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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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REGULARS

FEATURES

10 CSC WRAP-UP FOR 2015

INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

As of 2016, *Australian Anaesthetist* will be going quarterly! This means more opportunities to submit your articles! The March issue features of *Australian Anaesthetist* will focus on ODEC and world anaesthesia. If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 07 January 2016.
- Final article is due no later than 18 January 2016.

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

REGULAR

ASA EDITORIAL FROM THE PRESIDENT

DR GUY CHRISTIE-TAYLOR
ASA PRESIDENT

The Health Minister Sussan Ley recently said at the Royal Australian College of General Practitioners' Conference that her looming revamp of Medicare would bolster primary healthcare and cut the number of patients unnecessarily ending up in hospital. The ABC reported on Sunday, 27 September, that the Federal Government intended to carry out a 'spring clean' of the entire system.

At the time of writing this editorial, the ASA has just finalised its list of volunteers willing to contribute to the review. These individuals will be the vanguard of the speciality's effort to engage with the Medicare Benefits Schedule (MBS) Review Taskforce.

It is interesting to note the level of rhetoric and debate currently being entered into by the Minister of Health and the Chair of the Review Taskforce.

This has prompted warnings from two distinct, but significant, entities, namely the Shadow Minister for Health, Catherine King, and the President of the AMA, Professor Brian Owler.

Owler tweeted, "Deeply disappointed in government's attack on integrity of #Medicare and the medical profession to cut health funding and services" and Catherine King said that the "Government is going about this like a bull in a china shop…if you don't bring them with you, basically what you're going to end up [with] is to be at loggerheads with the profession".

A key element that will determine the success of this review is the integrity of the process. Fundamental to this are a number of essential prerequisites. The most central of these is to frame honestly and unambiguously what problem the review is designed to solve. If the key problem is affordability, then say so! If the key issue is failure of compliance and abuse of the system, then deal with it accordingly. Using terms such 'modernising' or 'spring cleaning' are misleading and confusing to all.

The review needs to articulate some of the key ideologies or guiding principles that will continue to underpin healthcare in Australia (and even more importantly, assign them a value or price) – patient choice, universal access, the sanctity of the doctor–patient relationship.

The review needs to be 'even-handed' in its approach to evaluating the value of services. Removing an item or service must bear some resemblance to the rigour of the processes applied to get a new item or service onto the MBS. The Society's recent application for the funding of ultrasound use for vascular access and nerve blocks was rejected by the Medical Services Advisory Committee (MSAC). In its response to our application, MSAC failed to support the listing whilst acknowledging it to be best practice, to increase productivity, reduce complexity and improve efficiency! What more, you might reasonably ask, do you need to demonstrate?

The public consultation process needs to assist the consumer by providing them with a clear set of guidelines and parameters as to what exactly they are being asked to provide feedback about. A vast amount of undifferentiated 'complaint' about what is 'unnecessary' or wrong with the system might do little to clarify the situation and only result in consumer dissatisfaction with the process.

The review must enlist the full and unfettered support of the medical profession.

Why? Well, simply put, without it – it will fail! Not only will it lack credibility, but it will be vastly short of manpower! Such a massive undertaking needs all the intellectual and academic capacity that can be mustered. The challenge is going to be to ensure that the profession remains fully engaged in the process and that the process maintains its momentum.

The review has raised the notion of 'waste' within the system, as well as the notions of 'low-value healthcare practices' and 'medical overuse'.

A recent article in the *Harvard Business Review* floated the idea of how the US can reduce waste in healthcare spending by $1 trillion – a number that we in Australia can barely comprehend[1]. The authors considered four categories: clinical waste, administrative complexity, excessive prices and fraud and abuse, with clinical waste being the greatest contributor. Such eye-watering numbers must compel any Health Minister to look for 'waste' in the Australian system.

Assoc Prof Adam Elshaugh, a member of the MBS Review Taskforce, has published on both low-value healthcare practices and the idea of medical overuse. In his 2012 paper[2], he sought to develop and implement a systematic, evidence-based and transparent process for identifying potentially low-value services in healthcare. In his latest paper, published in August this year[3],

he and his colleagues proposed an agenda for coordinated research to improve the understanding of medical overuse. It is claimed that overuse represents as much as 30% of provided services in the US, and that overuse has been associated with worse outcomes and death. Again, for any Health Minister, figures such as this are most compelling indeed.

In Prof Bruce Robinson's presentations on the review, it was clear that he is seeking to make the MBS a more 'dynamic' and responsive entity; and to do this it needs to be linked and driven by clinical guidelines.

In a recent editorial[4] in the Society of Cardiovascular Anesthesiologists newsletter, Dr Linda Shore-Lesserson makes some telling points about the issue of guidelines. She questions why there is so little regulation of such an important commodity in healthcare. Why, she asks, should we experience confusion, ambiguity and contradiction while attempting to follow clinical practice guidelines when our diagnostic routines, therapeutic practices, policies and perhaps even reimbursement are going to be judged based on our adherence to standards? The National Guideline Clearinghouse in the US has 471 guidelines on hypertension and 276 on stroke. Which do we choose and will it need to be an Australian guideline?

A recent survey demonstrated that GPs will continue to ignore Clinical Practice Guidelines unless they are useful[5].

The MBS Review represents a challenge to mainstream medicine to ensure that what we do is evidence-based, best practice, effective, productive, priced appropriately and not over-utilised. The reasonable corollary to this is to ask how are our patients and the population of Australia being served by the potentially less well-regulated and scrutinised areas of healthcare? What is the level of 'waste' in these systems? And what is the level of 'low value care and overuse'?

A brief walk down the aisle of your local pharmacy and other retailers will reacquaint you with the plethora of supplements, tonics and vitamin combinations currently available for purchase. This multi-billon dollar enterprise is especially thriving in the US and, as a recent article in the *Economist*[6] pointed out, this is largely due to legislative failure in that country. Strangely, it was regulations which gave the industry its biggest lift. In the 1990s, the Food and Drug Administration (FDA) considered new rules for supplements' health claims – "It set off a firestorm," remembers David Kessler, then the FDA's Commissioner; "the industry understood there were billions of dollars at stake". Lobbyists framed the issue as one of personal liberty. Bureaucrats would rob Americans of both vitamins and the freedom to care for themselves.

The result was a law that covered not just vitamins and minerals, but botanicals, amino acids, enzymes, metabolites and pills made from animal organs as well. The 1994 law let firms sell supplements without requiring the FDA's approval for safety or efficacy. It also, for the first time, authorised firms to tout the health benefits of their products. Manufacturers cannot claim that their pills can diagnose, prevent, treat or cure a disease, but they may make vague assertions that they "support a healthy heart" or are "essential for strong bones", and so on. As a result, rather than restraining the firms, the law unleashed them. There are now more than 20 times as many supplements on the market as there were in 1994.

A recent review published in the *New England Journal of Medicine*[7], indicated that there have been an estimated 23,005 presentations to accident and emergency departments in the US between 2004 and 2013 that can be attributed to the use of supplements.

The out-of-pocket expenses incurred by patients in their use of these substances are as real as any out-of-pocket cost as a result of medical care. In many cases, they are a wasteful diversion of resources that should be put to better use.

The evidence base of other health providers might also require some re-appraisal. Some of these are registered with AHPRA and others enjoy the financial support of private health insurers. There would seem to be a valid case to be made that if the medical profession is going to be (quite reasonably) subjected to the level of rigour and evaluation that it is, then the government should be ensuring that at least some reasonable levels of protection are in place to scrutinise other entities on an ongoing basis.

The ASA remains ready and willing to avail its resources to the MBS Review and to examine as scientifically and factually as possible its activities and treatment modalities, and seek to ensure best practice. Its members have shown themselves willing to engage in a review of anaesthesia as well as participate in review groups examining relevant, but non-anaesthetic, clinical activities.

The integrity of the review process must be maintained and the outcomes cannot be pre-determined.

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

REGULAR

UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

CSC 2015, DARWIN

Our 2015 Combined Scientific Congress, presented with the New Zealand Society of Anaesthetists in Darwin, has been and gone, and by all accounts, it was a resounding success. More formal and informative articles concerning the conference appear elsewhere in this edition; however, I would like to reflect on a couple of points that appealed to me.

Firstly, was the attendance and contribution of Professor John West. While all of the international speakers were of the highest calibre and made significant contributions across the four days, Prof West's attendance had a special significance to it. Here was a 'local boy', who has had a significant influence across the globe, being both welcomed and acknowledged by his colleagues. To see the almost rockstar reception Prof West received was an indication of the esteem he is held in by the profession!

As part of his attendance, Prof West was bestowed the Pugh Award by the Society. This award, which is offered to individuals who have made an outstanding contribution to the advancement of the science of anaesthesia, intensive care or related disciplines, was presented by the President and formed part of the congress opening ceremony. Prof West is only the fourth recipient of this prestigious award, an indication of his standing within the specialty.

The second point was to appreciate the contribution made by the Convenor, Dr Piers Robertson, the Scientific Convenor, Dr David Elliott, and all on the Congress Committee who ensured the meeting was of the highest standard. The time, energy and enthusiasm of this group ensured that delegates were offered valuable and enjoyable learning and social opportunities – on behalf of all in attendance, I would like to say thank you. Darwin continued the very high standard of ASA Congresses, and I am sure that the 2016 meeting, scheduled for 17 to 20 September in Melbourne, under the direction of Dr Simon Reilly and his team, will be a wonderful event.

Two other important awards were presented at the conference, both as part of the Society's Annual General Meeting. The first was the awarding of Life Membership to Dr Andrew Mulcahy. Dr Mulcahy has provided great service to the ASA in a number of roles, including Society President from 2011 to 2012, and Chair of the Economic Advisory Committee for many years. It was therefore fitting that he be made a Life Member and I am pleased to report that his lovely wife, Leonie, was able to be present for the occasion.

The second award was the Gilbert Brown Award, presented to Dr Noel Cass. This award acknowledges outstanding and meritorious services to the ASA, usually in one area. Dr Cass has, for 43 years, served on the Editorial Board of the *Anaesthesia and Intensive Care* Journal, and was a member of the original Board. For the last 25 years, Dr Cass has been the Book Review Editor for *Anaesthesia and Intensive Care*, and in this capacity has made an outstanding contribution to the ASA.

The Society has benefitted greatly from the contribution of these two gentleman, and it is fitting that they have been acknowledged in this fashion.

MBS REVIEW

At this point in time, the Medicare Benefits Schedule (MBS) Review is taking up a significant amount of the Society's attention, and I am sure is of great interest to all members. To this point, the ASA has been quite proactive in engaging on a number of levels, when and where appropriate. In September, a small delegation, led by the President, met with the Opposition Spokesperson on Health, Ms Catherine King, in Canberra and the same group is scheduled to meet the Federal Health Minister, the Hon. Sussan Ley, in November. Meanwhile, the Society has submitted its nominations for the respective review panels, and is optimistic that our representatives will be included. This level of engagement and involvement is important in positioning the Society in what will undoubtedly be a significant health debate in the coming months. The ASA intends to continue to be as active as possible, in order to best represent your needs.

UPCOMING MEMBER SURVEY

Meeting the needs of members through our service provision is a key aspect of our work at the ASA. To this effect, the Society is preparing a Member Survey for distribution in early 2016, looking at the services that we currently deliver and whether they are meeting members' needs. I encourage all members to complete the survey, as your feedback is important in shaping how services are delivered.

THANK YOU AND WELCOME

In closing, I would like to say farewell and thank you to Dr Ted Hughes. As many will know, Dr Hughes has recently stood down as President of the New Zealand Society of Anaesthetists. What many may not know is that Dr Hughes was, at the same time, Chair of the Anaesthetic Continuing Education Coordination Committee (ACECC), a significant role in itself. In completing his Chairmanship of this tripartite initiative, Dr Hughes has been instrumental in ensuring that all three bodies are actively working together to promote ongoing education opportunities in Australasia. To Dr Hughes, thank you very much. In addition, I would like to welcome Mr John Ilott as the recently appointed Chief Executive Officer of ANZCA. The Society wishes John all the best in his role and we look forward to working with him in the future.

CONTACT

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

2015 COMBINED SCIENTIFIC CONGRESS RECORDINGS NOW AVAILABLE

Videos of the plenary and refresher sessions from the recent CSC held in Darwin are now available for viewing online in the member's only section of the ASA website.

Simply login to the members section of the ASA website, and go to the NSC Presentations tab under Education and Events.

REGULAR

LETTERS TO AUSTRALIAN ANAESTHETIST

ASA SUPPORT OF THE MSA

I have just returned from a week in Mongolia, hosted by the Mongolian Society of Anaesthesiologists (MSA) and supported by Dr David Pescod. I was so moved and impressed by what I saw that I wanted to write and say that I think the ASA's support of the MSA over the last few years is just phenomenal.

The optimism, ambition and leadership of the MSA was evident everywhere we went. Every member seemed devoted, not only to improving their own practice, but also to supporting colleagues in the most rural areas, building up the student training program and modelling better systems of care. Their pride in the MSA office, a proper home for anaesthesia in Mongolia, was thrilling to see.

We heard so many stories of what anaesthesia was like across the country: dedicated providers, but outdated training and limited communication leading, in too many cases, to dangerous practice. But in just a few years, things seem to have turned around; anaesthesia is now the specialty that other groups (surgeons, obstetricians, paediatrics) and even the Ministry of Health are looking to for ideas about how to raise standards of care.

I know that the gratitude and deep affection the MSA feels for the ASA contributed significantly to these doors being opened to Lifebox, and we are very grateful. It has been such a pleasure to work with the ASA over the last few years, making surgery safer across the Western Pacific – and we look forward to many more years and projects together.

Sarah Kessler

Head of Outreach, Lifebox Foundation

RECENT SUICIDES

As Dr Guy Christie-Taylor reported in his October President's enews, there is a disturbing incidence of suicides amongst Fellows. It continues to amaze me, that there is no forward-looking study of all Fellows' Health. It would have to be confidential, i.e. protected data, and de-identified if required. Is it not a duty of care to monitor all those that fall under the ASA's umbrella?

Roger Henderson

Mount Eliza, Victoria

ANAESTHETIST WELFARE

There has been much published recently on the rise of propofol abuse by anaesthetists and trainees (refer to Rob Fry's articles in *Anaesthesia and Intensive Care* and the *ANZCA Bulletin*).

However, there is an 8% lifetime prevalence of substance abuse amongst Australian doctors. And the most common substance is alcohol.

The festive season is nearly upon us. It may be a good time to reflect upon our drinking behaviour. Would you have five or more drinks, twice a week or more? Do you regularly find it hard to stop drinking once you've started? If so, you would satisfy the WHO criteria for harmful alcohol consumption. If you've thought about cutting down, had others express concern about your drinking or ever felt guilty about your drinking, now might be a good time to talk to someone you trust. That someone could be someone you may not know very well, like your GP.

Be reassured that there are support groups specifically for doctors which have been found to be overwhelmingly valuable by those who attend them. In Victoria, Caduceus is available through the Victorian Doctor's Health Program. In other states, contact your local Health Program.

There is also the Australian Doctors in Recovery: https://www.idaa.org/sites/adr/. Which is part of the International Doctors in Alcoholics Anonymous: https://www.idaa.org.

Have a (sensibly) Merry Christmas and see you healthy and sober in the New Year!

Suzi Nou

Welfare Special Interest Group

MISSED MENTION

The recent edition of *Australian Anaesthetist* omitted a large segment of rural Australian anaesthesia's indebtedness to Ross Holland. In 1978, in a country hospital, the few Faculty documents carried little weight, while the standards of the ACHS did. Ross was instrumental in setting those standards and gradually raising the ACHS bar over the succeeding years.

Ten years later, the importance of ACHS standards still hold true when I moved to then rural Canberra.

It is sad to hear that ACHS is now seen as a hindrance, for in my experience, thanks to Ross's input, the standard of rural anaesthesia was gradually raised by ACHS – since no hospital then wanted the ignominy of failing ACHS certification.

Ray Cook

Canberra, Australian Capital Territory

TIPS AND TRICKS

As part of *Australian Anaesthetist*'s continous aim to improve itself as a member magazine, we have listened to your feedback and are excited to present a new regular section. 'Tips and Tricks' is written by members for members, as a medium to share hints and skills for all areas of practice, whether it be in theatre, the office or consultations.

PRE-INDUCTION BP, NECESSARY?

I don't do an immediate pre-induction BP. It's already been performed as part of their admission. To repeat it immediately, pre-induction, just adds to the patient's anxiety, is often artificially high and hurts! I start BP readings immediately post induction. If your concern is that you might forget to start readings, you won't. It's instinctive.

Dr Andrew Pembroke

Castlecrag, New South Wales

PREOP ONLINE QUESTIONNAIRE

I have developed a preoperative online questionnaire which I have been using extensively in my practice for the last year. It works a treat for me and other anaesthetists are finding it useful as well.

There is a commercial version at www.aqform.com where you can register and explore the site. If you'd like to see an example of the questionnaire I use, go to www.aqform.com/pf, enter my alphanumeric code JB0001 and click 'yes'. Feel free to fill out the form and submit it. You will then be emailed a copy of the completed questionnaire.

In addition, I use www.smsbroadcast.com.au to send out bulk SMS messages to my patients directing them to my questionnaire. I find this an incredibly efficient way to start my week, as it only takes five minutes and is far more targeted than simply emailing, which can often get caught in the spam filter.

Testimonial: "I find it a simple and efficient way to get a hold of patient information! Recommended!" (Terrence, WA).

Dr Jeremy Buttsworth

Perth, Western Australia

IS THERE STILL A ROLE FOR SHARP 18G NEEDLES?

This is by no means a bolt of enlightenment but more a search for support and feedback. When blunt 18g hypodermic needles were introduced for the purposes of drawing up drugs, our department at the time asked the question: "How are we to distinguish sharp from blunt needles on our sterile setup?" The point was made that there was nothing a sharp 18g needle could do that couldn't be done with a 19g and, as colour has been shown to aid safety, we managed to get sharp 18g needles removed from our hospital. Now there are plastic vial access needles, we could ask if we need these larger sizes at all; though I still use one to nick the skin prior to epidural needle insertion.

At subsequent hospitals, I have tried to introduce this simple safety change with mixed success. Is there still a role for sharp 18g needles that I am missing? I still believe that confusion between the two almost identical items poses a threat to medical and nursing staff, and our patients.

Peter McLaren

Southport, Queensland

HAVE YOU GOT A TIP OR TRICK TO SHARE?

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

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

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

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

COMBINED SCIENTIFIC CONGRESS 2015 WRAP-UP

What a great success it was! This was the 74th National Scientific Congress of our Society and the 7th Combined Congress with the New Zealand Society. Whilst our numbers were short of those predicted, the Congress was well-attended by over 700 delegates and exhibitors. It is well-recognised that the conference schedule is very busy now in Australia, with something available for your attention almost every week in a multitude of locations. The ASA constantly strives to maintain the relevance of its National Congress and several innovations were introduced this year to that end, reports Convenor, Dr Piers Robertson.

The location of a conference is the reason given by approximately 50% of delegates as to how they decide which meetings to attend. The setting on the harbour in Darwin is one of the most picturesque the Congress has seen and it was certainly looking its best. When we were in Darwin in 2009, the harbourfront environment and the Convention Centre were all brand new – they have since come into full bloom. The weather was warm, in the low 30s, and was comfortable to walk around in during the day, but provided cooler temperatures for our evening social events.

The committee worked very hard over three years to organise the Combined Congress. As you can imagine, the committee was spread far and wide, and so all meetings were held by teleconference. I was based in Adelaide with our GASACT representative, Brigid Brown, while David Elliott (Scientific Convenor), Pete Smith (PBLDs) and our ASA Secretariat, Katie Fitzgerald and Nicola Morgan, were in Sydney. The local Darwin crew comprised Brian Spain (workshops), Dan Holmes (AV) and Andrew Fenton (social events), and our NZSA representative David Kibblewhite was in Hamilton, New Zealand. Vida Viliunis (Special Projects) called in from Canberra and our conference organisers, the All Occasions Group, were in Melbourne. Having an experienced team made it all work smoothly, despite the distance – would you believe that the first time we all met in one place was the evening before the event opened?!

