaesthesia training.

I think a lot of people have become dismayed with the ANZCA response, myself included, and are looking to the ASA more than ever.

Thank you for running your articles to highlight the issues faced.

Anonymous

Perth, Western Australia

WORKFORCE UNCERTAINTY CALLS FOR DIVERSIFICATION

I read with interest the articles on workforce in the April edition.

The issues of workforce are very complex but perhaps part of the solution lies in the future of healthcare.

The two drivers of global healthcare are improved patient outcomes and decreased total healthcare costs. Different sectors have different mechanisms to manage these drivers. Companies in the multinational corporate sector (IBM, GE, Philips, etc.) are aligning themselves with two basic mechanisms: coordination and transformation.

As anaesthetists we operate in an environment that delivers real-time, hyper-dynamic multisystem risk/benefit data analysis, information integration and consumer engagement.

The health industry requires the same skill set to help health transform and coordinate to ensure the system is fair, equitable and sustainable now and into the future.

In my experience, the health industry has demonstrated an understanding of the need to engage with clinicians to help produce a sustainable healthcare system.

I would like to encourage members of the anaesthetic community to consider diversification as a mechanism to reduce the personal uncertainty that the current workforce issues present. The corporate world is an amazing place.

Dr David Noble

Bendigo, Victoria

david@bdihealth.com

AAGBI SCHOLARSHIP

My name is Tim Sullivan – I'm currently a second year trainee at Royal North Shore Hospital in Sydney. I was recently provided with the opportunity to attend the Association of Anaesthetists of Great Britain and Ireland's Group of Anaesthetists in Training Annual Scientific Meeting in Newcastle-upon-Tyne, through the Common Issues Group Scholarship program. Having returned and pushed through the jetlag phase, I just wanted to write a quick note expressing my appreciation to both the society and President, Richard Grutzner. I am fully aware of the privilege that the initiative affords. I had a marvellous time exploring

Newcastle, attending the conference and meeting new people. I look forward to reflecting upon and sharing my experiences as I write a formal report in the weeks to come. In the meantime, can I again express my thanks and reiterate the value of the Common Interest Group Scholarship program in broadening the horizons of Australian anaesthetic trainees.

Dr Timothy Sullivan

Roseville, New South Wales

HAVE YOUR SAY

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

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

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

FEATURE

PUBLIC PRACTICE REPORT: AROUND AUSTRALIA

Australian Anaesthetist has rounded up Public Practice Committee members from around Australia and asked them – How do you see the conditions of public practice in your state?

AUSTRALIAN CAPITAL TERRITORY

The Australian Capital Territory has a population of approximately 385,000 people. It is serviced by several private facilities and has two public hospitals – Calvary Public and the Canberra Hospital (TCH). TCH is the major teaching and referral hospital with a catchment estimated to include over 1 million people, extending east to the NSW Coast, South to the Victorian border and as far West as Griffith, NSW. These hospitals undertake approximately 12,500 elective surgeries and 6,500 emergency cases annually.

TCH provides surgical services for most diagnosis related groups, excluding solid organ transplant and high-end paediatrics. Its Anaesthetic Department provides services for 14 theatres and various other components of the hospital such as angiography, brachytherapy, pre-admission, acute and chronic pain services.

The Department of Anaesthesia at TCH has 51 anaesthetists, occupying almost 21 full-time equivalent (FTE) positions. Of these 21 FTEs, staff specialists contribute 14.5 (70%) FTEs amongst 19 (37%) doctors. In addition, TCH employs 30 anaesthetic registrars, which it distributes to both public hospitals and their Intensive Care Units at Albury and the Wagga Base Hospital.

All ACT staff specialists are currently involved in contract negotiations for a new enterprise bargaining agreement. The Australian Salaried Medical Officers Federation and the Australian Medical Association are representing their interests. Additionally, the anaesthetic staff specialists have nominated their own bargaining representatives. The main issue put forward by the group relates to on-call rosters. It is widely acknowledged that weekends on-call at the hospital have now become a rostered shift, nevertheless, ACT Health believes this is covered by a universal staff specialist on-call allowance. However, anaesthetists

believe that they can distinguish themselves from other craft groups who receive the same allowance but are called back into hospital very rarely.

The other major issue relates to staffing levels. Whilst the number of staff specialists have been increasing over the last three years, there has been a corresponding reduction in Visiting Medical Officer numbers. This trend represents a stance taken by the Health Directorate to only offer staff specialist contracts when advertising for new positions (a decision recently criticized by Dr Peter Hughes in the Canberra Times – 22 May 2014). At the same time, demand for anaesthetic services has increased, particularly in out of areas lists.

Dr Will Matthiesson

NEW SOUTH WALES

It will be difficult to mention the state of NSW public hospitals without discussing the federal budget that was announced in the middle of May 2014.

The Bureau of Health Information's latest report shows that from January to March 2014 nearly 49,486 elective surgical procedures were performed – an overall increase by 3% from the same period last year.

Most NSW hospitals performed well in the urgent surgery category, with 97% of patients receiving their procedure within the recommended time frame. However, the performance varied more for patients in the less urgent categories and variation is greatest for patients in the non-urgent category. NSW still has the longest waiting time for elective surgery with some patients having to wait for more than 300 days for knee replacements. Waiting time improvement is thought to be the extra funding made available when the Gillard government negotiated activity based funding guarantees, as well as reward funding that was to be paid to states and territories which met targets on performance measures such as emergency treatment and elective surgery.

On the opposite side of the spectrum, the aim of the new federal budget is to save money by cutting funding by $1.8 billion between 2014 and 2015 and 2017 and 2018 by walking away from the funding guarantees. An additional $16.4 billion will be saved over five years by scrapping its National Health Reform.

Agreement commitments

General Practitioner (GP) co-payments, combined with funding cuts, is more likely to overburden hospitals. Health program Director at the Grattan Institute, Stephen Duckett, estimated that about 300,000 fewer patients than expected will visit their GP once the co-payment is introduced;"A proportion of these will decide to visit a NSW emergency department which will further reduce the chance of meeting the targets and could have a significant effect on waiting times".

The financial pressure that the public system is under is never a new revelation however, to maintain the services into the future, the system has to change one way or the other and the Federal Government's move has been interpreted as a dare for the states, who have limited sources of revenue, to back an increase in the GST.

The Premier of NSW, Mike Baird, indicated that the private sector will have more roles to play in running public hospitals. Partnering with the private sector, the Northern Beaches Hospital will be opening its doors by 2018.

Private ownership of public hospitals is not a new idea, but past failures have come at great expense to the public purse. In 1994, a Coalition government led by Nick Greiner entered into a 20-year agreement with a private operator for the Port Macquarie Hospital to be built, owned and operated. The initial operator was Health Care of Australia. It was taken over by Mayne Health, which in turn sold its hospitals to Affinity Health. The state government took legal action against Mayne for breach of contract in relation to the proposed transfer of the hospital to Affinity. Under the privatisation contract, the government paid the private operator to treat public patients. The NSW Department of Health had to pay a monthly "availability" charge to the hospital over 20 years, estimated to total more than $243 million, plus capital servicing and other service charges. Unlike other public–private partnerships, the hospital would have continued to be owned by the company after the 20-year contract expired. In 1996, the NSW Auditor-General cited the hospital as an example of the public sector being left to shoulder burden and risk, saying: "the government is, in effect, paying for the hospital twice and giving it away". Problems that plagued the Port Macquarie hospital under private ownership included funding for elective surgery running out before the end of the financial year and very long waiting lists for surgery. At the time, a 'Buy Us Back' campaign, run by a community-based action group, lobbied strongly for a return to public ownership, which eventually happened in February 2005. Modbury Hospital in South Australia is another example that failed the test of public–private partnership.

The change in the public hospital funding will have profound and long lasting effects. It is yet to be seen if these changes will lead the private sector, and to that matter the insurance companies, to have more say in service provision.

Dr Ammar Beck

QUEENSLAND

Queensland's Public Health care system faces very uncertain times.

FEATURE

While the 'Dr Death' Jayant Patel case was still before the courts, the Queensland Government signed off on the Medical Officers' (Queensland Health) Certified Agreement No.3, aka MOCA3, while planning to launch its new vision for healthcare.

This launch involved changing the legislation (having a massive majority and no lower house) to allow the introduction of Individual Contracts that would have previously been illegal. The terms and conditions of the original contract, and the one that was presented to doctors for nine days of feedback, can only be described as draconian. The contracts appeared specifically designed to enable unfettered management control over the medical workforce.

Doctors were vilified in the media by the Government, both as individuals and as a whole. Communications were by party-line broadcasts, which contained mistruths and misrepresentations and thus, served only to inflame relations.

After a concerted effort over eight months by medical officers across the state, in conjunction with their two Unions (Australian Salaried Medical Officers Federation and Together), some negotiations were undertaken by the Government. The contracts which resulted are barely acceptable and some conditions agreed to by the Government are yet to eventuate (for example, the Contracts Advisory Committee). Future employees – our current trainees – stand to be paid substantially less than those employed now. The Government has successfully introduced a two-tiered workforce.

The implementation of the contracts by individual Hospital Services has been inconsistent, rife with mistakes and managerial manipulation. As a result, there has been a monumental loss of trust and faith in the employer. Over one hundred people have already resigned. Many services, particularly those in regional areas, are struggling to provide a service already. Those involved in negotiations (of which I was one) believe that more resignations will result, particularly as conditions deteriorate and workloads increase. We fear Queensland being left in the same situation that it was a decade ago – a wasteland that has taken a decade to repair.

The 31 May deadline for signing has now passed. Some chose not to sign and remain grandfathered on MOCA3 until 2015, but with the loss of income. Many Hospital and Health Services scrambled to make "acceptable" changes to the contracts in the week of signing, leaving little time for people to gain appropriate advice. Whilst some Hospital and Health Services refused to negotiate further. Morale in the Queensland public health system has been damaged, trust is absent and uncertainty for the future is rife.

The employment landscape for current and future Specialists in Queensland has been forcibly changed – for the worse.

Dr Nicole Fairweather

WESTERN AUSTRALIA

In Western Australia the economic austerity has impacted on public anaesthetic practice. Over recent years, there has been a freeze on new anaesthetic positions, resulting in new ANZCA fellows finding it harder and harder to find salaried positions in the public sector. Trainees are becoming increasingly anxious about their future opportunities within the public system. The prospect of finishing training with no salaried position and dwindling opportunities in the private system is becoming too real.

Interestingly, these issues have had no impact on the popularity of starting anaesthesia training, with competition to join the registrar training program being as fierce as ever.

The new Fiona Stanley Hospital is due to open next year. It will probably not add significantly any new positions to the system. The Anaesthetic Department will be comprised of anaesthetists from the two neighbouring hospitals rather than recruiting 'fresh blood'. This is obviously leading to significant logistical problems within not only the anaesthetic community, but in the health system in general. At present, the two departments have the difficult task of moving services to the new site.

The Government has conducted widespread audits looking to find efficiency and minimising waste in the system. In one major public health administration, contracts of their sessional anaesthetists are not being renewed. This has occurred despite seniority or years of service to the hospital. As yet, there is no indication that the sessional Visiting Medical Officer positions will be filled with full-time equivalents.

On a positive note, the proud traditions of Western Australian anaesthetists continue. Despite our geographical isolation, our anaesthetic communities continue to set high standards in service provision, research and education. Large numbers of quality trials continue to come out of our "little" state, our local training system enjoys an enviably high exam success rate, the provision of anaesthesia to our many remote communities has been improved by an excellent remote training program and we are lucky to have world leaders in simulation medicine as professional colleagues.

Dr Ralph Longhorn

SOUTH AUSTRALIA

We narrowly escaped the adversarial approach taken by Queensland Health when our Enterprise Bargaining Agreement (EBA) was reached earlier this year. Our EBA was finalised some

years after the old agreement expired, but the newly negotiated terms were not backdated in their entirety. Many of the terms and conditions would have little impact on our current work practices, but newly appointed specialists were facing the prospect of almost unlimited hours for a flat rate of pay. Fortunately, key performance indicators (KPIs) were not part of the proposal, but the increasing desire to run healthcare as a business would suggest that these are part of our future. Determining KPIs in health is challenging and it is worth our while giving some thought to these to prepare for the day when faced with new contracts that incorporate them. One wonders why the morale of the workforce can be held in such low regard.

Metropolitan teaching hospital specialist positions are few and far between, with more trainees graduating than there are retirees. There is little prospect for an increase in the number of anaesthetic specialists at The new Royal Adelaide Hospital due to open its doors in 2016, in spite of an increased theatre capacity of approximately 30%. Quite how this is all going to work will be interesting to see.

The situation regarding country hospitals is more interesting. In the south east, Mount Gambier Hospital has recently been accredited for registrar training. This work supports the full-time specialist surgeons in Mount Gambier. This model of care is yet to be implemented in other regional centres, but would create job opportunities for specialist anaesthetists who could work with the incumbent General Practitioner Anaesthetists.

South Australian Health is currently rolling out the Enterprise Patient Administration System (EPAS) and has promised its full implementation throughout the South Australian Health Public Hospital system. The "paperless" system has now become "paper light" as it becomes apparent that the system is poorly suited to the full suite of tasks that it is supposed to facilitate. The absence of a functional perianaesthetic module that is time efficient is of major concern. An electronic health record is on the horizon but is EPAS the one and is 2014 the right time?

The emphasis on the elective waiting times can be frustrating when faced with, at times, an overwhelming trauma/emergency theatre caseload. A better model for managing these emergency cases needs to be developed, addressing both practical and financial challenges.

Dr Simon Macklin

VICTORIA

In Victoria, in contrast to some other states, the political health landscape of recent months, under the coalition Governments of Ted Baillieu and now Denis Napthine, has been relatively unremarkable. Significant industrial relations disputes involving the Health Minister David Davis have encompassed first the nurses earlier in the electoral term, and now the ambulance officers. The Government was embarrassed somewhat into retreating from its initial hard-line approach to the former, and it is still to resolve long-running matters of disagreement with the latter group. Barring constitutional hiccups, voters are due to return to the electoral polls in late November. The impact from May's federal budget remains to be seen and currently the coalition is trailing substantially in the polls. It also remains to be seen what an Andrews Labor Government would have to offer. Presently, the overall outlook for doctors and their patients is not optimistic.

There have been several notable matters that have had significant ramifications for individual anaesthetists in recent months. In February, the Economics Advisory Committee received a request for assistance from a Victorian member who is in full-time salaried practice, rurally. The member had apparently been involved in discussions with the employer for several months, regarding a new contract covering the terms and conditions of employment. The final version of this contract was delivered with a demand that it be signed by the following morning. Apparently, if this did not occur, then the anaesthetist's employment would be terminated. It is believed that there was no opportunity for further negotiation. The member felt that they absolutely had no other option but to comply and to sign. It appears that there have been no untoward sequelae for them.

In March, the full bench of the Fair Work Commission refused the application of member Dr Mark Colson to appeal against the decision that denied his reinstatement at Geelong Hospital. Although it had been found that his dismissal had been conducted unfairly, and Barwon Health was ordered to pay him the maximum penalty in compensation, it had been determined that his return to work there would be 'inappropriate', primarily due to an irreparable breakdown of trust and confidence between management and Dr Colson. A significant number of the senior medical staff at Geelong Hospital have been displeased by the dismissal of Dr Colson, and have remained supportive of him, especially many of his colleagues in anaesthesia.

Recently in June, the ASA Victoria hosted another New Fellows Forum. The mood was slightly more upbeat compared with that at the same meeting last year. One of the new fellow participants summed up the prevailing likely consensus, by stating that for now it seems that a third of new fellows had fallen on their feet, a third were struggling still to source enough work, and a third were embarking on further fellowships,

FEATURE

such as in chronic pain management or in intensive care. It is certainly apparent that in the last five years, the number of staff specialist positions in public hospitals has dried up considerably.

Dr Peter Seal

TASMANIA

Working in the public sector as an anaesthetist in Tasmania is a rewarding and fulfilling role to have, but comes with a set of challenges that are, in some way, unique to the state. Most public sector anaesthetists have some form of permanent tenure, usually as full-time positions in the north and north-west regions. But, over recent years in Hobart, junior consultants have increasingly been given part-time employment, some times of a temporary nature, and have been supplementing their work in the private sector. On-call arrangements vary, predictably depending on the size of the department.

Everyone has their own reasons for working in Tasmania, but at the top of the list would be lifestyle, family connections and work related opportunities such as in research and education. In my experience, the hospitals in Tasmania are small enough that within departments a genuine sense of community is able to develop. For the motivated, there is enough flexibility for personal initiatives to be undertaken without excessive red tape. Part of the State Award provides for continuing professional development funding and an allocation of conference leave that permits attendance to at least one major anaesthesia conference each year. Additionally, clinical support sessions are reliably provided which allow for formal teaching, research, administrative and self-education activities to take place.

Research opportunities have always existed, but over recent years the culture of research has been growing across the state. In Hobart, for example, there is a clinical lead and a funded research nurse to facilitate the hospital's participation in several multicentre trials endorsed by the ANZCA Trials Group.

The after-hours commitments at the hospitals within the state vary depending on size, but they all attract a general mix of trauma, obstetric and paediatric emergencies. I consider this to be an essential part of maintaining a general skill-set and a major attraction of public practice. Our population is ageing and our restrained operating capacity selects for the sicker and more acute patient. In my hospital, around 40% of theatre cases are booked as emergencies, which results in a greatly varied and satisfying case mix.

Recent budget cuts have compounded the chronic industrial and financial constraints that have always existed in public practice. Cost and time efficiency seem forever to grow in importance and this can impinge on teaching opportunities, personal skills development, job satisfaction and even patient safety, all of which are factors that would otherwise be attractions to public practice. It is remarkable that despite these pressures, the anaesthetic community in Tasmania still finds ways to extend itself through research and continues to maintain a proud record of educational achievement.

Dr Daniel Aras

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THE NEW FEDERAL BUDGET AND PUBLIC PRACTICE

The Federal Budget—rather akin to cod liver oil—is supposed to be good for you, but tastes foul! Vice President, Dr Guy Christie-Taylor, gives *Australian Anaesthetist* the run down on the new budget and how it affects public practice in Australia.

So what is it that leaves you a bit green? The $7.00 co-payment that the Australian Medical Association says will result in patients facing higher out-of-pocket costs at their General Practitioner, the emergency department, pathology, radiology and at the pharmacy[1]? The tax levy on income earners over $180,000 which John Colvin, the CEO of the Australian Institute of Company Directors, says "will not help the economy, as it will hit consumption and investment, as well as undermining incentives to work, invest, innovate and take entrepreneurial risks"[2]? Or maybe it's the indexation of pensions to consumer price indexes or the twice-yearly indexation of petrol excise or the changes to Family Tax benefit B or the raising of the pension age to 70? Or maybe you just enjoy the thought of a further 58 F-35 Joint Strike Fighters[3]?

Maybe, however, the co-payment will "make Medicare sustainable, because what's fair for the PBS [Pharmaceutical Benefits Scheme] is fair for Medicare" and will help establish "one of the world's biggest medical research funds" and maybe the "Budget is not about what's easy or popular in the short term. It's about what is right in the long term"[4].

Well, the real kicker, which Alan Kohler describes in his article entitled *Almost an act of suicidal heroism*, is the cut to health and welfare. Writing in *The Australian* on Wednesday, 14 May 2014 he said:

> *No government in my memory has so risked its survival to a second term to provide such a deep and lasting rationalisation of health and welfare spending. I count 89 specific cuts to health and welfare transfers across several portfolios including Treasury and Veterans' Affairs as well as Health and Social Services adding up to $2.3 billion in 2014-15 and rising to $9.5 billion in 2017-18. The cuts go far beyond what the National Commission of Audit recommended and is one of the biggest reductions in Australian health and welfare spending in history.*

Tom Koutsantonis, the South Australian Treasurer, in responding to the Federal Budget cuts said recently:

> *I think it's fair to say there has not been a cut to health care like this in our state's history. This is the largest cut the Commonwealth has ever made to health since federation, that's how large it is*[5].

Well how will this affect me, you ask? I'm not entirely sure how the specifics in the rest of the country might work out, but please bear with me as I share with you the view of a staff specialist in South Australia. What are the potential outcomes of these 'draconian' cuts?

Over the last eight months 'six or seven' such incidents have occurred[6]. It makes you wonder?!

The South Australian budget followed soon after the Federal one, and was presented on Thursday, 19 June, providing very little to cheer about! The leader in *The Advertiser* read as follows:

> *Average households face an annual rise in their cost of living of at least $150 and the health system is in disarray as the State Government blames Canberra for its black hole budget.*

Upgrades to the Flinders Medical Centre, Modbury Hospital, Noarlunga Hospital and Queen Elizabeth Hospital have been put on hold as the Government warns that $5.5 billion in planned federal health cuts over a decade have left the system "no longer viable in its current state". The Treasurer has refused to rule out the closure of beds or entire hospitals as he scrambles to find additional savings.

Mr Koutsantonis said the government would set up a working group, which would include bodies such as the Australian Nurses Federation, the Australian Medical Association and the Public Service Association, as well as industry, to ask the best way to carve $332 million from the health budget.

The State Government has, in the interim, suspended the roll out of the $422 million IT program—EPAS (Enterprise Patient Administration System). The rollout will be put on hold, but it would still go ahead in the new Royal Adelaide Hospital.

In the meantime, the construction of the New Royal Adelaide Hospital has been plagued by an apparent inability of crane operators to avoid colliding with each other. Over the last eight months 'six or seven' such incidents have occurred[6]. It makes you wonder?!

The State Health Minister, Mr Jack Snelling, said that the $655 million reduction in federal funding over the next four years was the 'tip of the iceberg', requiring a total remake of the health system.' By 2023/24 the Commonwealth will only be funding about 20% and that has enormous ramifications[7].

You're paid too much in any case and your job could be done more cost effectively by alternative workforce entities!

There also seems to be a return to the Federal versus State finger pointing exercise or blame game with the Federal Health Minister, Peter Dutton, saying that "Commonwealth funding to SA is growing by $332 million over the next four years" and the State Government arguing that the "Federal Government health cuts will cost them $655 million over four years, blowing out elective surgery waiting times"[8].

On a more individual level the staff specialist has been confronted by Queensland Health's assault on terms and conditions[9], the payment of Division 293 Tax[10], the prospect of a 2% increase in tax (the so-called Temporary Budget Repair Levy), an increase in the Medicare Levy from 1.5% to 2.0%[11], a freeze on Medicare indexation, a significant rise in the emergency services levy[12], a shortage of employment opportunities (either real or due to relative oversupply) and then has had to contend with calls for a reduction in medical specialist's income[13].

There is little point in relying on 'luck' to manage this new challenge to health

So work harder, be more 'productive', pay more tax, watch the system around you be eroded by budget cuts, but don't complain! You're paid too much in any case and your job could be done more cost effectively by alternative workforce entities! Oh by the way, you can look forward to retiring at 70!

There is some consolation in Alan Kohler's view that you have helped avert civil disruption and unrest:

> *As it is, this Budget will produce cries of pain and outrage across the country; if it hadn't taxed those on $180,000 per year another 2% the losers would march on parliament, as they did in 1978*[14]

So, in the same way we have the 'American Dream', we have the 'Lucky Country'.

It is probably relevant to be reminded of what was actually written by Donald Horne when he penned those words "Lucky Country" in 1964:

> *In a hot summer's night in December 1964 I was about to write the last chapter of a book on Australia. The opening sentence of this last chapter was: 'Australia is a lucky country, run by second-rate people who share its luck'.*

Donald Horne lamented "I have had to sit through the most appalling rubbish as successive generations misapplied this phrase"[15].

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There is little point in relying on 'luck' to manage this new challenge to health and to our role in its delivery.

It would seem that any prediction about an increase in the number of anaesthetists required to meet demand must be balanced by the capacity of Governments and the economy to fund the demand. Hospital closures and reductions in beds do not augur well for an increase in public hospital jobs.

Is this the beginning of the end of 'universal healthcare'?

The question in South Australia, if the dire warnings of the Ministers are in fact true, is how well will we, as anaesthetists, cope with a potential freeze on jobs or, at worst, a reduction in services and job losses?