I cannot praise the efforts of the committee highly enough. The core of the Congress is always the scientific program and David Elliott, along with Brian Spain and Pete Smith, constructed an excellent program, as I hope attendees would agree. The role of the Scientific Convenor is difficult and requires significant skill in

organisation and people management – skills that David Elliott possesses in abundance. His vision for the Congress, including speaker selection and the trial of new innovations, brought the event to life and I wish to acknowledge and thank him here for the success of the event.

Whilst my job was mostly complete six weeks before the event (luckily, as it turned out), David, Brian and Pete were busy throughout the Congress ensuring that it all ran smoothly. Over the weekend, Brian coordinated a significant move of supportive equipment from and to the Royal Darwin Hospital, without which the event would have struggled. It is efforts like this, unseen in the background, that make these meetings run so well.

This year, our invited speakers came from the United States, United Kingdom, New Zealand and Australia. Prof BobbieJean Sweitzer from Chicago, Prof Debra Schwinn from Iowa, Prof Martin Smith from London, Assoc Prof Alicia Dennis from Melbourne and Dr Kelly Byrne from Hamilton formed the core of our scientific program and provided an excellent lineup of plenary sessions from which the rest of the program developed. One of the highlights of the Congress was our success in enticing Prof West from San Diego to join us in the Top End. His talks about his career and research in aspects of respiratory physiology were highly entertaining and through his YouTube videos, he deftly demonstrated why his instruction remains so important to our discipline. In recognition of his great contribution to our understanding of respiratory physiology, Professor West was awarded the Pugh Medal by the Society at the end of the opening ceremony.

But the major speakers were only a small proportion of the total number involved in the program. I wish to thank all those who gave considerable time and effort to deliver refresher course lectures, talks, workshops and small group discussions, as well as those who acted as chairpersons for certain sessions. Without this effort, at this and all the meetings across Australia and New Zealand, there would be no continuing education.

The informal feedback from delegates in the Exhibition Hall and the corridors was that they enjoyed the stimulating scientific program. Well done to those of you that made the trip to our northern frontier, especially those from New Zealand who travelled for over eight hours to be there. Amongst many others, I met two anaesthetists from Singapore at our Gala Dinner who were full of praise for the event. Without the delegates, even the best Congress would be nothing, so we thank you for rewarding our hard work by turning up. We hope you took the opportunity to give us feedback via the post-event survey, as this data is very useful in planning future events.

This year we made a concerted effort to record many of the sessions. These have been uploaded to the members section of the ASA website. All the main plenary sessions and refresher course lectures were recorded in addition to many others. These will be available as a slide/audio stream.

The exhibition hall was filled with companies who made the expensive effort to join us in Darwin. An active, engaged exhibition floor is always a core element of our anaesthesia meetings, not only to make delegates aware of new developments in pharmacology, equipment and other products essential to our practice, but also in forming of a significant part of the social fabric of the event. The Darwin Convention Centre is also to be congratulated for the high standard of their catering and facilities and for the responsiveness of their staff over the three days.

The social program was designed to capture many of the prime activities of Darwin at one of the best times of the year to visit. The Registration Welcome on the Friday night was very well attended and afforded the delegates the chance to to register early and catch up with friends. The first night's event saw us return to Crocosaurus Cove. With good food and drinks, the guests enjoyed several hours mingling with crocodiles and reptiles of assorted sizes, and the main attractions were very active (as those who entered the Cage of Death were able to attest). On Sunday nights in Darwin it is almost mandatory that you visit the Mindil Beach Markets to watch the sun setting into the Arafura Sea, to buy something from the hawker stands, and to sample some of the amazing selections of food available. We enjoyed a private area at one end of the markets for a pre-sunset drink and can boast that the sunset was indeed glorious. Our 'Night of Stars' themed Gala Dinner was held in the open air on the lawns of the SkyCity Resort, again at Mindil Beach. We all wore our brightest gear, enjoyed tasty food in a casual format and danced the evening away to great music.

I wish to thank all those who provided their personal support for the organisation of this Congress, most notably my wife Libby. Six weeks before the conference, I was presented with my own sudden unexpected health crisis and without her support I would not have been able to attend the event. The team at the ASA in Sydney, especially Katie Fitzgerald and Alaina Koroday, showed incredible professionalism in their work, making our jobs that much easier. In addition, All Occasions Group provided excellent service and I thank them all.

Next year, the National Scientific Congress returns to Melbourne between 17 and 20 September and I would encourage you to support the Convenor, Simon Reilly, and Scientific Convenor, Colin Royse, with your attendance. The national meeting remains the core event of the ASA's education calendar and retains its place as the primary source of the most up-to-date information across a very wide variety of sub-specialties, as well as keeping you in touch with the latest issues affecting us in the political and regulatory sphere. I look forward to seeing you there.

FEATURE

SCIENTIFIC CONVENOR'S WRAP-UP

A collaboration between the ASA and NZSA, the CSC attracted delegates from all over Australasia. With over 200 individual lectures, workshops, posters and PBLDs, the scientific program covered all aspects of anaesthesia and pain medicine. New at this year's Congress were hour-long 'refresher' sessions which proved particularly popular with delegates. This format of presentation is likely to continue to feature in future meetings.

We were very fortunate to have such high-calibre Australian, New Zealand and international invited speakers at this year's Congress. Prof John West, whose *Respiratory Physiology* textbook was a must-read for many of us in our training, delivered the Kester Brown Oration. John's detailed description of the pioneering studies into the effects of extreme altitude on respiratory function conducted on Mount Everest was enthralling. Assoc Prof Alicia Dennis was the Australian Society visitor and delivered a powerful plenary lecture examining the ongoing global impact of maternal mortality and why it remains at unacceptably high levels in many countries. Dr Kelly Byrne from Waikato Hospital was the New Zealand Society visitor. Kelly's plenary lecture, delivered with wry humour, addressed the non-technical and medicolegal issues that we face in our daily practice as anaesthetists. The international invited speakers at the Congress were Prof Debra Schwinn and BobbieJean Sweitzer from the US and Professor Martin Smith from the UK. Prof Schwinn used her plenary lecture to explain the emerging field of targeted or personalised medicine and the influence that genetic variability is likely to have on all our practices in the future. Prof Sweitzer is a perioperative physician, in addition to a practising anesthesiologist, and delivered a series of lectures based on perioperative risk and optimising outcomes for our patients. ProfSmith, a neuroanaesthetist from London, delivered several lectures that unpacked the issues that really matter in cerebral protection for both elective and emergency neuroanaesthesia.

This summary of the scientific program of the 2015 CSC only touches on the many topics covered and does not do justice to the literally hundreds of colleagues who gave their time and expertise to bring the meeting to fruition. Please take time to complete the post-congress survey if you have not already done so. The NSC/CSC is an ever-evolving beast and the feedback from delegates is our best resource in planning future meetings.

Dr David Elliott
CSC Scientific Convenor

FRIDAY REGISTRATION WELCOME & PRESIDENTS' RECEPTION

Registration drinks at the Darwin Convention Centre

Congress registration at the Convention Centre

Mrs Penelope West, Professor John West, Dr Guy Christie-Taylor and Mrs Sue Christie-Taylor

Professor West and Dr Ted Hughes, NZSA President, at the Presidents' Reception

ASA President, Dr Christie-Taylor, welcomes Congress delegates at the Presidents' Reception

Guests congregate at Northern Territory Parliament House for the ASA/NZSA Presidents' Reception

SATURDAY OPENING CEREMONY, KESTER BROWN LECTURE, SCIENTIFIC SESSIONS & CROCOSAURUS COVE

Convenor, Dr Piers Robertson, welcomes attendees at the Congress Opening Ceremony

Welcome to country

The audience at the Kester Brown Lecture, given by Professor West

An attentive audience at one of Saturday's refresher sessions

Dr Michael Barrington chairs the Regional Anaesthesia session

Invited speaker, Dr Kelly Byrne, at the Regional Anaesthesia session

Feeding time at Crocosaurus Cove

Dr Ben Piper and ASA CEO, Mark Carmichael, make the acquaintance of a snake

Inside the infamous Cage of Death

Congress delegates at Crocosaurus Cove

Exhibitor Adam De Barros gets up close and personal with a baby crocodile

Congress Convenors Drs David Elliott and Piers Robertson

FEATURE

SUNDAY PLENARY SESSION 1, WORKSHOPS & MINDIL BEACH MARKETS


Invited speaker, Professor Debra Schwinn, presents on genetic variation


Plenary session 1 audience


Delegates take part in an interactive workshop session


Participants of the paediatric advanced life support workshop


ASA Past President, Dr Richard Grutzner (far right), joins workshop participants


Ultrasound workshop featuring live model scanning for a 'hands-on' experience


Drs Kwok Ho and John Loadsman at the Mindil Beach Markets


A crowd gathers at Mindil Beach


Attendees watch the sun set over the beach


The markets at dusk


A spectacular Darwin sunset


Delegates on the beach

MONDAY ASA AGM, WORKSHOPS, SCIENTIFIC SESSIONS AND GALA DINNER

Dr Christie-Taylor opens the Society's Annual General Meeting

Dr Andrew Miller, Mr Mark Carmichael and Dr Mark Sinclair at the AGM

Dr Antonio Grossi, PIAC Chair, presents at the AGM

The CareFlight MediSim mobile education unit

Dr Ken Harrison leads a CareFlight 'Can't intubate/can't oxygenate' (CICO) workshop

Delegates take part in the interactive CICO session

Lunchtime session on maximising earnings in private practice

Group discussion at the Welfare Special Interest Group (SIG) session

Drs Suzi Nou, David M. Scott and Genevieve Goulding at the Welfare SIG session

Delegates gather on the lawns of SkyCity for the Gala Dinner event

Dr Christie-Taylor dons a loud shirt for the Gala Dinner

Dinner guests in the loud and colourful dress code

FEATURE

MONDAY GALA DINNER

Members of the CSC Organising Committee celebrate a successful Congress with Dr Christie-Taylor

The Gala Dinner under the stars

Workshop Coordinator, Dr Brian Spain, congratulated by Dr Christie-Taylor

Drs Cameron Hastie, Brett Chaseling and Graham Mapp dressed to impress

Delegates hit the dancefloor

The band entertains attendees at the Gala Dinner

TUESDAY HYPOTHETICAL SESSION & CONGRESS FAREWELL

Dr Vida Viliunas and panel members deliberate on ethical issues at the hypothetical session

The hypothetical session panel

Congress Convenor, Dr Robertson, farewells delegates and looks forward to next year's Melbourne NSC

2015 AWARDS, PRIZES & RESEARCH GRANTS

WINNERS ANNOUNCED

Kevin McCaul Prize

Dr Katherine Smither*
Viscoelastic coagulation testing in obstetric haemorrhage

*Accepted by Dr Dennis Millard on behalf of Dr Smither.

Jackson Rees Research Grant

Dr Kwok Ming Ho
Effects of Resveratrol on Severity of Acute Kidney Injury and Coagulation Parameters in a Haemorrhagic Shock Model

Gilbert Troup ASA Prize

Dr Sophie Liang
A systematic review and meta-analysis of continuous local anaesthetic wound infusion for acute postoperative pain following midline laparotomy

ASA Best Poster Prize

Dr Jonathon Fanning
Assessing the significance of cerebral hypoperfusion/desaturation as a cause of intraoperative neurological injury during transcatheter aortic valve implantation (TAVI)

Jeanette Thirlwell *Anaesthesia and Intensive Care* Best Paper Award

Drs Michael J Paech, Nolan J McDonnell, Aneeta Sinha, Celine Baber and Elizabeth A Nathan*
A randomised controlled trial of parecoxib, celecoxib and paracetamol as adjuncts to patient-controlled epidural analgesia after caesarean section. 42(1):15-22.

*Accepted by Dr Emelyn Lee on behalf of Dr Paech.

Life Member

Dr Andrew Mulcahy

Since joining the Tasmanian section of the ASA in 1989, Andrew has served the Society continuously, tirelessly and selflessly. Not only has he given of his time and energy but he has represented the Society with great distinction both in Australia and overseas. Much of the enormous success of the Economics Advisory Committee has been achieved in large part because of Andrew's contributions. In particular, it was during his time as Chairman of the committee that the new anaesthesia Medicare consultation items were introduced.

He has also served the Society on the Professional Issues Advisory Committee, the Public Practice Advisory Committee, the Awards, Prizes and Research Grants Committee as Chairman, as Convenor of the 1997 ASA NSC and of course as Vice President, President and Immediate Past President. In all of these roles he has worked conscientiously and diligently, bringing great attention to detail and enthusiasm to the tasks at hand. As President, Andrew represented the Society at home and overseas, superbly ensuring that whenever possible we had a ‘seat at the table’ and our views were heard, while always being keen to listen to all other opinions on the subjects under discussion. He has been a great ambassador for the Society, the specialty and the nation.

Gilbert Brown Award

Dr Noel Cass

Dr Cass' nomination for the Gilbert Brown Award was based primarily on his contribution to the Society’s journal, *Anaesthesia and Intensive Care*. In particular, Dr Cass was a founding member of the original Editorial Board of the Journal in 1972 and remained a member for 43 years until he recently retired due to deteriorating eyesight. For the past 25 years, Dr Cass has served as Book Review Editor for the Journal.

In addition to his role with *Anaesthesia and Intensive Care*, Dr Cass was nomintated for the Gilbert Brown Award for his other contributions to the Society more broadly. Dr Cass has been a member of the ASA since 1952 and was Chairman of the Victorian ASA Committee in 1964.

Dr Cass was also recognised for his contribution to the advancement of the specialty of anaesthesia through his extensive reseach activities and publications, as well as his teaching and training commitments at the Royal Children's Hospital in Melbourne, and for his activites in the Faculty of Anaesthetists, Royal Australasian College of Surgeons, including being Dean from 1968 to 1970 and Chariman of Examiners from 1966 to 1968. Dr Cass has also been active within medical defence and medical history societies.

Pugh Award

Professor John West

Prof John B. West of San Diego, California, was nominated for the Australian Society of Anaesthetists' Pugh Award for his outstanding contribution to the science that underpins the practice of clinical anaesthesia. This award has only be presented four times in its history.

John West graduated MBBS from the University of Adelaide in 1951. After his early clinical years as a Resident Medical Officer at the Royal Adelaide Hospital and then the Hammersmith Hospital, London, Prof West began his lifelong research and teaching endeavor – the pursuit of a greater knowledge and understanding of human respiratory physiology in health and disease.

John's first original work described the nature of ventilation–perfusion relationships in the lung. He then went on to further define the inequality between ventilation and bloodflow within the lung and the reasons for this inequality. Put simply, Professor West was able to show for the first time that bloodflow is much greater at the bottom of the lung than the top. Following on from this work, Prof West explored the effect of gravity on lung mechanics and the role of surfactant. For anaesthetists, these discoveries had many practical and vital applications, for example, in the conduct of one-lung anaesthesia, for the understanding of pulmonary embolic disease and for management of the acute lung injury associated with prematurity and shock states.

Prof West has also been a pioneer in the field of high-altitude physiology. This work has advanced the knowledge of human oxygen transport and consumption and the body's response to hypoxia. Again, these are areas of profound clinical interest and value to anaesthetists.

In the course of these pursuits, Prof West has been awarded a MD, a DSc and PhD and was made the Foundation Professor of Medicine and Physiology at the University of California, San Diego, when it opened in 1969. In this role, he has, for over 40 years, taught medical students and future anaesthetists those fundamentals of pulmonary physiology that are essential for the safe practice of anaesthesia. Through his concise and wonderful respiratory textbooks and now the medium of YouTube, Prof West has also offered this vital teaching to decades of anaesthesia trainees in Australia, New Zealand and beyond.

ASA & NZSA 2015 Combined Scientific Congress

On behalf of the ASA & NZSA CSC 2015 Organising Committee, we would like to thank all the sponsors who supported this year's CSC. We look forward to welcoming you all to Melbourne in 2016.

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FEATURE

THE MEDICAL SERVICES ADVISORY COMMITTEE PROCESS

The Economics Advisory Committee (EAC) is often asked to apply for a well thought out and logical anaesthesia item number to be introduced into the Medical Benefits Schedule (MBS), or to have an axed item number reinstated (e.g. item 55054 for 2D ultrasound use in association with certain invasive procedures), writes Queensland EAC Representative, Dr Tim Wong.

The (quite reasonable) expectation of the member is that, after a few months of discussion with government departments, the MBS Fairy God Mother waves her magic wand and 'Bippity Boppity Boop!', a new item number appears or the lost one reappears. This is far from the truth. The whole process can take many years, and the equivalent of hundreds of thousands of dollars in time and effort. Then, eventually, a watered-down version of the new item number *may* appear in the MBS. For example, the introduction of a range of pre-anaesthesia and referred consultation MBS items occurred in 2006 – the process of this application began in 1991. Furthermore, the Department of Health (DoH) insisted on these items not being just time-based (as per the ASA items), but also having detailed complexity and documentation requirements. Much more commonly, the proposal for a new item or reinstatement of an item is rejected purely for budgetary reasons.

So what is the process we need to go through in order to introduce a new item into the MBS? Any ASA member may contact the EAC to raise the idea of a new Relative Value Guide (RVG) item. This will be discussed among the EAC via email, teleconference and/or at the annual face-to-face meeting. The timeframe for this is approximately three to six months. Once the proposed new item number is discussed, and an appropriate descriptor unit allocation and RVG item number is assigned, the proposal is then presented to the ASA Board for ratification. Once ratified, the item is added to the ASA RVG (when the next edition of the RVG is released, usually in December). At the same time, we notify the AMA and recommend the new item be added to the AMA's List of Medical Services and Fees. The process of introducing a new item into the ASA/AMA RVG is a relatively easy one, with a turnaround of less than a year. However, introducing a new MBS item, or re-establishing an axed item, is a very different matter.

In the past, the ASA would have open and frank discussions with the Federal DoH, and ultimately the Minister of Health (who had discretionary powers to fast-track the process if the case was well presented and argued), who would make a decision. In more recent years however, all such applications have had to go through the Medical Services Advisory Committee (MSAC) process.

WHAT IS THE MEDICAL SERVICES ADVISORY COMMITTEE?

From the MSAC website (msac.gov.au):

> *The Medical Services Advisory Committee (MSAC) is an independent expert committee that provides advice to the Minister for Health on the strength of the evidence relating to the comparative safety, clinical effectiveness and cost-effectiveness of any new or existing medical service or technology, and the circumstances under which public funding should be supported through listing on the Medicare Benefits Schedule (MBS).*
>
> *MSAC was established in 1998 to improve health outcomes for patients by ensuring that new and existing medical procedures attracting funding under the MBS are supported by evidence of their safety, clinical effectiveness and cost-effectiveness.*
>
> *Evaluation of evidence associated with medical services has been an integral part of the process for the listing of new medical technologies and services on the MBS.*

As mentioned, essentially all proposals for new Medicare funding must go via MSAC.

There have been 84 completed assessments over the last four years, and 31

applications are currently being assessed (including application 1308 by the ASA, for three new MBS items to cover all forms of local anaesthetic nerve blockade performed for postoperative analgesia).

MSAC states that its role is to assess the "safety, effectiveness and cost-effectiveness" of services where a new MBS listing is sought. High levels of evidence are required, both clinical and economic. In recent years, MSAC has increased its focus on the economic aspects of the services in question. The process is difficult and time-consuming, and frequently ends in failure. Some applications have been successful and have resulted in new MBS items being introduced. These are typically for very specific services with specific indications, e.g. genetic testing to guide cancer therapy. Also, newly recognised specialties such as addiction medicine and sexual health medicine have been successful in obtaining items for consultation services. Where applications are rejected, it is usually a lack of economic evidence that is the issue, although some have been rejected due to uncertainties regarding the clinical evidence.

MSAC has also been involved in reviews of existing MBS items or groups of items, again assessing the evidence for safety, effectiveness and cost-effectiveness. In some cases, this has resulted in no change to the MBS, e.g. the review of the use of pulmonary artery catheters in anaesthesia and intensive care practice. Other reviews have resulted in modifications to the MBS, with existing items removed and newer, more specific items introduced, e.g. the review of bariatric surgical services. The MBS is now being subject to a separate full review, so MSAC may now go on just with new applications.

This all sounds well and good. Naturally, the ASA supports the idea that new items should be backed by evidence. However, there is much more to the story, which can be shown by the experiences of the ASA with MSAC.

The ASA has had one application go through the complete MSAC process, and another (application 1308) that is nearing completion.

MSAC Application 1183 (2D ultrasound scanning in the practice of anaesthesia)

The use of 2D ultrasound scanning to guide certain vascular access and nerve block procedures has been proven to enhance safety and effectiveness. However, as we all know, an anaesthetist needs training and experience to use ultrasound effectively. This requires the investment of both time and money. Many anaesthetists (or groups) purchase their own ultrasound equipment, which is a significant further investment. So it only makes sense to charge a fee for ultrasound when treating private patients. And patients deserve Medicare and private insurance rebates for these fees.

Therefore, some years ago, the ASA added two items to the RVG:

- CV800: The use of 2D ultrasound guidance to assist percutaneous major vascular access (including arterial access) and peripherally inserted central catheters (3 units).
- CV805: The use of 2D ultrasound guidance to assist percutaneous neural blockade (3 units).

Of course, these items do not have MBS equivalents. So listing one of them on an account meant the patient would receive no rebate, and would have to pay the whole fee. However, Diagnostic Imaging Item 55054 was applicable:

- MBS Item 55054: Ultrasonic cross-sectional echography, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies (MBS Fee $109.10).

Again, so far, so good. However, two issues arose:

1. All claims for diagnostic imaging MBS items required compliance with the Diagnostic Imaging Accreditation Scheme. This scheme was aimed at ensuring all forms of diagnostic imaging subject to MBS claims were performed safely. Most of the requirements were not relevant to anaesthetists' use of ultrasound (e.g. radiation safety), and the ASA was able to obtain exemptions for the non-relevant requirements.
2. As might have been expected, the DoH statisticians noted the rapidly rising number of anaesthesia-related claims for 55054. This led to a ban on the claiming of 55054 in association with anaesthesia services from November 2012. The reason given was that the use of ultrasound by anaesthetists had not been assessed by MSAC for safety, effectiveness and cost-effectiveness. Notably, as far as we are aware, it has never had such an assessment performed for any other specialty either. But the Minister ratified the decision at the time, and our only way forward was an MSAC application for MBS-equivalent items to CV800 and CV805.

And so the MSAC application was made. There is little point going into the details of the three-and-a-half-year application process, but suffice it to say, it took an enormous amount of the EAC's time and effort, and also directly cost the ASA approximately $20,000 (to have Deloitte Access Economics assist us with the economic aspects of the application, which were beyond the skill range of a group of anaesthetists).

FEATURE

SO WHY DID THE MSAC APPLICATION FAIL?

As far as MSAC is concerned, the review of the available evidence showed that ultrasound is safe, and effective at improving the efficacy of procedures and avoiding complications. But because its cost-effectiveness was uncertain, the application was rejected. That is not particularly surprising, given almost all of the literature examines the clinical issues, not economic. What was surprising, and disappointing, was that very little of the critique by Deloitte Access Economics, and their alternative calculations, were taken into consideration.

Furthermore, let us consider some of the statistics and direct quotes from MSAC's final summary, which recommended rejection. The summary is referred to as a Public Summary Document (PSD), and all data and quotes to follow are sourced from this document. It is available at http://bit.ly/1Y3n0v3.

MSAC repeatedly refers to an "assumed patient copayment" of $65.00 for item 55054, when item 55054 did in fact apply to anaesthetists' services (2012). They calculate a total cost per annum here of $4.7 to $7.1 million, and use this in the cost-effectiveness analysis. We have no idea where this figure came from. The government's own statistics at the time showed that the average co-payment for anaesthesia services (where a co-payment in fact existed, which it did not in around 89% of cases) was between $70.00 and $130.00. This figure applied to the whole anaesthesia service, which could have involved four or more MBS items. The ASA has repeatedly queried the source of the data for this 'assumed' $65.00 patient co-payment, but we have been ignored.

MSAC does not support an MBS item for an intervention that is so useful that it is almost becoming standard practice. The PSD states that ultrasound may now represent "best practice care", and so therefore MBS listing is "not necessary", and also that MSAC "does not support a new MBS listing for a procedure which utilises a technique that enhances clinical practice in performing a faster and more reliable procedure". Perhaps we need to present a technique that makes clinical practice *slower* and *less reliable* in order to gain approval?

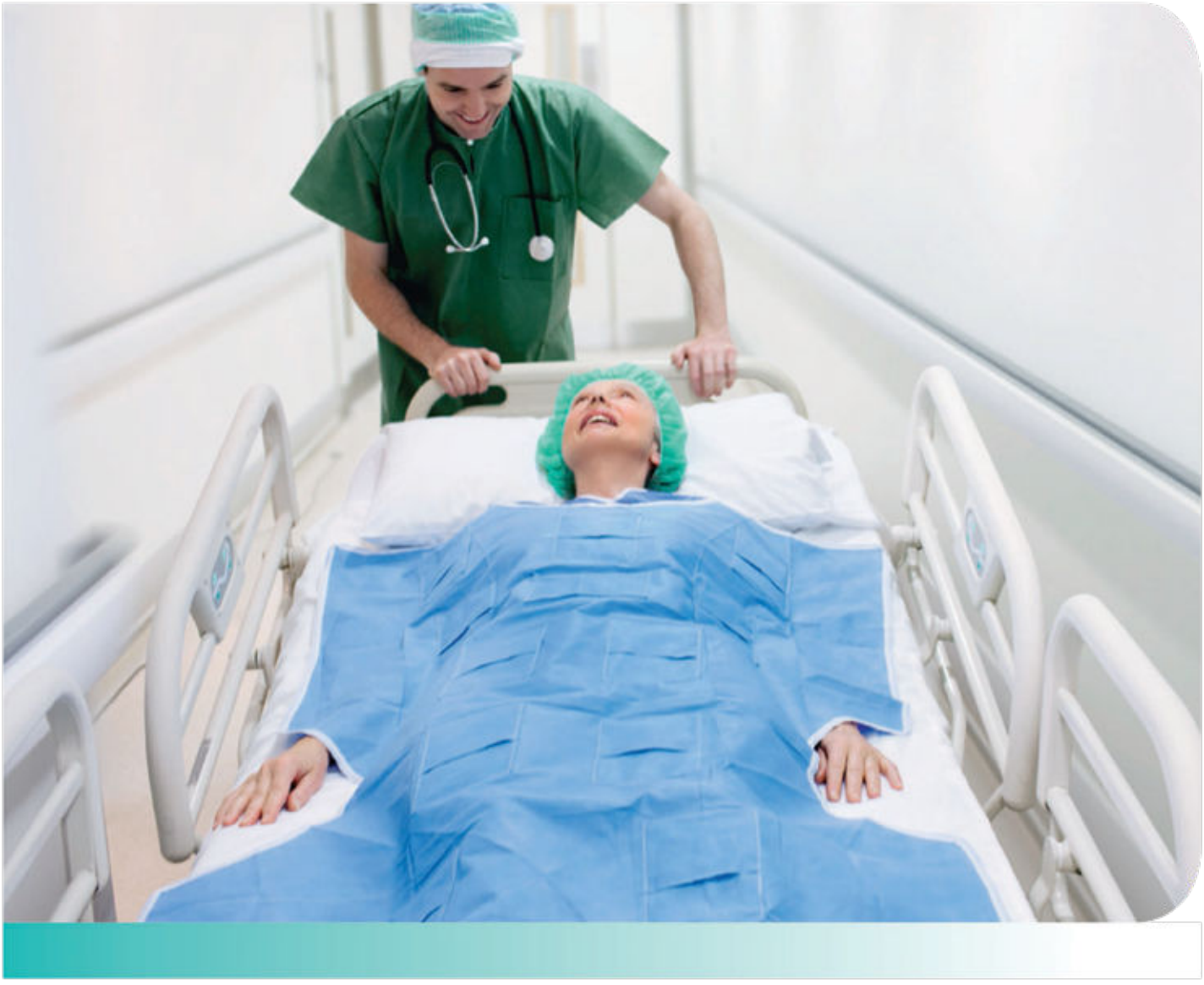
MSAC acknowledges that ultrasound improves efficacy and efficiency, but goes on to state "the efficiency benefits of ultrasound use in anaesthesia accrue overwhelmingly to the anaesthetist in terms of clear time savings and simplification of delivery". Leaving aside the fact that "simplification of delivery" sounds like the statement of a non-clinician, is MSAC seriously arguing that efficiency gains benefit only us? Surely the whole theatre team, and the hospital itself, benefits here?

MSAC is also very concerned that anaesthesia "has very high out-of-pocket costs" and that the MBS listing of ultrasound could "drive an increase to out-of-pocket costs by justifying an additional item on the patient's bill". No figures are presented to support these allegations. No opinion as to what is a "very high" out-of-pocket cost is given (nor for that matter a 'high', 'moderate' or 'low' out-of-pocket cost). The government's own statistics from the Private Health Insurance Administration Council (now merged into the Australian Prudential Regulation Authority) show this set of statements to be grossly erroneous. Where anaesthesia out-of-pockets exist (now in just over 13% of cases), they are, in fact, lower than for most other procedural specialties. There is also absolutely no evidence that new anaesthesia items result in an increase in out-of-pocket patient expenses. In 2006 a range of brand new anaesthesia consultation items were introduced into the MBS. This was the last significant change to anaesthesia MBS items. Since that time, out-of-pocket costs have decreased, not increased.

The EAC has written to the Chair of MSAC, Prof Robyn Ward, to outline these concerns. The MSAC process, at least in regards to the ultrasound application, is clearly deeply flawed. At the time of writing, no reply has been received. The ASA also intends to highlight these concerns when meeting with Minister Ley in the near future. By the time this article is published, the meeting will have already been held. ASA members should check the ASA website and the regular President's enews for updates, or contact the EAC via email at policy@asa.org.au with any queries.

A BRIEF ADDENDUM

The MSAC application for new MBS items to cover all local anaesthetic nerve blocks performed for postoperative analgesia (not just the limited range that are already covered by MBS items 22040 to 22050) is now nearing completion. The Health Technology Assessment expert group examined the issue on behalf of MSAC, and has released its assessment of the clinical and economic evidence. As per ultrasound, the clinical aspects of the application are supported (local anaesthetic nerve blocks are safe and effective), but again the economic evidence is less certain. We are concerned that, unless MSAC reviews its processes and attitudes towards new MBS items, and in particular its penchant to fall back on unsupported anecdotes and personal opinions about the fee-for-service system and the billing practices of anaesthetists, this application will receive the same treatment in its final PSD. The fact that a $53.00 co-payment for existing nerve block items has been included in the economic calculations does not bode well! This time, the ASA has decided not to spend tens of thousands of dollars on an expert economic response to the MSAC paper, given how little impact it had on the ultrasound application.



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FEATURE

THE 'HEALTHIER MEDICARE' INITIATIVE AND MBS REVIEW

In April 2015, Federal Minister for Health, The Hon. Sussan Ley, announced the introduction of the 'Healthier Medicare' initiative. EAC Chair, Dr Mark Sinclair, examines the consequences for anaesthetists.

BACKGROUND

Three areas were listed for consideration:

- The establishment of a Medicare Benefits Schedule (MBS) Review Taskforce.
- The establishment of a Primary Heath Care Advisory Group (PHCAG).
- The development of clearer Medicare compliance rules.

The PHCAG is to be led by Dr Steve Hambleton, Immediate Past President of the AMA (and practising GP). Its task is to "investigate options to provide better care for people with complex and chronic illness, innovative care and funding models, better recognition and treatment of mental health conditions, and greater connection between primary health care and hospital care".

According to the Minister, the aim of the compliance review is "to develop clearer Medicare compliance rules and benchmarks [as there is] a small number (of medical practitioners) who do not do the right thing in their use of Medicare. Their activities have a significant impact on Medicare and may adversely affect the quality of care for patients". ASA members are no doubt aware of the Medicare Compliance Program, which has been in place for several years. Should any member be approached by Medicare regarding compliance concerns, he or she should inform the Society promptly.

However, the major issue to be discussed here is the MBS Review. The role of the Taskforce is to assess all current MBS items (which number over 5,700), as well as the underlying Medicare rules and regulations. The stated aim of the review is to "consider how services can be aligned with contemporary clinical evidence and improve health outcomes for patients".

A number of clinical committees will be formed, with each to review a group of 'related items'. The chair of each committee will be a practising expert in the relevant clinical area. The committee

members will be:

- specialists from the relevant discipline,
- clinicians from related disciplines (e.g. an anaesthesia review committee might have a surgeon as a member),
- experts in evidence evaluation, and
- consumer representatives.

The clinical committees will advise which items are, and are not, in need of more detailed review, those which might need minor amendments, or those which are obsolete. A working group (which will include the chair of the clinical committee) will then focus on these items, with the aim of reporting back to the Minister by the end of 2016.

In July, the Head of the Review Taskforce, Prof Bruce Robinson (Dean of the University of Sydney Medical School and practising gastroenterologist), along with other members, travelled to Canberra, Adelaide and Perth to hold meetings with stakeholders. ASA representatives attended the Canberra and Adelaide meetings. Following these meetings, the current AMA President, Prof Brian Owler, convened a Review Forum at the AMA House in Canberra on 19 August, where Prof Robinson was a speaker. Drs Guy Christie-Taylor, Jim Bradley, ASA Policy Manager Chesney O'Donnell and I attended the forum on behalf of the Society.

Several specialties or groups of services are to be subject to 'priority review', with reports anticipated by the end of 2015. These are:

- diagnostic imaging, in particular, bone densitometry, imaging for deep vein thrombosis and pulmonary embolism, and knee imaging,
- obstetrics (antenatal pathology testing),
- ear, nose and throat surgery (tonsillectomy, adenoidectomy, grommets),
- haematology (blood transfusion, iron studies, coagulation studies),
- thoracic medicine (sleep studies, respiratory function tests),
- upper and lower gastrointestinal endoscopy, and
- the MBS rules and regulations.

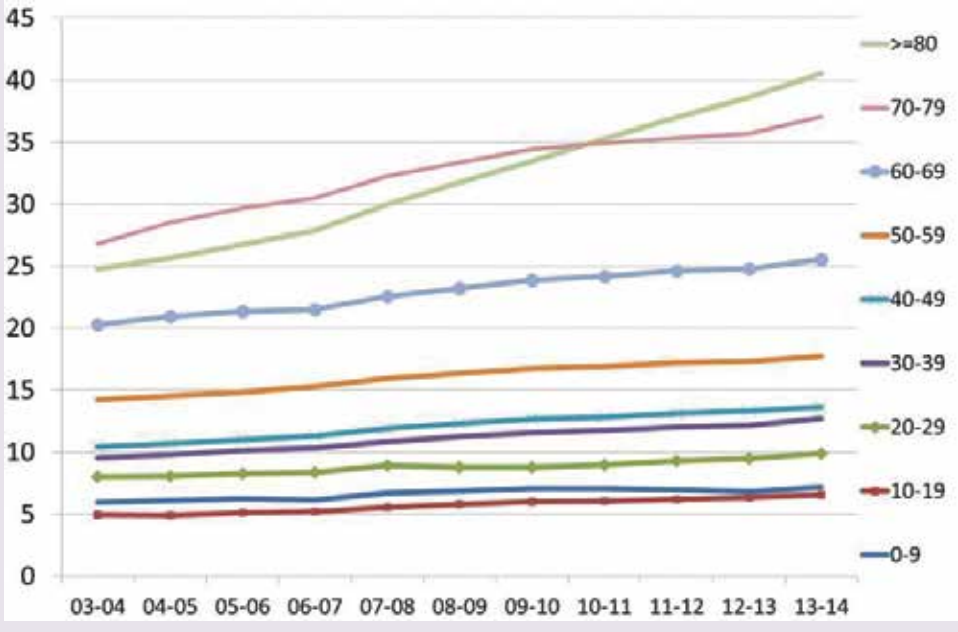

Figure 1: Services per capita by age group, 2003–2004 to 2013–2014. From "Building a Healthier MBS" (presentation to the AMA Forum, Prof Bruce Robinson, 19 August 2015).

Anaesthesia MBS items have not been identified as needing 'priority review' and will therefore not be looked at until March 2016. However, nominations for committee membership were required by the end of September. A number of members of the EAC, PIAC and the ASA Board of Directors have volunteered to participate, and their names have been sent to the Review secretariat. This includes nominees to the 'priority review' committees for obstetrics, ear, nose and throat surgery, gastrointestinal endoscopy, and the MBS rules and regulations. At the time of writing, no reply has been received. Members will be kept up to date via the ASA website and the President's enews.

THE MBS REVIEW: ISSUES TO CONSIDER

The ASA strongly supports the idea of modernisation of the MBS in order to ensure its items, descriptors and explanatory notes accurately reflect modern medical practice. However, like the AMA, the ASA has a number of concerns about the overall aim of the Review, especially given the messages received at the taskforce meetings and AMA Forum, as well as certain statements made by the Minister.

The Minister and Prof Robinson have been at pains to point out that there is no specific cost-saving agenda and have emphasised the fact that no cost-saving target has been set. However, much of the discussion has centred on the steadily accelerating expenditure on Medicare. At the stakeholder meetings, the AMA Forum and in the media, Minister Ley and Prof Robinson have stated that there is an 'estimate' that 30% or more of health expenditure is wasted on services, tests and procedures that provide no or negligible clinical benefit and, in some cases, might be unsafe and could actually cause harm to patients. This figure comes from the US, not Australia. As we all

FEATURE

Table 1: Medicare-funded service statistics

	2014–2015	2004–2005	% change
Australian population	23.95 million	20.18 million	19%
No. of MBS services	368 million	236 million	56%
Benefits paid	$20.19 billion	$9.92 billion	104%*
Benefit paid per patient	$843	$491	72%*

*Not adjusted for inflation

know, the American health system is very different to ours, and our expenditure per capita is about half of that in the States.

The fact that the number of services being received by patients is increasing across all age groups, and that increasing Medicare expenditure cannot be explained just by our ageing population, has also been emphasised (Figure 1). Furthermore, a ministerial press release published in late September, encouraging patients to report any Medicare-funded services they have received and which they considered to be "unnecessary or outdated", also publicised the statistics shown in Table 1. The Minister has also been quoted as saying that any savings realised by the review could be reinvested back into the general budget.

Given these and other statements that have been made, it is difficult to accept that saving money is not a major aim of the review. The fact that we are in the middle of an unprecedented six-year freeze on indexation of Medicare rebates, which will save an estimated $3.5 billion, is clear evidence that cost savings are very high on the government's agenda, regardless of the aims of the MBS review itself. As far as anaesthesia is specifically concerned, the MBS fee is currently 25% of the value of the AMA fee. In 2004/2005 this figure was 29%. The ongoing Medicare freeze means it may fall to below 20% by 2018. There is clearly no need to save money on anaesthesia rebates. Failed indexation is already achieving this goal.