Will it be necessary to move to a more consultant led service with fewer trainees, a reduction in teaching lists and more focus on service delivery, will there be an erosion of non-clinical roles such as teaching and research, will we delegate some of our roles to other health practitioners, will we see an even more intransigent and difficult Government when we negotiate our next enterprise agreement, will we see a more focused debate on healthcare rationing and will end-of-life and intensive care unit matters be more intensely debated? Will expensive and new technologies simply be quarantined, will professional development entitlements be curtailed, is an increase in private health care possible to fill gaps in service, will standards and capacity in the public sector slowly erode and is this the beginning of the end of 'universal healthcare'?

There are many more questions in South Australia at this time than there are answers and it is made more problematic in the State with the enormous expenditure on the new Royal Adelaide Hospital. The problem of the new Royal Adelaide Hospital is compounded by the fact that the size and design of the hospital is based on some fundamental assumptions. These include the need for a functioning primary health care system, a functioning set of hospitals that are delivering much of the routine elective surgical care and capacity within the system to discharge patients to care in the home or community[16]. Failure to provide these other services will result in a hospital that, within months or even days of its opening, will be overwhelmed and at capacity – not much scope for 'future proofing' the State!

There is clearly going to be a period of considerable uncertainty and ongoing 'consultation' and debate, together with a few more crane incidents, before it becomes clearer what exactly will be left of health in South Australia. The staff specialist in South Australian hospitals will have to accept a large degree of uncertainty as well as the necessity to be 'flexible', nimble and fleet-footed and willing to do what it necessary to preserve their jobs, maintain standards and patient safety. What they cannot do is assume that it is business as usual and that nothing has changed – it has and it is profound.

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PUBLIC VERSUS PRIVATE ANAESTHETIC PRACTICE

As an anaesthetic registrar you don't tend to think too much about private practice – at least I didn't, writes Dr Michael Challis.

There were far too many other things to focus on – studying for exams, preparing for tutorials, seeing preoperative patients, studying for exams, doing night shifts, recovering from night shifts, trying to spend time with my wife and children, trying to keep fit (and sane)... and did I mention studying for exams?! Most of you will be familiar with all of that. I occasionally thought about what life would be like after I finished my training, but I really had no idea what my working life or my work-life balance would be. I had bosses that worked purely in the public system, others that worked a variable amount between public and private and some who had been my consultants early on in my training who had shifted to 100% private. We even had (and still do) a senior 'full-time' private consultant who worked as a sessional Visiting Medical Officer in public one day a fortnight, but full-time in private for the remainder. I was fairly sure I would venture into private work at some point, but only after I had 'settled in' to being a consultant in the public system for a few years.

As it turned out, I finished my training a couple of years too late to be able to walk into a permanent full-time public position, as had been the trend for locally trained new fellows in our hospital over a long period. The current workforce issues resulted in me starting my life as a consultant working part-time in public and part-time in private practice – not what I had planned or expected. So what is the right balance? Is one better than the other? What are the pros and cons for each? How do you even get started in private practice when you have only just finished your training? I had lots of questions. Asking a few of the younger consultants who did both gave me some answers. As it stands, I don't quite work 50:50 in public/private (I work slightly more in public), but for the last two and a half years I have worked regularly in both settings and have learned for myself what the major differences are – good and bad. If you are trying to decide what you want your practice to be (public, private or mixed) then the main points that I think are worth considering follow.

INCOME

I may as well start with the obvious one! Is being an anaesthetist in private practice all about earning more money? I personally don't think so. Australian anaesthetists are highly trained and regarded. Before I started working in private a couple of my colleagues told me that I needed to decide how much I was going to charge, they said "you need to decide what you think you are worth". That sounded a bit too philosophical, wasn't there an easy way to start out? I had no idea about billing, informed financial consents, the Relative Value Guide, no-gap funds, known-gap funds etc. What was I worth? I had no idea. How do you even work it out?

When an intra-operative crisis/emergency occurs, and the patient survives because of my training, knowledge and skills, then how much am I worth to that patient and their family? How much is a human life worth? It is impossible to put a number or dollar value on that. Social norms give some guidance as to what would be excessive or inadequate, but it is very difficult to quantify. Clearly anaesthetists don't earn money like the world's top movie or sports stars (that would be socially inappropriate). But, by the same token, we are not likely to be poor either. In fact, we earn more than most other people. Society is generally fairly comfortable with that, especially when they appreciate the training, difficulties, expectations and responsibility that come with our job. The general public understands that dealing with very sick patients, and being prepared to treat potentially life-threatening emergencies (expected and unexpected), comes at a cost. You need to pay highly trained and skilled people well to do difficult or 'high-stakes' jobs.

Unfortunately, none of this makes it any easier to decide how much I am worth! It is illegal to charge a fixed fee agreed upon with your colleagues, and the Australian Competition and Consumer Commission (ACCC) could have you charged with collusion for doing so. The Australian Medical Association (AMA) has published their recommended rate or 'unit value' for anaesthesia billing, currently $77/unit. As far as I am aware, this takes into account all sorts of factors and is based on working solely in private practice without access to paid leave (sick leave, annual leave, professional development leave etc).

> ...how much am I worth to that patient and their family? How much is a human life worth?

It also takes into account factors like having to pay for private indemnity insurance, renting rooms, paying staff, non-paid administrative time etc. The decision to charge 'AMA rates' or less is a significant one, as Medicare currently values an anaesthetic unit at $19.80, but will only rebate the patients three quarters of that – $14.85. Most health funds, assuming no 'gap' is charged, will rebate the patients a bit less than half of the AMA rate (including the Medicare rebate). If you charge a 'gap', then the patient has an out-of-pocket expense. I don't like talking to patients about money and doing the informed financial consent – I find it awkward – but it is a necessary part of being a private practitioner. When I work in private I am running a business and my business can't survive unless I earn an income for the services I provide. The way I see it, there is a balance that must be met: I have to feel that I am adequately remunerated (bearing in mind the time it takes, the training I have undertaken, the life-saving skills I have, the responsibility that I take on when I look after a patient, the inconvenient times I get called, etc). But, I also have to feel comfortable that I am not perceived to be a 'greedy doctor' (e.g. by charging a very large 'gap' to every private patient). It is an individual choice and there is no right answer. You have to feel comfortable with your decision of how much you think you are worth.

As I mentioned, one of the major differences between full-time public versus full-time private practice is that in private practice you don't get paid sick leave, annual leave, long-service leave, professional development leave, etc. – none of those things that are 'a given' in the public system. If you don't work, you don't get paid – it's a simple equation. Superficially, you could say that private work pays better than the equivalent work in public (based on income earned for hours worked on equivalent cases). This doesn't tell the whole story though. While working in public you are also accruing all of those types of leave. Most public anaesthetists also get non-cash benefits as part of their employment agreement. These may include salary packaging, private practice billing schemes, allowances (on-call allowances, Continuing Professional Development allowances and phone and internet allowances) and the hospital may provide you with a car and/or a fuel card.

> ...the bottom line is that there is a significant degree of employment/income security in the public system and, in the current employment environment, that is like gold for anaesthetists!

Some of these are dependent on whether you work full-time or part-time. Full-time private anaesthetists have to pay for these things out of the income they generate from billing patients, but also have the additional costs of billing services (either staff at the rooms or online billing services), purchasing or renting rooms, paying staff etc. It's not as simple as saying that private practice pays better.

EMPLOYMENT SECURITY

A permanent contract in the public system is something you can 'take to the bank', so to speak. There is no such guarantee in private practice. Your employment is at the mercy of the surgeons you work with. If a surgeon decides they don't want to work

FEATURE

with you any more that portion of your employment ceases. That might come with very little notice. Surgeons also move out of town, and unfortunately, they are not immune from getting ill or even injured. If your surgeon can't operate, you won't be providing any anaesthetics either, and your income will be affected.

In stark contrast to the private sector, in public you will get paid if you turn up. Even if the list is cancelled the contractual arrangement dictates that you will be paid. There are often many other things that you end up doing if your list in the public hospital is cancelled or finishes early. As a public servant, it is reasonable that you are expected to work for your money, but the bottom line is that there is a significant degree of employment/income security in the public system and, in the current employment environment, that is like gold for anaesthetists!

WORKING HOURS

Life as an anaesthetist in the public sector can also have advantages in terms of working hours. There is a general reluctance to allow elective cases to proceed beyond the nominal 'finish time' of the list and, in general, lists finish earlier in public compared to private. Don't get me wrong, theatre over-runs often occur in public, but they are seen as a failure of sorts and are generally associated with some unhappiness in the theatre complex. The managers don't want to pay people overtime for staying late, the nurses don't want to stay late (and sometimes can't because they have duties outside the hospital), and if the elective lists run late, then it can impact on our ability to keep the emergency lists running after-hours.

Another advantage of the public teaching hospital is that, if a competent registrar is able to continue/take over the case (as the evening registrar), the consultant may be able to go home. In some public hospitals if an elective case is expected to go for several hours past 6pm, then the first on-call anaesthetist may take over. However, any 'gains' made above, may well be cancelled-out by the higher acuity on-call workload in public. Being on-call at the only tertiary referral hospital (and trauma centre) in the state is invariably a lot busier than when I am on-call for the small private group I work for. My private on-call does not include obstetrics and this is obviously a significant factor in after-hours call-outs. However, the larger private group do most of the on-call work (including obstetrics at two hospitals) and my perception is that those guys can be pretty busy when they are on-call in private. It depends on how things work in your area; so the differences in after-hours work between public and private may be big or small.

In the private sector things run differently during the day – the list runs until the list finishes. If that happens to be 10pm (or later), then so be it. Private patients rarely get cancelled for time issues. Another feature of private anaesthesia practice is if you start the case, you finish the case, even if that happens to be 10pm (or later).

> The trainees will soon let you know (either intentionally or unintentionally) if you are not up to date... so it forces you to revise what you've already learnt and thought you knew

That may conflict with guidelines promulgated by certain organisations about safe working hours, and it will be interesting to see if the seemingly routine practice of private elective surgical lists running well into the evening changes in the future. It is not that employees in the private sector want to work later than their public sector colleagues, and some staff still have children to pick up from day care etc, but somehow the juggernaut seems to roll on regardless.

Private lists can be very long and there are no spare people around (like in the public sector) who can give you a lunch break, or even a toilet break. You don't have a registrar (although that may be changing in some places) to allow you to leave the theatre for periods during the operation. And it doesn't stop there. Postoperatively, you may get called about all sorts of things that you would never get called for in the public sector because the surgical team or anaesthetic registrar deals with them (for example, intravenous fluid prescriptions, analgesic issues, replacing intravenous lines, reviewing blood test results and medication issues). The level of involvement you have in these things is dependent firstly, on the surgeon (some surgeons expect you to deal with these things and some are happy to do it themselves) and secondly, it depends how involved you want to be.

TEACHING AND RESEARCH

A major difference between public and private is the presence of trainees in the public system. This allows consultants to 'give back' to the system that trained them, by helping to train the next generation of anaesthetists. Apart from allowing you to share the wisdom and skills gained from your training and practice, it also keeps you on your toes – especially when the registrars ask things that you can't remember, or perhaps never understood! Another useful aspect of working with a trainee (especially a senior trainee) that I have become aware of is that it helps to build my confidence in my own practical skills and decision-making. When a senior registrar can't get that epidural or spinal in (or arterial line or whatever it may be), and they ask me to do it, then when I do it successfully it boosts my own confidence. This is part of consolidating the knowledge and skills acquired during training, and if you start out working on your own exclusively in private you may not experience these confidence-building moments as a junior consultant.

Teaching tutorials is always a good way to keep up to date. The trainees will soon let you know (either intentionally or unintentionally) if you are not up to date,

be it basic sciences or fellowship exam topics, so it forces you to revise what you've already learnt and thought you knew and then make sure you are aware of any updates since you last read about it. Nobody wants to look like a fool when taking a tutorial!

While some anaesthesia research occurs in private hospitals in Australia, it would be fair to say that is the exception rather than the rule. Generally speaking, if you want to be involved in research then you need to be affiliated with a university and/or a public teaching hospital. We have a clinical lead for research in our department and a business case was developed to help us fund our own anaesthesia research nurse from participating in these large studies. I am lucky to be involved in two multi-centre ANZCA Trials Group studies that our hospital is participating in. If I was working solely in private practice, it would still be an option for me, but it becomes much more difficult. I would have to do it in my spare time and I would not get paid for that time. As it stands, I am allotted regular paid, non-clinical time in my public position and I can use some of that time for research purposes (as well as the other non-clinical tasks I am involved in and required to do). Working in the public sector is a huge advantage if you want to be involved in research.

PATIENT POPULATION

As a fellow I asked someone about the differences between public and private and one thing I was told was patients in private are generally healthier and take less medications. While it is generally true that in private you don't have to deal with the really sick patients that typically inhabit public hospital intensive care units and high dependency units, many private hospitals do have an intensive care unit, so you may still find yourself dealing with sick patients. Private patients still come with weird and wonderful diagnoses, just like those in public. Sometimes the decision is made that certain operations for particular patients are best done in the public system where there are more high-level resources available to cater to their individual circumstances, and that is on a case-by-case basis. That is appropriate. For example, an operation with a very high risk of bleeding should be done in a hospital with a blood bank, potentially with access to a cell saver and a well-staffed, high-level intensive care unit that can manage potential complications and won't be relatively 'resource-poor' in terms of managing that patient postoperatively. Many private hospitals would not tick all of those boxes.

Sometimes I can't understand how things that should be so simple are made so complicated and hard to achieve

Trauma centres are invariably in public hospitals too; so essentially, all major trauma ends up in the public system. A mate of mine who is a burns and trauma surgeon stated the obvious when he told me there is not much demand for that work in private. These tend to be higher acuity cases with more complex problems.

EQUIPMENT

I can only comment on the public hospital where I work, but the equipment available is far superior to what is available at any of the private hospitals I work in. Just in terms of airway equipment, my public hospital has at least five different video-laryngoscopes I could choose from (a C-Mac with a wide selection of blades, A.P. Advance, McGrath, King Vision, Bonfils) as well as a choice of 'fibre-optic' scopes in varying diameters. In each of the private hospitals where I work there is one type of video-laryngoscope and a fibre-optic scope. These fulfil the requirements but the range of choice is much more limited, and given that one device does not fit all situations, occasionally this may be problematic. Although, the converse could also be argued – being familiar and experienced/skilled with one piece of equipment is better than being unfamiliar with several.

BUREAUCRACY, TEAMWORK AND BEING YOUR OWN BOSS

When it comes to bureaucracy the public service has no equal. The longer I work as a public servant (this is my 16th year working as a doctor in a public hospital) the more I can relate to the classic BBC comedy Yes Minister, and sometimes that scares me! The inordinate amount of 'red-tape' and steps for approval of certain things in the public system is enough to make your brain hurt – if you let it. Sometimes I can't understand how things that should be so simple are made so complicated and hard to achieve. If you feel the need for edification on the finer points of bureaucracy, I can recommend winding down at the end of a long day with a few episodes of Yes Minister, Sir Humphrey will do his best to clear up any points of confusion.

One of the big advantages to working in private is being your own boss. You don't have to work if you don't want to. Obviously if you have regular commitments to surgeons then you have an obligation to find a replacement if you are planning to go away, otherwise the surgeon might make more permanent arrangements while you are gone that don't involve you when you come home! There is a degree of choice about whom you work with in private and having a good working relationship and friendship with your surgeons makes work quite enjoyable. As your own boss you don't need to apply for leave (unlike in a public department), you don't need to submit reimbursement forms for work-related expenses, you don't have to worry about whether your allowances are being paid correctly (or at all) and you don't have to

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do all of those non-clinical tasks that you may find less enjoyable than providing anaesthesia, and which can take up a lot of time.

SUMMARY

So, is one better than the other? In my opinion I don't think it's easy to say. Every anaesthetist has their own reasons for choosing what the balance of their employment is – purely public, mixed public/private or purely private. However, the choice for new fellows has almost vanished. With a relative lack of public hospital positions available, if anaesthesia graduate numbers continue as they have done for the last several years, the employment situation for new anaesthesia graduates may become even more difficult and the only viable option may be to seek work in the private sector. This inevitably puts pressure on the pre-existing private anaesthesia landscape. New fellows need work to pay the bills and support themselves and their families. In the absence of available public positions, new fellows have little choice but to try and obtain work wherever and whenever they can. This may result in established private anaesthetists (who likely have sufficient work agreements with surgeons) battling to retain the lists that have routinely been 'theirs' for so long. This potentially creates a hostile private sector and only time will tell what the outcome of this workforce supply and demand issue will be. Hopefully, the situation will be easier to navigate and less problematic in the coming years.

Why do I work in both public and private? I like the public department that I trained in and now work in. I like most of the people I work with there. The anaesthetic nurses know me and 'my story'. It's a bit like an extended family. I like the opportunity to do more complex cases that push me as a clinician. I enjoy working with registrars because they make me think about things, they keep me up to date and they make me justify my practice. I enjoy watching them mature through the training process and I enjoy passing on things that I think are important, things that I picked up from my teachers and mentors. I also get the chance to be involved in research (even though it is still a bit new to me). The paid leave and paid non-clinical administrative time are a big bonus too.

I like working in private because the surgeon-anaesthetist interaction seems more personal. The independence in practice and reduction in overt bureaucracy are very appealing. With no registrar I actually get to do everything, rather than watch and give advice – and I'm quicker! I like the idea of being my own boss and only working when I want to, but also being able to take leave whenever I want, I don't need the approval of someone else. The ability to determine what I think I am worth, and bill accordingly, is also satisfying.

Personally, I think working a mix of public and private gives you the best of both worlds.

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FEATURE

FORTY YEARS OF SERVICE TO MEDICAL PUBLISHING

After 40 years at *Anaesthesia and Intensive Care,* Dr Jeanette Thirlwell recently stepped down from her position as Executive Editor. Long time colleague and friend, Dr Michael Cooper, has written this article for *Australian Anaethetist* to honour Jeanette's tremendous service to medical publishing.

Jeanette initially started at the Journal in 1974 working with the founding editor, Ben Barry. The Journal was founded in 1972 and she has worked with all five editors as Assistant Editor, Associate Editor and then Executive Editor from 1993.

In 1989, she attained a Diploma of Publishing and Editing to give her a more thorough background in medical publishing. Over these years, and throughout all the changes the Journal has undergone, Jeanette has put her characteristic stamp of taste and excellence on every publication in terms of production, style, layout and language. Her enthusiastic work behind the scenes was indefatigable and deadlines were always achieved in her quiet and accomplished manner. In the early days, she was very involved in attracting advertising to the Journal, which was imperative for its financial success. Jeanette has also edited the ASA Newsletters for many years, making sure the anaesthetists of Australia were kept well informed of all developments on a national basis – and it was this cohesive and all-inclusive approach that marked her style. She wrote and organised essential articles such as, obituaries acknowledging the contributions of our colleagues so that no-one was forgotten. Jeanette recognised the need for cited publication of academic papers relating to the history of anaesthesia, pain medicine and intensive care. In 2005, she initiated the Journal's annual History Supplement, which publishes scholarly works that perhaps would otherwise not make it into *Anaesthesia and Intensive Care*, but were nonetheless worthy of publication.

All of her editorial work, especially in the early days, was done while still working as a Paediatric Anaesthetist at the Royal Alexandra Hospital for Children at Camperdown, then at Westmead in Sydney, raising her family and supporting her busy neurosurgeon husband, Robert Jones, who in turn has supported Jeanette in all her endeavours. Her work with the Journal and the ASA has been recognised by being awarded the President's Medal, the Ben Barry Medal and Life Membership, the highest award of the ASA. She has also been awarded the Robert Orton Medal, the highest award of the Australian and New Zealand College of Anaesthetists.

Most people, however, are not aware of Jeanette's editorial contributions outside of the Journal, both nationally and internationally. She has served with distinction on the Publications Committee of the World Federation of Societies of Anaesthesiologists (WFSA), including being on the Editorial Board of *Update in Anaesthesia,* a well-recognised major resource for anaesthetists in the developing world. She proofed and styled David Pescod's excellent textbook *Developing Anaesthesia: Guidelines for Anaesthesia in Developing Countries.* Furthermore, Jeanette edited the major paediatric anaesthesia textbook for the developing world *Understanding Paediatric Anaesthesia* with Charles Coté and Rebecca Jacobs, as well as Garry Phillips' recent publication, *Intensive Care Medicine in Australia, its origins and development.*

There are many publications released in Australia that would not have been such superb works without Jeanette's editorial and style skills. These have included: *One Grand Chain – The History of Anaesthesia in Australia 1846-1962* (Volumes 1, 2 and References), authored by Dr Gwen Wilson, and *Australasian Anaesthesia, 1992* (the Blue Book).

Jeanette has always been a passionate supporter of the history of our specialty. She has organised and chaired many history sessions at Society and College meetings over the years and was integral in establishing and coordinating the Gwen Wilson Archives Project. She has chaired the History of Anaesthesia Special Interest Group and was Co-chair of the Organising Committee of the very successful 8th International Symposium for the History of Anaesthesia held in Sydney in January 2013. Jeanette will continue her association with the annual History Supplement and as a member of the Editorial Board.

Each year a subcommittee of the Editorial Board of *Anaesthesia and Intensive Care* allocates a prize for the best original paper published the preceding year, which is awarded at the National Scientific Congress of the Society. In recognition of Jeanette's enormous contribution to anaesthesia and medical publishing, *Anaesthesia and Intensive Care* and the ASA are pleased to announce that this award will now be known as the "Jeanette Thirlwell *Anaesthesia & Intensive Care* Best Paper Award".

c.2000, Jeanette with Richard Bailey, assisting with the library and museum.

c.2000, Jeanette in her office at Edgecliff.

c.2000, Jeanette with her husband, Bob and incoming Executive Editor for the AIC Journal, Linda Weber.

c.1996, World Congress reception and dinner at the University of Sydney. Jeanette with her husband, Bob, and ex-President Pat Mackay.

c.1994, Winning the President's Medal at Fiji, with John Roberts.

c.2000, Jeanette is awarded the Ben Barry Medal, with Ben Barry.

Jeanette with Dave Fenwick.

Another paper ready for press.

c. 2002, Sorting sharps.

FEATURE

73RD NATIONAL SCIENTIFIC CONGRESS—GOLD COAST

The 73rd National Scientific Congress of the Australian Society of Anaesthetists will be held from 4 to 7 October 2014 at the Gold Coast Convention and Exhibition Centre in Broadbeach. As Convenor, Dr Anthony Coorey, invites you to attend what is set to be a fantastic four days on the Gold Coast.

Broadbeach, at the centre of the Gold Coast, is one of Australia's best known travel destinations. It offers a wonderful warm climate, arguably Australia's best surf beaches, large shopping and entertainment districts and is well serviced by public transport with the soon to open "G train" light rail.

The Gold Coast Convention and Exhibition Centre is a world class conference venue, but is of sufficient size to preserve the intimacy and social nature for which ASA meetings are renowned.

There are over 15,000 hotel and apartment rooms within three kilometres of the venue, with a range of accommodation that should include something for everyone.

The theme for our meeting is "Practice, Precision and Professionalism". Our Scientific Convenor, Dr Stephen Bruce, and his Scientific Program Committee – Drs Peta Lorraway (Small Group Discussions), Phil Melksham (Workshops) and Pat See (Refresher Courses) – have designed a program that focuses on each of the three elements of the theme.

This year we have over 700 workshop and Small Group Discussion spots available, including over 300 specially designed workshop places that will enable participants to fulfil some of their Emergency Care Continuing Professional Development requirements.

Our lecture program centres on our three invited speakers: Drs Michael Barrington, David Bogod and William Harrop-Griffiths. Together they bring a wealth of experience in research, neuraxial blockade, medicine and law, obstetric anaesthesia and medical ethics. The 2014 Kester Brown Lecture is to be delivered by Mr Tony Morris QC, a prominent Queensland barrister with extensive experience in investigating and dealing

with professional misconduct from both a medical and government perspective.

We have been fortunate enough to gain the support of many of the tripartite Special Interest Groups and the new Allergy Working Group in designing detailed and up-to-date content for the program.

This year's lecture program includes refresher sessions, with content focusing on common clinical conundrums and new technologies being introduced into current practice. We are also trialling a new stream of presentations aimed not only at anaesthetists, but their associates and practice managers too. These sessions include relevant updates on welfare, professional issues, finance, Economics Advisory Committee news and human resources management.