If saving money is not the aim, what is? Until recently this was unclear, with no specific stated direction to the review, nor any quantifiable aims revealed. However, a Government consultation paper, released on 27 September, does give a little more detail. The Review Taskforce proposes that the vision for the MBS be:

> *The Medicare Benefits Schedule provides affordable universal access to best practice health services that represent value for the individual patient and the health system.*

The consultation paper further states:

> *An important objective of the Review will be curbing inefficiency by ensuring that low-value services—that is, services which provide no or negligible clinical benefit and, in some cases, might actually do harm to patients—cease being funded. This will allow Government investment to be directed to more effective, evidence-based services, maximising the quality and value of the health outcomes delivered by existing Medicare funding and improving sustainability, while also allowing the adoption of new health care technologies—some of which are presently not funded through the MBS but which have already been adopted as best practice. A key part of this approach will be ensuring that MBS items are evidence-based, fit-for-purpose and reflect contemporary medical practice. An evidence-based MBS underpins best clinical practice and facilitates better health outcomes for patients.*

This set of statements is most interesting. It was originally stated that the review would not consider the introduction of new MBS items. However, this position has been somewhat modified after feedback from the stakeholder meetings and the AMA Forum. The AMA has strongly argued that the consideration of new MBS items to cover more modern and improved services must be part of the review process. More recent statements from the Taskforce have taken this on board to some extent. The consultation paper states "the Review may well recommend changes to existing items, or the introduction of new items, where these relate to existing services". However, it also further states "the consideration of entirely new services for inclusion on the MBS will be managed, as usual, by the Medical Services Advisory Committee". ASA members are well aware of the time-consuming, burdensome process of applying to MSAC for the introduction of new MBS items. Dr Tim Wong has written a detailed article on MSAC for this edition of *Australian Anaesthetist*.

The idea that "new health care technologies…some of which are presently not funded through the MBS but which have already been adopted as best practice" could be the subject of new MBS items is completely at odds with the attitudes displayed by MSAC. This body has clearly stated, in rejecting the ASA's application for funding for the use of 2D ultrasound, that ultrasound may now represent "best practice care" and that therefore, MBS listing is "not necessary", and furthermore, that "MSAC does not support a new MBS listing for a procedure which utilises a technique that enhances clinical practice in performing a faster and more reliable procedure". How a government body that expresses such opinions can successfully take part in "modernising" the MBS and "allowing the adoption of new health care technologies" very much remains to be seen. The AMA has firmly stated, and the ASA agrees, that there must be a capacity to include new items on the MBS, via a

process that does not involve a full MSAC assessment.

While the overall aims of the review may not be entirely clear, there is one specific aim that has been clearly stated, namely, to change the situation where multiple item numbers apply to a single episode of care. The consultation paper states:

> *One of the issues already identified by stakeholders is the growing use of multiple items for one episode of care provided on the same day by one practitioner…It may be useful to consider introducing bundled payments for some specialist services, where care continues over a discrete period of time.*

There has been no attempt made in the consultation paper to explain how 'bundling' MBS items will improve patient outcomes. However, it will almost certainly reduce Medicare expenditure. Anaesthesia services frequently involve the use of multiple items (patient and emergency modifiers, diagnostic and therapeutic services provided in association with anaesthesia). These items are an essential feature of the RVG in its aim to calculate a relative value for each individual clinical scenario, and multiple items are only applied in appropriate clinical circumstances.

ASA members are well aware of the time-consuming, burdensome process of applying to MSAC

The application of multiple RVG items is not a matter of routine, as it may be for certain surgical services (e.g. operative cholangiography in association with cholecystectomy). It is also of note, and of concern, that MSAC too has a strong anti-multiple-item agenda. Again, this can be seen in their rejection of the ultrasound application. In their summary document, MSAC states that it will not support additional MBS items for procedures performed "at the same time" as another, and that an item is not justified for a service which will "be adopted irrespective of MBS funding".

There are also concerns regarding the structure and function of the clinical committees. At the time of writing, the policy is that medical colleges, societies and associations will not be allowed specific representation. Rather, committee members will be expected to 'confer' with their colleagues as required. In its communications with the Minister, the AMA has strongly argued for direct representation of these bodies on the clinical committees, given such representatives would certainly be experts in the relevant field(s).

The ASA cannot accept a reintroduction of funding arrangements from the mid-20th century

The clinical committees will deliberately be comprised of less than 50% members of the relevant discipline, and decisions will be made using a 60% or greater majority of the group – consensus will not be required (although dissenting opinions will be minuted). There is of course a need to minimise conflicts of interest, but this arrangement means that experts in the relevant field will be in the minority on the committees. It is therefore possible that inappropriate or incorrect recommendations will be made. The AMA has also raised this issue directly with the Minister.

The final, significant concern of the ASA relates to another statement in the government's consultation paper. The paper states that there is a need to review various rules and regulations underpinning Medicare. According to the paper, there may be a need to review the "arrangements of payment of MBS benefits for an assistant or anaesthetist at surgery". The AMA has already expressed significant concern regarding alteration of MBS funding arrangements for surgical assistants. This funding is an essential component of surgical training, as such training commonly occurs in a private setting.

However, the suggestion that funding arrangements for anaesthesia need to be reviewed is of extreme concern. Such a statement can only come from someone who is ignorant of the role and responsibility of anaesthetists or, even more concerning, from someone who is disrespectful of our professional standing. Given anaesthetists are highly qualified specialists with independent responsibility for patient care and outcomes, our billing of private patients, and the applicable Medicare rebates, must be kept separate. The RVG for anaesthesia must continue to be used as the basis for fees and rebates. This also applies to the services of GP anaesthetists, who must undergo specialised training and adhere to CPD requirements in order to provide anaesthesia services. The ASA cannot accept a reintroduction of funding arrangements from the mid-20th century, when a surgeon would collect a 'bundled' fee and distribute a small amount of this to the assistant and the anaesthetist, the latter then sometimes being a GP or surgical trainee, rather than a fully qualified specialist or appropriately trained GP anaesthetist.

It is inconceivable that any alteration of current funding arrangements could improve patient outcomes (with Australian anaesthetists already providing a standard of care equal to or better than anywhere else in the world). Such an alteration could only possibly be motivated by cost savings.

CONCLUSIONS

The ASA supports the concept of a review of Medicare. Many items have been in the MBS for decades and many may be outmoded or outdated. There are also significant numbers of modern, high-quality, and medically necessary investigative and therapeutic services which are not represented in the MBS.

However, statements along the lines that only 3% of MBS items have appropriate evidence to back them (which has led the Minister to assert that 97% do not have any such evidence) are misleading and inappropriate. Many highly safe and effective treatments do not have high-level evidence behind them, and probably never will, but this does not mean they should be removed from Medicare. For example, as we are all aware, there is no evidence that anaesthesia improves patient outcomes. There is no realistic way of obtaining such evidence, unless the Minister, the Taskforce and MSAC would care to assist us in designing a randomised controlled trial, and to call for volunteers for such a trial, comparing surgical patient outcomes with and without anaesthesia.

The ASA will not support the review if the evidence points towards a primary aim of cutting costs. Members will be aware that the AMA is already losing confidence in the review's processes. The ASA supports the AMA in its statements that the review must be clinician-led, and aimed at supporting patient care. Therefore, the review must, as the AMA has stated, have a clear and overarching vision, specific and quantifiable aims, and must have direct involvement of the specialist colleges, societies and associations. New items must be able to be added to the MBS, without the cumbersome and expensive full MSAC process, especially given the ASA's concerns about the agendas of MSAC, as previously discussed.

As far as anaesthesia is specifically concerned, the RVG must be maintained as the method for calculating anaesthesia rebates. It is a robust schedule, which allocates relative values for anaesthesia services perfectly appropriately, based on surgical, patient and anaesthesia factors.

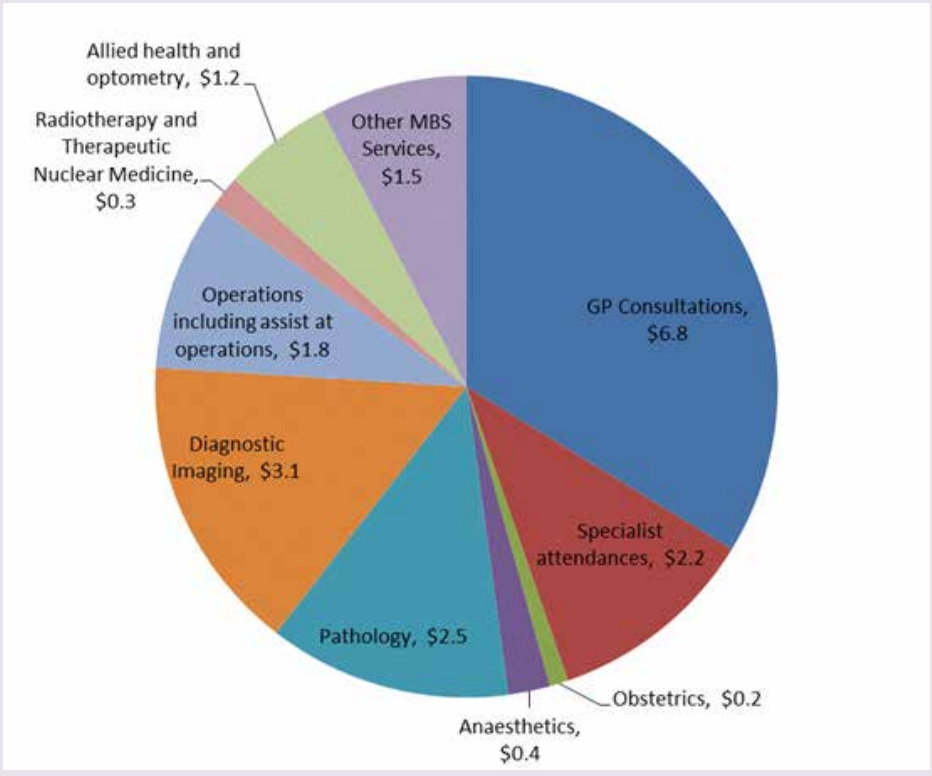

Figure 2: Medicare Expenditure by Specialty 2014 to 2015 ($ billion). From MBS Review Consultation Paper.

Individual payers, such as Medicare, can determine the rebate they wish to pay per RVG unit. However, non-clinicians, and non-anaesthetist clinicians, do not have the knowledge to alter the structure, items and relativities of the RVG. Any concerns about the RVG, if such concerns even exist, must always be handled by the ASA.

The Australian taxpayer already receives excellent value for its investment in anaesthesia services via the Medicare system, given the world-class standard of care provided, combined with the woefully inadequate level of the Medicare rebate. This has been exacerbated by the inadequate (and now frozen) indexations of rebates over many years. The Taskforce's proposed vision for Medicare, that it provide "affordable" universal access, has already been achieved, as failure of indexation essentially makes each service more and more affordable year by year. And, as discussed, anaesthetists have already achieved the proposed vision of "best practice health services". There is no cause for concern about the quality of anaesthesia services, and certainly no concern regarding the costs. The government's own statistics show that our services cost Medicare approximately a quarter of the expenditure on surgical services, which are after all provided by practitioners with the same level of qualifications as ours (Figure 2).

However, the ASA always remains prepared to enter into dialogue and processes aimed at ensuring Medicare funding is appropriately directed to services of proven quality, with the goal of wise spending of taxpayers' funds, and best possible patient outcomes for the money spent.

FEATURE

HEALTH INSURERS & THEIR CONTRIBUTION TOWARDS THE ANAESTHETIC FEE

The remuneration of Australian anaesthetists in private practice was historically subject to the whims of the surgeons they worked for (note 'for' not 'with'), writes New South Wales EAC Representative, Dr Callum Gilchrist.

Patients paid one single fee to the surgeon, who then doled out a bit to their anaesthetist (appalling!). When anaesthesia rebates were (finally) introduced, the account included the surgical item number and Medicare allocated a number of units to the anaesthetic. The actual number of units depended on Medicare's assessment of the value of the service and the average time taken for the operation. Factors such as patient age and medical status, the actual time taken, or emergency situations, were deemed irrelevant. It is only since November 2001, and due to the work of the ASA, that anaesthetic fees are now based on the Relative Value Guide (RVG), which clearly represents a vastly improved method of calculating anaesthesia fees and rebates. This improvement more than justifies your annual ASA fee and that of your colleagues (membership plug!). Even now, Medicare expenditure on surgical services is approximately quadruple what is spent on anaesthesia, reflecting the historical nature of the anaesthetic fee being a mere fraction of the surgical fee, so there remains work to be done. I am lucky enough to have as fellow EAC members some of those responsible for the introduction of the ASA's RVG into Australian practice, and we on the EAC are privileged when they share their knowledge of health economics and the evolution of our current method of deriving an anaesthetic account.

Private patients make up 80% of private hospital admissions, whilst 60% of acute and 40% of elective surgery occurs in private hospitals (approximate figures, April 2015[1]). In June 2015, 47% of the population has private health insurance with hospital cover. Private health insurers spent a little over $13 billion on hospital treatment during the 2014 to 2015 financial year. Of the $3.4 billion spent in the June 2015 quarter on hospital treatment, only $538 million was spent on medical fees (15.6%), compared to $2.4 billion on hospital costs

FEATURE

(69.7%), so medical fees are not a major influence. Funds themselves made over $1.4 billion profit. Dealing with patients in the private sector having different types of insurance coverage is a fact of life for most anaesthetists. Having an appreciation of the size of the private health insurance industry, in addition to an understanding of what they offer anaesthetists, will hopefully assist each anaesthetist in their daily practice.

CORE KNOWLEDGE

For Medicare-eligible patients, the federal government will provide a rebate to the patient equal to 75% of the Medicare Benefits Schedule (MBS) fee for inpatient services ($14.85 per RVG unit). All Australian private health insurers are obliged to top-up this patient rebate with 25% of the MBS fee ($4.95 per RVG unit). This means the minimum combined Medicare and health-fund rebate an Australian Medicare-eligible insured patient can expect to receive is 100% of the MBS fee ($19.80 per RVG unit). Any extra health fund contribution which brings the total rebate to more than 100% of the MBS fee is at the discretion of the insurer, which means they can impose terms and conditions on these extra payments as they see fit. Each anaesthetist is required to register with the funds to be eligible to issue accounts utilising these above-MBS fee rebates. All Australian health insurers offer above-MBS fee rebates, and learning the specific conditions they impose can assist each anaesthetist to ensure that the fund contributes the maximum possible amount to the anaesthetic fee, thereby minimising out-of-pocket costs to the patient. Members should remember the importance in maintaining financial independence when setting their fees, both individually and for the specialty and profession as a whole.

Health insurance policies offering above-MBS rebates available to Medicare-eligible Australians can be broadly described as offering 'known-gap' and 'no-gap' products.

Known-gap products are far superior, offering above-MBS rebates, yet still permitting a co-payment or 'known-gap' to be charged to the patient. This means that, for a given fee, the out-of-pocket cost or 'gap' to the patient is reduced, provided the terms and conditions of the policy are met. The primary condition of relevance for these products is the maximum size of the co-payment permitted.

No-gap products insist that the monies paid to the anaesthetist for a given service represent the total fee payable. Any deviation from this fee means the patient is ineligible for the no-gap product and is only entitled to receive 25% of the MBS fee from the insurer.

The last two years have seen a shift in the health insurance landscape. Now that Bupa and HCF have switched, most Australians are covered by known-gap products. Members of a fund that only offers a no-gap product (e.g. NIB) will always face increased out-of-pocket expenses if the anaesthetist charges any fee that exceeds the no-gap total rebate, when compared to any of the known-gap products (provided the conditions of a known-gap policy are met).

Salaried anaesthetists in public hospitals are penalised by some of the funds. These anaesthetists are restricted from charging patients any out-of-pocket expenses, and some funds refuse to pay more than MBS rates for services performed.

The ideal insurance product

- Known-gap,
- All policies within a given fund are eligible for above-MBS fee rebates,
- No onerous conditions placed on an anaesthetist to enable participation,
- Anaesthetists can choose to opt in or out on a patient-by-patient basis,
- No conditions are placed on the size of the patient co-payment for the patient to remain eligible for above-MBS fee rebates,
- Fund contribution covers up to and including the AMA fee,
- Annual indexation of both fund contribution and the maximum patient co-payment (if a maximum is specified – ideal = no limit) with indexation being identical to that of the AMA fee,
- Consistent unit values are evident in the schedule of benefits, and
- Public hospital practitioners are not penalised.

FUND SPECIFICS

Utilise this knowledge to minimise patient gaps for a given fee

With approximately 20,000 private health insurance products on offer in Australia, I admit that I do not know the details of each and every one of them. There are lesser-known or accessible products that offer excellent rebates and have proportional premiums. As such, what follows is a description of the common and easily accessible insurance products of which I am aware. I welcome any feedback, and would be most interested to receive information about any product that I have omitted.

Doctors' Health Fund (DHF)

- The *Top Cover* product is simply outstanding and deserves special mention. It makes no demands of the provider, simply agreeing to cover the AMA fee for any procedure. By paying a premium 35% higher than their AHSA Access Gap Cover–eligible product (*Prime Choice*), the member reaps a massive 235% increased contribution, up to the AMA fee (i.e. the combined Medicare and fund contribution increases from $34.41* to $81.00 per RVG unit). By covering up to the AMA fee, and through having nil restrictive terms or conditions on eligibility for this benefit, the DHF's *Top Cover* product stands out when compared to every other fund detailed in this article.
- DHF is owned by Avant (a medical indemnity provider) and a small reduction in your medical indemnity premium is available to those anaesthetists who are members of both organisations.

AHSA funds

This category includes CBHS, Navy Health, Westfund, Defence Health, rt health fund; see www.ahsa.com.au.

- Known-gap product called *Access Gap Cover* (one policy each with Australian Unity Health Limited and Transport Health are not known-gap policies), which provides a total rebate of $34.41* per RVG unit. When in doubt, you can contact the individual fund involved to confirm patient eligibility for an *Access Gap Cover* account.
- Maximum patient co-payment of $400 per item number, but the total must not exceed the AMA fee for that item. In addition, for items where there is no direct AMA equivalent (e.g. 17610, 17680, 598 and 600), the maximum co-payment for each item number is $400.
- It is not commonly appreciated by anaesthetists, nor by billing services, that it is frequently possible for an account based on the AMA fee of $81 per RVG unit to be eligible for the *Access Gap Cover* scheme, potentially saving patients a considerable amount if such a fee were to be charged.
- Requires written informed financial consent and indication on the account that this has been achieved.
- No other fees may be charged in relation to a hospital inpatient service if you issue an *Access Gap Cover* account for your services to a patient.
- Salaried doctors at public hospitals are only eligible for MBS fee rebates.

BUPA

- Known-gap product, with a maximum patient co-payment of $500 per doctor per episode of care to be eligible for the known-gap rebates of $33.91* per RVG unit.
- Informed financial consent must be obtained "at the first consultation leading to the episode of care" (does not specify whether it must be written).
- No other out-of-pocket fees beyond the $500 known gap may be charged in relation to an admitted episode of care if you issue a *Medical Gap Scheme* account for your services to a patient.
- The EAC's Chair, Dr Mark Sinclair, was influential in ensuring that this known-gap product was available to anaesthetists on a patient-by-patient basis.
- Salaried doctors at public hospitals are only eligible for MBS fee rebates, and medical perfusionists can only claim above-MBS rebates if a clinical perfusionist is not in attendance.

HCF

- Known-gap accounts can include a maximum patient co-payment of $500 per hospital admission.
- Different schedule of benefits for the no-gap versus known-gap *Medicover* arrangements (e.g. 25000 paid at $34.70 versus $33.50, respectively). There are a small number of item numbers where the schedule of benefits for the no-gap product is significantly increased (approximately $41.60 per RVG unit) compared to the known-gap product.
- No other out-of-pocket fees beyond the $500 known gap may be charged for professional services rendered during a hospital admission if you issue a *Medicover Known Gap* account for your services to a patient. For those anaesthetists who have registered for the *Medicover No Gap* scheme, then this amount is zero.
- Use of the *Medicover Known Gap* product requires obtaining informed financial consent (whether it is written or not is not specified).

Medibank Private and AHM

- AHM was taken over by Medibank Private in 2011, and both now offer a known-gap product called *GapCover* which offers a total rebate of $32.70 per RVG unit.
- There is a maximum patient co-payment of $500 per doctor per episode of care to be eligible for the known-gap rebates.
- Not all policies are eligible for *GapCover* benefits – when in doubt, contact the fund to confirm eligibility, as only MBS fee rebates may be possible.
- Written informed financial consent is required, indicating any out-of-pocket costs the patient will face.
- Salaried doctors at public hospitals are only eligible for MBS fee rebates.
- Medibank Private recently came under criticism for the managed-care style private hospital contract changes they tried to introduce. These events should serve to remind every anaesthetist that maintaining independence in setting your own fees has importance and potentially larger ramifications if sacrificed. The EAC is scheduled to meet with Medibank in the near future.