We will have a large trade display incorporating both anaesthetic and non-medical booths. All delegates, be they medical or non-medical, are invited to enjoy their breaks in the trade exhibition. Our only caveat is that Medicines Australia strictly regulates the behaviour of our medical trade exhibitors and they are only permitted to formally interact with medical delegates. Our non-medical exhibitors are free to interact with all delegates. I encourage you to register both yourself and your associate/Practice Manager so that they can take advantage of this exciting opportunity.

Australian anaesthetic meetings are characterised by their unique and relaxed social functions. It is here that some of the best exchanges of clinically useful information occur and this year's National Scientific Congress will be no different. There are welcome drinks for our early registrants on the Friday night. Saturday will feature the Healthcare Industry cocktail reception in the Exhibition Halls. This will be followed by our own Anaesthetic band 'The Vapours' playing sets at the Kurrawa Surf Club, only a ten minute walk from the Exhibition Centre. Please note this is a casual licensed function with drinks available for purchase from the bar.

Sunday evening sees us heading over to Warner Bros. Movie World for a fantastic evening of fun, rides, music, food and, of course, movies. This event will cater to delegates of all ages and their families. Our Gala Dinner will be hosted at the Jupiters Hotel and Casino, aptly themed "Casino Royale". This is your chance to splash out on the 'bling', dress to the nines and enjoy a big night out – Gold Coast style! There will be a special 'chill-out zone' allocated for those who need a break from the hectic pace of a super spy and wish to indulge in a little quiet conversation.

Of course, we are catering for the early-birds too, with early morning walks along Broadbeach each day except Tuesday.

I would like to take the time now to thank the many people who contribute to the production of a major meeting such as this. Our Professional Conference Organisers, ICE Australia, staff at the ASA, trade exhibitors, committee members and, of course, our 200 presenters who have given their time voluntarily for this event. The service you have all provided is critical in ensuring a successful future for our meetings. The ASA National Scientific Congress provides opportunities for us all to learn from each other and ensure the highest clinical standards are maintained in Australian anaesthetic care.

I look forward to welcoming many of you to the Gold Coast this year.

Gold Coast visitor highlights†

Venue	Distance from GCCEC	Opening hours	Admission
Warner Bros. Movie World	23.9 km	10:00am–5:00pm	Adult $89.99 Child*: $69.99††
Dreamworld	29 km	10:00am–5:00pm	Adult $89.99 Child*: $69.99
Sea World	11.3 km	10:00am–5:00pm	Adult $89.99 Child*: $69.99††
Wet'n'Wild Water World	23.3 km	10:00am–5:00pm	Adult $59.99 Child*: $39.99††
Tamborine Rainforest Skywalk	47.7 km	09:30am–5:00pm	Adult $19.50 Child**: $9.50
Currumbin Wildlife Sanctuary	14.3 km	08:00am–5:00pm	Adult $49.00 Child***: $33.00
Infinity Attraction	3.8 km	10:00am–10:00pm	Adult $24.90 Child***: $16.90

† Prices are subject to change. †† All Tickets $99.99, buy a VIP Magic Pass for unlimited entry to Sea World, Warner Bros. Movie World and Wet'n'Wild Water World. *3 to 13 years, **6 to 16 years, ***4 to 14 years.

INVITED SPEAKER ABSTRACTS

DR DAVID BOGOD, MB BS, FRCA, LLM
NOTTINGHAM, UNITED KINGDOM

Consultant Anaesthetist, Nottingham University Hospitals NHS Trust, UK

PITFALLS, PERILS AND PLEASURES OF PUBLICATION

There is increasing pressure on young, and not-so-young, anaesthetists to publish or perish; and a concomitant rise in the number (if not necessarily the quality) of publications prepared to consider our outpourings. Why then does it so frequently go so wrong, and what do we have to do to get into print these days?

Journal editors – a notoriously grumpy bunch – are not keen to accept case reports, fascinating though they might be to the author. They rarely have a significant effect on clinical practice, nor do they add greatly to the scientific record, and usually have a deleterious effect on the impact factor, which remains the metric of choice for editors and publishers. Similarly, surveys and audits of practice are often regarded as 'science-light', especially when, in the former, response rates are poor or, in the latter, the results have little applicability outside the authors' institutions.

Original research remains the bedrock of publication, although most editors will welcome a well-written review article. However, research carries its own pitfalls, often falling at the hurdles of woolly planning, excessive complexity, parochiality of hypothesis or inadequate power. Ethical problems are becoming increasingly frequent and can present a minefield for the inexperienced or venal; these will be considered in some detail during my presentation. Guidance on the problems that editors commonly face can be found at the website of the Committee on Publication Ethics – highly recommended reading for anyone interested in the subject.

During this talk, I will focus on ethical problems ranging from mild misdemeanours (self-plagiarism, salami-slicing), through significant infringements (plagiarising others, multiple publication) to capital crimes (data manipulation and fabrication). The world of medicine has been beset in recent years with very serious examples of research fraud and the careers (and sometimes liberty) of Drs Hwang, Sudbo and Poehlman, amongst others, have been terminated as a result. There appears to have been a particular upsurge of fraud in the anaesthetic community – although this may be a result of anaesthetic journal editors being especially vigilant and proactive – and the cases of Reuben, Boldt and, most recently, Fujii, have focussed the public's gaze in a very undesirable way on our profession.

The uncovering of Fujii, in particular, is of interest as it was achieved largely single-handedly by one anaesthetist in the UK. John Carlisle worked tirelessly for more than a year to apply well-recognised statistical techniques in a novel way, exhaustively demonstrating the extreme implausibility that Fujii's baseline data could have resulted from random subject recruitment. Something that journal editors had suspected for years was finally proven beyond reasonable doubt by one dedicated anaesthetic detective, who has now shown us a method for detecting fraud which could have widespread applicability.

Finally, there is the matter of publication bias which, at its worst, can seriously distort the scientific record and lead to unwarranted complacency about the efficacy of new therapies. This is being addressed, at least with respect to clinical trials, by editors insisting on trial registration before subjects are recruited to studies.

NERVE BLOCKS AND NEGLIGENCE

Claims for damage associated with regional anaesthesia made up 44% of claims against anaesthetists in the UK between 1995 and 2007 – considerably more than would be expected if the ratio of regional to general anaesthesia was taken into account.

The most common successful claim against anaesthetists in the UK relates to pain felt during caesarean section under spinal or epidural anaesthesia. While this is not negligent per se, we often fail to ensure an adequate block or to respond appropriately when the patient complains of pain. Good record keeping – a recurrent theme when considering medicolegal claims – will often mean the difference between a successful defence and a finding of negligence.

Consent is another recurring theme. When the patient has a real choice to make between regional and general

SESSION TIMES

Pitfalls, Perils and Pleasures of Publication
Saturday 04 October 2014, Room 5, 1330–1500

Nerve Blocks and Negligence
Sunday 05 October 2014, Plenary Session 3, 0830–1000

Keeping it Clean – Antiseptics and the Neuraxis
Sunday 05 October 2014, Arena 1B 1530–1700

Communicating Risk Information During Consent
Monday 06 October 2014, Room 5, 1030–1200

anaesthesia, or whether to undergo an epidural or nerve block for postoperative pain relief, they must be presented with a well-balanced explanation of the risks and benefits of the alternatives in order to make an informed decision. Again, good record keeping will allow a defendant anaesthetist to demonstrate that he or she took these precautions.

Direct trauma to the spinal cord is difficult to defend, notwithstanding studies that show it is common to make an error of one to two levels when selecting an interspace for needle insertion. Frequent warnings in the literature, coupled with the increasing availability of and competence with ultrasound, make these cases even more likely to settle in a claimant's favour.

Traumatic nerve damage is not limited to central neuraxial blockade and there are, in particular, a substantial number of cases of brachial plexus injury resulting from interscalene blocks. Nerves arising from the lumbar and sacral tracts are also prone to needle trauma by the over-exuberant anaesthetist, but they can also be damaged by surgical techniques and neurophysiological tests are often required in order to accurately identify the culprit.

In recent years, several cases of severe adhesive arachnoiditis have arisen following seemingly innocuous spinal anaesthesia. At their worst, these lead to paraplegia or even tetraplegia and cerebrospinal fluid obstruction may necessitate multiple cranial decompression procedures. The cause of these cases is not yet fully elucidated, although some courts have found that, on the balance of probabilities, the spinal drugs had become contaminated with chlorhexidine, the antiseptic most commonly used for skin preparation. A high-profile Australian case where chlorhexidine was inadvertently used in place of saline to identify the epidural space has added some scientific validity to this view.

In both the UK and Australia, postsurgical epidurals have been associated with a significant incidence of complications. Haematoma and abscess can, if unrecognised, cause irretrievable spinal cord compression and these cases often result in a finding of negligence on the grounds of poor quality postoperative observation. Spinal cord ischaemia can be an indirect consequence of spinal or epidural administration, particularly when combined neuraxial and general anaesthesia in the frail or elderly patient leads to a critical fall in perfusion pressure during surgery. An increasing realisation that the benefits of postoperative neuraxial block do not always warrant the associated risks appears to be leading to a decrease in popularity of these techniques.

KEEPING IT CLEAN – ANTISEPTICS AND THE NEURAXIS

Antiseptic solutions generally achieve their bactericidal effects by disrupting the cell membrane, so it should come as no surprise that they can cause damage to human cells. Weston Hurst demonstrated this effectively in 1955 using an experimental monkey model and showed that even very weak solutions of chlorhexidine, cetrimide and other antiseptics, when injected directly into the cisterna magna, caused a progressive adhesive arachnoiditis with direct neuronal damage, meningeal cellular proliferation and inflammation leading to cerebrospinal fluid flow obstruction and vascular medial and adventitial necrosis with luminal obliteration.

Despite its proven neurotoxicity, chlorhexidine has become the antiseptic of choice for percutaneous anaesthetic procedures, including spinal and epidural techniques, largely because of superior efficacy in producing a sterile field when compared to its rival, povidone iodine (which is also neurotoxic, albeit probably less so). Aqueous solutions are not as effective as those containing alcohol, so chlorhexidine in alcohol has become the recommended antiseptic for central neuraxial block, with the risk of neurotoxicity outweighed by its superiority in reducing surgical site infection, which carries a concomitant risk of meningitis or epidural abscess. National bodies recommending this approach include the Royal College of Anaesthetists (in the NAP3 report), the American Society of Anesthesiologists and the American Society of Regional Anesthesia.

Sporadically, however, individual cases arise whereby a patient who

INVITED SPEAKER ABSTRACTS

has undergone seemingly uneventful spinal anaesthesia has gone on to develop a severe progressive adhesive arachnoiditis, leading in the worst cases to paraplegia and obstructive hydrocephalus. In the UK, a woman who developed this pathology after spinal anaesthesia for caesarean section was awarded substantial damages when the judge concluded, somewhat in the face of the evidence, that her spinal drugs had become contaminated with the chlorhexidine solution used to prepare her skin. His judgment was supported, however, by an Australian case where a woman known to have been inadvertently given chlorhexidine into the epidural space developed the same clinical picture. Medicolegal experts around the world are aware of other such instances, some of which have been reported in the scientific literature. While a link to chlorhexidine is not proven, it seems to be a likely causative factor.

Thus, while chlorhexidine in alcohol remains the antiseptic of choice, there are questions which need to be answered regarding the correct concentration and how it should be applied. In the UK, an expert group was formed under the aegis of the Association of Anaesthetists of Great Britain and Ireland to consider these questions. At the time of writing, it has yet to publish its final report, but a preliminary version which went for consultation suggests that there is no significant advantage of 2% over 0.5%, so the latter concentration should be used.

As to how it should be applied, pre-soaked antiseptic sponges ('swabsticks') are becoming increasingly popular; these keep the antiseptic solution captive within a hollow container which doubles as a handle, thus reducing the risk of cross-contamination. However, an air hole in the handle can cause leakage onto the operator's gloves if held incorrectly and, more importantly, these are only available containing a 2% solution. Therefore, these are not an option if 0.5% is to be employed and operators must take scrupulous care to avoid contamination of anaesthetic drugs, needles and syringes. Sensible precautions include a 'two stage' approach, with skin preparation completed before equipment is opened or uncovered, a complete ban on having the antiseptic in an open container on the sterile field and always allowing sufficient time for the skin to dry before proceeding.

COMMUNICATING RISK INFORMATION DURING CONSENT

Before any clinical procedure, from checking blood pressure to carrying out major surgery, it is mandatory that consent is obtained from the patient. This is particularly important where the patient has a realistic choice (e.g. whether to undergo or eschew cosmetic surgery or considering the options of spinal versus general anaesthesia for caesarean section), but a basic consent process remains necessary whatever the circumstances. In all Western-style jurisdictions, it is a standard requirement, both ethically and legally, that the patient be presented with enough information to consider their options in an informed manner.

In the paternalistic past, whenever the law has intervened in questions of consent, it has tended to apply the maxim "Was there a reasonable body of medical opinion that would support the way the consent process in this case was carried out?". This 'reasonable doctor' test has, in most jurisdictions, been supplanted by the 'prudent patient' test, which asks the question "Would a sensible patient expect to have been told about this risk, so that he/she could take it into account when deciding whether to proceed?". Indeed, the best standard, and one supported by many professional bodies, would replace the 'sensible patient' with 'this particular patient', meaning that information should be individualised.

How an anaesthetist should do this, particularly in a time-limited situation such as emergency caesarean section, or when the patient is partially incapacitated by pain or distress, such as epidural analgesia in labour, is far from clear. There is an increasing reliance, quite correctly, on prior provision of information, often in the form of a patient information leaflet or a web-based resource. This also has the advantage of being able to be presented in different languages, increasingly important in the polyglot societies now common in Europe and other areas of the world.

Attempts have been made to apply a numerical cut-off point for risks that should be explained to a patient; in the 1980s and 1990s it was taught that a risk need not be mentioned if the likelihood of it occurring was less than 1%. It is doubtful that these maxims have ever been supportable in a court of law, however, particularly as they do not take account of the severity of the risk – an incidence of 1% of headache is one thing, a 1% risk of death or paraplegia quite another. In practice, the explanations provided by anaesthetists have tended to become skewed in recent years, with a probable overemphasis on the hazards of regional anaesthesia compared to those associated with general anaesthesia. Most anaesthetists in the UK will explain the 1 in 66,000 risk of permanent neurological damage following spinal anaesthesia for caesarean section, but will not speak of failed intubation or accidental awareness, both of which have a much higher incidence and one of which can be fatal.

The field of epidural analgesia for pain relief after major lower limb or abdominal surgery is one where risk and benefit are quite finely balanced, and where the patient has the advantage of viable alternatives. Good information provision is therefore particularly important in these circumstances, and I will be considering this in more detail in my presentation.

DR MICHAEL BARRINGTON, MB BS, FANZCA, PHD
MELBOURNE, VICTORIA

Senior Staff Anaesthetist, St Vincent's Hospital, Melbourne and Associate Professor, University of Melbourne, Melbourne, Victoria

POSTOPERATIVE NEUROLOGICAL SEQUELAE – HOW OUR UNDERSTANDING HAS EVOLVED

This presentation will include:

- Factors that potentially contribute to the risk of and reported incidences of neurological complications following regional anaesthesia.
- The anatomical features that result in peripheral nerves being susceptible to injury at a given location.
- Postoperative neurological features related to patient and surgical factors versus peripheral nerve blockade (PNB).
- The hazards of peripheral nerve injection injury.
- Surgery specific risks such as positioning and tourniquet.
- Preoperative neural compromise as a risk factor for nerve injury.
- The challenges of determining aetiology of nerve injury from clinical assessment and investigation.
- New understanding on the microanatomy of peripheral nerves, mechanisms of peripheral nerve injection injury, direct toxic effects of local anaesthetics; the existing strategies and monitoring to decrease the risk of postoperative peripheral nerve injury associated with PNB.

The key learning outcomes I hope to convey include an understanding of the mechanisms and aetiology of postoperative nerve injury and an appreciation of the complexity of localising the site of injury and determining aetiology.

Perioperative nerve injury (PNI) is frequently associated with a range of perioperative processes, anaesthesia and surgery. Anaesthetists are often inadequately prepared to manage a patient with PNI. Being aware of all potential causes and communicating their significance to patients and other health care professionals is important in managing a patient with PNI.

A nerve located in a superficial position is vulnerable to injury. Nerves are vulnerable to compression when they pass through confined compartments, for example, the median nerve in the carpal tunnel and the ulnar nerve at the elbow. Postoperative swelling under the carpal ligament or in the carpal tunnel may cause acute median or ulnar nerve dysfunction. Nerves positioned on the extensor surface of a joint, such as the sciatic nerve at the hip and the ulnar nerve at the elbow, are susceptible to stretch during flexion.

There are factors that protect nerves from injury due to stretch or traction. Nerve trunks within tissue beds, fascicles within nerve trunks and axons within fascicles have a slight undulating course, resulting in relative excess length. Nerves are often attached loosely by their epineurium to adjacent structures. There is a non-specialised network of areolar (deep fascial) connective tissue that fills the space between specialised structures such as nerves, muscles and vessels.

Inadvertent injection of antibiotics, steroids, bovine collagen, botulinum toxin and local anaesthetics into peripheral nerves are associated with marked histological, and in some instances permanent, neurologic deficits. The perineurium has mechanical characteristics that are resistant to penetration with a short bevel block needle. This is in contrast to the epineurium, which is less likely to impose resistance to an advancing needle. In addition, the relative cross-sectional area of non-neural and neural components mean that, should intraneural injection occur, the nerve block needle will more likely be located within the non-neural components than penetrate the perineurium.

Most of our insights from peripheral nerve injection injury are obtained from animal experiments. Clearly this type of experimentation is not possible in humans and the mechanism by which needle injury disrupts the biophysics of peripheral nerves is not fully understood. Although some degree of axonal injury may potentially occur, despite there being no injury to the perineurium, site of injection is thought to be critical, with the

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INVITED SPEAKER ABSTRACTS

SESSION TIMES

The Australasian Visitor's Lecture: Postoperative Neurological Sequelae – How our understanding has evolved
Sunday 05 October 2014, Arena 1B, 0830–1000

Whodunnit: A case of postoperative brachial plexopathy following continuous infraclavicular blockade
Monday 06 October 2014, Room 1, 1300–1430

Does regional anaesthesia improve outcome following major orthopaedic surgery in the modern era?
Tuesday 07 October 2014, Arena 1B, 1100–1230

main source of peripheral nerve damage being the injection of local anaesthetic into a fascicle, causing myelin and axonal degeneration, blood-nerve barrier disruption and neurologic deficits.

Therefore, avoidance of deliberate trauma to nerves, including intraneural injection, is a key safety principle of regional anaesthesia. However, intraneural injection may occur in clinical practice and not cause overt signs of nerve injury. Unintentional intraneural (but probably extrafascicular) epineurial injection may be more common than previously recognised. However, the epineurium also contains blood vessels and their disruption may cause ischaemia, haematoma, inflammation and fibrosis.

Exposing peripheral nerves to high concentrations of local anaesthetics may result in neurotoxicity and nerve injury, particularly if the injected solution is intrafascicular, the concentration is high and the duration of exposure prolonged. However, needle penetration of a nerve may result in minimal damage if it is not combined with local anaesthetic injection within the nerve fascicle.

Nerve injury occurs following positioning for surgical requirements. Mechanisms of nerve injury related to surgery include traction, transection, compression, contusion and ischaemia. Regardless of exact mechanism, a continuum of severity of nerve injury has been described, including physical disruption of intraneural blood vessels causing patchy ischaemia or haemorrhage, elevated intraneural venous pressures, endoneurial oedema, impairment of axoplasmic flow, Schwann cell damage, myelin displacement, axonal degeneration and Wallerian degeneration.

Tourniquet inflation causes nerve damage by mechanical deformation or ischaemia. In the context of meniscectomy surgery, tourniquet compression can result in electromyographic evidence of femoral denervation limiting functional recovery.

The presence of a preoperative neural compromise theoretically places a patient at increased risk of PNI. Preoperative neural compromise may result from several mechanisms: entrapment, metabolic, ischaemic, toxic, hereditary and demyelination. Entrapment neuropathies can involve the ulnar, median, radial, lateral femoral cutaneous nerves, femoral, peroneal and proximal nerve roots. Potential risk factors for PNI include medical conditions that adversely impact on the calibre and function of the small blood vessels that supply nerves. Toxic aetiologies include alcohol and Cisplatin chemotherapy. Patients with multiple sclerosis may have subclinical preoperative neural compromise within the peripheral nervous system.

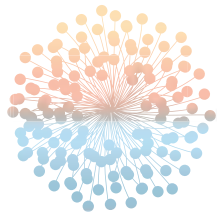
Evaluating PNI relies on clinical assessment, electrodiagnostic testing and magnetic resonance imaging (MRI). However, MRI diagnostic capacity is limited because a range of pathological mechanisms may lead to non-specific MRI changes (increased signal intensity). Determining the aetiology of PNI requires an injury to be definitively localised and identifying whether it is concordant with the PNB site or distinct from it. Electrodiagnostic tests including electromyography (EMG) can provide important information including localisation and severity of a focal nerve lesion. Importantly, EMG can reveal evidence for a pre-existing peripheral neuropathy, and help determine the timing of an injury and likely prognosis. EMG determines if the pathological process involves loss of myelin, axonal degeneration or both, however EMG will not determine the mechanism of injury. Features of demyelination are slowing of nerve conduction velocity, dispersion of evoked compound action potentials and conduction block. Pathological changes on EMG take three to five weeks to develop; however, this information does not necessarily determine the mechanism and cause of the PNI. There are pitfalls with being overly reliant on EMG, because a diagnosis is often dependent on one critical finding. Implicit in the electrophysiological diagnosis of many conditions is the presence of a normal EMG outside the region of interest. Abnormalities outside the region of interest suggest alternative or additional diagnoses.

Summary

PNI has a diverse and complex aetiology, being associated with a range of perioperative processes, anaesthesia and surgery. Mechanisms of PNB mediated injury include mechanical trauma from needle and injectate, ischaemia, direct local anaesthetic toxicity and inflammation. The main source of PNB-mediated neurologic complications is likely mechanical fascicular injury and/or injection of local anaesthetic into a fascicle causing myelin and axonal degeneration. Avoidance of deliberate trauma to nerves, including intraneural injection, is a key safety principle of regional anaesthesia. Fortunately, most postoperative neurological deficits appear to resolve with time and the incidence of serious long-term neurologic complications attributable to PNB is relatively uncommon. Distinguishing patient, surgical, anaesthesia and other potential aetiological factors is demanding and in some situations the exact cause remains speculative. Localising the site of injury in a patient with a peripheral perioperative nerve injury – and therefore determining aetiology – may not be possible in every case. If all the clinical and electrodiagnostic features align, then localisation may be possible.

Key messages

- Peripheral nerves vary in their morphology and susceptibility to injury.
- There is no evidence that one nerve localisation technique is superior to another with regards to reducing the likelihood of nerve injury.
- Animal data link high injection pressures to subsequent fascicular injury, but there are no human data that confirm or refute the effectiveness of injection pressure monitoring for limiting nerve injury.
- Peripheral nerve injection injury with local anaesthetic is greatest when the injection is intrafascicular in location. This is likely related to exposure of axons to vastly higher concentrations of local anaesthetics, compared with extraneural application of anaesthetics and mechanical damage to the perineurium and associated loss of the protective environment contained within the perineurium.
- Current ultrasound technology does not have adequate resolution to discern between an interfascicular and intrafascicular injection.
- The presence of a preoperative neural compromise theoretically places a patient at increased risk of perioperative nerve injury.
- Postoperative neurological features are more likely to be related to patient and surgical factors than to PNB.
- Severe permanent nerve injury directly attributable to PNB is rare.
- Electromyography and MRI are important investigations in cases of PNI to confirm a nerve injury and define its extent and severity. The timing of electromyography is important and sequential studies may be required for diagnosis.



FEATURE

ONLINE ANAESTHETISTS

With the rise of handheld devices, Wi-Fi accessiblility and an expectation to maintain an online presence professionally and socially, *Australian Anaesthetist* asked three members about their practice and where they saw themselves within the online environment.