St Luke's

- Known-gap product called *St Luke's Gap Cover,* which allows opt in/out on a patient-by-patient basis
- Patient co-payment for each item number must be no more than 10% of the rebate as listed in the *St Luke's Gap Cover* Schedule of Fees (e.g. 25000 pays $34.10 and the maximum patient co-payment for this item number is $3.41, meaning the maximum allowable fee to retain eligibility for the above-MBS fee rebates for 25000 is $37.51).
- Written informed financial consent is required beforehand, except in emergencies where it is required to be obtained as soon as is practicable after treatment has been provided.
- No other fees can be levied to the patient.

NIB

- No known-gap arrangement – of note, of those funds featured in this article, NIB is the only remaining 'no-gap only' insurer.
- *MediGap* permits services rendered in public hospitals by VMOs to private patients to be remunerated at the no-gap rate ($31.50 per RVG unit), whilst salaried staff specialists are only eligible for SF rebates ($19.80 per RVG unit).

FEATURE

- Auditing of your billing under the *MediGap* scheme, whereby the anaesthetist must comply within five business days whilst covering their own costs of such an audit, are requirements when using this product. These conditions are an improvement on previous conditions, and this is largely due to the efforts of Dr Mark Sinclair.
- No other fees may be charged in relation to a hospital inpatient service if you issue a *MediGap* account for your services to a patient.

HBF

- HBF's *Medical Gap* scheme has undergone some major changes since July this year. Previously, there was a difference in the products offered to Western Australian versus non–Western Australian anaesthetists. This has changed and there is now a national scheme that offers anaesthetists two choices:
  - o No-gap all HBF patients and receive $38.30 per RVG unit, with no ability to opt in/out on an individual patient basis.
  - o Receive $29.85 per RVG unit with the ability to opt in/out on an individual patient basis. This option is a known-gap scheme, but the co-payment is limited to ~10% of the *Medical Gap* scheme rebate (e.g. for 23010 the rebate is $29.85, and the scheme allows a maximum of $32.85 to be charged, whilst for 17610 the rebate is $64.85 and the scheme allows a maximum of $71.35 to be charged). If the co-payment exceeds this ~10% of the scheme's rebate, then the patient is only eligible for MBS fee rebates. This means the maximum unit value possible, whilst remaining eligible for above-MBS fee rebates, even with the patient contributing the maximum possible co-payment, is less than the unit value rebated in the AHSA, Bupa and HCF above-MBS fee rebate schemes. This is true even when no co-payment is charged.
  - o For both choices, no other fees of any description are permitted.
  - o This requires informed financial consent and indication on the account that this has been achieved.
- HBF's *Medical Gap* scheme specifies a 'Limited Surgical Items List'. Any anaesthetic service associated with surgical item numbers on this list may not be eligible for the *Medical Gap* scheme – the surgeon needs to seek approval on a case-by-case basis.
- Any service provided to a private patient in a public hospital only attracts the MBS fee in total – 'no gapping' is not possible, regardless of VMO or staff specialist status.

GMHBA

- Known-gap product with two benefit levels on offer:
  - o Approximately 90% of members are eligible for contributions valued at 120% of the MBS fee (e.g. 25000 paid at $23.80). This means that 'no gapping' remunerates only slightly better than the MBS fee, possibly increasing the likelihood of significant patient co-payments.
  - o Their premium product, referred to as *Gap Saver Cover*, offers rebates based on the AHSA schedule (e.g. 25000 currently paid at *$34.80). Previously, this was referred to as their 'Platinum' product.
- There are no conditions on the size of the co-payment for the patient to remain eligible for the above-MBS fee rebates.
- Written informed financial consent is a requirement of the fund to utilise any above-MBS fee rebates.
- Not knowing which type of policy the member holds makes providing informed financial consent difficult. Calling the provider enquiry telephone number (1300 301 437) is the best way for this to be quickly checked.
- GMHBA is also the company behind Budget Direct Health Insurance, Frank Health Insurance and RACT Health Insurance, which have similar offerings to GMHBA (e.g. Frank Health Insurance has a *More Gap Cover* option which rebates at the same levels as the *Gap Saver Cover* GMHBA product, whilst any work performed in public hospitals is only eligible for MBS rebates).

Mildura District Hospital Fund (MDHF)

- This is a known-gap product where patients can be eligible for rebates equaling, at most, 120% of the MBS fee (e.g. maximum rebate of $23.80 for 25000). This means that 'no gapping' remunerates only slightly better than the MBS fee, possibly increasing the likelihood of significant patient co-payments.
- There are no conditions on the size of the patient co-payment for the patient to remain eligible for the above-MBS fee rebate.
- Informed financial request is required for above-MBS fee rebates.
- Public hospital work provided by both salaried and VMO anaesthetists is eligible for the 120% MBS fee rebate.

*averaged value across Australia.

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BREAKDOWN OF AUSTRALIAN PRIVATE HEALTH INSURERS

Fund specifics:	DHF - Top Cover	DHF Prime Choice, Smart Saver	AHSA - Aust Unity, Transport Health	AHSA - all other funds	Bupa	HCF - KG	HCF - NG	MBP/AHM	St Luke's	NIB	HBF - KG	HBF - NG	GMHBA Gap Cover Saver	GMHBA all other hospital cover	MDHF
Known gap or no Gap only	KG	KG	KG	KG	KG	KG	NG	KG	KG	NG	KG	NG	KG	KG	KG
All policies with hospital cover are eligible for above-MBS fee rebates	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Onerous conditions placed on anaesthetist to participate	No	No	No	No	No	No	No	No	No	Yes	No	No	No	No	No
Opt in/out on patient-by-patient basis permitted	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
IFC required, and form if specified		Yes – written + specified on account	Yes – written + specified on account	Yes – written + specified on account	Yes	Yes	N/A	Yes – written	Yes – written	N/A	Yes + specified on account	N/A	Yes – written	Yes – written	Yes
Conditions on size of co-payment to remain eligible for above-MBS fee rebates	No	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	N/A	Yes	N/A	No	No	No
Unit value of rebate presuming eligible	$81.00	$34.41*	$34.41*	$34.41*	$33.91*	$33.50	$34.70	$32.70	$34.10	$31.50	$29.85	$38.30	$34.80	$23.80	$23.80
Other miscellaneous fees permitted	N/A	No	No	No	No	No	No	No	No	No	No	No	N/A	N/A	N/A
Miscellaneous specifics	Members of Avant get discount				Perfusionist face restrictions			Recent controversial hospital negotiations			Case-by-case approval for >MBS rebates†	Case-by-case approval for >MBS rebates†	~10% of members	~90% of members	
Public hospital restrictions – VMO vs salaried/SS		Yes for SS	Yes for SS	Yes for SS	Yes for SS			Yes for SS		Yes for SS	Yes for both VMO + SS	Yes for both VMO + SS			No

Left blank if no specific mention was made. †For surgeries involving 'Limited Surgical Items List'. *=averaged value across Australia, NG=no-gap, KG=known-gap, IFC=informed financial consent, SS=staff specialist.

FEATURE

NEVER EVENTS

The concept of 'never events' has created much controversy this year, as health insurers seek ways to reduce their costs and communities look for someone to blame when complications occur. In an era of increasing cost-containment and accountability, this may not be surprising. Quality improvement requires a positive reporting culture and cooperative analysis rather than cost-shifting and blaming. PIAC Chair, Dr Antonio Grossi, looks more closely at this issue.

There was once a time when a patient would cross out undesired complications on a consent form with a red Texta before signing. The 'never events' story bears some similarities.

The term 'never events' was originally coined in 2001 by Ken Kizer MD, the then CEO of the National Quality Forum (NQF) in the US, to describe the serious nature of certain adverse events[1]. Public accountability requires that certain serious events should be reported in a standardised fashion and investigated to identify systemic preventable factors. The NQF uses the more appropriate term 'serious reportable events' (SREs) which meet the criteria of being clearly measurable and identifiable, indicative of system failures and of concern to the public and healthcare providers[1]. In the US in 2008, the concept of linking a financial penalty to the healthcare facility where the SRE occurred was introduced as an incentive to avoid these complications.

In the UK the 'Never Events Policy and Framework'[2] has been introduced to protect patients from avoidable harm. The stated intention is to promote a blame-free culture of quality improvement. These events are defined as 'wholly preventable', 'have the potential to cause serious patient harm or death', 'may recur', and are 'easily recognised'[2]. Through extensive consultation, the revised list of never events includes wrong-site surgery, wrong-implant prosthesis, retained foreign object post-procedure, wrong route of administration of medication, and transfusion or transplantation of ABO incompatible blood components or organs. Other events, such as maternal death due to postpartum haemorrhage

and opioid overdose in an opioid naïve patient, have been removed.

The NHS maintains that it ought not pay for 'poor-quality' healthcare. Therefore, there is a financial penalty to organisations reporting never events. Duckett[3] argues this should be applied in Australia. Harrop-Griffiths[4] argues that this dichotomy is at the heart of the problem. There cannot be a blame-free culture when individuals and organisations are sanctioned when adverse events are reported. The term 'never events' carries significant negative connotations.

Public accountability requires that certain serious events should be reported in a standardised fashion and investigated to identify systemic preventable factors.

This year in Australia, health insurance companies have devised their own lists of adverse events and complications which would attract financial penalties[5]. The evidence to support these decisions has been less than forthcoming.

The quality and safety literature recognises that healthcare involves complex adaptive systems[6] interacting with human factors. Promoting an open culture of reporting, followed by a process of 'Open Candour'[7] and root cause analysis to identify system errors will lead to increased safety.

> *We cannot change the human condition, but we can change the conditions under which humans work.*
> James Reason[8].

In Australia, the states have mechanisms such as the 'Sentinel Event Program' (Victoria)[9] for reporting and managing serious events that are infrequent, independent of the patient's condition, usually involve some major system deficiencies and may have resulted in an adverse event. System problems contributing to poor outcomes include time pressure, inappropriate workload, fatigue, lack of leadership, poor communication, teamwork deficiencies, unsuitable equipment, facilities, procedures, protocols and policy[8]. Perversely, the threat of sanctions may alter the behaviour of healthcare facilities and practitioners in ways which may not be in the patient's best interests.

Sometimes complications arise despite the appropriate provision of care. Applying financial sanctions is cost-shifting, not quality improvement. Instead of a diffusion of responsibility, what is required is true leadership. This includes working together as functional teams to address system problems and foster a culture of quality improvement.

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FEATURE

COLLABORATE TO DE-SILO HEALTHCARE PROCESSES

Adelaide anaesthetist and Managing Director of Perioperative Solutions, Dr Douglas Fahlbusch, highlights the importance of feedback to improving healthcare processes. This is the latest contribution to an ongoing dialogue about better healthcare delivery published across several issues of *Australian Anaesthetist*.

Feedback is important for healthcare improvement, helping to reduce risk and cost. It also adds to a health carer's work satisfaction, and a patient's involvement. with their treatment. Can we institute feedback and combine regulatory, professional and personal requirements in an increasingly complex healthcare system? Perioperative Solutions is trialling a semi-automated CPD compliant follow-up system and applying for medical idemnifier premium reduction with its use.

The idea comes from *The Checklist Manifesto* (2011), by surgeon Atul Gawande[1], who compares complex systems such as healthcare and large-scale construction. Both utilise teams of experts and encounter competing regulatory requirements. Successful completion of projects in construction can only occur when the teams of explorers interact frequently. Compare this with the 'lone expert' model of healthcare delivery, which is individually efficient and collectively inefficient.

Dr Drew Wenck[2] raised the inherent tension between healthcare operations and accreditation in the April issue of *Australian Anaesthetist*, which generated discussion between the Australian Council on Healthcare Standards, the Australian Commission on Safety and Quality in Health Care and others in the August issue. In the same edition, a number of generic steps that are useful in improving healthcare processes were identified[3]. In order to help reconcile the competing demands of patients, healthcare workers, healthcare facilities and accreditation bodies, I believe we must address the following concerns.

1. PATIENT PREFERENCES

Patients desire more input in their healthcare. Providing an opportunity for feedback is an important part of their involvement. The high use of mobile devices in Australia enables automation of inclusive processes such as postoperative surveys:

- 92% of Australians use the internet[4].
- 55% of all adults use a tablet to access the internet, 81% on a daily basis[5].
- Significantly, of adults over 65, 68% use the internet and 28% use their phone to do this[4].
- Ownership of mobile phones and use of SMS is very high. Unlike email, SMS has a high response rate due to the perceived personalised nature of the medium[6], enabling a direct and rapid connection between the patient and healthcare facility and/or clinician.

2. STAFF PRIORITIES

Time is a frequent barrier to systematic patient follow-up. However, patient follow-up is a standardised process with 'known' patients – patient details are already 'in the system' which can be triggered to send out messages at predefined postoperative intervals. Thus, no extra demand need be placed on staff time.

3. CLINICIAN PRIORITIES

Clinician perceptions and requirements can often differ from externally prescribed requirements[1]. Happily, automation can be used to satisfy both sets of criteria without increasing administrative burden. What is initially perceived as 'yet another external requirement' can be recast as an opportunity to obtain better engagement from hospitals with clinicians, staff and patients by better understanding their needs.

Automation could provide raw data for a clinician to use for continuing professional development and medical education. For example, diagnostic set and patient follow-up data which could be used by a clinician for practice review/auditing requirements, as recommended by the Medical Board of Australia, the Australian Health Practitioner Regulation Agency and the colleges, and by medical indemnifiers. Indemnifier criteria for premium discounts could be met in this way.

4. INTERNAL PROCESSES

It is a mistake to insert a new process without considering the pros and cons compared to existing infrastructure. Establishing a new process provides an opportunity to review, optimise and reduce the complexity of existing processes. The Institute of Healthcare Improvement (IHI) framework for clinical process redesign is outlined below.

5. CLINICAL QUALITY GOALS

As already noted, hospital quality goals can be satisfied in combination with patient, staff and clinician quality goals in order to benefit all parties.

6. REGULATORY REPORTING

Seeing regulatory reporting as an opportunity to simultaneously satisfy other requirements reduces the associated burden. Automating the process provides objectivity and transparency. Self-reporting

THE IHI FRAMEWORK[7]

When redesigning processes, in this case postoperative feedback/follow-up, we have considered team members above. The flow of work is examined using the IHI framework:

1. Identify a care segment that has opportunities for improvement. Care segments such as postoperative follow-up are ideal for this type of process mapping and redesign, as they can have a high apparent consumption of resources such as labour and time due to perceived competing needs that, on closer inspection, have more in common than realised.

2. Develop a first draft of a care-segment process map by interviewing people involved in the process: clinicians, nursing staff and administrators.

Understanding current processes and desired outcomes is essential. A bipartisan supervisor, coach or quality improvement representative will help facilitate the conversation. It is best to prepare the interviewees with a list of 'Frequently Asked Questions' to help speed the process.

3. Pen and paper versus electronic. The first stage – recording the components of the process to be mapped and improved is more easily done on paper that can be physically manipulated on a pin-board to create a new workflow with new or altered components. Once a likely workflow is created, an electronic medium is recommended for team-dissemination and feedback.

4. Observe the care segment twice to validate the process map. Observing the process in real-time and considering proposed changes will reveal unexpected improvements and obstacles.

5. Close the loop with the experts after the observation. Once the process maps are completed and the care segment observed, it is essential to share findings with the people involved. This highlights opportunities for improvement, and identifies non-value-added processes. It also identifies gaps in processes that are believed to occur all the time, when there may be barriers that lead to these processes only occurring 30% to 50% of the time.

FEATURE

risks editing of results. Nonetheless, it is important for clinicians to retain input into the process, as not all patient groups or practices are equal.

7. BUSINESS GOALS

Retaining patients and referring practitioners is of paramount importance to the success of a clinical practice and healthcare facility. Good clinical practice is the cornerstone of this. Routine postoperative surveillance is key to continuous practice improvement, improving clinical care, reducing cost and securing future patient referrals.

8. INFORMATION TECHNOLOGY CAPABILITIES.

Establishing new IT capability provides an opportunity to review and optimise existing IT infrastructure – it is ill-advised to adopt a new capability without considering the impact upon existing infrastructure. Fortunately, the requirements for messaging patients and storing survey responses mirror, and are usually met with, existing infrastructure.

By way of example, we trialled a semi-automated text message follow-up system over the last 12 months that covered 1,064 serial patients, 850 (80%) with mobile phones, 354 of whom (41%) responded. The average rating was 9.3/10. This response rate is far higher than traditional paper surveys, and far cheaper and less time-consuming than a telephone survey.

A FINAL CONSIDERATION

In designing a postoperative/post-anaesthesia follow-up system, one must be cognisant of the criteria of the Therapeutic Goods Administration regarding medical devices.

A snapshot of recovery at a point in time does not meet these criteria. If the progress of recovery after surgery and/or anaesthesia was recorded, this would likely meet the criteria for 'Therapeutic and Diagnostic Functions' and an application for registration as a 'therapeutic good' by the Administration may be required[8].

Feedback is important for healthcare improvement, and it adds to health-carers' and patients' involvement and satisfaction. Borrowing from other complex systems demonstrates ways to cut through increasing complexity with expert teams that place people at the centre of the process. Improved engagement with the process reduces risk and cost through fewer errors, less rework, lower staff turnover, less retraining and improved patient (customer) retention and referrals.

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FEATURE

THE ANAESTHESIA WORK-FORCE: WHERE NOW?

The August 2015 issue of *Australian Anaesthetist* (pages 12-16) offered a 'snapshot' of the anaesthesia workforce, writes Specialty Affairs Advisor, Dr Jim Bradley.

It was noted that the Medical Board of Australia has reported that there were 4,595 specialists in anaesthesia registered in Australia as of 31 March 2015, exceeding the workforce demand projections of the Health Workforce 2025 study some three years ahead of time.

Critical to a consideration of this statistic is whether this indeed represents anaesthesia workforce oversupply. It has been mentioned previously that this topic is long on rhetoric but short on facts, and one can be reminded that one party's 'facts' might also be viewed as merely opinion by others.

As 2015 draws to a close, the ASA has evolved a much clearer position about the anaesthesia workforce, and it is this view that we have taken this year to government and its instrumentalities.

In summary, the anaesthesia workforce in Australia is distributed between capital cities and their adjacent conurbations, regional cities, and finally, more distant centres. Both case-mix and workload vary between these areas, but there is insufficient information available to determine what drives these variations.

What the ASA can now say, based on the responses of its specialist members expressed through workforce surveys, is that the specialist anaesthesia workforce is currently adequate in all geographic locations. There is objective (including reported actual and desired clinical workload and ease of access to professional and recreational leave) and subjective (derived from questions relating to workload and estimates of local workforce adequacy) data to support this position. Further, subjective opinion is that too many specialist anaesthetists are being trained, but the ASA view would be that this position cannot be *objectively* supported at this time. Also, it is not possible to establish that current adequacy equals future adequacy.

The Federal Department of Health is currently assessing the anaesthesia

workforce, with a report expected soon. The ASA, in meeting with officials of the Federal Department of Health in August, noted that previous assessments of the anaesthesia workforce did not draw on the input of the private healthcare sector or the representative organisations (the ASA and AMA), though this deficiency has now, to an extent, been remedied. It was also clear at this meeting that relatively little was known about the contribution of non-specialist providers of anaesthesia to anaesthesia delivery. This becomes important in addressing expressed government intention to "improve medical training to produce the number and proportion of specialists needed in Australia". This objective is underwritten by workforce "pump priming" (to use an expression originally coined by the AMA at the time of the dramatic increase in the number of medical graduates some ten years ago), the consistent rhetoric being that an increase in the supply of medical graduates will solve the problem of workforce shortages in some specialties and some geographical locations.