DR ALLAN PALMER

I was introduced to the internet in 1994 and was fortunate enough to be able to shape some of the earliest attempts at online education and medical professional discussion within my field. My first website was called 'Gasbone', an anaesthetic education server where users were able to distribute recorded departmental lectures, host discussion forums and ultimately, broadcast lectures from the 1996 World Congress of Anaesthesiology in Sydney to a worldwide audience.

The next decade saw my career shift to a more traditional solo private practice. Clinically, the web had little impact on practice models that remained largely unchanged from a generation before.

The early 2000s welcomed Google into everyone's homes and resulted in a surge of 'self-diagnosis', which generated a need for online content. Concurrently, a social revolution was underway and I enthusiastically joined the social media explosion. By the early 2010s it was evident that being online didn't mean having a personalised website, but rather, having an online social profile. Many patients Google the names of their carers before meeting face-to-face. This can lead to misunderstandings before the relationship has even begun. I suggest to all readers that they Google their own name and, if they don't like the results, that they create an individual Google profile that is accurate and can be directly controlled. Personally, I am a big supporter of Google+, Google's own social network, as it has carefully managed to limit the impact of advertisers and public relations people and maintain a sense of professional social networking, while allowing a crossover with personal interests.

My business card shows my Google+ profile page, not my own website. Unlike other social networks, Google+ has excellent privacy controls, allowing me to share articles of interest with the general public and more specific professional material with colleagues around the world in our private online community 'Gasnet'.

Alongside social media growth came podcasts – downloadable video and audio presentations. Some are highly relevant to anaesthesia. I listen to these as I drive between hospitals, converting the daily commute into Continuing Professional Development points! Is there an Australian anaesthesia podcast? There may be soon!

My practice has also benefited from apps like Skype, Facetime and Google Hangouts. For me, it is now routine to conduct preoperative consultations via video conference. Being able to 'see' the patient is a vast improvement over phone consultations and when I do meet these patients face-to-face on the day of surgery, I am usually greeted by name and welcomed, the doctor–patient relationship already established.

If I were to start over, my first priority wouldn't be creating a website, but growing an online social identity. Considering medical board restrictions on advertising and use of testimonials, I believe it is safer to stick to a personally directed social media profile, rather than a website that becomes lost in the internet noise, dwarfed by opinions and posts of dubious validity. Once your profile is established, become engaged in discussion. By becoming a socially enhanced anaesthetist, you may discover others with similar interests around the world and gain a fresh perspective on your own career.

Follow Dr Palmer

Google+ : https://plus.google.com/+AllanPalmer/

Twitter: https://twitter.com/medicalmusings @medicalmusings

Email: allan@palmer.net.au

ASA NSC 2014

Dr Allan Palmer will also be presenting at this year's National Scientific Congress at the Gold Coast.

His presentation – The Socially Enhanced Anaesthetist – will be in Room 5 on Sunday, 5 October 2014, 1330 to 1500.

DR DAVID PAGE

Anaesthesia is an applied science where the anaesthetist is the patient advocate, a 'sleep doctor' who gives them the deep and meaningful experience that they don't have, while minimising the risk of adverse outcomes.

We all have guiding principles we use to improve patient outcomes. The KISS (Keep it Simple Stupid) principle is a time honoured one. The use of technology to improve anaesthesia is to be applauded. High-resolution ultrasound for patient assessment and aiding regional blockade is one such example.

Considerations

However, when technology takes the focus off the patient, clinicians need to consider the implications. The move towards real-time electronic anaesthetic data entry seems to be driven by non-clinicians trying to reduce costs, without due consideration having been given to the impact on patient care.

Not to be misunderstood, I applaud electronic recording in the wards as this facilitates real-time communication between staff and ancillary departments, which can only improve patient outcome. However, including the written anaesthetic record in real-time digital recording is not a logical extension. The desire to move this way this seems to come from idealism rather than from pragmatism and appears to be driven by the desire to reduce storage and the costs of keeping hardcopy patient notes.

Lawyers are not responsible for the cost of the legal system, yet, curiously, doctors are made to accept that 'cost efficiencies' dictate changes that may negatively impact patients, which we are ultimately held accountable for in this modern 'Litigation Lotto' world.

Reality

The aim of the preoperative visit is to prepare the patient for theatre. It involves many things aside from reviewing and adding data into a log. There is a short period of interaction when nuances, emotional energy and maintaining eye contact are very important. It would be a challenge to maintain this rapport while attention is distracted by interacting with a screen. Far too frequently, the patient changes the answer to a key question when prompted by an alert interviewer. This includes drug allergy, co-morbidity and family history. Having data already on the anaesthetic chart before assessing a patient is fraught with risks of potential errors being recorded and perpetuated.

However, perhaps an improvement here could be the use of Wi-Fi enabled tablets, which would allow file access and data entry while not needing to turn away from the patient. Security, privacy concerns, access rights and accountability for data logging are considerations which can be overcome during the preoperative visit. They become more problematic in the operating theatre.

FEATURE

Real-life application

Application of our skills in theatre requires constant vigilance. It is truly the application of an applied science. Distractions such as entering usernames and passwords on multiple screens on a regular basis, simply so we can log data in a secure and accountable way, leaves the patient unobserved, or indeed, neglected during that time.

Selecting drugs administered from drop-down lists, before entering the numerical dose and selecting dosage units from another drop-down list, takes time away from our primary care role. Adding electronic postoperative care orders is similarly time consuming and must be done without interruption lest security issues arise.

Embracing change?

Many of our cases are quite short in duration, but it has been my experience that they can be markedly prolonged by the electronic intraoperative anaesthesia entries that are becoming prevalent in more hospitals. They also involve the most patient distraction time relative to case duration. This can't possibly be in the interest of patient safety and care. Procedures like airway management require alertness, observation and timely intervention. This can't be facilitated by turning away from the patient to interact with a screen.

We have witnessed great advances in on-call rostering and efficacy and safety of patient procedures with the use of electronic technologies. However, I believe that real-time anaesthetic data recording is not an improvement in patient care and adding a scanned copy of the written anaesthetic record to the observation printout for electronic filing would be better – KISS.

DR CALLUM GILCHRIST

I have always been the type of anaesthetist to ring up my patients – I don't like any surprises when I chat to my patients on the day of surgery and the last thing I want to do is cancel a patient on the day of surgery for a reason that, in reality, I should have sorted out before their admission. Before Anaesthetic Group (www.anaestheticgroup.com) I spent approximately 10 hours every week calling patients to ensure their anaesthetic and informed financial consent details were in order prior to their admission. Considering you need a private location to call patients, this was normally done at my home study, either during the working day if I didn't have a list, or, more commonly, in the evenings. This was a frustrating experience, as it wasn't always a convenient time to speak to the patient – many were busy at work themselves or simply didn't answer the phone. In terms of work/life balance, imagine coming home from work to see your family and simply walking straight to your study to make the calls. When I was home I wasn't really 'at home' – certainly not a happy work/life balance.

Online developments, apps and new technologies have always appealed to me. My iPhone and iPad are always close by, they are my 'office'. I do think anaesthetists like gadgets – we use complicated equipment every day – but more than that, we love any form of technology that makes our lives easier (doesn't everyone?!).

Prior to my website, Anaesthetic Group, I used to mail a questionnaire to patients, but often they were received after the patient's surgery or I couldn't read the writing. Online preoperative questionnaires and technology solve these problems.

My website, Anaesthetic Group, has made life so much easier. The story behind it? Well, it was all my wife. One day, she was working from home in the study as I rang up all my patients. She wondered whether having to repeat the same questions to each one was the best use of my time. She could sense the last patient I had called didn't want to discuss his clinical history at work, yet she understood that I needed to know his medical circumstances to ensure his operation went well. Plus, she recognised that people nowadays just don't want to talk on the phone – email and online are the future. She suggested we (*she*) create an online questionnaire. Anaesthetic Group was later born when my anaesthetist friends approached her for their own website, having seen how much time it saved me. We knew the market, we recognised the need and we created the product.

Building a basic website is easy – creating an excellent, automated and secure online application is very time consuming, but worth it. Our first stage was researching what anaesthetists needed and what patients wanted. It took over six months of research and collaboration with several web designers and developers. My wife currently manages a large online business and had the staff and skills to put it all together. It was a slow process – we needed to ensure the finished product was secure (confidentiality is paramount!), user-friendly (to the anaesthetist and the patient) and catered to the future.

The fusion of my medical background and my wife's marketing and business knowledge has made Anaesthetic Group the success it is today. She saw the need and I gave the constant feedback. She made the site primarily to save me time – time I could spend with her and our family – yet also ensured it would appeal to other anaesthetists (as well as their partners) and

that patients would be happy to use it too.

In fact, I've found that patients love Anaesthetic Group. It is another layer of rapport the anaesthetist is able to build. Plus, it allows the patient to put a face to someone they might not have previously seen. I'm now accustomed to meeting a patient on the day of surgery and for them to greet me with a "Hi, Dr Gilchrist" or "Hello, Callum". This degree of familiarity and rapport is something I had never thought possible without having physically met the patient beforehand. Anaesthetic Group allows anaesthetists to create their own profile page and be introduced to the patient. It gives anaesthetists a face and a voice, and, in addition, the ability to supply extra pages for patients to download, which provide further information about their anaesthetic procedure, e.g. "Post-Op Pain Relief" or "After Your Epidural" information sheets.

To me, online patient care/prep is the future of anaesthetic practice, both public and private. Apart from the large amounts of time saved, the accuracy of information is key. Patients don't like to be bothered. They don't want to have to take a day off work to visit a hospital for a preoperative consultation when they are already taking time off for an operation and recovery. Anaesthetists like to anaesthetise – *that* is their speciality, not ringing up patients to ask repetitive questions. Similarly, patients like to be able to complete questionnaires in their own time, when they can adequately think about the questions.

Since switching to an online platform to perform the bulk of my preoperative assessments, the amount of private time that needs to be devoted to the task of calling patients has plummeted by over 90%.

I have also been able to take on more private work as I know I don't need to devote one day a week to calling patients. This has made a significant difference to my free time and also to the enjoyment of my evenings, as knowing I had to call 'x' number of patients would always weigh on my mind until I had completed the task. Plus, at the end of the day, my wife is happy. When I'm home I'm actually home – and, as the saying goes, 'happy wife, happy life'!

Key components of Anaesthetic Group (www.anaestheticgroup.com)

- **Improving Efficiency/Saving Time** – Anaesthetists can easily improve their efficiency and reduce their pre-op calls to patients. Anaesthetists don't want to hire staff. Anaesthetic Group is about managing your practice without the need for staff – it's all automated.
- **Web Presence** – Patients want to know about the faceless doctors that have their lives in their hands. Many anaesthetists don't want to have their own website, but they realise that they need some form of public profile.
- **Facilitating Patient Communication** – Anaesthetists usually don't like ringing up patients, yet patients often want to contact them.
- **CPD Approved/Up to date with Professional Requirements** – ANZCA's new Continuing Professional Development program involves Patient Experience Surveys. Anaesthetic Group has been set up to facilitate this patient feedback.
- **No Contracts** – Start for a month and cancel anytime. No contracts, no locked-in periods.
- **Informed Financial Consent** – Being a member of the ASA's Economics Advisory Committee, I see that many patient complaints are because the anaesthetist didn't make any effort to establish rapport prior to the day of admission, or there were inadequate attempts to provide informed financial consent. Anaesthetic Group introduces the anaesthetist and provides the opportunity for the patient to request a fee estimate and indicate how they would like to pay the anaesthetic fee.
- **Easy to get Clinical History** – Patients fill in the questionnaire in their own time. It's surprising the amount of traffic we see at midnight! Patients feel more comfortable answering these questions in a private place where they have access to accurate medical information. It also allows patients to think about the questions and answer accurately in their own time.
- **By an Anaesthetist for Anaesthetists** – Online preoperative assessment fills a definite gap in the previously available options to assess patients in private practice. Pre-admission clinics in private hospitals are normally not run by anaesthetists, are of limited use and are not always available. Physician reviews are normally sporadic if the surgeon organises it, but again not all anaesthetic issues are addressed. Seeing patients in rooms is a luxury that few anaesthetists have access to. Anaesthetic Group means the patient is directly screened by the anaesthetist after the patient has done the hard work of entering the data.
- **Instant Notifications** – Questionnaires are sent instantly via email, so anaesthetists can easily and quickly look them up before a case. I often receive questionnaires for patients on lists literally months in advance.
- **Device Friendly** – Fully responsive design means patients can even fill in the questionnaire from their mobile. Many anaesthetists SMS patients the link and the patient can answer the questions on their devices on the go.
- **Easy and Simple** – All the anaesthetist needs to do is choose a plan, set up a profile and Anaesthetic Group handles everything else.
- **Secure and Safe** – the website is built on Australian-hosted services and all forms are secured to ensure patient information is safe.
- **Scaleable/Custom Branding** – Group practices can have their own 'look' and special plans to suit their members.

REGULAR

THE AUSTRALIAN PRIVACY PRINCIPLES

Dominique Egan, Partner at TressCox Lawyers, explains to *Australian Anaesthetist* the updates to the Privacy Act.

The Federal Privacy Laws have recently been amended. The provisions of the *Privacy Amendment (Enhancing Privacy Protection) Act* 2012 commenced on 12 March 2014.

The amendments to the Privacy Laws include replacing the Information Privacy Principles (IPPs), which applied to the public sector, and the National Privacy Principles (NPPs), which applied in the private sector, with one set of principles, the Australian Privacy Principles (APPs). The APPs reflect the obligations under the IPPs and NPPs and include a number of new obligations. This article provides an overview of some of the key amendments for those in the health care sector.

The amendments also include new regulatory powers for the Office of the Australian Information Commissioner, including the power to conduct a privacy performance assessment, accept an enforceable undertaking and, in the case of serious or repeated breaches, seek civil penalties.

There are 13 APPs with which health care providers must comply when dealing with personal and/or health information. Personal information is information or an opinion about an identified individual or from which the identity of an individual may reasonably be ascertained. Health information is personal information about an individual's health or disability, an individual's express wishes about the future provision of health services and a health service provided or to be provided to the individual.

The amendments include defined permitted general exceptions and health exceptions which, if applicable, mean that in relevant circumstances, health care providers may not have to comply with the requirements of the APPs.

APP1 requires health care providers to ensure they comply with the APPs and that the entity has a process in place to deal with inquiries or complaints. Health care providers must have an up to date Privacy Policy that addresses:

- the kinds of personal information the provider collects and holds,
- how the provider collects and holds that information,
- the purposes for which the provider collects, holds, uses and discloses personal information,
- how an individual may complain about a breach of an APP and
- whether the provider is likely to disclose personal information to overseas recipients and, if so, the countries in which those recipients are located.

The Privacy Policy must be readily available, free of charge and in an appropriate form.

APP4 addresses how health care providers are to deal with unsolicited personal information. If the health care provider could have collected the information from the individual concerned, then the information must be dealt with in accordance with the APPs. If this is not the case, then, provided is it lawful to do so, reasonable steps must be taken to destroy or de-identify the information.

As was the case under the NPPs, personal information should be used and disclosed for the primary purpose for which it was collected (APP6). It may be used for a secondary purpose in defined circumstances, including that the individual would reasonably expect it; or the use or disclosure is required or authorised by law; or a permitted general situation exists; or a permitted health situation exists.

A permitted general situation includes the following:

- lessening or preventing a serious threat to any individual's life, health or safety or the public health or safety and it is unreasonable or impracticable to obtain consent (this is a 'lesser' threshold than under the NPPs where the threat had to be an imminent threat),
- taking appropriate action in relation to suspected or unlawful activity or serious misconduct and
- locating a person reported as missing.

A permitted health situation includes disclosures of health information to the person responsible, where the individual who is the recipient of the health service is unable to consent and the disclosure is necessary for the provision of

appropriate care or treatment, or made for compassionate reasons and is not contrary to an earlier express wish of an individual.

Healthcare providers may only use personal information for direct marketing if:

- the personal information was collected from the individual,
- the individual would reasonably expect their personal information be used or disclosed for direct marketing,
- a simple means to make a request not to receive direct marketing is provided and
- the individual has not made such a request.

In cases where information is not collected from the individual but from a third party, the information may only be used for direct marketing if:

- the individual has consented or it is unreasonable or impracticable to seek consent,
- the organisation provides a simple means to opt-out and the individual has not opted out and
- each communication includes a prominent statement that the individual may opt-out of receiving further material.

As was the case under the NPPs there are circumstances in which a health care provider may decline to provide an individual with access to his or her personal or health information. If access is refused, written reasons must be provided to the individual. Similarly, if a request to correct information is refused, the individual must be provided with written reasons for the refusal. In both cases, the individual must be provided with information about his or her avenues of complaint.

A copy of the APPs and further information may be found on the Office of the Australian Information Commissioner's website: www.oaic.gov.au.

For more information, please contact:

Web: www.tresscox.com.au

Email: contact_us@tresscox.com.au

Offices:
Sydney: (02) 9228 9200

Melbourne: (03) 9602 9444

Brisbane: (07) 3004 3500

Canberra: (02) 6156 4332

Australian Privacy Principles Act (2014) What anaesthetists need to know:

Australian Government

The Federal provisions of the Privacy Amendment (Enhancing Privacy Protection) Act 2012 commenced on 12 March 2014. The amendments will consolidate previous public and private sector principles under the Australian Privacy Principles (APPs) with a number of new obligations. There will be **13** APPs with which health care providers must comply with when dealing with personal and/or health information.

For further information visit the Office of the Australian Information Commissioner (OAIC) website: http://www.oaic.gov.au/privacy/privacy-act/australian-privacy-principles

REGULAR

10 FINANCIAL TIPS POST-BUDGET 2014

LOMAX FINANCIAL GROUP
Integrated financial advice

Ian Gibson from Lomax Financial Services gives *Australian Anaesthetist* ten hot tips to manage your money.

This year's Federal Budget has been labelled harsh, but there are ways to take advantage of current circumstances. There is still a lot of work that needs to be done to get the relevant legislation passed and there remains some doubt on several issues.

Although these delays to proposed changes add to a prolonged period of financial uncertainty in Australia, now is definitely the time to act.

While the Government debates the Budget, you can improve your financial position by taking advantage of new superannuation caps, the budget repair levy, negative gearing, structuring your home loans and reviewing your personal risk insurance and book keeping software.

01. CASH FLOW PLANNING

The first very necessary step – without cash flow, most other financial strategies struggle.

You don't have to sort out every cent. Approximate figures will help, however this step is a MUST. The saying "revenue is vanity, cash flow is sanity, but cash is king" certainly rings true.

If you are not confident in this area, talk to your accountant who should be able to help.

02. USE THE BUDGET REPAIR LEVY (BRL) TO ADVANTAGE

This levy will apply 2% additional tax to an individual's income over $180,000 per annum for three years from 1 July 2014 to 30 June 2017.

Taxpayers in this category may expect to pay the following:

Taxable Income	Temporary BRL
$200,000	$400
$250,000	$1,400
$300,000	$2,400

"Leapfrog" the BRL

High net worth income earners should look for investment strategies that provide opportunities to claim a tax deduction during this period while income and capital gain is taxed in the period after the BRL is removed.

In addition, taxpayers considering selling assets or taking superannuation lump sums between 1 July 2014 and 30 June 2017 may need to take into account any additional levy they may incur as a result.

03. CREATE AN OFFSET LOAN ACCOUNT AGAINST YOUR MORTGAGE

An absolute must if you wish to maximise your future wealth development and take advantage of current higher tax rates.

It does not matter if you are looking to turn your existing home into a future investment property (please do not pay off your mortgage) or if you simply wish to have access to 'rainy day money', this is a strategy that should be seriously considered.

You can use your offset account 'cash' to fund a new home and turn your existing home into a tax-deductible investment property.

Or, if you are not looking to move, you can use your offset account as 'rainy day money', saving you interest against your mortgage rather than having another savings account where you pay tax on interest earned.

04. THE NEW SUPERANNUATION CONTRIBUTION CAPS

Get to know the new limits if you wish to take advantage of the tax breaks.

Tax Deductible Contributions (known as Concessional Contributions) change for:

- under 50 year olds from $25,000 to $30,000
- over 50 year olds from $25,000 to $35,000
- over 60 year olds – your limit stays at $35,000

These changes, if utilised, will give you an instant and convenient opportunity to save tax. It will save you money.

Non Tax Deductible Contributions (now known as Non-Concessional Contributions) increase to:

- $180,000 per year
- roll forward for three years $540,000

Placing your funds into Super is one of the best tax advantaged strategies that you can use. However, if you are concerned as to exactly what happens with your money after it hits your Superannuation Fund, you really need to talk to your accountant or financial planner to ensure the advantage is enhanced.

Note: On 1 July 2014, the Super Guarantee increased from 9.25% to 9.5% and will remain that way until 30 June 2018.

05. SUPER SPLITTING STRATEGIES

If there is a difference in the age of individuals in a relationship (i.e. married), it may be advantageous to transfer Superannuation funds from the younger partner to the older partner. This will provide access to Superannuation assets earlier than possible for the younger partner (there is an advantage in age after all!). This is a very useful strategy to help pay off personal, non-tax-deductible debt.

06. CONSIDER A SMSF (SELF MANAGED SUPERANN-UATION FUND) STRUCTURE

The numbers alone demand some attention.

As recorded in September 2013, there were 509,000 SMSFs (with over 1 million members). At the bottom of the market in 2009, they had $651 million in international shares. That number is now $2.08 billion.

At the bottom of the market in 2009, they held $77 billion in Australian Equities. In September 2013 it was $171.8 billion.

Some benefits of a SMSF include:

- Controlling tax deductible contributions (maximising benefits).
- Taking control of dividend incomes.
- Benefitting from the franking credits.
- Having a choice on investment (e.g. Direct Equities, Corporate Bonds, property).
- Benefitting from the ownership of personal insurance policies.
- Having control over tax payable and refund benefits.
- Easy transition to retirement.
- Reduced administration in retirement.
- Estate planning.

07. PERSONAL INSURANCE UTILISING YOUR SUPERANNUATION

Reduce the net cost of insurance premiums. Make sure you get a 15% tax deduction on insurance premiums. Take advantage of the tax-deductible options.

There are changes to the legislation around disability insurance within Superannuation. If you are unsure of your situation, you need to check with your insurance specialist in regard to this matter.

Total and Permanent Disability (TPD – Own Occupation) and Trauma insurance are no longer a tax-deductible cost to Superannuation Funds. There are also problems with access to insurance proceeds 'trapped' within the Superannuation environment.

Take control of your insurance and your Superannuation and ensure that you not only get the most beneficial structure but also one in which you (not your Superannuation Fund) will get the tax benefit. This may result in setting up a Self Managed Superannuation Fund that you have full control over.

08. SALARY SACRIFICE – THE BUDGET REPAIR LEVY AND TIMING

For those affected by the Budget Repair Levy, salary sacrifice is now even more attractive. It is a MUST DO strategy.

For those on a lower income, provided cash-flow permits, it remains the most effective and convenient tax minimisation strategy available.

09. NEGATIVE GEARING JUST BECAME A LITTLE MORE ATTRACTIVE

While the marginal tax rate has been increased for those earning a taxable income of $180,000 and above, negative gearing has become more attractive.

The break-even point for this style of investing has just dropped a little lower.

There are various financial products in the market, typically known as "structured products". These are specifically designed to provide investors with 100% capital protection on the principal amount and give exposure to a range of domestic and international growth opportunities. Some of these products also come with an ATO tax ruling, giving you certainty for claiming a deduction on the interest.

As with any tax effective investments, you must speak to your financial planner to determine if the investment suits your needs, cash flow and growth objectives.

10. LOOK TO UPDATE YOUR SOFTWARE

Simplify your life and recover your leisure time by using up-to-date software.

There are many new software packages now available to help monitor and manage your financial affairs. Many of these allow you to access your records no matter where you are in the world (sometimes known as Cloud software).

This type of software not only allows you to regain some of your valuable leisure time, but also enables your accountant to focus more on Business Advisory services, rather than the compliance matters that simply have to be done. Take advantage of the skills available through your accountant.