Finally, this brings us to the purported "maldistribution of anaesthetists". Government opinion (underwritten by the reports of Health Workforce Australia) is that, in anaesthesia, there is a "moderate concern" in relation to dependence on specialist international medical graduates. This seems to the ASA to be a consequence of input from state governments to Health Workforce Australia in relation to long-standing staffing difficulties in non-metropolitan public hospitals.

The ASA's view then is that the 'problem area' with the anaesthesia workforce is the provision of services within the public sector, more commonly in non-metropolitan areas, and not with the provision of services within the private sector. It is appreciated that there is a strong political component to how this matter is perceived, and to how it might be addressed. The actual needs of facilities in rural and remote areas which might require anaesthetists are currently undefined, as is an appropriate mix of specialist and non-specialist anaesthetists.

The emphasis of ASA advocacy is consequently shifting to proffering 'solutions' rather than debating data (or opinion).

When workforce issues became a focus of the ASA about three years ago, the driver was the employment concerns of young specialists and their expressed desire for public hospital employment as an underwriter of the professional consolidation of skills. This remains important, with an appreciation that 'generalism' (which currently enjoys government support) will be hard to achieve – or retain – if there is an oversupply of anaesthetists.

ASA workforce surveys have been of invaluable assistance in establishing and validating our knowledge and understanding of the anaesthesia workforce, and our consequent advocacy on behalf of members. There will be a further workforce survey in early 2016 with, in the interests of trend analysis, questions largely unchanged from the two most recent surveys. Your future support is solicited.

DISTRACTIONS IN THE OPERATING ROOM

The ability, or otherwise, of music (soft or loud, classical or something altogether different), newspapers, crosswords or whatever to distract the anaesthetist from his or her task is often discussed.

Much more recently, the use of mobile phones, tablets and laptops has become common in the operating room.

The issue of whether or not using these devices whilst administering an anaesthetic distracts the anaesthetist will probably never be fully resolved, but we do know that texting certainly distracts motorists.

The American Society of Anesthesiologists recently[1] canvassed the issue using a questionnaire commonly used to identify 'problem drinking', asking whether anesthesiologists had ever felt the need to cut down on the use of an electronic device, whether they had been annoyed by criticism of the use of their electronic devices, whether they ever felt guilty about the use of their electronic device, and whether they reached for their electronic device as soon as they wake up…..

It was suggested that answering 'yes' to two or more of the above questions indicated a particular difficulty in relation to electronic devices, but it was also noted that blanket policies in relation to the use or otherwise of electronic devices in the operating room were likely to be impractical.

Situational awareness, regardless of distractions, was said to remain the key to vigilance.

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Our Twitter followers have nearly doubled since December 2013, from 716 to 1387!

57%
of ASA emails are being viewed on mobile devices

The Harry Daly museum is home to over **1,700** anaesthetic related objects

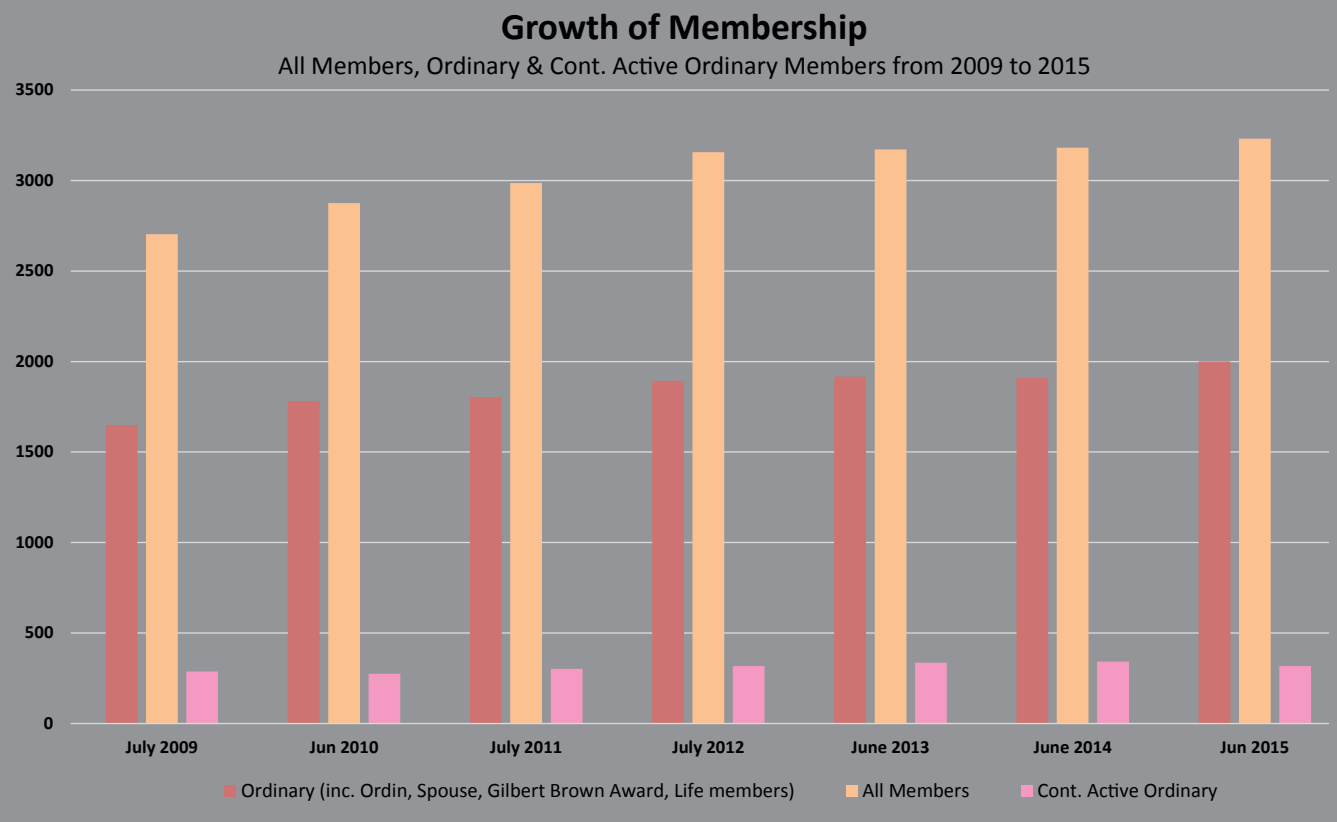
The ASA represents 30.7% of trainee anaesthetists in Australia

Know someone who should join?
Show them the Trainee Membership page under the Membership tab on the ASA website!

20,916
ASA website visits, YTD

Average visit: 2 min 17s

Here's what the ASA has been doing to Support, Represent and Educate our members this year!



21 government submissions (86% PIAC:14% EAC)

1000+ attendees at ASA-run events!

100+ volunteers registered on the ODEC database*

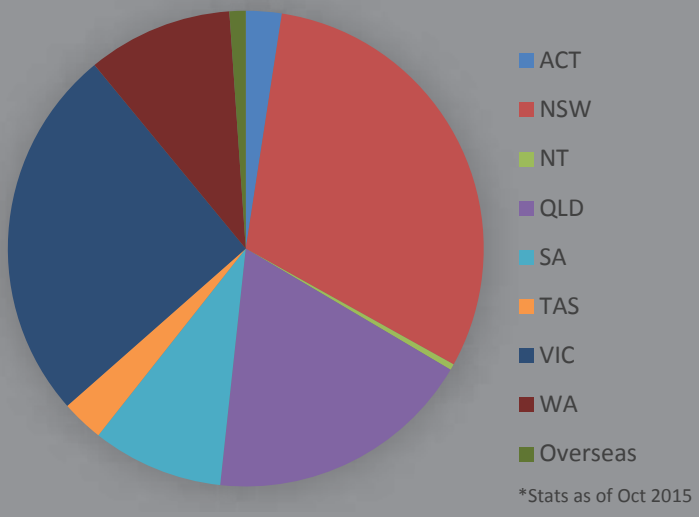
*Join on the ASA website. Go to the Volunteering page under the Membership tab and click through to enter your details.

$10,500 GASACT CIG Scholarships* per anum

*applications open January 2016!

There are 95 Fifty-year members of the ASA, including the 15 who will be awarded this status on 1 Jan 2016!

ASA Membership by State*



*Stats as of Oct 2015

883 ASA RVG App downloads

58% members who read the President's enews*

*a typical open rate, according to Informz, is 39%

216 joined the ASA this year!

2188 *Anaesthesia and Intensive Care* app downloads

250+ MEMBERS SCORED ASA-BRANDED TOBLERONES AT THIS YEAR'S CSC (MMM!)

POLICY BASED QUERIES...

68% EAC

22% PIAC

10% Other

98% resolution rate (238 queries received YTD)

Queries are handled by the policy team, EAC and/or PIAC. If you email through your query, it is important to have all the relevant information ready – this may include documents such as invoices/accounts.

FEATURE

SOCIAL MEDIA SAVVY ANAESTHETISTS

In recent years, the proliferation of social media has given rise to a number of potential pitfalls that await doctors who choose to share personal information online. *Australian Anaesthetist*'s Caitlin Murphy delves into this ethical minefield, examining how to harness the power of this technology while maintaining patient confidentiality and your professional reputation.

Social media offers many avenues for medical professionals to network with colleagues, share knowledge and keep abreast of recent developments in their field. These platforms also allow for increased doctor–patient interaction and the dissemination of important health information to the public. However, physicians need to remain cognisant of the privacy issues that surround this online activity, as professional integrity can easily be compromised with one thoughtless post.

Readers should be warned that no security settings on sites such as Facebook are completely impenetrable and that there is no guarantee that posts intended for a small or private audience (or even a 'locked' or 'invisible' group) will remain secret. The anonymity that the internet can *appear* to afford users is simply no excuse for unprofessional conduct.

PATIENT CONFIDENTIALITY

The onus on doctors to maintain their patients' privacy extends to the online sphere and practitioners who breach this code on social media are liable to disciplinary action[1]. Even when efforts are made to de-identify details of an interesting case, it may not take much detective work for a virtual contact to recognise themselves or someone they know in a doctor's update. This is especially true in areas with smaller, more tightly knit populations, where professional and social networks are more likely to overlap. Moreover, it is likely to be the details of embarrassing or unusual cases that are the most tempting to tell friends about – these are the very cases that require the most discretion from medical professionals!

Furthermore, doctors should be aware that posting a photo of a patient to social media without first obtaining that patient's consent can also constitute

a serious breach of privacy[2]. This is in keeping with standards of practice long held in the world of academic publishing to protect the privacy of patients with sensitive conditions.

As a rule of thumb, physicians should think very carefully before sharing anything about their patients online. In 2010, the NSW chapter of the AMA was forced to issue a general warning to practitioners about their behaviour on social media after a "disgruntled patient" found derogatory remarks written by their doctor about them on Facebook[1]. This incident should remind readers that comments posted online (even those intended as nothing more than flippant asides) can always come back to haunt social media users.

PROFESSIONAL STANDARDS

Medical professionals who choose to use social media need to remember that it is not just patients who could be offended by their internet presence. Racist, sexist or homophobic commentary (or the endorsement of such content suggested by a virtual 'like' or 'share') is unlikely to curry favour with potential employers, who often search the social media profiles of job candidates as part of their recruitment process.

Similarly, party photos that document inebriation or illegality may leave a less-than-stellar impression. This is especially important for younger doctors, whose teenage and student years have likely been chronicled onlinet. Old Tweets, Instagram photos, YouTube videos, Facebook posts and blog entries that may well represent a much less mature version of you are still able to be dredged up years later, thanks to Google. Before applying for a job or scholarship, it is wise to see what results are returned when you search your own name and to attempt to remove any potentially incriminating or embarrassing content.

MAINTAINING BOUNDARIES

With the help of a simple search, social media allows doctors to uncover details about their patients that may not otherwise be disclosed. While such easy access to information is potentially useful in, for example, helping to correctly identify an unconscious patient or allowing professionals to intervene when a patient posts about suicidal ideation, it also presents a number of serious ethical considerations[3].

It may be tempting to monitor a patient's activity on social media to ensure that they have indeed quit smoking or aren't driving against medical advice, but such snooping threatens the foundation of trust needed to build and maintain successful doctor–patient interaction. Dr Carwyn Hooper, Lecturer in Medical Ethics and Law at St George's, University of London, warns that "searching for information about patients out of sheer curiosity or sending Facebook friend requests to patients for voyeuristic reasons is beyond the pale"[4] and readers would do well to consider the distinction between concern and curiosity before looking up patients online.

On the other hand, it is not uncommon for patients to initiate virtual contact with treating practitioners. Most practical guides for doctors navigating social media strongly discourage making 'friends' with patients online and *Australian Anaesthetist* suggests that requests for access to your personal profiles be either ignored or answered with a friendly but firm explanation about the importance of maintaining professional boundaries.

One option that physicians have for deliniating between private and professional use of social media is to establish a professional page that is separate from any personal accounts. This can be 'liked' or followed by patients and information shared can be limited to that which is clinically or professionally relevant. It is even possible to employ others to build and manage these sites[5].

THE ASA AND SOCIAL MEDIA

The Society maintains a presence on social media through platforms such as Facebook and Twitter and this has proved an extremely useful way to connect with members, advertise Society events and stay up to date with developments in the world of anaesthesia. While we certainly encourage anaesthetists to get in touch with like-minded colleagues through these networks, we caution all members to exercise care online, for all the reasons discussed.

At the time of writing, the ASA is reviewing its own social media policy, which will be made available to members soon.

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REGULAR

LEGAL NEWS: NEGLIGENCE, HEALTH LAW AND DISCRIMINATION

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MEDICAL NEGLIGENCE – KEY CONCEPTS

When examining cases concerning medical negligence, more often than not the main issue revolves around the doctor giving advice regarding the risks of a particular procedure. As a guiding principle, the patient must be fully informed as to the risks associated with their operation so that they can make an informed decision and provide consent. There have been several cases that highlight the parameters associated with this and question whether or not a doctor would be at fault if something were to go wrong.

Bolam v Friern Hospital Management Committee [1957] 1 WLR 582

In this famous British case, the issue here was whether or not a doctor was negligent in their treatment of a patient and if that doctor's practice followed the standard of a responsible body of medical opinion. The voluntary patient, Bolam, claimed to have suffered bone injuries from electroconvulsive therapy. The jury gave in favour of the hospital, resulting in the Bolam Test, which states that if a medical practitioner subscribes to a reputable school of clinical thought in relation to a procedure, then that doctor is not negligent.

Rogers v Whitaker (1993) 67 ALJR 47

In an Australian case, the Bolam Test was re-examined, placing more reliance on the court's decision as opposed to the test. The issue here was whether or not a medical practitioner had a duty to warn about the risks associated with a medical procedure. The patient, Whitaker, had surgery on one eye, but alleged that her other eye had become damaged as a result and the doctor failed to warn her of the risks before surgery. She was awarded $808,564.38 by the court; however, the defendant, Dr Rogers, appealed and it went to the High Court. The appeal was dismissed because the Court argued if a 'reasonable person' were warned of the risks, then they would not have had the procedure.

Civil Liability Act 2003

The Bolam Test was not strictly invoked in *Rogers v Whitaker (1993)*, but was restored as a defence in Australia by the *Civil Liability Act 2003*. The Act re-established the argument that, for a medical practitioner, a liability of negligence arising from the provision of their services does not incur if it can be shown that the professional had acted in a manner at the time of the service provided that was widely accepted in Australia by their peers' professional opinions to be competent. However, the Act has no impact on *Rogers v Whitaker (1993)* as it relates to the provision of consent.

TORT AND HEALTH LAW – WHEN 'ACCIDENTS' HAPPEN

While the giving of advice has been a common element in medical negligence, historically there have been cases when advice wasn't necessarily the issue. One in particular demonstrates the issue concerning when an accident has been made, unbeknownst to the medical practitioner.

Roe v Minister of Health [1954] 2 All ER 131

In English tort law a decision was made in the Court of Appeal of England and Wales which impacted on common law practiced within the Commonwealth at the time. Patients undergoing surgery in a hospital run by the Minister for Health suffered permanent paraplegia when it was discovered that an anaesthetic consisting of Nupercaine had been contaminated. It was common practice to store such anaesthetic in glass ampoules immersed in a phenol solution, so infection could be reduced. However, the glass itself suffered from micro-cracks that could not be seen with the naked eye. At the time, negligence required plaintiffs to show that a duty of care had been breached by the defendant causing loss or damage to the plaintiff. The standard of care was judged via the objective test of what a 'reasonable man' would or wouldn't do under such circumstances and as determined by the court. Denning LJ lay the basis as to how the standard of care should be judged and whether it

be on a scientific or technical knowledge at the time of the alleged negligence. Comment was also made that the maxim '*res ipsa loquitur*' or 'the thing speaks for itself', having no magical qualities. The final decision was that there was no negligence since, as stated by Denning LJ., "the micro-cracks were not foreseeable" and "no reasonable anaesthetist would have stored the anaesthetic differently". There was no breach of duty. However, the liability for negligence of those who administered the treatment rested with the hospital and not the doctor. The anaesthetist in this instance was working part-time and not directly employed by the hospital.

INTRODUCTION TO RACIAL AND SEXUAL DISCRIMINATION LAWS

A September 2015 report commissioned by the Royal Australasian College of Surgeons (RACS) revealed that half of all surgeons in Australia and across all specialties have experienced some form of discrimination, bullying or sexual harassment. This is an opportune time to re-examine the legislations that governs anti-discrimination laws. According to the Australian Human Rights Commission website, "less than 3% of racial hatred complaints proceeded to court"[1] , with 53% being resolved at conciliation. In relation to racial and sexual discrimination, before any matter sets foot into a courtroom, it must first be reviewed by the Commission.

Under Section 28A, the *Sex Discrimination Act 1984* defines sexual harassment as unwelcome sexual behaviour which "offends, humiliates and intimidates" a person. This is very similar to the provision under section 18C of the *Racial Discrimination Act 1975*, which defines racial harassment to be reasonably likely to "offend, insult, humiliate or intimidate" another person or a group of people. The two common words in each provision are 'offends' and 'humiliates'.

The provision s18C exists not to criminally punish an offender – in fact it is not a criminal offence to offend under the *Racial Discrimination Act (Cth) 1975*. It exists as a civil measure and as a legal safety valve or a framework of "conciliation in cognate legislation". To quote Justice Bromberg in *Eatock v Bolt and the Herald & Weekly Times Pty Ltd [2011] FCA 1103*, it exists:

> *For the civil provisions, racial tolerance was to be promoted through remedial measures encouraging understanding and agreement, rather than punishment, deterrence and the stigma of a criminal conviction* at [205].

Section 18C also exists in cognate to s18D. One encourages responsible speech, while the other protects free speech. In brief, s18D protects free speech, artistic expression and scientific debate if comments are made in good faith and supported by clear facts. The constitutional validity of Part IIA of the *Racial Discrimination Act 1975* was upheld by a Full Court in *Toben v Jones (2003) 129 FCR 515* (Carr, Kiefel and Allsop JJ). Justice Bromberg refers to this regarding the provisions of Part IIA as:

> *...set in a framework of conciliation in cognate legislation...": Toben at [135] (Allsop J); Bropho v Human Rights and Equal Opportunity Commission (2004) 135 FCR 105 at [68] (French J)"* at [205].

An early example of a sexual discrimination case was *Ansett Transport Industries (Operations) Pty Ltd v Wardley (1980) HCA 8*. This case was brought to action under the *Victorian Equal Opportunity Act 1977*. The facts of this case revolved around Reginald Ansett's attitude towards women. He felt that if he recruited Deborah Wardley to become a pilot, the passengers wouldn't feel safe. It didn't matter to Ansett that Wardley's test scores on the intake were higher than some men who were later recruited. The High Court flatly dismissed his appeal and upheld the law's prohibition on excluding a woman from recruitment on the basis of gender. It was a significant precedent.

However, in the case of *New South Wales v Amery (2006) HCA 14*, which was brought under the *Anti-Discrimination Act 1977 (NSW)* despite having an indirect sexual discrimination claim upheld by the NSW Court of Appeal, the High Court subsequently rejected it. The facts of the case concerned long-term casual teachers who were women and who complained of sex discrimination because of their pay-scale. They felt that, as women, they were also disproportionately represented in the long-term casual category in comparison to permanent teachers who were flexible enough to be stationed anywhere across the state. The obvious difference was that many of the women were also mothers. The High Court's reason for their decision was based upon the argument that casual and permanent were two completely different categories with their own conditions.