Ian Gibson is the Manager of Lomax Financial Services Pty Limited (AFSL 235096) a member the Lomax Financial Group, Accountants and Financial Planners (BRW Top 100 Accounting Firm) in Chatswood, NSW.

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

For more information, please contact:

Web: www.lomaxfinancial.com.au

Email: lfg@lomaxfinancial.com.au

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Phone: 02 8404 6700

REGULAR

CAREERS IN ANAESTHESIA
CAREFLIGHT

Australian Anaesthetist spoke with Dr Natalie Kruit about her time with CareFlight, a critical care aeromedical retrieval service and charity based in Australia.

TELL US A LITTLE ABOUT YOURSELF AND YOUR CAREER.

I am currently in my final year of anaesthetic training and am employed as a provisional fellow with CareFlight. I have completed an undergraduate degree in psychology and nursing and worked as a registered nurse in intensive care and emergency for the duration of my medical degree.

HOW DID YOU GET INVOLVED WITH CAREFLIGHT?

Having grown up in a family full of paramedics, I was interested in trauma medicine and resuscitation from the start of my medical degree. I first got involved with CareFlight when I was a medical student undertaking my elective. Once I had completed that, I knew retrieval medicine was what I wanted to specialise in and have been working towards a career in pre-hospital medicine ever since.

CAN YOU TELL US A LITTLE ABOUT CAREFLIGHT AND THE TYPES OF PATIENTS THAT IT ASSISTS?

CareFlight is a not-for-profit organisation that was established in 1986. Since then, it has treated over 25,000 patients. It is an aeromedical charity that assists in transporting critically ill patients by helicopter, aeroplane and road. Not only does CareFlight respond to primary trauma, it also plays an extremely pivotal role in bringing intensive care to patients in remote rural areas, stabilising those patients and transporting them to tertiary level care. CareFlight doctors and nurses care for over 5,000 patients per year.

WHAT IS A TYPICAL CAREFLIGHT DAY? ARE YOU INVOLVED WITH THE ADMINISTRATION OF ANAESTHESIA?

There is no typical working day at CareFlight, which is why I love it! The work is diverse and every day is different. Some shifts I will be rostered on base, responsible for responding in the helicopter to primary trauma. The trauma we are exposed to can range from patients trapped in serious motor vehicle accidents to patients who have injured themselves in remote locations, which requires us to be winched in to extricate and treat.

Other days I am on call from home and involved in moving critically ill patients around the state, either by plane or by road. These jobs can often be the most challenging. I can find myself in a remote location, where I am the only doctor for kilometres and kilometres, coming in to pick up a critically ill patient. That's when you know that it really is all up to you!

Pushing that red button is not going to result in anyone coming!

We are also involved with CareFlight International, who transport critically ill patients from overseas locations.

As exciting as the job sounds, there is a lot of downtime! We can go multiple shifts without responding to a job. During the quieter periods we practise and hone our skills. On-base simulations take place and lectures occur along with daily case discussions. It is because we do not get to use our skills on a regular basis that activities like these are so important. They keep us primed for when a major job does happen.

CAREFLIGHT MUST BE VERY DIFFERENT TO WORKING IN A HOSPITAL, PRESENTING ITS OWN UNIQUE CHALLENGES. WHAT ARE SOME MAJOR CHALLENGES YOU'VE FACED? HOW DO THEY DIFFER FROM A USUAL HOSPITAL SHIFT?

Yes, pre-hospital work is uniquely challenging. The environments can be hostile and involve working in confined spaces, extremes of temperature, wind and rain. Obviously, the abundance of equipment available to you in a hospital is lacking and you have to work with limited resources. Having said that, much time and consideration has gone into the equipment made available to us and the equipment

we do have is all you really need to treat and stabilise a patient. We are incredibly spoilt in the hospital environment!

Clinical decisions have to be made based on your own experience and the information that you have in front of you at the time – which is not very much. That's one thing I really enjoy about this job. It hones your ability to make diagnostic decisions without the help of technology. I have also had to develop of level of 'comfort' with the fact that I do not always know what is going on with the patient and all I can really do is treat an issue as it arises. When I initially started, this was quite disconcerting as, in the hospital with resources around you, you often have a vague sense of underlying pathological mechanisms.

When a helicopter arrives to the scene of a major accident it often attracts lots of people, including the media. Not only are you working out of your comfort zone and under pressure, but you have an audience watching you too, which can be daunting at times.

There are multiple teams and considerations you need to take into account. Multidisciplinary teamwork is taken to a whole new extreme. You learn to understand the objectives of firefighters and police officers. You learn how to incorporate what you need to do with what they need to achieve, how to resolve conflict in objectives and move forward in the best interests of the patient.

Lastly, we are often managing a patient at altitude, which causes a further change in the patient's already abnormal physiology. Special considerations need to be taken into account, such as what the maximum altitude is that the patient can tolerate. Consideration then needs to go into transport times and access you have to the patient if they deteriorate. You can't just land and get out if the patient becomes unstable. Thus, you need to do your best to make them as stable as possible prior to take off. This can involve anticipating and intervening to prevent a deterioration. As anaesthetists, we are used to expecting and planning for worst case scenarios.

HAS CAREFLIGHT HELPED YOU TO DEVELOP ADDITIONAL SKILLS THAT YOU CAN APPLY IN YOUR REGULAR PRACTICE? WHAT ARE THE MOST VALUABLE SKILLS YOU'VE GAINED?

I have already learnt so much from prehospital medicine. The communication and teamwork skills I have learnt are invaluable. A good leader is able to bring out the best in their team and that requires a certain skill that I will no longer take for granted. I have learnt that not only is it important to be a good team leader, but that it is also just as important to know when to be a 'follower' and let someone else take the lead.

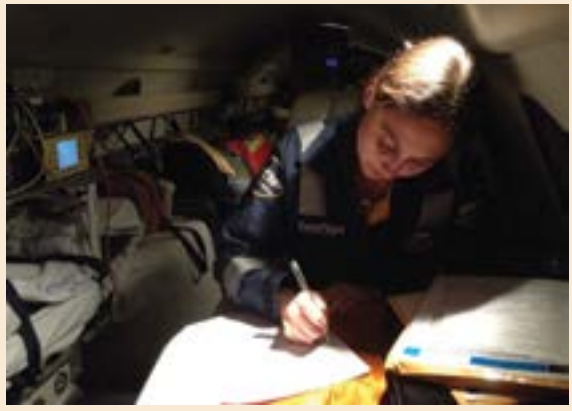
A supervisor of mine once called CareFlight a "finishing school for anaesthetists". I now understand what he meant. The job has forced me to make independent clinical decisions and back myself in that process. This can be hard when you don't have blood tests, x-rays and computed tomography scans there to confirm your impression. I am learning to trust the knowledge and experience I have acquired throughout my training.

IS THERE A STRONG SENSE OF CAMARADERIE BETWEEN THE MEDICAL AND AVIATION STAFF?

Yes, we have a lot of contact with the aviation staff. We initially undergo extensive aviation training to ensure that we are safe and have a basic understanding of helicopter operating procedures.

A typical 'crew' or team manning each aircraft will be a pilot, crew person, paramedic and doctor. When we fly, we are all considered 'crew' in the sense that we are all responsible for each other's safety and maintaining vigilance in the air. Safety is considered paramount in this organisation – and for that, I am glad!

Ready to fly.



On board.

REGULAR

One of the best aspects of this job is the strong sense of camaraderie. We function as a team in the truest sense of the word. Everyone knows their role and understands the role that the others in the team play. There is a mutual respect for each team member's unique skill. No one is made to feel foolish, rather, knowledge deficits are recognised and then built upon. I guess that comes from appreciation that the job is stressful enough as it is.

We spend so much time together on base that I guess it is inevitable that this strong sense of alliance develops.

HOW OFTEN DO YOU WORK WITH CAREFLIGHT? HOW DO YOU FIT IT IN WITH YOUR REGULAR WORK COMMITMENTS?

At the moment, CareFlight is a full-time job. When I become a specialist, I can choose to do this work part-time, along with keeping up my anaesthetic practice. You can't work full-time in retrieval, you need to maintain your vocational skills as much as possible to make you useful when that big job comes in!

DOES IT TAKE A PARTICULAR TYPE OF PERSON TO WORK FOR CAREFLIGHT?

Yes, I think it does take a particular type of person. You need to be able to back yourself and be confident in your decision making, along with possessing humility and an ability to critique your work and strive for improvement on every job.

You do need to be physically fit and that is a requirement of entry into CareFlight – a fitness test is undertaken. Not only is physical fitness a requirement, but I feel it is also a personal duty. You are not an isolated individual in this line of work and each member of the team relies on you as much as you rely on them. You do not want to be a burden or a risk to your team by being physically unfit.

You need to be able to lead as well as follow, as teamwork is paramount.

CAN YOU DESCRIBE YOUR MOST MEMORABLE EXPERIENCE WITH CAREFLIGHT?

Strangely enough, my most memorable experience with CareFlight did not involve treating a patient. Rather, it was the training that we went through. The Canyon training day particularly stands out for me. This training day involved the SCAT (Special Casualty Access Team) paramedics taking us into a canyon to teach us what it is like to rescue and treat a patient in these environmental conditions. It was unlike anything I have ever done and I pinched myself at times thinking 'am I actually getting paid for this?'. The Canyon day pushes you to your limits mentally and physically and you find yourself doing things that you never thought you were capable of – yes, I know it sounds like a corny cliché, but it is so true! It is a real testament to those SCAT boys that they got a bunch of novice registrars through that canyoning experience. The skills they posses are truly amazing.

IS THERE A HIGH DEMAND FOR ANAESTHETISTS AT CAREFLIGHT?

Anyone who works in a critical care area would be suitable to undertake a term with CareFlight. Anaesthesia has prepared me well for this job, in the sense that a lot of what anaesthetists do is resuscitation. Throughout our training, we learn a lot about general physiology, pharmacology and pathology, which has definitely served me well. We also have a variety of well practiced clinical skills that, by the end of our training, come easy to us. That is a bonus when you are having to perform these procedures in remote and difficult environments with no one to bail you out!

To get involved with CareFlight, email Kelly Kean at kelly.kean@careflight.org or the Human Resources Manager at recruitment@careflight.org

Canyon Day.

Managing a patient on a cliff edge.

Vertical Awareness Day.

Canyon Day.

Australian Society of Anaesthetists
Annual General Meeting

Date: Monday 6 October 2014
Time: 3pm to 5pm
Location: Arena 1B, Gold Coast Convention and Exhibition Centre

Please join us at the Gold Coast for the election of the Board of Directors, reports from key Office Bearers and the presentation of Prizes, Awards and Grants.

Visit www.asa.org.au to view the previous minutes and relating documents.

ASA
Australian Society of Anaesthetists

ANAESTHETISTS IN TRAINING
PUBLIC PRACTICE

Dr David Elliott, Staff Specialist Anaesthetist at Westmead Hospital, Sydney, New South Wales and ASA Federal Scientific Officer offers food for thought for trainees considering Public Practice.

For a trainee nearing the end of their time as a registrar, taking the next step to being a consultant can be daunting. We train our junior anaesthetists to be excellent doctors, but there is no module in the curriculum titled "Career Development". The choice between public and private practice, being a staff specialist or a Visiting Medical Officer (VMO), going out as a sole practitioner, joining a group private practice or some combination of these presents a bewildering array of options to the advanced trainee. This is where having a trusted and involved mentor can be an invaluable resource. In most states, the Group of ASA Clinical Trainees (GASACT) run a one-day Part 3 course, usually during the second half of the year, which aims to provide information to bridge the transition from trainee to consultant. The GASACT program at the annual National Scientific Congress is also a great way to obtain information and meet trainees from other states and territories.

The following are some of the important aspects of entering practice in the public hospital system that you should keep in mind when looking ahead.

WORKFORCE

Workforce is the hot topic in anaesthesia in Australia at present. As the number of anaesthetists finishing their training continues to rise, the availability of substantive consultant positions in our public hospitals has reduced. This is particularly so in the larger cities where, in some cases, it has become very difficult to find work as a Staff Specialist. VMO positions are sometimes easier to obtain, but may be offered on a 'zero hours' basis. This means that while an anaesthetist is technically on the books in a department, the VMO will only get work on a sporadic basis when required to fill gaps in the roster. Any advanced trainee wanting to stay on in a department as a consultant, whether as a staff specialist or VMO, needs to make this intention known to the senior members of the department. Becoming a visible and valuable member of a department is vital when it comes to the job interview. Developing a special interest in an area that is not already well serviced in an anaesthetic department is also very important when it comes to standing out from the crowd.

CONTRACTS AND ENTITLEMENTS

There are a myriad of different employment contracts for both staff specialists and VMOs across various parts of the country and even from hospital to hospital within the one city. As a very general guide, the apparent hourly rate you will be paid as a VMO is higher than as a staff specialist. However, in most cases employment as a staff specialist offers other benefits which generally do not form part of the VMO contract. These include factors such as time allocated for administration, teaching and research, the provision of annual leave, sick leave, training and study leave, conference allowances, private practice allowances and salary packaging arrangements.

From an administrative point of view, it is far easier and less time consuming to enter public rather than private practice, especially as a staff specialist. Getting an ABN, setting up a new bank account and organising a post office box all take time, though to a large extent, this can be bypassed if you join an established practice with efficient office management. It is also important to plan for the inevitable drop-off in income that will occur in the first few months of private practice before regular work builds up.

CAREER DEVELOPMENT

Arguably, this is the most important consideration when deciding between public and private practice. As a VMO or staff specialist in a public hospital anaesthetic department, opportunities for participating in Continuing Medical Education activities, teaching and research tend to be easier than as a private practitioner. While there are

ever-increasing numbers of vibrant, collegial group private practices, training courses, conferences and online learning resources, an anaesthetist working in full-time private practice does need to make a conscious decision to allocate time to spend on these activities. Sweeping generalisations perhaps, but these are important considerations to make in terms of continuing to learn and develop over a professional lifetime. Fortunately, the opportunity to participate and 'give back' through our two main professional bodies and other organisations is almost limitless.

WORKING ENVIRONMENT

The type of work an anaesthetist is exposed to is more dependent on the size and location of the hospital than whether you are in private or public practice. A large private hospital with an emergency department, a dedicated intensive care unit and a busy obstetric unit may well undertake far more challenging cases than a small district public hospital. However, it is fair to say that you are more likely to be exposed to critically ill patients and emergency cases in the public hospital sector.

There is no 'absolute best' working environment for every anaesthetist and what suits one person will be anathema to another. Whether in private or public practice, your early days as a consultant will inevitably involve some degree of compromise. Not every list will be stimulating and at the cutting edge. There will be some tedious administrative tasks to undertake no matter what your style of practice.

However, the good news is that as a trainee on the cusp of becoming a consultant anaesthetist, you are entering an exciting, rewarding and ever-changing professional life.

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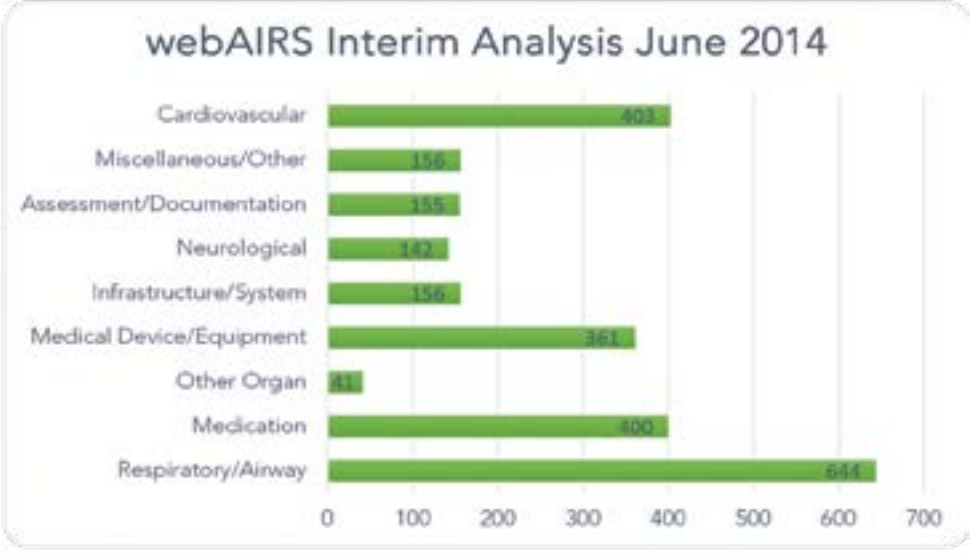
WEBAIRS NEWS

In this issue, Dr Martin Culwick looks at Patient Safety at the ASA NSC 2014, program improvements and ethics approvals and CPD.

A total of 2,468 incidents have been submitted and a preliminary analysis has been performed as of 12 June 2014. These analysis data have been used in presentations at the annual scientific meetings of the parent organisations of the Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) which include the National Scientific Congresses of the ASA. So far, this year's webAIRS data have been presented at the AACA and ASURA combined 2014 meeting in Auckland, at the Airway Special Interest Group meeting and at the ANZCA Combined Scientific Meeting 2014 in Singapore. Preparation is under way for a series of journal submissions using this data and ANZTADC invites interested members to become involved with the in-depth analysis and the creation of these papers.

PROGRAM IMPROVEMENTS

The single email address to log into multiple hospitals feature has been running since February 2014 and further refinements have been added following the suggestions of webAIRS users. A new feature has been added which allows the collection of denominator data from sites with compatible anaesthetic record keeping software. At the time of writing this report, denominator data has been collected from 2,491 cases over a three-week period and the results of incident analysis from these cases will be included in the next set of webAIRS results. webAIRS welcomes suggestions for the collection of denominator data from other sites and is prepared to work with individual sites to allow the collection of data from their information systems.



ETHICS APPROVALS

New Australian Privacy Principles were introduced in March 2014. This has affected the information required for new ethics approvals. In addition, the National Health and Medical Research Council has also released new information relating to ethical considerations for quality assurance and for audit activities. As a result, some Human Research Ethics Committees have released specialised forms for quality assurance and audit projects, whereas others may require a Low and Negligible Risk application or a full ethics review. ANZTADC is preparing a document with information to assist with these applications. These issues will be discussed and finalised at the next ANZTADC meeting and then this document will be made available on the webAIRS website.

PATIENT SAFETY AT THE ASA NSC 2014

Presentations at the ASA National Scientific Congress – Gold Coast 2014

ANZTADC will be presenting webAIRS data in several sessions at the ASA National Scientific Congress held at the Gold Coast

in October 2014. On Saturday afternoon, 4 October, webAIRS anaesthetic anaphylaxis data will be presented in the Anaesthesia and Allergy Group session in Arena 1B. Later on the same day, webAIRS data will be presented in a session titled "Analysis of Anaesthetic Incident Data". This will include Crisis Management algorithms using a Smart Phone by Joshua Daly, the Impact of webAIRS incident data on Crisis Management by Martin Culwick and Insights from Incident Reporting in the United Kingdom and Ireland by Dr William Harrop-Griffiths. Dr William Harrop-Griffiths is one of the invited international speakers and is also President of the Association of Anaesthetists of Great Britain and Ireland. In addition, there will be two small group discussions using webAIRS data which will be facilitated by Martin Culwick and Kersi Taraporewalla. These sessions will involve incident data and case discussion and will attract Continuing Professional Development credits in the practice evaluation category.

For more information, please contact:

Adjunct Professor Martin Culwick, Medical Director, ANZTADC

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.

ASA MEMBER LOGO AVAILABLE NOW

The ASA has developed a new logo specifically for members to use on personal documentation to show their affiliation with the ASA

ASA Member

To download the logo and logo guidelines, please log into the Membership section of www.asa.org.au, or call 1800 806 654.

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INSIDE YOUR SOCIETY

MEMBERSHIP UPDATE

The ASA is pleased to introduce our new Membership Services Manager, Veronica Pardey, who has written a little about herself and her vision for the ASA.

I am delighted to have recently joined the ASA as your new Membership Services Manager.

I am proud to have spent my entire career working in the not-for-profit sector with a focus on building and developing relationships with members, donors, alumni and supporters. My career has seen the development of my skills in roles at the Art Gallery of New South Wales, the Sydney Symphony, the National Maritime Museum, and, most recently, at the University of Sydney.

Prior to joining the ASA, I spent nine years at the University of Sydney as their inaugural Development Manager in the Faculty of Economics and Business. Working closely with the Dean and Board of Advice, I set the strategic direction and implementation of the Faculty's alumni and philanthropy programs and built a dedicated community of supporters aligned to the Faculty and University's vision and mission.

In all of the roles I have held, the key overriding aspect for me has been working closely with individuals who feel a passion for and affinity with the organisation they area part of and who have a strong desire to see that organisation thrive and succeed – whether as an alumnus of the University of Sydney, a donor or subscriber to the Sydney Symphony or a member of the Art Gallery Society. I have found that there is a palpable energy that exists among constituents who make a choice to become a member or supporter of a chosen organisation. I see this as a strength that will hold us in good stead as we look to ensure we are retaining a robust membership base, while also growing our stream of new members.

In my first few weeks in the job I have been busy reading up on past issues of *Australian Anaesthetist*, familiarising myself with the history of the ASA and talking at length with our CEO and dedicated colleagues here at head office. I have spoken with some of you over the phone or through participating in a number of Committee meetings and I have enjoyed getting to hear and understand more about what the ASA means to you.

In particular, I have read our CEO's message published in the April 2014 edition of *Australian Anaesthetis*t on the "value proposition" of why someone joins a particular organisation and felt it would be timely to consider these reasons in line with the current strategic direction. As articulated in our vision statement, our purpose as an organisation is to "act exclusively for the benefit of Australian anaesthetists "and our strength is dependent on the contribution of members through their subscriptions and involvement in the many activities of the ASA. This led me to ponder further what is it that motivates us to join an organisation and continue our association with it, year upon year, often over decades? I believe such a choice is a combination of the 'heart and mind' or the intangible and tangible benefits you believe you will receive as a member. Certainly, the value proposition of tangible benefits needs to be clearly articulated, but often the underlying motivation might be uniquely personal and may stem from a desire to be engaged with a group of like-minded colleagues, or a pride in the pursuit of excellence, integrity and innovation, or the desire to be a mentor or teacher, advocate or leader. I also believe that initiatives like the work supported by ODEC, Lifebox, the ASA volunteer database and the Pacific Fellowships highlight a strong philanthropic spirit that inspires many of you to continue your involvement as members.

Over the comings months I look forward to connecting with many of you to hear and learn more about what matters to you. I hope to be able to reach out to many of you either face-to-face at the upcoming NSC, over the telephone or via the various committee teleconference meetings and associated industry gatherings.

With a proud heritage of 80 years of service, coupled with a focussed strategic vision to be delivered over the coming years, it is an exciting time to be a part of the ASA. I look forward to collaborating with the staff and you to enhance your membership and provide services that are of benefit, relevance and value, and to providing support to you as a specialist and in your practice.

Please don't hesitate to contact me on 1800 806 654 or v.pardey@asa.org.au.

WHAT THE ASA IS DOING FOR YOU

Strategic Vision

To support, represent and educate our members to enable the provision of the safest anaesthesia to the community.

The ASA works to serve our members to ensure they keep up with the pace of change in an ever evolving industry. This is achieved by working to be a visionary association, led by a national Council of trusted professionals that stands for excellence, relevance, rigour and authenticity.

Member responsiveness and advocacy

- We have a dedicated Policy Team ready to assist members and their practice staff with queries relating to economic, professional, legal and workforce concerns.
- We are led by a dedicated Council of trusted professionals and 10 special focus Committee's, who as a body of committed members stand for excellence, relevance and rigour.
- Regular e:news, quarterly magazine and email updates to keep you informed and provide the information you need to uphold the integrity and ethical and professional standards of the profession.

Education

- We offer a range of events, including the National Scientific Congress, Continuing Medical Education, trainee and Practice Manager events.
- Members have access to *Anaesthesia and Intensive Care* journal and a wide range of other international journals through Medline.

Helpful assistance

Reliable, efficient assistance – a proactive group of professionals who are here to help provide relevant information, resources and services – whether you are a trainee, fellow or retired practitioner.

The ASA Advantage Program

The ASA Advantage Program provides you resources and savings that suit you and your practice including:

- travel,
- vehicle purchasing,
- financial and
- publications discounts.

A full listing of our Corporate Partnerships is available in the membership section of the ASA website under the Membership tab.

INSIDE YOUR SOCIETY

POLICY UPDATE

The ASA Policy Team comprises of Policy Manager, Chesney O'Donnell, and Assistant Policy Officer, Josephine Senoga. Their role is to provide support to various committees and guidance to our members.

Chesney O'Donnell has over 15 years of experience in various senior roles, from police investigation to briefing counsel in law and being a Senior Ministerial Policy Adviser in Police and Fair Trading. He has also been an academic at the University of Sydney, the University of New South Wales and Macquarie University in the field of policy, law, politics and macroeconomics. As a qualified lawyer admitted to the Supreme Court of NSW and a Masters graduate, he comes with the expertise needed to help guide a path for the ASA in the fields of policy analysis, government and stakeholder liaisons, membership queries and committee secretariat assistance. Since joining the ASA in 2012, Chesney has assisted with submissions and ministerial advisory meetings and attended various health and human services related conferences and forums.

Josie Senoga holds a Masters in Public Policy from the University of Sydney and a double Bachelor's degree in Psychology and Leadership studies from the University of Richmond, Virginia, USA. Having worked closely with other member based organisations, Josie brings a vital skill set to the policy team. Prior to joining the ASA, Josie worked as a Policy Fellow at the Left Right Think Tank. Josie is highly knowledgeable in the processes and functions of government and comes with vast experience in the field of policy development, analysis and review.

GROWTH OF QUERIES

Queries from members has been a growth area for the team in the last few years. From 2010 to 2013 we have seen contact from our membership grow from 90 to over 300 individual queries annually. Queries possess a policy component and are a great avenue for discovering new issues facing members. As a legal requirement, queries are always de-identified before distribution.

The key committees are comprised of members who are experienced practising anaesthetists and assist with each query within the Economic Advisory Committee, chaired by Dr Mark Sinclair, the Professional Issues Advisory Committee, chaired by Dr James Bradley and the Public Practice Advisory Committee, chaired by Dr Simon Macklin. The policy team is actively engaged with policy analysis in the form of legislative change, the Federal Budget, strategy, submissions and position statements. Government and stakeholder liaisons with interest groups, government departments and ministers is another important component of the team's increasing activities.

WHAT IS POLICY AND HOW DOES POLICY WORK?

In principle, policy is about social change and progress. It works by changing the laws through our parliaments which are dominated by a bicameral (two house) system, with the exception of Queensland and the Territories which are unicameral. The separation of powers between our parliament, executive government and judiciary help create a balance between our law makers, enforcers and interpreters.

HOW DO YOU CHANGE THE LAW?

By passing a new bill through parliament or making an amendment to an existing act or legislation. In our Federal Parliament this means that a new law needs to be voted in favour of in both the House of Representatives or lower house and the Senate or upper house. Previous successes for the Policy Team include effective advocacy against the $2,000 cap on self-education. Current areas of interest include nurse endoscopy and out-of-pocket expenses.

If you have any questions about the ASA Policy Team or any of the work the team or their committees do, please do not hesitate to contact the team on policy@asa.org.au or phone 1800 806 654.


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INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

Dr Mark Sinclair, Chair of the Economics Advisory Committee (EAC), reports on the Medicare rebate freeze, applications under consideration by MSAC and the current focus on out-of-pocket costs to Australian healthcare consumers.

MEDICARE REBATE FREEZE

The Federal Government recently released its first Budget. As the Australian public is well aware, government expenditure on a wide range of services is to be cut. This includes Medicare expenditure. Medicare Benefits Scheme (MBS) rebates for specialist services are to be 'paused' for two years from July 2014. The response from the private health insurance industry has been variable. As expected, payers associated with the federal government, such as Medibank Private and the Department of Veterans' Affairs (DVA) have not indexed their schedules. Small indexations have however, been made by insurers such as Bupa, the Australian Health Service Alliance (AHSA), St Luke's and NIB. The chart summarises the July 2014 situation. A more detailed spreadsheet will be available on the ASA website.

RVG Unit Values and Indexation	Fund	RVG Unit Value	July 2014 Indexation
	MBS	$19.80	0.0%
	DVA	$32.70	0.0%
	AMA	$77.00	0.0%[1]
	CPI		2.9%[2]
	Known Gap		
	Medibank	$32.70	0.0%
	AHSA3	$34.41	1.2%
	HBF	$29.85	0.0%
	St Luke's	$33.80	1.2%
	Bupa[3]	$33.91	0.8%
	No Gap		
	HCF	$34.65	0.0%
	NIB	$31.50	1.5%
	HBF[4]	$38.30	0.0%

1. The AMA Fee is due to be indexed in November 2014
2. The CPI figure is for the year ended March 2014
3. Average value; the actual value varies from state to state. Follow the link to the ASA website (above) for further information
4. HBF does not offer its "no gap" product to anaesthetists outside of WA

DEPARTMENT OF HEALTH (DOH)

As members will recall, the ASA currently has two applications under consideration by the Medical Services Advisory Committee (MSAC). This body has the role of providing advice to the Federal Minister for Health and Sport regarding public funding (eg. Medicare) for new services and technologies, based on their assessment of the available clinical and economic evidence. In recent years there has been a much stronger emphasis on economic issues.

Application 1183 (ultrasound guidance to aid vascular access and nerve block procedures) is nearing the final stage of its assessment. The detailed report produced by the Health Technology Assessment group (HTA) was received earlier this year. The claims for the clinical benefits of ultrasound guidance were basically accepted, but HTA believes the economic arguments are much less convincing. However, the EAC has identified a number of apparent weaknesses in the economic assessment. The ASA has therefore engaged the services of Deloitte Access Economics, to analyse the economic aspects of the HTA report. This assessment was completed in early July, and the EAC will now make a

detailed response to the HTA report.

At the time of writing, the ASA has recently formally notified MSAC that we wish to have application 1308 (local anaesthetic nerve blockade for post-surgical analgesia) subjected to a "contracted assessment" by HTA. As with the ultrasound application, the ASA does not have the in-house expertise to pursue the alternative (a "submission based assessment"), as this requires a detailed and properly presented analysis of the economic evidence. Furthermore, HTA assessments are free of charge to MSAC applicants. However, given our experience with the contracted assessment for application 1183, we expect to have to carefully analyse the HTA conclusions. It is possible that again, input from outside experts will need to be sought.

As mentioned previously, the EAC will continue with its application to the DoH for improved Medicare funding for complex initial attendances in the practice of pain medicine. This will no longer need to go through the whole MSAC/HTA process, but rather will need a detailed submission on the clinical and economic issues involved. DoH has provided the EAC with a range of Medicare statistics on consultations and procedures performed in the practice of pan medicine, and these are currently being incorporated into the submission.

Members will no doubt recall that the ASA has had numerous concerns with MSAC processes over many years. In particular, the lengthy and drawn out nature of the application process, and the poor quality of discussion documents released by MSAC, have been identified. These concerns are by no means unique to the profession of anaesthesia. Over the past year or two, MSAC representatives have held regular seminars, to which interested parties have been invited, in several capital cities. ASA representatives, including myself and past and present members of our Policy team (Chesney O'Donnell, Danielle Ashford, Josephine Senoga), have attended some of these meetings. Our specific concerns, as well as other issues, have been discussed. MSAC has emphasised that it is continually seeking to improve its work, in particular relating to improved transparency of their assessment processes, and increasing the dialogue with applicants, particularly in the early stages of applications. Hopefully our input has been taken on board. The EAC will continue to watch the situation with interest, and keep members up to date with any developments.

INQUIRY INTO OUT-OF-POCKET EXPENSES IN HEALTH CARE

In March 2014 the Australian Senate referred the issue of out-of-pocket expenses in the Australian healthcare system to the Community Affairs Reference Committee for inquiry and report by July 2014. The ASA was invited to make a submission and did so. At the same time, we were invited to make a submission to a separate inquiry into the issue of the Medicare safety net. This was not considered an urgent matter for the ASA, as the safety net is only relevant to outpatient services.

The inquiry considered all possible sources of expense to patients, including for example hospital costs, and the costs of prosthetic devices. The ASA submission was confined to the issue of out-of-pocket expenses for doctors' fees, particularly in anaesthesia. Our argument centred mainly on the fact that close to 90% of inpatient medical fees (and 84% of anaesthesia fees) involve no out-of-pocket costs, and where such costs exist it is purely due to the inadequacy of Medicare and private health insurance rebates. The appalling level of indexation of Medicare rebates over three decades was highlighted, as was the increase in patient out-of-pocket expenses resulting from insurers with a 'no gap only' policy as opposed to 'known gap' (members will no doubt be aware that in the case of 'no gap only' insurers, if the fund's rebate is not accepted as the full fee, the patient will receive only the MBS Fee of $19.80 per unit, as opposed a rebate of around $30-35 per unit). The ASA's commitment to best possible informed financial consent practices was also reiterated.

The submissions made to this enquiry can be found at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Australian_healthcare/Submissions

The ASA submission is no. 60, currently on page three of the list of submissions.

The ASA was asked to appear before the Senate Committee on July 3rd, and was represented by Drs. Richard Grutzner, Mark Sinclair and Mr. Chesney O'Donnell. We discussed the role of the ASA, and answered a number of questions related to out-of-pocket expenses for anaesthetists' fees. The Senators appeared very interested in our views, in particular on the inadequacy of the available rebates, poor indexation, and the difference between "known gap" and "no gap only" insurers. The impact on out-of-pocket expenses where insurers refuse to provide a "known gap" policy was emphasised, and seemed of particular interest to the Senators.

The Committee is due to report on the findings of the inquiry by 8th August. Members should watch the ASA website and the eNews for updates.

COSMETIC SURGERY VERSUS PLASTIC SURGERY PATIENTS

The ASA has recently been made aware of policies introduced by Medibank Private and AHM regarding procedures that are "partly medical" and "partly cosmetic", and by Bupa for a range

INSIDE YOUR SOCIETY

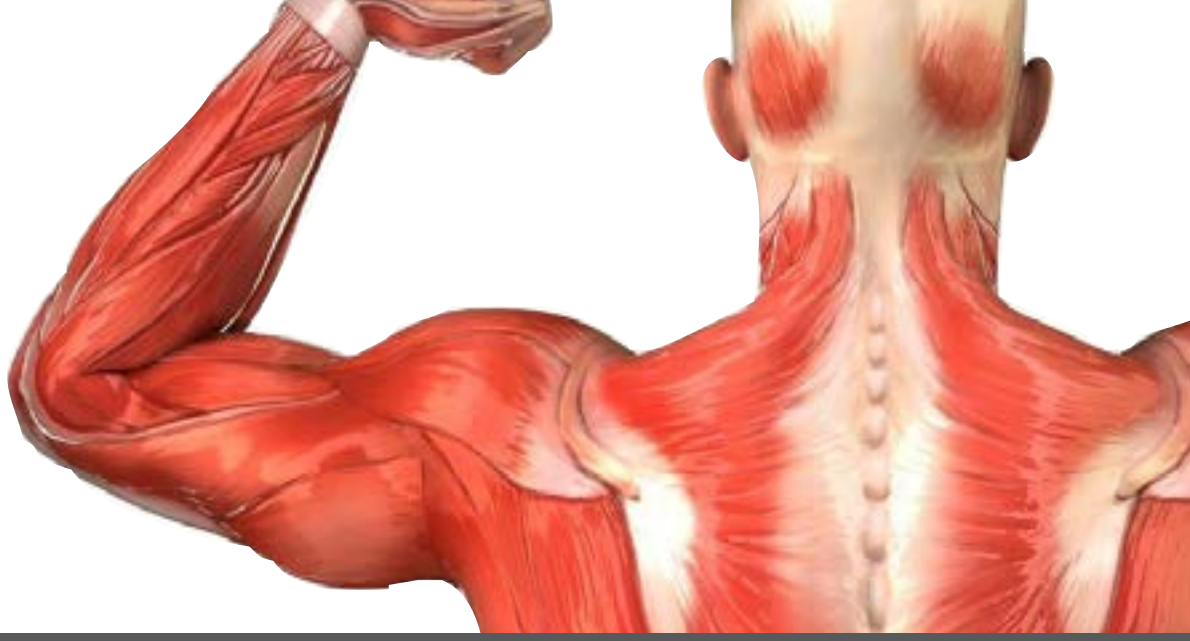
of procedures such as reduction mammoplasty, abdominoplasty, and other lipectomies (members are reminded that AHM is now part of Medibank Private).

Medibank Private/AHM will require patients having surgery for "partly cosmetic" procedures to pay for their hospital costs upfront and claim this back from the insurer. Furthermore, the ASA understands there has already been a case where this insurer has decided that certain parts of a procedure are cosmetic and will not be covered. This patient was covered for removal of a skin lesion, but not the skin grafting performed at the same time. The insurer will not accept the argument that the application of a valid Medicare item means the procedure is medically necessary.

Bupa has provided a list of procedures that it considers may be cosmetic, and refuses to fund the procedure unless clinical information proving medical necessity is provided at least 10 working days prior to admission. Members may recall that Bupa has already indicated it will only provide partial cover for bariatric surgery and assisted reproductive services, depending on the specific insurance product the patient has purchased.

Obviously these actions create an increasingly complex, uncertain and unfair situation for patients insured with these funds. It is the experience of the ASA that the majority of patients insured under these policies are completely unaware of their implications. There will be many instances where patients are subjected to significant unexpected costs. Furthermore, the increasing interference by insurers in the relationship between clinician and patient clearly moves us closer and closer to a 'managed care' scenario. We must avoid the USA-like situation in which third party payers, by taking it upon themselves to decide which cases to fund or not fund, can take over the clinical decision-making process.

The Australian Society of Plastic Surgeons (ASPS) has already taken action on the matter, including meeting several times with the Private Health Insurance Ombudsman, and seeking the advice of medicolegal experts, as well as the AMA and other relevant bodies. The ASA has asked the ASPS to keep us informed, as well as offering ASPS any assistance we can. ASPS are keen to meet with us to discuss this and other current issues, which could have much wider implications than simply the care of this small subset of patients. Again, members are reminded to watch for online updates from the ASA.



Anatomy and Ultrasound for Peripheral Nerve Blockade

Overview

A 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 QLD 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 6 to allow adequate time for practice at each workstation. This event has been established since 2005 with positive feedback from previous participants.

Registrations must be made online and close on 5th September 2014.
www.etouches.com/aupnb14

When

- Friday 3 October 2014

Time

- 7.00am till 5.15pm
  (Gold Coast transfer departing at 5.30am)

Tuition Complete Programme:

- AU $700 inc GST Early Bird on or before 1 August
- AU $795 inc GST per person after 1 August

Includes education material and Trainer costs:

- University of QLD specimen preparation and lab usage
- Certificate of Attendance
- Workshop materials
- Morning Tea, Lunch and Afternoon Tea
- Gold Coast return transfers (if applicable)

Venue

Gross Anatomy Facility
Otto Hirschfeld Building No 81
University of Queensland, St Lucia, Brisbane

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INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

This has been a busy period for the Professional Issues Advisory Committee (PIAC), Dr James Bradley, Chair, reports.

ANAESTHESIA WORKFORCE

As foreshadowed in the March issue of *Australian Anaesthetist*, workforce issues are a continuing focus of PIAC. No longer-term solutions have emerged at this time. Any changes will involve both 'winners' and 'losers', e.g. a move to provide more direct patient care '24/7' by specialists rather than trainees in the public sector will reduce the exposure of trainees to emergency cases and also reduce the access of would-be anaesthesia vocational trainees to training positions. While it would be difficult to deny that all patients should have the 100% anaesthesia care by specialist practitioners that private patients enjoy, the recent Senior Medical Officer contracts dispute in Queensland has shown that politics, management and money will combine to make the prosecution of any proposition advocating the highest level of professional care for patients problematic. Put simply, the least expensive short-term financial solution will prevail, notwithstanding proposals for higher level service delivery or an optimal future workforce. The key is obviously the management of new graduates entering into vocational training in anaesthesia and the unexplored nexus between service delivery positions and future workforce needs. In many ways, Directors of Anaesthesia in teaching hospitals along with their State Departments of Health determine de facto the number of anaesthesia trainees; it is their immediate needs, which are certainly in part finance driven, that determine the number of trainees.

In the shorter term, a tightening of the 457 visa system and entry to the 'skilled occupations list' could provide some limited relief. The Australian Medical Association (AMA) has made a recent submission in this area.

The ASA contributed to Health Workforce Australia's (HWA) National Medical Training Advisory Network consultation review in 2013 and is aware of the commitment of various stakeholders (including AMA and ANZCA) to this body which was charged to shape the future medical workforce. The 2014 Federal Budget suggests that a number of previously funded federal health instrumentalities will be consolidated or terminated, but it is expected that HWA's activities will continue, though perhaps under alternate ownership.

The 2014 ANZCA Annual Scientific Meeting contained a session addressing the anaesthesia workforce. Presentations by the outgoing President, Lindy Roberts, and Richard Waldron reiterated the views presented at the ASA Workforce Summit held in December 2013. The incoming President, Genevieve Goulding, addressed 'ANZCA and trainee numbers' and the ANZCA 2013 Graduate Outcomes Survey was also presented. This latter report generally corroborated the findings of ASA surveys. Members will by now be aware of the current ANZCA strategy in relation to current workforce concerns, and its concern about the possibility of Australian Competition and Consumer Commission action in relation to any College initiated modification of access to anaesthesia training positions.

The current PIAC view is that it is too early yet to see any significant addressing of workforce issues, with so many 'players', both government and non-government, and so many potential 'losers' as well as 'winners'. It is possible that a balance cannot be achieved until graduate numbers are aligned to future projected medical workforce numbers. This could entail a decade of graduate and specialist oversupply, with ongoing concern about the maintenance of quality of training and the retention of skills, coupled with the professional and economic consequences of an oversupply of 'providers' in an increasingly regulated and administered healthcare environment.

GOVERNMENT AND NON-GOVERNMENT BODIES

National Registration and Accreditation Scheme (NRAS)

The NRAS is being reviewed after its initial three years of operation. The ASA is determining its response. Concerns include the increasing costs of registration, delays in 'processing' complaints, aspects of 'mandatory reporting' and the greater

control over the profession by Australian Health Practitioner Regulation Agency. Against this background, the legal action being brought against the Optometry Board by ophthalmologists in relation to a unilaterally declared expanded scope of optometry practice and the taking back of elements of complaint regulation by states from the national process (from 1 July 2014 in Queensland, and under consideration in Victoria), are of immediate interest to the Society.

Australian Private Hospitals Association (APHA):

The ASA was represented at the APHA Annual Congress held in Brisbane in late March 2014. Speakers at the conference included the Federal Minister for Health (Hon. Peter Dutton) and representatives of the APHA, the Australian Healthcare and Hospitals Association, the Australian Health Insurers Alliance and the AMA. It was apparent that there is a dramatic lift in support for the 'private sector' by the current government and that the delivery of healthcare to public patients by private healthcare operators is set to increase. This in itself has implications, which had been largely unseen until now, for teaching hospitals and, of course, vocational training.

It was noted that the APHA and the Australian Health Insurers Alliance had a 'somewhat adversarial' relationship in recent years and that 'government always likes to receive a consistent representative message', in this context, from the private hospital and insurance industries.

Other points made were:

- The Ministerial Advisory Council, Health Workforce Australia and the Australian Commission on Safety and Quality in Health Care "need to be educated about the private sector".
- The APHA believes "transparency of private health insurance products" is needed.
- The APHA is concerned about "leakage" of private patients to public facilities and sees access to 'emergency medicine' in private facilities as very important.
- The APHA is very interested in all aspects of public hospital management, including co-located public/private.

It is obvious that a newfound cooperation between the private hospital operators and health insurers could see a very different practice environment for hospital-based specialists in the medium term and beyond, and this is an area that the ASA will watch carefully.

Revalidation

A Conjoint Medical Education Seminar: Revalidation was held in Melbourne on 14 March 2014. It was conducted by the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians and the Royal College of Physicians and Surgeons of Canada. The Medical Board of Australia had previously opened for discussion the topic of whether formal revalidation needed to be introduced in Australia and the combined colleges predicted interest from practitioners, regulators, industrial bodies and educators/trainers.

The difference between Continuing Professional Development (CPD) and 'revalidation' was explored repeatedly throughout the day, with a number of definitions proffered and a view being that 'revalidation' would, amongst other things, demonstrate a continuing commitment to the improving of one's professional performance, with it being context specific, i.e. aimed at one's current practice rather than one's knowledge at the time of achieving fellowship. It was obvious that the Royal Australasian College of Physicians and the Royal Australasian College of Surgeons had a view to put, principally perhaps to the Medical Board of Australia, and that it was that the colleges were able to lead any ongoing evolution of CPD. Further, the Royal Australasian College of Surgeons already has processes in place that can identify 'outliers' and also address their 'remediation'. It is also apparent that individual colleges and their fellows practise in quite different ways and that CPD as such is very much specialty specific. It was suggested that the Medical Board of Australia could outline its general requirements of CPD (or revalidation) but leave the detail to the Colleges. Questions were asked in relation to whether CPD/revalidation would capture "the 2% or 3% of practitioners who pose the greatest risk to the community", noting that any 'frequent flyers' would likely be known to the Medical Indemnifiers and the Medical Boards. This is a theme that was explored earlier this year in a Medical Journal of Australia editorial (MJA 2014, 153-156). Further, the cost, both financial and in time, to the profession was queried, noting that in the United Kingdom for example, the expense of 'revalidation' was borne by the National Health Service. Although the organisers had canvassed input from other parties including practitioners and 'industrial bodies', there was no invited contribution from 'member based organisations', including the AMA. In closing, it was suggested from the floor that the Productivity Commission might examine the economic virtues of 'revalidation'.

HWA 'Extended Scope of Practice: Advanced Practice in Endoscopy Nursing Project'

As mentioned in the May President's enews, the ASA responded to HWA's request for comment. Our response considered the proposed training pathway, the level of training that might be achieved through it, the scope of practice that could be underwritten and the implications that the training of nursing endoscopists could have on anaesthesia services.

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The ASA advised that the common, current model of endoscopy using appropriately credentialed anaesthetists and (medical) gastroenterologists in this country is well established, highly efficient and safe. In relation to anaesthesia and sedation, we reiterated that there was an established professional position, underwritten by ANZCA Position Statement PS9.

In summary, the ASA position is:

- that the nursing qualification which would enable nurses to undertake endoscopy must have a clear regulatory framework around it and be transferable.
- that, should nurses become eligible to undertake endoscopy, they must be trained to the highest level currently recognised e.g. nurse practitioner.
- that the exact scope of practice must be clearly defined. This must be clear with respect to upper and lower gastrointestinal procedures as well as diagnostic and therapeutic procedures.
- that the ASA must be fully engaged in any discussions that arise concerning sedation and anaesthesia services needed to support this new role.
- that there must be clearly demonstrable evidence that this new role delivers increased productivity, maintains patient safety and does not limit access to training that is reasonably needed for existing medical workforce trainees.

Grattan Institute report:

The Grattan Institute released a report entitled 'Unlocking Skills in Hospitals', including references to "nurse provision of sedation for gastrointestinal endoscopy". Subsequent ANZCA and ASA media releases addressed the report. The current position of the ASA is (as with our report to HWA concerning nurse endoscopy) one of support for the multi Collegiate PS9, and of course, for its own position statement on gastrointestinal anaesthesia.

ASA POSITION STATEMENTS, PATIENT INFORMATION BROCHURES AND ONLINE PATIENT ADVISORIES

Work continues at committee level to revise these documents. *Anaesthesia and You* has been updated and aligns with the information contained in the "Patient Information" area of the Society website.

The Mi-tec brochure addressing *Anaesthesia for Children* has also been updated and is available for purchase by members.

OTHER

Private healthcare facilities

Concerns continue to be expressed in relation to organisational arrangements and governance issues within private facilities. There is a divergence of views on the suitability of private facilities for student placements in anaesthesia, and more complexly, for intern and vocational training positions. It is obvious that, despite some enthusiasm to date for training in the private sector underwritten by federal monies (and enthusiastically received by some private facilities), that not all stakeholders have been fully engaged in this process. Members having difficulties in this area, or in relation to credentialling, clinical privileges and scope of practice, are encouraged to contact the Policy Team at the ASA, who can provide advice based on knowledge of what is currently happening within the country.