1. https://www.humanrights.gov.au/glance-racial-vilification-under-sections-18c-and-18d-racial-discrimination-act-1975-cth 29/04/14

REGULAR

HOW MUCH DO YOU NEED TO RETIRE COMFORTABLY?

Recently, the ex-Chair of the Super System Review, Jeremy Cooper, wrote an opinion piece that suggested $1 million won't necessarily guarantee a comfortable retirement. If that is the case, how much do you need? What do you have to do now to get on track? Will your super be enough? And how do you work it all out for yourself? In this installment of *Australian Anaesthetist*, Stuart Wemyss of ProSolution financial services will try and answer all these questions, as well as providing a calculator so you can model your own situation.

HOW MUCH INCOME DO YOU NEED?

When I ask clients how much income they think they will need to fund retirement, invariably, 80% of people answer "$100,000 per year after tax". When I ask how they arrived at that figure, there is rarely any science involved.

To work out how much money you will need, you should start with how much you spend on living expenses today and make adjustments from there. There are probably going to be two major adjustments. Firstly, if you currently have kids then your expenses will likely decline as you will have fewer mouths to feed come retirement. Secondly, you may want to holiday more often and/or pursue certain hobbies or pastimes that you're unable to or don't do now.

There is no 'average' when it comes to living expenses. For example, $50,000 per year might be enough for some people, whereas others will need $150,000 per year. For most people, it's going to be somewhere in that range.

To use the calculator, you just need to work out how much you would need if you were retired today (i.e. in today's dollars). The calculator will work out what that means for the future.

SURVIVORSHIP RISK

Don't be blind to the pace and impact of medical advancements

Life expectancy tables suggest that, statistically, as a 40-year-old male, I can expect to live to approximately 81 to 82 years of age. However, when completing my own financial planning, I have based my life expectancy on an age of at least 90 – because I don't want to risk running out of money.

I think it's difficult for us to accurately assess our life expectancy as it will probably be impacted by medical technologies and treatments that haven't even been discovered yet. For example, IBM's artificially intelligent supercomputer, Watson, is now being used by US oncologists to develop treatment plans. It can do work that would take teams of specialist doctors many decades to complete (reviewing studies and other patient cases) in a matter of hours to develop treatment plans.

Moore's Law is an observation that the power of a computer chip will double every two years – a prediction made 50 years ago that has turned out to be true. So I think it is reasonable to expect that, as a result, our life expectancy will be extended.

When it comes to undertaking your own planning, you need to think about two things. Firstly, when you input your life expectancy into the calculator, overestimate this figure so as to allow for these medical technological advances. Secondly, the goal is to accumulate retirement assets sufficient in both value and type that will provide enough income to fund your retirement goals i.e. so you don't have to eat into your capital. If you can achieve that, your survivorship risk becomes immaterial.

WILL YOUR SUPER BE ENOUGH TO FUND RETIREMENT?

Or do you need to make additional investments?

That is going to depend on your age and your income. However, most people are going to need and want additional investments for two reasons. Firstly, for most people, super will not be enough to fund the kind of comfortable lifestyle most people desire and aim for. Secondly, the problem with relying on super is that the government is in complete control. They can (and do) change the laws

and move the goal posts. They decide when you can retire (i.e. access super). Most people are not comfortable with putting their life/retirement plans in their government's hands.

Are your existing investment assets going to help?

Maybe you have already started investing in other assets, such as property and/or shares, in addition to super. If so, well done! You can input these investments into the calculator too. The calculator assumes these investments will perform well (i.e. at a long-term average capital growth rate of 7% p.a.). So you need to ask yourself, how certain are you that your existing investments will perform at this level? What have the returns been to date? You really need to monitor this closely because your retirement is dependent upon it. You must get your existing house in order before you make any additional investments.

HOW CAN YOU GET ON TRACK?

The calculator will show you two potential solutions (if it estimates that you are not on track to fund retirement).

Firstly, you can begin by investing some money each month. I would recommend investing in a low-cost index fund as a start.

Secondly, you can borrow to invest. Borrowing to invest essentially allows you to bring forward the next 10, 20 or 30 years of cash flow and invest it today. Then, over the next 10, 20 or 30 years, you can direct your surplus cash flow towards repaying (actually offsetting) the debt.

The quality of your assets will drive 80% or more of your success

You cannot expect to invest in average or below-average assets and expect above-average returns. If you want above-average returns, you must invest in above-average assets! Therefore, if you are going to invest (particularly if you are going to borrow to invest), you had better make sure that you invest in the highest quality assets you can find. Quality must be your primary focus. Anything else is a distant second.

Stuart Wemyss is an independent and licensed chartered accountant, financial planner and mortgage broker with over 18 years' experience in financial services. He founded ProSolution Private Clients in 2002. Send any questions or comments to swemyss@prosolution.com.au

THE CALCULATOR

To download the Excel calculator visit: www.prosolution.com.au/calc.

You are free to use it however you like – save it on your computer, send it to friends and family and so forth. It's all yours!

However, a word of warning. The calculator is not a substitute for professional, independent advice. It will prepare high-level estimates. It is not a financial-planning model. It makes certain assumptions and generalisations which may or may not be appropriate for your circumstances. Please keep this in mind when you use it.

REGULAR

CAREERS IN ANAESTHESIA
INTERVIEW WITH AN MSF ANAESTHETIST

Dr Sivapalan Namasivay is an experienced anaesthetist. Since 2011 he has worked with the international medical aid organisation, Médecins Sans Frontières (MSF), in Yemen, Syria and, most recently, in Nigeria.

WHY DID YOU DECIDE TO WORK WITH A HUMANITARIAN AID ORGANISATION?

For nearly 20 years, I had worked as an anaesthetist in public and private health systems. Both provided unique challenges and experiences, yet there was always the feeling that I was exercising my skill and knowledge within a comfort zone.

Like many, I became aware that medical professionals like me could go one step further by taking on a role in humanitarian medical aid. It did not take me long to realise that MSF did this the best and was based on principles that resonated positively with me.

YOUR MOST RECENT FIELD ASSIGNMENT WAS TO JAHUN, NIGERIA. WHAT IS MSF DOING THERE?

MSF is primarily focusing on maternal care. MSF operates out of a government hospital facility where we are responsible for women coming in for maternity care. Pregnant mothers arrive with serious complications such as cardiac failure secondary to severe anaemia and convulsions from severe eclampsia. We try to reduce the associated morbidity and mortality by managing these complications and then providing safe childbirth by normal delivery or caesarean section. We also run a surgical treatment facility for the repair of vesico-vaginal fistulas (VVF).

WHAT WAS YOUR ROLE DURING YOUR TIME IN JAHUN?

I was working in the operating theatre as a medical anaesthetist, where I supervised and assisted the three nurse-anaesthetists who provided day-to-day anaesthetic services. But most importantly, I managed the medical emergencies of patients admitted to the intensive care unit.

Most of our patients arrive in a compromised state of health and in the late stages of pregnancy. The obstetricians work hard to ensure safe delivery and the paediatrician takes care of the newborns. The majority of these patients have other complications and my role was to manage these pre- and post-delivery and, when surgery was necessary, provide a safe mode of anaesthesia.

I also managed patients admitted for extensive VVF repair surgery pre-, intra- and post-surgery.

HOW DOES BEING AN ANAESTHETIST IN A HUMANITARIAN CONTEXT DIFFER FROM WORKING IN A DEVELOPED COUNTRY LIKE AUSTRALIA?

The working environment and the medical cases you face can be extremely challenging and the medical infrastructure and treatment modalities available are often very basic. This differs from a developed country like Australia where the working environment is close to ideal and you can reasonably expect the most up-to-date treatment methods

Dr Namasivay and the Jahun team.

and medication. As a result, I have had to dig deep into my bag of accumulated skills and knowledge. I have learned to improvise and, in a way, this has taught me new skills and to appreciate skills and knowledge that I had not utilised for a long time.

WHAT DOES IT TAKE TO GO INTO THE FIELD AND DO THE WORK YOU DO?

You need to possess the required skills and knowledge, and a conviction that you could contribute positively to the humanitarian challenges taken on by MSF. If you are willing to get out of your comfort zone, you will get to see the practice of medicine in a new light, make new friends, visit new places and absorb new cultures.

HOW HAS THE EXPERIENCE CHANGED OR AFFECTED YOUR LIFE?

Wherever I have gone with MSF, there were always lessons to learn: about life and about people, but most importantly that it is possible to make a difference. As an anaesthetist I work with surgeons mending broken bones or improving bodily functions. When someone's life gets better, so does mine.

MÉDECINS SANS FRONTIÈRES IS LOOKING FOR ANAESTHETISTS

Challenge yourself and help us keep operating

Médecins Sans Frontières Australia is currently looking for anaesthetists to work in the field.

If you're able to commit to a minimum of six weeks and would like to learn more about working for the world's leading independent organisation for medical humanitarian aid, then visit www.msf.org.au/recruitment/

REGULAR

WEBAIRS NEWS

Many adverse events reported to webAIRS are the result of confusing drug labelling, warn Drs Martin Culwick, Genevieve Goulding and Mir Wais Sekandarzad.

Between October 2009 and April 2015, there were 564 medication incidents reported to webAIRS. One hundred and fifty-one of these incidents involved a wrong drug either given in error or almost given in error. In the literature, many of these errors are attributable to slips in attention due to busy or distracted staff[1]. However, some are a direct result of the drug packaging or are associated with the use of unfamiliar medications.

WebAIRS has analysed 66 incidents in which insulin was mentioned and of these, 14 incidents were directly related to errors or near-misses involving insulin. Analysis of these incidents revealed that there is a major problem in the labelling of the insulin ampoule compared with other drugs used in anaesthesia.

The ampoule shown in Figure 1 is the Novo Nordisk brand (Bagsværd, Denmark) but all brands of insulin ampoules sold in Australia and New Zealand use similar wording. The dosage written on the insulin ampoule label has the format "100 IU/ml 10 ml", whereas most other ampoules used during anaesthesia have the format 'mg/ml' or 'mcg/ml'. For instance, midazolam is labelled as "5 mg in 5 ml" and fentanyl is labelled "100 mcg in 2 ml". Many of the insulin errors that have been reported to webAIRS have resulted from the assumption that there are 100 IU of insulin in 10 ml. These errors were also associated with a doctor making up an insulin infusion on their own for the first time. It should be noted that the error might have been avoided if an insulin syringe had been used, as this displays the number of units that have been drawn up. The error may also have been averted if a formal double-check of ampoules were always performed. Fortunately, only one of the cases resulted in hypoglycaemia and this was detected early enough to prevent serious harm. It should also be noted that the Novo Nordisk product insert specifically states that the product is for use with a U100 insulin syringe[2]. It is also unlikely that the formulation or labelling will ever change because of the large user-base of diabetics using this concentration and using insulin syringes. In addition to the errors highlighted in this article, there are also a number of other potential hazards associated with administration of insulin that are set out in some detail on the website for the Institute for Safe Medication Practices. The authors recommend that readers visit this website for more information relating to the safe administration of insulin[3].

We also recommend that an insulin syringe always be used to draw up insulin, whether for subcutaneous injection or for the preparation of intravenous infusions. In addition, it may be worthwhile to prepare an insulin kit containing the above items and storing them together in a sealed plastic bag in the medications fridge (Figure 2). As each of the items is in a sterile container, it is not necessary to sterilise the outer bag. An article containing the complete set of data and recommendations is in the process of being prepared for submission to *Anaesthesia and Intensive Care*.

There has been a steady increase in incident reporting since the webAIRS program was released in 2009, with 881 events having been reported so far this year. Reporting incidents to webAIRS helps maintain an important source of information about adverse events, and it also attracts two CPD credits per hour in the Practice Evaluation category.

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3. Institute for Safe Medication Practices. A clinical reminder about the safe use of insulin vials. From https://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=42. Accessed October 2015.

For more information, please contact:

Dr 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.

Figure 1: Novo Nordisk brand ampoule.

Figure 2: Insulin kit for the preparation of intravenous infusions.

INSIDE YOUR SOCIETY

MEMBERSHIP UPDATE

As a professional organisation we continue to 'support, represent and educate' our members to help them provide the safest possible anaesthesia across the country. Charles Baker, ASA Membership Services Manager, reports on a busy 2015 for this month's *Australian Anaesthetist*.

Over the last few years, the ASA has continued to strengthen our contribution to the anaesthesia speciality, as well as actively engaging and supporting members through:

- advocating and representing members' interests as anaesthetists through our dedicated Policy Team,
- providing the *Anaesthesia and Intensive Care* Journal and *ASA Relative Value Guide* in both print and app formats,
- organising and granting access to a variety of state and national events, including our successful National Scientific Congress, set to return to Melbourne in 2016,
- publishing updates and articles of interest in our member magazine, the *Australian Anaesthetist*, and
- making available other resources and services, such as our ASA Advantage Program, access to the Harry Daly Museum and Richard Bailey Library collections, the opportunity to train in developing countries and access to a number of awards, prizes and research grants.

The Membership Services Team is ending 2015 on a positive note, and while we continue to provide high-quality service and benefits to our existing membership, we have also been focused on innovative ways to *regain*, *retain* and *acquire* members.

TRAINEE MEMBERSHIP

As growth in new membership continues, our trainee numbers are also on the rise. This truly highlights a strong number of anaesthetists entering the workforce and the ASA is keen to continue to support and deliver services to this membership segment. Our ongoing support for trainees during their Fellowship is demonstrated by our provision of Part 3 courses, as well as through our collaboration with ANZCA, who deliver all Part 0 courses.

RETAINING MEMBERS OF A NOT-FOR-PROFIT

For many of our members, the decision whether or not to renew has been made well before renewal time, based on their experience with the Society throughout the year. However, as a membership-based organisation, there will always be a significant proportion of our members who fall into one of the following four categories:

Undecided. These members have thought about their membership and are not sure whether they want to renew or not. The Society tends to re-engage with these members following their first renewal notice.

Moved. This category includes members who have changed their contact details, such as email or postal address and/or phone number, but have not advised the Society. It is important that member details are updated to ensure we can continue communication with our members.

Busy. Most of our members lead very hectic lives and renewal notices from the Society are easily misplaced. It is understandable then that some of our members are too busy to remember to renew on time!

2016 Membership Renewals

You should have received your 2016 membership invoice in the post in early December. Pleast contact us if you didnt.

Email: membership@asa.org.au
Phone: 1800 806 654
Mail: PO Box 6278
North Sydney
NSW 2059

We support. We represent. We educate. Thank you for your ongoing loyalty as an ASA member.

Not satisfied. Unfortunately, a small proportion of our members do not feel they are represented by the strategic goals and objectives of the organisation.

The Membership Services Team continues to develop strategies that will potentially increase membership renewal across these segments. We remain focused on addressing matters that are practical, relevant and represent your issues in the specialty.

TOWARDS 2016

We look forwards to your ongoing involvement and commitment in 2016 and, on behalf of the Membership Services Team, I would like to thank all of our members for your ongoing support, allowing us to work with you and continue to represent your views.

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

Hardly a day goes past when a major headline news item does not impact on PIAC activities, writes PIAC Chair, Dr Antonio Grossi.

Ongoing issues includes the following:

REVALIDATION

The CAMERA report promulgated this year has strongly supported 'Model C'[1]. This includes "engagement in self-directed and directed interactive CME, facilitated online learning, blended learning, annual appraisals, participation in multi-source feedback and review of patients' complaints"[1]. Dr Joana Flynn has previously stated that any revalidation introduced in Australia should be evidence-based, practical and cost-effective[2]. The ASA has supported this view. Perhaps in response to ongoing reports of poor health outcomes, such as the perinatal mortality at Djerriwarrh Health Service, Bacchus Marsh, and cardiac arrests at Sydney's The Cosmetic Institute, there seems to be a renewed vigour to 'protect the public'. The timeframe to pilot CAMERA Model C has been estimated at 12 months. The ASA has been lobbying to ensure that any revalidation model is relevant to anaesthetists' practice, does not introduce unreasonable cost burdens and has been validated to be effective in protecting the public and restoring confidence.

SUBMISSIONS

The PIAC continues to represent anaesthetists by making submissions to the following organisations:

a. National Health and Medical Research Council (NHMRC) and National Safety and Quality Health Service Standards (NSQHS)

b. SOL (Skilled Occupation List)

c. NSW State Scope of Clinical Practice Unit – Report and Scope of Clinical Practice Template

d. Providing input to ANZCA on professional standards (PS07 Pre-anesthesia Consultation; PS61 Management CICO)

e. Medical Board of Australia – registered medical practitioners who provide cosmetic medical and surgical procedures

MEETINGS

The PIAC has been represented at several productive meetings this year, including NMTAN (February and August), Shadow Minister for Health (Ms Catherine King), the New Health Reform Workshop (Dr Simon Reilly Melbourne), the Senate Select Committee on Health, the Medical Board of Australia, meetings with Policy Directors at ANZCA, RACS, the American Society of Anesthesiologists, National Allied Health Conference, Health Service and Policy Research Conference, Associations Forum National Conference.

WORKFORCE ISSUES

Members' enquiries this year have been dominated by situations exacerbated by the oversupply of anaesthetists. This has created tensions in the supply of anaesthetic services in some areas and has empowered some hospital administrators to make unreasonable and unsafe demands of their anaesthetists. The ASA is monitoring and lobbying in this area to maintain high-quality and safe anaesthesia services for patients.

RURAL ANAESTHESIA STRATEGY/SOLUTION

It seems that rural areas with smaller populations in more isolated locations have particular problems in attracting and retaining specialist services. The ASA is working with stakeholders to develop a strategy and solution to provide sustainable anaesthesia services in rural areas.

SCOPE OF PRACTICE

The PIAC has been active in this area, presenting at the New Health Reform Workshop, making submissions to NSW SSCPU, and participating in further discussions.

GOVERNANCE

A number of professional documents, Mi-tec patient information sheets and position statements were revised by PIAC this year. These have proven useful for members clinically and in dealing with stakeholders at an organisational level.

Clinical governance in the private and public sector remains an important focus for PIAC. Whilst hospitals may have their own peculiar by-laws, there is significant legislation in place, which determines the delivery of healthcare across theses jurisdictions. This includes Occupational Health and Safety Acts, Worksafe/ Fairwork Acts, the Medical Treatment Act, the Health Practitioners Regulation National Law Act, Guardianship and Administration Acts, the Power of Attorney Act, Mental Health Acts, the Drugs, Poisons and Controlled Substances Act, the Coroners Act and several more. Members are encouraged to contact PIAC if they consider there has been a breach in natural justice in relation to their professional practice. Advice has been given in relation to clinical privileges, credentialing, provision of on-call, behavioural concerns, occupational health and safety. A framework for engaging with private hospitals and the Australian Private Hospitals Association is on the agenda.

CORPORATISATION OF MEDICINE

This year, Medibank Private disseminated an extensive list of adverse events, which would not attract payment. This promotion of a 'blame' culture threatens open disclosure and quality improvement. The implication for the sustainable, long-term delivery of appropriate, effective, cost-efficient and safe care has been threatened by this corporatised approach to healthcare. Preserving professional autonomy involves providing quality anaesthesia services and behaving professionally.

CONSENT AND MATERIAL RISK

The PIAC is developing tools to assist members in obtaining valid consent. The criteria of competence, voluntariness, specificity and understanding need to be met. Consent is more than merely signing a form. It is about an ongoing dialogue with the patient about that which is important and relevant to them.

WELCOME AND THANKS

I would like to welcome Dr Annette Turley from Queensland and Dr Moira Westmore from Western Australia who have joined the PIAC and bring new skills. My thanks are extended to Drs Guy Buchannan, Richard Clarke and Phillip Morrissey who have stepped down from the committee this year.

Dr James Bradley continues to provide support, advice and mentorship, for which PIAC is very appreciative.