Propofol

Contamination of a limited number of batches of propofol manufactured in India and retailed by two suppliers to the market in Australia have seen restricted availability of this drug in many hospitals and other facilities. This is a consequence, in part, of the response of manufacturers to the competitive purchasing processes of facilities and has been seen elsewhere in recent years to a greater extent than we have experienced before. The issue has been discussed at Common Issues Group meetings on a number of occasions, and a World Health Organization list of 'essential drugs' does exist. Despite much discussion, no solution for these occasional crises has emerged.

Special Committee Investigating Deaths Under Anaesthesia

Members will be aware of the latest report (2011-2012) of the NSW Special Committee Investigating Deaths under Anaesthesia. Findings address adequate preoperative assessment and adequate postoperative management, including appropriate access to 'high dependency' or greater levels of postoperative care. Members are reminded that specific consultation item numbers were negotiated some years ago to support and encourage preoperative assessment prior to hospital admission.

2014 ASA NATIONAL SCIENTIFIC CONGRESS

The PIAC will be conducting a panel discussion at the National Scientific Congress this year at the Gold Coast. The session is entitled "My future practice: how will it look in five years' time?" and is scheduled for 1330 on Sunday, 5 October 2014. The panellists have particular expertise in Medical Board and medical indemnity matters and experience in the operation of private facilities and in contractual employment matters. They will be joined by ANZCA President, Dr Genevieve Goulding. We hope to see you there on the spectacular Gold Coast.

ASA CPD FOLDER NOW AVAILABLE

The ASA CPD recording folder is NOW available for members. If you would like your own ASA branded CPD folder please contact membership@asa.org.au.

The folder contains custom made tabs which help to break up the categories into easy to organise sections, example surveys, recording sheets and an overview of the new CPD criteria.

INSIDE YOUR SOCIETY

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

Overseas Development and Education Committee (ODEC) Chair Dr Rob McDougall reports on helping developing nations improve access to safe anaesthesia in our region and beyond.

The Overseas Development and Education Committee (ODEC) oversees all aid, including educational, financial, material or skill based, outside of Australia and New Zealand, which involves ASA members or. It acts jointly and cooperatively with ANZCA, the New Zealand Society of Anaesthetists, the World Federation of Societies of Anaesthesiologists (WFSA) and other aid organisations.

The main focus of ODEC is to support and promote anaesthesia training in the Pacific. Over 75% of the substantial ODEC budget goes towards Pacific anaesthesia and this support has seen significant achievements via the ASA Pacific Fellow and Visitor Programs and support for the Pacific Society of Anaesthetists' annual meeting.

2013/14 has been an exciting period for ODEC. Highlights include the highly successful Pacific Super Meeting run in conjunction with the Asian Australasian Congress of Anaesthesiologists (AACA) in Auckland in February 2014, the continuing expansion of the Essential Pain Medicine program, the launch of the ASA Volunteer Database, Lifebox and continuing projects in Mongolia, Laos and Cambodia.

In addition to our existing activities, 2014/15 will see the launch of the Timor Leste Fellowship and continuation with the campaign to place access to safe anaesthesia and surgery on the agenda of the World Health Assembly.

PACIFIC SUPER MEETING AND AACA

The AACA in Auckland in February 2014 was the most significant WFSA congress since the 1996 World Congress in Sydney. Over 30 Pacific anaesthetists, representing 12 Pacific nations, attended the AACA and for the first time, a Pacific Super Meeting was held for two days preceding the main congress. This was the first joint meeting of the Societies of Anaesthesia of Papua New Guinea, Pacific and Micronesia, ever. It is planned to hold a similar meeting in conjunction with the 2016 World Congress of Anaesthesiologists in Hong Kong. As well as providing funding, the ASA assisted by helping to find locums to cover the absence of the Pacific anaesthetists from their home hospitals.

At the AACA, ODEC member, Dr Chris Bowden, was elected onto the Board of the Asian Australasian Regional Section of the WFSA. Chris has made a tremendous contribution to anaesthesia development in the Pacific region and this new position will give him further opportunities to continue his excellent work!

ESSENTIAL PAIN MEDICINE

The success of Essential Pain Medicine (EPM) has been highlighted in past editions of *Australian Anaesthetist*. Over 30 countries have hosted EPM courses and the course materials are available in 16 languages. The ASA has assisted with programs in Indonesia, Myanmar, the Pacific and Mongolia in 2013/14. In 2014/15 there are further plans to assist with EPM in Myanmar and Bhutan. Many other organisations are involved in supporting this significant project and include ANZCA, WFSA, Interplast, Royal Australasian College of Surgeons and International Association of the Study of Pain. Recently, Tasmanian Alkaloids, one of the largest manufacturers of opioids, made a contribution to ODEC to assist with the expansion of EPM.

ASA VOLUNTEER DATABASE

The ASA has created a database of specialist anaesthetists from Australia and New Zealand who are interested in assisting with humanitarian medical work. This is used to both provide anaesthetists with overseas work opportunities and to provide organisations with the names of anaesthetists interested in working abroad.

The database is now live and has been used to match volunteers to a number of short-term service trips.

All interested anaesthetists are encouraged to register via the "Volunteering" section under the "Membership" tab on the ASA website.

LIFEBOX

The ASA has raised a significant amount of money for Lifebox. So far the ASA has conducted needs assessments, purchased oximeters and held training in oximeter use across the Pacific and in Mongolia. ODEC is working towards introducing or expanding Lifebox programs in Laos, Cambodia and Bhutan in 2014/15.

Lifebox is now also including education on the World Health Organisation Surgical Safety Checklist as part of this project.

URGENT REQUEST FOR A LOCUM IN TONGA

Tonga is still in urgent need of a locum anaesthetist to help support the sole anaesthetist, Dr Selesia Fifita, at Tonga's main teaching hospital on Tongatapu. Tongatapu is the main island of the Kingdom of Tonga with 75% of the Kingdom's 100,000 population. A locum is required until February 2015, though shorter periods are negotiable. This is a very competitive, AUD tax-exempt, salaried, AusAID-funded position. It includes flights, relocation and child allowance in addition to salary. Please direct enquiries to Dr Selesia Fifita: selesiaf@yahoo.com and applications to: saiafaapea@hotmail.com and sfmaasi@gmail.com.

ADVOCACY FOR ACCESS TO SAFE ANAESTHESIA AND SURGERY

The Executive Board of the World Health Organisation met on 26 May 2014 in Geneva. At the meeting the 34 members of the Board (mostly Ministers of Health) unanimously passed the agenda item "Strengthening Emergency and Essential Surgical Care and Anaesthesia as a Component of Universal Health Coverage". This item will now proceed for further consideration at the next meeting of the Board in January 2015 and from there should go before the 68th World Health Assembly in May 2015 as a formal resolution.

This is a landmark in the campaign to advocate for access to safe anaesthesia and surgery. Dr David Wilkinson, President of the WFSA, has commented:

> *If approved, the resolution would change the situation of our profession, and of surgical patients around the world, for the better. It is likely that it would also significantly influence the amount of resource made available for anaesthesia, shifting national and donor budgets towards the 11%+ of the global burden of disease that could be addressed by surgery.*

LIFEBOXES FROM GEELONG

Q: What made you think you could run a campaign in Geelong?

Give people who want to help the chance and they will.

A good reason

In 2013, 71,000 operating theatres functioned without a pulse oximeter. That's an urgent problem. If one of those were an Australian hospital, something would be done about it. It is acknowledged that accessing oximetry is critical to improving healthcare on the world stage. We set our sights on donating four oximeters in ten days—and enough came in to send off 14. That was astounding; a fantastic reward! Okay, but how does a place like Geelong try tackling a humungous oximeter gap problem?

Within reach

One oximeter is affordable. Lifebox means one oximeter, $250, can improve healthcare. Right, so who exactly are we?

We are Geelong

Someone once said that Geelong anaesthetists "are like most other anaesthetists… we are quirky, and we like gadgets and coffee and solo sports. We think we're normal, but we are weird-as-all-hell". We check monitors during surgery, replace empty syringes, do pain clinics and put back ultrasounds. We look a lot like departments that have helped in the past.

People to look to

In the annual reports there are dozens of stories about things people have done—cycled, baked, danced. Small and large hospitals at home and abroad had already set the example. So, if anyone could do it, so could we. Our approach?

Guided by a hope

We showed the powerful message of the 'Make It Zero' YouTube video to as many people as possible—on iPhones, by email, by asking the nurses to talk about it, by playing it on the big TV in the theatre lunchroom, by placing cards on top of the anaesthetic trolleys.

Then we just asked people for help and hoped that they would—anaesthetists and trainees, nurses, periop staff and industries. It was called the 'Make It Zero Geelong 2013 Campaign'. The result –14 oximeters – thundered past all our expectations.

Given a chance

Deep down, people want to help the most disadvantaged of patients. Lifebox gave us a method, and the campaign gave us an opportunity.

Fourteen more theatres in developing countries now have oximeters. This could change the outcome for any patient needing surgery, not only in 2014, but also in the years to come.

I sincerely thank Geelong for giving this campaign a chance to run. A campaign in a generous, gadget-loving, coffee-drinking, weird-as-all-hell department.

By Paul Chan

INSIDE YOUR SOCIETY

GROUP OF ASA CLINICAL TRAINEES UPDATE

We have been very busy at the Group of ASA Clinical Trainees (GASACT) this year, writes Chair, Dr Natalie Kruit. Our prime focus over the last six months has been to represent trainee interests in the workforce debate. We were involved in the ASA's Workforce summit held in December 2013. The summit demonstrated the complexities of the workforce issue currently troubling new fellows and led to active discussion and debate that will hopefully lay the foundation for improvement in the future.

NEW EDUCATIONAL RESOURCES

Excitingly, we have just launched our new webpage www.gasact.org.au. Full of exam learning resources, links and interesting articles it is well worth a visit. Each state will be running educational registrar events throughout the latter half of the year. Educational topics will range from ultrasound and regional training to Part 1 and Part 2 teaching. Make sure you look out for these events in your state or contact your state representative for more information.

ADVOCACY

Where possible GASACT works closely with ANZCA and the training committee. We will continue to work hard to be that independent voice that represents your issues and helps to resolve any problems related to training you may have as they arise. Please do not hesitate to contact us at gasact@asa.org.au.

NEW ADDITIONS TO THE COMMITTEE

I would also like to welcome our new committee members. Dr Brigid Brown has been elected into the role of Co-Chair, Dr Ben Piper – New South Wales, Dr Elisabeth Power – representative, and Dr Nicole Diakomichalis – South Australia. If you are interested in representing trainees in your state please email gasact@asa.org.au.

COMMON INTEREST GROUP SCHOLARSHIP WINNERS

Every year the ASA provides three scholarships to attend one of three international anaesthetic meetings. I am delighted to congratulate Dr Ben Piper, who will be attending the Canadian Anaesthetic Society meeting, and Dr Tim Sullivan, who will be attending the Group of Anaesthetic Trainees meeting in the United Kingdom. I will be fortunate enough to attend the American Society of Anesthesiologists meeting in New Orleans this year. Many thanks to Dr Michelle Horne for adjudicating the process.

UPCOMING TRAINEE CONGRESS AT THE NSC

This year's National Scientific Congress at the Gold Coast is fast approaching and the GASACT congress is shaping up to be a fabulous event. The GASACT congress is specifically designed for trainee needs. We have listened to trainees, and have designed an educational program that is in tune with those needs. To kick off the congress there will be registrar cocktails on Saturday, 4 October. This is a great opportunity to catch up with colleagues and friends.

Stretched over two days (5 and 6 October), the GASACT congress sessions include poster presentations, information regarding foreign provisional fellowship opportunities, registrar welfare and a clinical psychologist's advice on exam preparation. GASACT guest speakers include Prof. David McGiffin, Cardiac and Lung Transplant Surgeon, and Assoc. Prof. Michael Muller, Burns and Trauma Surgeon, both of whom will offer unique perspectives of the complexities of these special patient populations.

PART 0 COURSES

Every year GASACT, in conjunction with ANZCA, run introductory courses for those trainees interested in a career in anaesthesia. Once again, these have been a great success. All were well attended in each state. Talks varied from workforce issues, navigating the Training Portfolio System and having partners come in to chat about how anaesthetic training impacts on them.

UPCOMING PART 3 COURSES

The Part 3 course is an event held by GASACT in an effort to educate senior

trainees on the issues they will face once they have their fellowship. The course addresses the mysteries of billing, financial planning topics, workforce, issues with private practice and setting up your own private practice.

If you know any trainees looking for some assistance or guidance as they embark on their professional career, make sure to let them know of the excellent work GASACT is doing to support and represent ASA members. Feel free to put them in touch with the Membership Office at membership@asa.org.au.

UPCOMING COURSES

Western Australia: Part 3 course

When: 29 November 2014, followed by the inaugural Christmas party.

Where: TBA

New South Wales: Part 3 course

When: 29 November 2014

Where: TBA

Victoria: Part 3 course

When: Late 2014, TBA

Where: TBA

South Australia/Northern Territory: Part 3 course

When: 17 January 2015

Where: AMA House, 161 Ward Street, North Adelaide

RETURN TO CONTENTS

INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

BIOGRAPHY PROJECT

You will have seen in the last issue of *Autralian Anaesthetist* that a letter was published about the launch of the Biography Project. This project offers RAG members the opportunity to lodge a personal biography with the ASA. So far our curator, Ms Anna Gebels, has received three contributions from retirees for storage in the Society Archives.

QUEENSLAND

Dr Col Busby

The last Queensland annual dinner for retired anaesthetists was held in November 2013. For the second year running the venue was the Board Room of ANZCA's QLD office, for which we are extremely grateful.

Chris Bassett represented the College at the luncheon. It has always been a pleasant re-association with the College for some retirees who had never previously visited the premises of the College, some have also indicated that similarly, they have not yet visited the new premises of the ASA.

Conversation and reminiscing was so intense that the obligatory photograph was forgotten until the still talking stragglers were departing. All present indicated an eager anticipation for the next retirees' luncheon.

We would also like to take this opportunity to ask that retirees please update their email and postal addresses with the ASA. The ASA generously provides assistance with contacts and mail-outs, but unfortunately the task of maintaining contact is difficult if addresses are not current.

We are aware that some of our senior colleagues are reluctant to drive and require assistance to attend. A luncheon will be organised later this year and we encourage retirees, when responding to the forthcoming invitation, to please let us know if they would like assistance or have special needs.

SOUTH AUSTRALIA

Dr John Crowhurst

In SA, our RAG meets for lunch on the second Tuesday of each odd month at the Kensington Hotel. Whilst there are now some 70 odd colleagues on the Group mailing list, attendance at each of the past five meetings has varied from 12 to more than 30 and include colleagues from anaesthesia, intensive care and pain medicine. Several times a year we share our venue with retired surgical and other colleagues from the Modbury Teaching Hospital.

Whilst the informal format of a meal and a chat has remained very popular at the Kensington Hotel, we invited Dr Peter Sharley, Deputy Director of Intensive Care at the Royal Adelaide Hospital (RAH) and immediate past President of the AMA (SA), to address our meeting last September. Peter updated us on the progress, advantages and potential pitfalls of the new RAH currently under construction and due for completion in 2016. A most enlightening, if not partly depressing, insight into what will be one of the most modern public hospital facilities in Australia.

Our two oldest members, Drs Tom Allen and Jim Ferris passed recently, as did Dr Sally Drew, who was Director of Anaesthesia at the RAH for many years. All three were mentors and teachers of most of us in the RAG. Their obituaries will be published in the ANZCA Bulletin.

Any retired or semi-retired colleagues from other states are most welcome to join us on the second Tuesday of each odd month.

Please contact Dr John Crowhurst by phone: (08) 7225 1390 or 0400 804 294, or email: jacrow@optusnet.com.au

VICTORIA

Dr Pat Mackay

The Annual General Meeting was held in November 2013 and the office bearers elected for 2014 were: Dr Patricia Mackay OAM (President), Dr Rod Westhorpe OAM (Secretary), Dr Christine Sweeney (Treasurer) and committee members: Drs Jean Allison and Michael Davies. It is with sadness that we announce the passing this year of long standing members Drs Diana Tolhurst (Furness), Marie Swanney (Cockbill) and Lelia Harris.

During 2013, four meetings were held with highly successful presentations by Dr Joel Symons (Alfred Hospital) "Perioperative medicine, the new frontier", Prof. Ian Gust (Melbourne University) "New Influenza strains", Dr Michael Seyfort (retired anaesthetist), who gave a stunning presentation of his photography of birds of the Northern Territory, and Prof. David Story (Melbourne University)"Academic Anaesthesia-Quo Vadis?".

The first two meetings in 2014 have been of a historical nature. In March, Professor of History at the University of Sydney, Warwick Anderson, provided a fascinating overview of the effects of World War II on medical practice and at the upcoming meeting on 1 July, John Crowhurst from Adelaide will

present a paper on "The significance of the anaesthesia events at Pearl Harbor".

We have been fortunate in our choice of speakers and have endevoured to maintain a mix of professional and social issues, but fixing dates and speakers constitutes the most trying part for the Committee.

The meetings are held in the pleasant surrounds of the Lyceum Club and are followed by a convivial luncheon carefully planned by our treasurer. The retired anaesthetists of Victoria are most grateful for the facilities provided by the Club and for the facilitation of arrangements by its many anaesthetic members. At the annual meeting it was unanimously resolved that this arrangement should continue due to the excellent facilities, ease of access and relatively modest costs, which are carefully managed by our astute treasurer so that we have a small positive bank balance.

Our relationship with the Victorian section of the ASA is very strong, with both Jean Allison and myself receiving the minutes and being welcome at the monthly meetings which always have an agenda item related to RAG (Vic). In addition, our Secretary, Dr Westhorpe, has been included on the planning committee for the 1916 Annual Scientific Meeting in Melbourne.

WESTERN AUSTRALIA

Dr Wally Thompson

A Steering Committee met in January 2014 and supported the establishment of a Retired Anaesthetists Group (RAG) in WA. The move was also supported by the Chairs of local/regional committees of the ASA and ANZCA in WA. An initial gathering of retired anaesthetists was held at the University Club of WA on 4 March 2014.

The gathering was attended by: Drs. Terry Bourke, Max Sloss, Nerida Dilworth, Geoffrey Clarke, Neville Davis, Robert Wong, Lynley Hewitt, Geoffrey Mullins, Geoffrey Gee, Vlad Martin, Gabriel Myburgh, Nanda Menon, Alex Menon, John Watson and Wally Thompson. Apologies were received from: Drs. David Perlman, John Rigg, David Young, Brent Donovan, Millar Forbes, Teik Oh, Robert Edeson, Pamela Tonkin, and Robert Harrison.

Wally Thompson welcomed those attending and noted that some time ago he had been approached by Prof. David Gibb and asked why there was not a RAG in WA. Wally outlined some of the activities of the RAGs in other states and noted that, following a recent discussion with Bob Wong, Geoffrey Gee and David Perlman, there was an agreement to move towards setting up a Western Australian RAG. The proposal was to initially have a gathering every three months and a luncheon/dinner once a year, then see how things developed. There was broad support from those present for this to occur and Wally accepted the role of Convener.

A second gathering was held at the University Club on 3 June and there were 13 attendees (including Sam Epari from Hobart) and five apologies. The photo below is courtesy of Dr Bob Wong. John Rigg was also in attendence.

NEW SOUTH WALES

Prof. David Gibb

A small but enthusiastic band of retirees attended a luncheon meeting of the NSW Branch of RAG at Frenchy's Cafe located in the Artists Precinct, Georges Heights on Tuesday, 15 April 2014.

This is a very interesting area with panoramic views of the entrance to Sydney Harbour, extensive military fortifications dating back to the early days of the colony and numerous artists' workshops and galleries. It was a beautiful sunny day and the meal was good quality, simple French cuisine. It was excellent. Following the luncheon, we took a short coastal walk which included inspection of a World War II artillery fort and stunning views over the Sydney Harbour Heads.

AUSTRALIAN CAPITAL TERRITORY

ACT RAG is sad to announce the passing of Dr James Purchas. Drs George Jerogin and Hugh Laurence have volunteered to represent RAG in the ACT.

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

QLD RAG luncheon. From the left: Tony Kelly, Col Busby, Ian Colbert, Mary Plant, Tony Lynch, Vera Lukursky, Dave McConnel and Nanette Crimmins.

WA RAG luncheon. Back row, left to right: David Altree, Neville Davis, Teik Oh, Brian Trainer, Jimmy Wong, Geoffrey Mullins, Wally Thompson, Geoffrey Gee. Front row, left to right: David Perlman, Bob Harrison, Vlad Martin and Sam Epari.

NSW RAG luncheon. Left to right: Richard Fear, David Gibb, Jane Baker and Barry Baker

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

Curator of the Harry Daly Museum, Anna Gebels, reports on the exciting future ahead for the ASA's Harry Daly Museum and information on how you can help.

An exciting new era has begun at the Harry Daly Museum. We have commenced researching and writing content for the exhibition in our beautiful new space in North Sydney. We took advantage of the disruption of the move to stocktake and consolidate our collection. As such, choosing examples of historically significant and interesting anaesthetic equipment to showcase has been made especially easy, utilising our now up-to-date eHive collection management system.

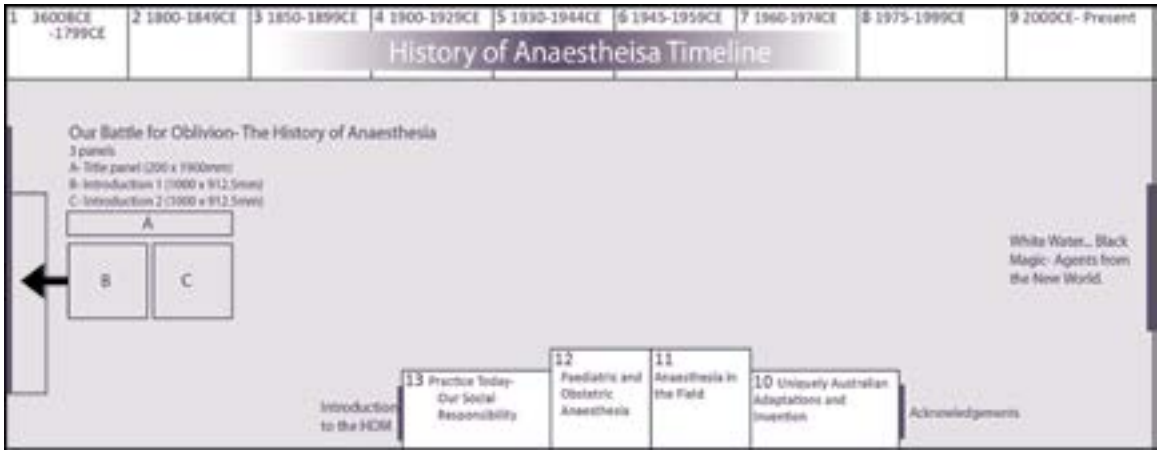
To whet your appetite for what is to come, we've included a draft plan of the proposed content areas of our exhibition. You will notice that a significant area will be dedicated to a physical representation of the history of anaesthesia timeline. The ground work for this has been laid by Dr Reg Cammack and is available to download from the Harry Daly Museum website in the "Online Exhibitions" section. We are now seeking a number of items to complete our timeline, listed in the table (left).

If you have any of these items at a loose end, and would like to donate to our museum, please contact me at agebels@asa.org.au.

Our exhibition will be installed in stages over the coming year and we would like to take this opportunity to thank you for your patience as we strive to create a display that will showcase the history of the anaesthetic profession, and our spectacular collection, in the very best manner.

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

Equipment	**Empty packaging** (or marketing materials advertising the following drugs)
Flexible Bronchoscope c.1970	Cisatracurium c.1996
Asprin c. 1900- 1950	Remifentanil c.1996
Microcuff endotracael tube c. 2004	Ropicacain (Naropin) c.1996
McCoy laryngoscope c. 1993	Celecoxb c. 1998
Sprotte needle c. 1987	Rofecoxib (Vioxx)c. 1999 (withdrawn 2004)
Glidescope. C. 2001	Fentanyl patch c. 1998
	Dexmedetomidine (Precedex) c.2008
	Pseudocholinesterase (butyrylcholinesterase) c.2005
	Exparel c. 2011



Australian Society of Anaesthetists Membership Achievements

GASACT Common Issues Group Scholarship:

Association of Anaesthetists of Great Britain and Ireland
GAT Annual Scientific Meeting: 11–13 June 2014, London, UK
Dr Timothy Sullivan

American Society of Anesthesiologists
United States Annual Meeting: 11–15 October 2014, New Orleans, LA, USA
Dr Natalie Kruit

Canadian Anesthesiologists' Society
Annual Meeting: 13–16 June 2014, Newfoundland, Canada
Dr Benjamin Piper

Queen's Birthday Honour

awarded to

Professor Arthur Barrington Baker, NSW
For significant service to medicine, particularly to cardiovascular anaesthesia, to medical education, and to professional medical organisations

Every year, the ASA supports and funds three fellowship positions based at the Fiji National University Department of Medical Sciences. Visit the ASA website for more information.

ASA
Australian Society of Anaesthetists

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin, Chair

The SA/NT Committee of Management ASA Annual General Meeting was held on 21 May 2014. Drs Simon Macklin (Chair), Tim Benny (Vice-Chair) and Tim Porter (Treasurer) were all elected unopposed. Thank you to all who were able to attend.

This was followed by the combined ASA/ANZCA Continuing Medical Education meeting, where Dr Tom Painter presented to a packed house: 'POISE 2'. The support for the last two Continuing Medical Education meetings has been excellent and I encourage you to continue to support these meetings in the future.

Electronic health records, in the form of the Enterprise Patient Administration System, continue to be rolled out in the public sector with the Queen Elizabeth Hospital due to come online later this year. It has recently been introduced at the Repatriation General Hospital and has been used at Noarlunga and Port Augusta Hospitals since before Christmas. A dedicated group of staff at the Repat are working hard to make the perioperative component more functional and assist new users in the transition from "paper heavy" to "paper light". Its introduction at the Royal Adelaide Hospital is expected soon. Electronic health records are on the horizon but whether it will be Enterprise Patient Administration System remains to be seen.

Discussion continues with our colleagues at the Royal Australasian College of Surgeons and the Obstetric Anaesthetists' Association in our response to the South Australian Coroner's recommendations.

Social Event

"Wine, Wheels and Where to go" is an event not to be missed. Reserve Friday, 29 August free of all other engagements so you can join us for an evening of fine cars, fine wines and fine holiday destinations. This will be accompanied by delicious food. Watch your email inbox for further details. Registration will be online. Non-members are welcome and don't forget the 10% discount when you propose a new ordinary member!

I welcome our newcomers to the ASA and thank the existing membership for their involvement.

The support from the SA/NT Committee of Management is, as always, greatly appreciated.

We can be contacted via Tracey from the ASA South Australian office on (08) 8361 0105 or 0419 543 820.

TASMANIAN COMMITTEE

Dr Michael Challis, Chair

Dr David Brown has stepped down as Chair after four years and I would like to thank him for his service. Luckily for me (as the new Chair) he has agreed to stay on as Deputy Chair and share his experience and wisdom with me.

Along with the ANZCA regional committee, we were gratified to have a very successful combined annual meeting in Hobart in March. We had a record attendance and the standard of the meeting was very high. Our invited speaker, Professor Jose Carvalho from Toronto, updated us on the latest in obstetric anaesthesia. The poster session was very competitive and of a very high standard and Dr Anders Bown won the ASA Prize for the best presentation. There was also a fantastic ultrasound-guided cadaveric regional anaesthesia workshop run by some of our local regional anaesthesia experts and this was very popular.

There will be many opportunities for Tasmanian anaesthetists to satisfy their 'Emergency Response' Continuing Professional Development requirements without leaving the state in the near future. Our winter Continuing Medical Education meeting in August will offer an Advanced Life Support refresher workshop. We will also offer an interesting difficult airway management workshop in November that will cater for anaesthetists, trainees and Ear, Nose and Throat surgical registrars, which will utilise cadavers and manikins. We aim to run an altered version of this course (just for anaesthetists) at our 2015 Annual Scientific Meeting.

On the industrial front, re-negotiation of the long-expired Tasmanian salaried medical practitioner's award has failed and Australian Medical Association representatives are now meeting in the

Industrial Commission. Those negotiating have done a fantastic job so far and hopefully a satisfactory outcome will be achieved soon.

The new Liberal state government has also put the redevelopment of the Royal Hobart Hospital on hold and the Chief Executive Officer of the Royal Hobart Hospital has been stood down amid allegations of impropriety. This has unfortunately created uncertainty for many and further exacerbates uncertain job prospects for new fellows in Tasmania.

VICTORIAN COMMITTEE

Dr Peter Seal, Chair

Melbourne will be hosting the Diamond Anniversary 75th ASA National Scientific Congress from 17 to 20 September 2016 at the Melbourne Convention and Exhibition Centre. The Convenor is Dr Simon Reilly and the Scientific Convenor is Prof. Colin Royse.

The New Fellows Forum was held at Cru Café on 11 June. This year, the discussion was considerably more optimistic in terms of workforce issues.

The 35th Annual ANZCA/ASA Combined Continuing Medical Education meeting will return this year to the Sofitel Hotel on Saturday, 26 July. Meanwhile, another successful and well-attended ANZCA/ASA Combined Quality Assurance meeting took place at the College in March. Earlier in March, the Victorian Section Annual General Meeting and Annual Dinner was held at Kooyong Lawn Tennis Club.

Also in March, the full bench of the Fair Work Commission refused the application of member Dr Mark Colson to appeal against the decision that denied his reinstatement at Geelong Hospital. Although it had been found that his dismissal had been conducted unfairly, and Barwon Health was ordered to pay him the maximum penalty in compensation, it had disappointingly been determined that his return to work there would be 'inappropriate'.

In February, the Economics Advisory Committee received a request for assistance from a Victorian member who was in full-time salaried practice. When the final version of their contract was delivered, the member was required to sign it by the following morning. Apparently, if this did not occur, then the anaesthetist's employment would be terminated. It was believed that there was no opportunity for further negotiation. The member felt that they absolutely had no other option but to comply and to sign. The member was most grateful for the support and advice that they had received from the ASA.

WESTERN AUSTRALIAN COMMITTEE

Dr Ralph Longhorn, Chair

Our Autumn Scientific Meeting in March was a great success and was well attended. The competition for workshops was fierce, but Western Australian anaesthetists should be reassured that the Continuing Professional Development team is working hard to meet the demands of our local anaesthetists.

We have at last finalised the convenor for the NSC 2017– Dr David Law will spearhead a team from Sir Charles Gardiner Hospital. Thanks to all those who have stepped forward to help in this undertaking.

The annual Bunker Bay meeting, convened by Drs Twain Russell and Silke Brinkman, will be held on 17 to 19 October 2014 at Pullman Bunker Bay Resort, Dunsborough. The conference theme is "Crises", with the lecture program providing updates in crisis preparation and management from a variety of clinical specialties. This will be supplemented by workshops covering the new Continuing Professional Development emergency response activities. The conference dinner will be held at the Eagle Bay Brewing Company on Saturday night. This should be an excellent meeting and would be well worth the trip from the eastern states.

Our state committee continues to work effectively and we are in the process of setting up a new fellows group to look after our new members. This will be led by Dr Mike Soares. All Western Australian ASA members in their first five years of practice are encouraged to contact Mike through our local ASA office. We feel it is important to support new fellows and understand the issues of those most affected by the workforce problems.

NEW SOUTH WALES COMMITTEE

On 21 June the New South Wales Committee held their Annual General Meeting. Murray Selig stepped as Chair of the Committee and Dr Mike Farr was elected Chair unopposed. Dr Ammar Ali Beck was appointed Vice Chair. Catherine Downs also resigned from the Committee. The Committee would like to thank Murray and Catherine for their valued input and dedication.

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from May to July 2014.

TRAINEE MEMBERS

Dr Anthony Baird	QLD
Dr Christopher Alexander Brunsdon	ACT
Dr Karthikeyan Chandrasekaran	SA
Dr Andrew John Goldberg	VIC
Dr Lin Hu	NSW
Dr Diyana Ishak	TAS
Dr Rebecca Louise McBride	QLD
Dr Adam Mitchell	TAS

ORDINARY MEMBERS

Dr Gerard Ariotti	NSW
Dr Cecile Anne Francoise Blanchot	VIC
Dr Angela Chia	VIC
Dr Erin Corcoran	QLD
Dr Rajesh Devarakonda	VIC
Dr Victoria Anna Eley	QLD
Dr Claire Hinton	WA
Dr Rowena Lee Knoesen	VIC
Dr Nicholas Webster Marks	SA
Dr Christopher Hugh Mitchell	WA
Dr Amar Pal Saluja	NSW
Dr Kavita Sarang	VIC
Dr Paul Scott	QLD
Dr Timothy Aryadi Suharto	NSW
Dr Devinda Sanjaya Wickramaratn Suryaarachchi	WA
Dr James Telfer	QLD
Dr Andrew Travis	WA
Dr Angela Mary White	SA
Dr Samuel John Willis	SA

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Theresa Marie Cockbill (VIC) and Dr Gisele Mouret (NSW).

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

AUGUST 2014

SA/NT Function – Wine, Wheels and Where to Go

Dates: 29 August 2014

Venue: BMW Showroom, West Terrace, Adelaide, South Australia (entrance via Phillip St)

Contact: Katie Fitzgerald, ASA, Events@asa.org.au
Registrations are to be made online, please visit www.asa.org.au for further information.

OCTOBER 2014

Anatomy and Ultrasound for Peripheral Nerve Blockade

Date: 3 October 2014

Venue: Gross Anatomy Facility, Otto Hirschfeld Building, University of Queensland.

Contact: Katie Fitzgerald, ASA, Events@asa.org.au
Registrations are to be made online, please visit www.asa.org.au for further information.

ASA National Scientific Congress

Date: 4–7 October 2014

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

Website: www.asa2014.com.au

Contact: Katie Fitzgerald, ASA, Events@asa.org.au

NOVEMBER 2014

NSW Regional Conference

Dates: 1–2 November 2014

Venue: Crowne Plaza, Terrigal, NSW

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

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

4th World Congress of Regional Anaesthesia and Pain Therapy

Dates: 24–28 November 2014

Venue: Cape Town International Convention Centre

Contact: wcrapt2014@kenes.com

Website: http://www.wcrapt2014.com

GASACT Part 3 NSW

Dates: 29 November 2014

Venue: TBA

Contact: Katie Fitzgerald, ASA, Events@asa.org.au

GASACT Part 3 WA

Dates: 29 November 2014

Venue: TBA, 9am to 1pm

Contact: Katie Fitzgerald, ASA, Events@asa.org.au

JANUARY 2015

GASACT Part 3 SA/NT

Dates: 17 January 2015

Venue: AMA House, 161 Ward Street, North Adelaide

Contact: Katie Fitzgerald, ASA, Events@asa.org.au

FEBRUARY 2015

Australasian Symposium on Ultrasound and Regional Anaesthesia

Dates: 20–23 February 2015

Venue: Hyatt Regency, Perth

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

ACECC
Anaesthesia Continuing Education Coordinating Committee

LIFESTYLE

OPINION: TAKING CONTROL OF SUPPLY AND DEMAND

Having read the feature articles regarding anaesthesia workforce issues in the April edition of the *Australian Anaesthetist*, provisional fellow, Dr James Miller, feels that the authors were addressing the problems and proposed solutions within the *current* mindset of the provision of anaesthesia.

The focus on maintaining our quality of training and service in the current environment, as dictated by state and federal governments and hospital budgets, appears reactionary, especially with the constant reference to the need for "more data". Unless we switch our thinking and take control of the commodity we provide the health service, the current oversupply of anaesthetists is the beginning of the end, as we watch the erosion of our professional autonomy, our ability to maintain control over the provision of anaesthesia services and ultimately, the decline in our earning capabilities.

Prior to studying medicine I earned a Bachelor of Commerce, majoring in Accounting and Marketing, which taught the recurring principles – that of supply and demand and the importance of branding. These principles now need to be applied to the specialty of anaesthesia, for, as Lindy Roberts' article implies (with relation to supply and demand), they help explain the cause of current workforce issues. I believe they also provide the solution to overcome these issues and the detrimental effects of oversupply in an economic system.

As a provisional fellow, I am acutely aware of the dire workforce situation I am entering. Austerity measures of state and now federal health budgets, the effects of the recent global financial crisis on retirement planning and the increased number of both local and overseas trainees, and ultimately junior consultants, entering the market have resulted in a situation of oversupply. Finding a solution aimed at reducing the supply side of the equation (i.e. decreasing training numbers) is politically unattainable. The rapid expansion of medical schools and junior doctors entering the workplace is secondary to policies of the Howard Government, with their goal of increasing supply, the economics of which result in a decrease in demand pressures and therefore, the ability to erode pay and working conditions of doctors who are cast as either the heroes or villains of the health system on a cyclical basis. If left unchecked, this will result in both a reduction in public

and private earning potential, compounded further by a shrinking pool of private work and pressures from health funds for no-gap billing. Given these pressures, there are anaesthetists who are, through various arrangements, providing financial incentives to surgeons, either directly or indirectly, to secure lists. While this may be of immediate financial benefit to all involved, it is disastrous for the long-term earning capacity of the profession. Furthermore, it is often illegal. Couple this with health insurers' drive to control the unit price, no-gap billing and individuals' willingness to undercut colleagues, and the autonomy of our profession will be further eroded in line with our job security and real wages.

As a provisional fellow, I am acutely aware of the dire workforce situation I am entering

The problem of oversupply of medical graduates and the restriction of training places in the future are not areas that we as a profession can greatly control. Governments focusing on the bottom line over and above patient care reduce our ability to argue this point. While we have some influence upon training numbers by ensuring that departments are not pressured into increasing trainee populations beyond that which they are able to provide appropriate supervision and caseload to (therefore maintaining quality), the ability for us to control the supply side of the equation is limited. To focus solely on a reduction in oversupply as a solution to workforce issues is short-sighted. To overcome oversupply, we need to actively increase the demand for anaesthesia services. To increase demand, we need to create a brand and position it appropriately.

The recent ANZCA community survey discussed by Dr Roberts found only 50% of respondents thought that anaesthetists were doctors, irrespective of the fact that 96% reported to have had some experience of general anaesthesia. Of those who were aware that anaesthetists are doctors, only 41% knew we have the same training and qualifications as other specialists. This clearly demonstrates that we are failing to communicate who we are and what we do. This is despite the fact that anaesthesia is involved with a larger proportion of hospital admissions than almost all other specialities and a far greater proportion than any other individual surgical specialty. If we are incapable or unwilling to promote our worth to our patients, where is the impetus for hospital CEOs, health funds and governments to appropriately identify and value the services we provide?

As unpalatable as we may (or may not) find it, I believe it is time that we as a profession identify our unique and essential skill set, place a true value on this and then sell it. This requires us to identify the role that we play within the health system and the degree to which the system is reliant upon us to function efficiently and safely. By consciously identifying this, we will then be able to appropriately value our service and ourselves.

With this value realised, we then need to create a brand around the profession of anaesthesia and position this brand accordingly. This needs to be advertised to the medical profession, governments and population as a whole. This is not a cheap exercise and not one that can be done in-house at either ANZCA or ASA level—as the recent "What is an an-ees-the-tist?" posters designed for National Anaesthesia Day clearly demonstrate. While I appreciate that the intention of this campaign was to positively build the profile of anaesthetists, it must be judged to have failed on every level.

By creating value in our brand, especially in the eyes of public, we make it difficult for stakeholders—including surgical specialties, health funds and governments—to devalue and erode our individual autonomy, our earning potential and ultimately, the ability of the profession to safely and effectively control the provision of anaesthesia services. Furthermore, it would help improve market share in the field of sedation as it would drive patients to request FANZCA practitioners when attending self-sedating proceduralists and dentists, for example, the result being an increase in demand.

I believe it is time that we, as a profession, identify our unique and essential skill set, place a true value on this and then sell it

Now is the time to take ownership of our skill set. To proudly stand behind the true value of the services we provide and to identify what these services enable the health system to achieve. We should proudly attach a monetary value for these services (that can be justified) and as such, brand and promote them loudly. This requires a collective effort between bodies such as ANZCA and the ASA, as well as the individual efforts of practitioners to actively resist undercutting colleagues, unlawfully paying surgeons to work for them (rather than with them as professional equals) and resisting the pressure to perform no-gap anaesthesia. Additionally, it requires individuals to personify an image that the anaesthesia profession should be communicating. It requires strategic planning, money and a truly professional branding and marketing campaign commitment in the short and longer terms, the results of which will see an increase in demand for our services that can help alleviate oversupply secure our autonomy and earning potentials.

Anaesthesia is one of most popular specialties. As a profession, it creates specialists with a unique skill set who are integral to the overall functioning of the health system. In addition, it achieves excellent patient outcomes in the face of an ageing population with significantly increased risk-factors. It is a product that we are all stakeholders in. If we do not proudly capture and brand this, our autonomy, incomes and job prospects will continue to decline. We will lose the ability to create the demand for our services and maintain the quality of the product that is supplied to the health system.

LIFESTYLE

THE GRAPE ESCAPE

Dr Don Maxwell, former President of the ASA (1982 to 1984), tells *Australian Anaesthetist* about his escape to New South Wales' wine country during and after practice.

My life has always been a busy one and in 1962, at age 30, when I first went into private practice as an anaesthetist, it never occurred to me that one day I might retire. I had graduated with an MB BS (Sydney), had two post graduate degrees, FFARACS and FFARCS (Eng.) and trained at St Vincent's Hospital in Sydney and the Nuffield Department of Anaesthetics, Oxford with Sir Robert Macintosh, before embarking on private practice. I had been appointed to St Vincent's Hospital, Sydney and Prince of Wales Hospital, Randwick and had been invited to join the prestigious "anaesthetic group" at 86 Elizabeth Bay Rd, widely known as "The Eastern Suburbs Gas Company". I quickly developed a thriving private practice. Well trained anaesthetists were highly regarded by surgeons! I was married with a growing family and the world was my oyster.

Over the next few years I became NSW Secretary of the ASA and then joined the NSW Committee of the Faculty of Anaesthetists (now the College). I well remember having a conversation around this time with Harry Daly, one of the great pioneers of the ASA. He advised that I must develop an interest other than in anaesthesia. He said "you will retire from anaesthesia one day and your family will grow away from you. You will need other interests". "Join the army" he said.

While I did not join the army, I did take his advice. I learnt to sail and continued to sail a J24 sloop with the Cruising Yacht Club of Australia for many years.

My real diversion came in 1968 when I purchased a property, *Maluna*, in the Hunter Valley, New South Wales with a view to producing quality wines. The whole idea was a romantic fantasy at the time. The wine industry was just taking off. While the Hunter Valley was the oldest wine-growing area in Australia, at this time there were only a few wineries in the whole area and virtually no new vineyards. How it was all to change.

I was attracted to the Hunter Valley because of its beauty and its proximity to Sydney. My father's family also came from

the Hunter. and I had fond memories of holidaying there with relatives as a child. My roots in the Hunter were strong and I had determined that there was a future in the wine industry and the interest took hold.

There were other factors involved as well. I was very busy in my work, but needed an escape. There is a history of doctors wanting to go back to nature, to get a little dirt under their nails. It has affected the Lindemans, the Penfolds, more recently Max Lake and many others. Doctors often have a 'feel' for growing things and they have a background in the basic sciences of chemistry, biology and bacteriology, all needed for growing and making wine.

In any case, in 1968 I took the plunge and purchased *Maluna*, a 165 acre property which had become available. Land was relatively cheap in those days and the bank manager was kind. There were no vines on the property at the time, but I had learned it had a history as a quality vineyard. Indeed, it was one of the original vineyards of Pokolbin, Hunter Valley, planted by the pioneer Wilkinson family in 1854. It had produced high-quality wines up until the Great Depression of the 1930s, at which point the vines were pulled out as there was no market for wine. It became a cattle property instead.

The project was quite a challenge. The property was a mess. *Maluna* adjoined a state forest in the foothills of the Brokenback Range and a fierce bushfire had raged through the overgrown vacant paddocks in early 1968, taking the fences, the original house and the old winery. Everything was blackened and in need of repairs and rebuilding.

"You will retire from anaesthesia one day and your family will grow away from you. You will need other interests" - Harry Daly

We began slowly. Joe Mellis, the district agronomist, was a great help in soil testing and vineyard planning. We repaired the fences and bought some cattle to keep the grass down (bushfire insurance). The neighbours were generous and free with their advice to the novice. I knew so little, but I read widely and listened carefully. I received further help from the viticultural division of the NSW Department of Agriculture. And I made one key decision—I employed Bill Tinkler, the son of my neighbour, who had a viticultural background and was a graduate of Tocal Agricultural College. He was then 18 and worked for me for a further 27 years!

It was hard work, but the family and I loved it. We all bucked in for the planting, helping at weekends and holidays. Initially, we camped onsite and then lived in a caravan for many years (we could not afford a house); but over three years we planted 45 acres of vines with the help of Bill Tinkler and occasional part-timers. I learned so much and met so many interesting people from all walks of life, I certainly found "an interest" other than medicine as Harry Daly had advised!

Concurrent to my wine endeavours, I was very active in my hospitals, with the Faculty of Anaesthetists (State Chairman 1972 to 1973) and then with the ASA (State Chairman 1977 to 1978 and President 1982 to 1984). I think the vineyard gave me the oxygen to do these other things.

Wine and the vineyard occupied every spare moment of my time, and the family became very involved and spent lots of time there with me. I also decided to further my knowledge and studied part-time for two years to attain a wine science degree at Charles Sturt University, but did not have time to complete it. I visited many of the great wineries of Australia and came to know many of our winemakers well; and through them came to visit some of the great wineries of France and the Napa Valley in California. The Mondavi family in the Napa Valley were great hosts and my wife and I will never forget a vertical tasting of five vintages of great reds at the famous Chateau Petrus in Pomerol, Bordeaux hosted by its owner. I did not know then that each bottle commonly sells for over $1000!

Our first wine was bottled (made for us at Hungerford Hill Winery) in 1973, and in

Maluna 'Old Hill' pickers in the distance

Shiraz grapes: a hard day's labour

LIFESTYLE

1977 I first showed our wines at the Royal Sydney Show. Our Pinot Noir topped the class. Our Chardonnay won a silver medal and our Shiraz a bronze. Since then, the vineyard has consistently won gold medals year after year. We were even able to make good Champagne (the name was still allowed outside France then). In 1988 it won gold medals in Brisbane, Sydney and Melbourne and won the trophy for best in show in Melbourne. We were even able to serve it at my son, David's, wedding in 1988 and our daughter, Susan's, in the same year.

In the first few years during the 1970s, we marketed the wines under our own label "Maxwell's Maluna Wines", but with over 10,000 cases a year in production, it was too much to handle. Since then, we have allowed others to market the wines under their labels and life has become much simpler. We have always outsourced the making of the wine, recognising that great wines need a great winemaker as a separate skill, but I have always had input into how it is made. In recent years the wines have been made at Len Evans' Tower Estate Winery and at Brokenwood.

As the vines have matured (many are now over 30 years old), the wines from *Maluna* have become better and better. The varieties now grown are Shiraz, Chardonnay and Semillon. In 2012 our 2006 Semillon won the gold medal for its class and also the Decanter Wine Trophy in London for the best white wines in all classes at the show. That one was made by Brokenwood wines.

Over the years *Maluna* has filled a large part of my life. It has played host to many friends including visitors from the ASA, the College of Anaesthetists and to many overseas visitors. It has bound the family together.

I retired from anaesthesia in December 2000 and later sold the vineyard in 2006. I continue to have a great interest in our speciality, which never stops moving forward, and also in wine and *Maluna,* which continues to produce wine of great quality today.

Vintage in full swing at *Maluna*

Don, Jan and Sheeba the dog, early days

Checking; are they ready to pick?

Under the peppercorn tree. Ben Barry (white shirt) with wife Colleen (red shirt) and Brian Horan (behind)

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