POLICY DEVELOPMENT

The PIAC activities are supported by the extensive policy research and development of Chesney O'Donnell and Josephine Senoga from the ASA Policy Team. A range of briefs are prepared during the year which assist the committee in its work. My thanks are extended to all the team at the Society, including Mark Carmichael, who facilitates these processes.

With increasing cost containment and regulatory pressures, 2016 will require your input and support to maintain the high quality and safety of anaesthesia. The PIAC embraces the challenge to assist you in this endeavour.

References

1. Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA) at Plymouth University Peninsula Schools of Medicine and Dentistry (UK).
2. Flynn J. Medical Board of Australia media release, 24 March 2015

INSIDE YOUR SOCIETY

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

ODEC oversees all aid given outside Australia and New Zealand involving ASA members or resources, including educational, financial, material and skill-based assistance. It acts jointly and cooperatively with ANZCA, the New Zealand Society of Anaesthetists, the World Federation of Societies of Anaesthesiologists and other aid organisations. ODEC Chair, Dr Rob McDougall reports on recent activity.

Currently, ODEC is responsible for projects in Fiji, Micronesia, the Solomon Islands, Timor Leste, Myanmar, Cambodia and Laos. The ASA continues to be a partner in the Mongolian Anaesthesia Project together with Interplast Australia & New Zealand. The ASA continues to partner with ANZCA, WFSA and other bodies in delivering Essential Pain Management in the Asia Pacific region.

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. South Pacific anaesthesia training is based at the Fiji National University (FNU), where a one-year Diploma in Anaesthesia and a four-year Masters in Anaesthesia are offered. Currently, there are 17 trainees. Each year, the ASA places at least two Australian or New Zealand anaesthetists (either senior trainees or new fellows) at the FNU campus in Suva for periods of up to three months under the Pacific Fellowship Program. In 2015, the Pacific Fellows were Drs Tim Coulson (Victoria), Jenny Hewlett (Victoria) and Luke Heywood (Queensland). Currently, there are only four consultant anaesthetists actively involved in training in Suva, so the contribution of the Pacific Fellows to clinical supervision and exam preparation is significant. FNU has recently requested that the ASA send more fellows! Information about this program can be found by emailing Dr Justin Burke at j.burke@alfred.org.au.

The ASA also supports the activities of the Pacific Society of Anaesthetists (PSA), which has over 50 members from the various Pacific Island states. In particular, the ASA provides financial and logistical support for the annual PSA Refresher Course and sponsors an ASA member to attend as the Pacific Lecturer. In 2015, the PSA Refresher Course was held in Suva and the Pacific Lecturer was Dr Andrew Fenton (Darwin).

An often-forgotten part of the region is Micronesia, which consists of over 2,000 islands spread out across the northern Pacific. In 1994 the ASA first ran the Micronesian Anaesthesia Refresher Course (MARC) which has since occurred biennially; it is now run by the Micronesian Anaesthesia Society, which was established in 2005 with ASA support. In recent years, the Japanese Society of Anaesthesiologists has been a supporter of this highly interactive and practical course.

Timor Leste is not technically part of the Pacific, but has been integrated into Pacific anaesthesia activities. Dr Flavio Brandao de Araujo, who completed his specialist training in anaesthesia in Fiji, and Dr Eric Vreede are currently the only specialist anaesthetists in Timor Leste. In 2016, the ASA will commence the Timor Leste Fellow Program, which will be similar to the Pacific Program. Dr Sam Rigg (Darwin) will spend three months in Dili from February. Prospective Timor Leste Fellows should contact Dr Brian Spain at brian.spain@nt.gov.au.

Each year the ASA sponsors at least one Pacific anaesthetist to attend the NSC/CSC. In 2015, Dr Lawrence Sogoromo (Papua New Guinea) was the ASA Pacific Visitor at the Darwin CSC. Additionally, Sydney Anaesthetics sponsored Dr Andy Ilo (Vanuatu) under the ASA Pacific Visitor Program. Dr Flavio Brandao de Araujo (Timor Leste) was jointly funded by the ASA and NZSA to attend as our third Pacific Visitor.

In 2015 and 2016 the ASA will assist doctors in the Solomon Islands assess their capacity for surgery and anaesthesia. This is an important step in ensuring reasonable access to safe essential surgery and anaesthesia care and will serve as a template for other nations in our region to follow.

Next year will also see the 16th World Congress of Anaesthesiologists in Hong Kong and the ASA will work with the PSA to ensure that there is strong Pacific attendance at this important meeting.

ODEC welcomes the submission of new projects for consideration. Preference is given to proposals which:

- Support the development of anaesthesia and resuscitation in the Asia Pacific Region.
- Have limited alternative funding possibilities.

- Are sustainable over the long term, with good prospects of self-sufficiency.
- Have a strong teaching/education component.
- Involve members of the ASA or members of anaesthesia societies of the host country.

In other news, the ASA, NZSA, ANZCA, Lifebox and Interplast are close to finalising an agreement for Lifebox Australia & New Zealand. This arrangement will allow tax deductibility for Australian donations to Lifebox. In partnership with Lifebox, we have commenced a training project in Indonesia.

Finally, the ASA has a successful matching process for those anaesthetists keen to volunteer overseas. The ASA Volunteer Database currently has over 80 anaesthetists, and in 2015 a number of volunteers were found for the Royal Australiasian College of Surgeons and Interplast service trips as well as ASA-supported teaching activities. More information on the database can be found at on the ASA website.

ASA MEMBER IS AWARDED THE WFSA CHURCHILL SCHOLARSHIP

The ASA is pleased to announce that ASA member, Dr Phoebe Mainland, from Alfred Hospital Melbourne, was awarded the Churchill Scholarship by the WFSA as a result of her work with connectors.

Phoebe's project, "To enhance the safety of Australian patients by reducing misconnections between medical devices", was based on an International Organisation for Standardisation project in which Phoebe was involved, developing a series of connector dimensions so different connections are used on medical devices for different applications, in order to reduce the risk of misconnections. Luer connectors will be limited to intravascular and hypodermic applications, and alternative connectors have been specified for neural, respiratory tubing, limb cuff inflation and enteral applications. Australia will adopt these connectors for the different clinical applications once the designs have been verified.

Phoebe's research involves reviewing the experiences in the UK and US of implementation of medical devices with different connectors. She will spend seven weeks visiting key people in both countries to learn about their recommendations for smooth introduction of these devices. She is expected to give feedback to the Australian Commission on Safety and Quality in Health Care and patient safety groups.

Originally published on the World Federation of Societies of Anaesthesiologists website. From http://www.wfsahq.org/latest-news/latestnews/467-wfsa-safety-and-quality-of-practice-committee-member-awarded-a-churchill-scholarship. August 2015.

ODEC MEETING AT THE CSC, DARWIN

ODEC Panel: WFSA President, Dr David Wilkinson, A/Prof Alicia Dennis and Dr Andy Ilo

Dr Andy Ilo and Dr Lawrence Sogoromo

Full house at the ODEC meeting

ODEC Chair, Dr Rob McDougall

Dr Lawrence Sogoromo

Dr Andy Ilo

WFSA President, Dr David Wilkinson

A/Prof Alicia Dennis

2015 PACIFIC SOCIETY OF ANAESTHETISTS ANNUAL REFRESHER COURSE

This year Dr Andrew Fenton was fortunate enough to be invited and sponsored by the ASA to attend and speak at the Pacific Society of Anaesthetists (PSA) annual meeting in Suva, Fiji. Here, he recounts his time at the event.

Held on a floating pavilion in a quiet, misty bay on the outskirts of Suva, the meeting was everything you would expect – relaxed, friendly and full of laughs. In true Pacific style, the only times dictated on the meeting program were 'before lunch' and 'after lunch'.

As well as local anaesthetists and trainees from the hospital in Suva, the meeting was attended by anaesthetists and anaesthesia providers from all over the South Pacific, including Tonga, Samoa, Vanuatu, Kiribati, Rarotonga and the Solomon Islands. This annual meeting represents a rare opportunity for all of these hard-working practitioners (most of whom are one of only several anaesthetists in their home country) to not just take part in some continuing medical education, but also have some much-needed time away from work to relax and catch up with their colleagues from neighbouring countries. One of the most striking impressions I had from the meeting was how invaluable the networking and collegial support provided by the PSA was, given their meeting is for a group of anaesthetists who work in very isolated and difficult conditions, separated by thousands of kilometres of ocean.

The content of the meeting included educational updates, presentations and debates on current evidence-based practice, some high-quality research projects by trainees, and my favourite component, the 'country updates'. Every country presented an overview of work at home, including a description of their current workforce ('1 in 2' or '1 in 1' on-call seems to be normal), their case-load and a few 'interesting' (terrifying) case presentations. Those of us present from Australia were amazed, not just at the stories being told, but also at the humour and humility with which they were conveyed. In a year in which *Global Surgery* is under the spotlight and the problems of delivering safe anaesthesia to remote communities seems an almost insurmountable challenge, it was heart-warming to hear from a solo practitioner providing an invaluable service to possibly one of the world's most isolated communities on Kiribati.

Attending the 2015 PSA Meeting also highlighted for me the importance of the support given by the ASA and NZSA for Anaesthesia training in the Pacific over the past few decades. I have also previously had the privilege of being sponsored by the ASA as a Pacific Fellow in 2011 to travel to Suva and teach anaesthesia trainees from all over the Pacific. Attending the meeting this year were three other Australian anaesthetists who have also been Pacific Fellows at various times (including Dr Mark Ng who led a superb simulation education program at the meeting). Their ongoing involvement is a great indication of the long-term interest fostered through these short-term positions sponsored by ODEC. Invaluable support is also provided in the form of locums who cover those attending the meeting.

What a view! Dr Fenton's outlook during the meeting

Drs Steven McGloughlin, Kenton Biribo and Andrew Fenton traversing the bridge to the floating conference venue

INSIDE YOUR SOCIETY

GROUP OF ASA CLINICAL TRAINEES UPDATE

GASACT has had a busy end to 2015 with the trainee stream of the CSC in Darwin as well as the Part 3 courses in November, GASACT Chair, Dr Ben Piper, reflects.

It was great to see many trainees taking advantage of the excellent Darwin hospitality at the Combined Scientific Congress in September. Professor John West was the headline act and did not disappoint. He entertained with reflections on his work with NASA, spirometry at the top of Mount Everest and the pulmonary circulation in race horses and their relevance to the evolution of anaesthetic practice. We thank the organising committee and, in particular, Dr Brigid Brown for her contribution to this successful event. With this hard act to follow, we are eagerly looking forward to Melbourne 2016!

I am glad to report an excellent attendance rate for the November Part 3 Courses which were held in New South Wales, Victoria and Western Australia (all on the 14th!). Senior trainees have shown an eagerness to gain some insight into the world after fellowship. Just a reminder to our fellow GASACT members that these Part 3 Courses are not exclusive to ASA members. We encourage you to sign up your fellow colleagues to come along too!

As we begin to look forward to 2016, there are a few notable developments for trainee members:

- The ability for advanced trainees to access FREE registration to the National Scientific Congress in Melbourne (or future NSCs) on payment of advanced membership fees, a net saving for trainees of over $900.
- The increase in the three SIG scholarship awards for 2016 to $4,000 each, which will allow three members to travel to Canada, UK or the US and attend the relevant national conference. Applications will open in the new year.

GASACT at the CSC, Darwin. Back Row: Dr Dennis Millard (WA), Dr Greg Bulman (VIC), Dr Ben Piper (Chair), Dr Christopher Mumme (ACT), Dr Adam Hill (NSW), Dr James Anderson (WA), Dr Scott Popham (QLD). Front Row: Dr Brigid Brown (SA, Co-Chair), Dr Nichole Diakomichalis (SA), Dr Debra Leung (VIC), Dr Jennifer Hartley (ACT), Dr Karla Pungsornruk (QLD)

I take this opportunity to bring to the membership's attention that each state and territory has trainee members that sit on a committee, giving up their own time and making a great contribution to our profession that often goes under-appreciated. These members are now etched into internet stardom on the GASACT webpage. In this issue of the *Australian Anaesthetist* we are highlighting the very good work of the Queensland representatives, Dr Karla Pungsornuk and Dr Scott Popham, on the development of a mentorship program.

IMPLEMENTING A MENTORING PROGRAM IN QUEENSLAND

Karla Pungsornruk, GASACT Queensland Junior Rep

The word 'mentor' originates from Greek mythology, when Odysseus, legendary King of Ithaca, entrusted his old friend Mentor with his son, Telemachus, on his departure for the Trojan War. Since then, the word mentor has been adopted to refer to someone who is considered to be wise or a trusted advisor or guide.

Mentoring can be described as a voluntary "dynamic, reciprocal relationship in a work environment between an advanced career incumbent (mentor) and a beginner (mentee) aimed at promoting the career development of both"[1]. There are clear advantages for both mentors and mentees and a positive experience can achieve lasting change.

Mentoring has been shown to be an influential factor in specialty selection, personal development, career enhancement and career satisfaction for medical students,

fellows and staff physicians in various disciplines[2]. Mentoring allows the mentee to seek advice, guidance and support on both personal and professional issues and may offer networking opportunities, improve welfare and enable the mentee to adapt rapidly to new environments, setbacks and obstacles[3]. In turn, the mentor may benefit from professional stimulation, sharing personal experiences, self-reflection and a sense of satisfaction resulting from the mentee's personal and professional growth[3].

Mentorship clearly plays an important role in career progression, however there is little evidence that explains its role in anaesthesia. In a single survey of anaesthesia trainees in the UK, 70% stated that they would have benefited from a mentor–mentee relationship; although, only 20% of trainees could identify a mentor[4]. In Canada, a recent survey showed that 94% of trainees believed mentoring during training was important[5]. Fifty-four percent of the Canadian anaesthesia residency training programs had formal mentorship programs, but 42% of trainees did not interact regularly with their mentor. The two most common modes of contact were face-to-face (92%) and email (70%), and the most commonly discussed topics were career planning, clinical expertise, work–life balance and exams[5]. It was found that trainees were much more likely to have a mentor during training when a formal mentorship program was in place (82% versus 17%) – adoption of a formal mentorship program can be considered as a potential strategy to improve the rates of mentorship[5].

The Queensland GASACT representatives, Scott Popham and I, have been working alongside the Queensland ASA Committee to establish an ASA mentorship program. Our aim is to develop a formal mentorship program to facilitate the process for our members in order to aid career development. This will be a voluntary and confidential process. Our hope is that the ASA Queensland mentorship program will connect trainees with consultants who may be external to their institution, facilitating relationships and networks outside of the training network that the trainee is attached to. This allows opportunities for consultants who are exclusively involved in private practice to mentor anaesthesia trainees. By introducing a mentor system that is separate from the Directors/Supervisors of Training or other faculty members, we anticipate that this will encourage more open discussion.

Our intention is to form a pool of willing consultant volunteers from throughout metropolitan and regional Queensland who we will match with interested trainees. A brief exchange of information will be made before a face-to-face meeting is arranged between the mentor and mentee.

Currently, the mentorship program is in its infancy, however we believe that a mentorship experience will prove valuable for all involved. ASA Queensland members interested in participating are invited to supply their details to the following email address: asaqld@amaq.com.au.

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INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

SOUTH AUSTRALIA

Dr John A. Crowhurst

Our Group in SA meets for lunch on the second Monday of every odd month at the Kensington Hotel, where we have our own private dining room and, from time to time, a guest speaker. However, our November meeting was on the third Monday, because of an AMA end of year function that was scheduled to be held the previous Monday. Our membership comprises of colleagues from anaesthesia, intensive care and pain medicine and now numbers more than 70. Typically, attendance at SA RAG meetings during 2015 has been between 20 and 30.

At our September meeting, Dr Mervyn Allen motivated much discussion and concern with his presentation: 'Cruising the high seas: a nasty case of "mourning" sickness', which reviewed his involvement with the tragic death of a crew member on a cruise liner on which he and his wife were passengers. Some major deficiencies in the medical facilities and care aboard such ships were revealed.

At our September meeting we also welcomed two colleagues, Drs Pam Tonkin and Stuart Ingles, who recently returned from Western Australia to live in Adelaide.

It is with deep regret that we learned of Dr Des Dineen's sudden death in July. Des, along with Tom Allen and Ian Steven, both now deceased, was one of our pioneering paediatric anaesthetists at the Adelaide Children's Hospital. He is remembered as a splendid teacher and it was unfortunate that many of our members who were abroad or interstate did not learn of his death for some weeks afterwards. Our condolences were made known to his wife, Gen, and family. Despite the slow dissemination of the news, there were many colleagues at his funeral.

Consequently, I have put forward a proposal to the ASA and ANZCA offices federally and in all states to institute a system of communication that whenever a colleague dies, all RAG members are notified ASAP. Hopefully such a scheme will be operational early in the new year.

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

WESTERN AUSTRALIA

Dr Wally Thompson

WA RAG held a luncheon on 22 October at the restaurant at the Univserity Club which was well attended.

The WA RAG is looking forward to their upcoming Christmas function in early December to close another successful year.

GET IN TOUCH

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

Or you can call the ASA office on: (02) 8556 9700

RAG Lunch at this years CSC, Darwin. Left to Right: ASA Vice President, Dr David M Scott, Dr John Gibbs, Dr Don Maxwell, Dr Don Stewart, Dr Diana Khursandi and Dr Rod Westhorpe

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

HARRY DALY MUSEUM

The Harry Daly Museum is happy to share our most recent additions to our historic collection. We thank Dr David Milroy Whish and his father, Dr Keith Milroy Whish, who have generously donated a wealth of items that once belonged to Dr George Milroy Whish – their grandfather and father, respectively.

Enlisting into the army in 1916 at the age of 28, Dr George Milroy Whish served in England and France during World War I. Returning to Australia in 1919, he was discharged from service and continued his medical career as a GP and surgeon. Amongst the donations we received are Dr Whish's surgical, needle and scalpel kits, as well as horsehair sutures preserved in oil.

The horsehair sutures have been added to our new exhibition 'Our Battle for Oblivion – the History of Anaesthesia and Pain Management', exploring anaesthesia in the field. To see them on display along with a vast array of other fascinating anaesthesia-related items, we welcome your visit the Harry Daly Museum. We are open by appointment on Thursdays and Fridays between 10 am and 4 pm. To book, please contact jkiely@asa.org.au.

For further details and images of these wonderful new additions to our museum, browse our collection online at eHive https://ehive.com/account/4493, find it on Trove or follow the links from the ASA website.

Julianne Kiely

Curator, Harry Daly Museum

New additions to the Harry Daly Museum collection that once belonged to Dr George Milroy Whish. Top: horsehair sutures. Bottom: surgical kit.

HISTORY OF ANAESTHESIA SIG AT THE CSC




CONTACT US

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

RETIRED ANAESTHETISTS GROUP BIOGRAPHY PROJECT

Dear RAG Member,

The ASA would like to remind you of the Biography Project that was started early 2014. Under the project, members are offered the opportunity to submit a brief personal biography to the Society for storage in the ASA archives. This biography is intended to convey, not only aspects of professional career, but also of domestic and social life, and all areas of special interest.

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

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

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

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

QUEENSLAND

Dr Jim Troup, Chair

Queensland has seen major improvements in the industrial sphere since the last update. The Palaszczuk government has followed through on its promise to restore industrial conditions to senior medical officers. The legislative changes to restore fairness have occurred. The recently negotiated Medical Officer's Certified Agreement (MOCA 4) was put to a ballot and 94% of those who responded voted for the agreement. This came into effect at the end of November. There has been a lot of hard work from the ASA members and non-members to get us to this position. Thank you all.

The local GASACT representatives have been innovative in developing a mentorship scheme for trainee members to gain support and advice from a more senior member of the profession outside the structure of the training program. This has just started to roll out. I look forward to the possibilities of helping our junior colleagues and, at the same time, giving them ideas of what life as an anaesthetist is like after training has finished. This will hopefully lead to more memberships being taken up.

The Queensland Department of Health is developing a Medical Workforce plan for Queensland. The State Committee is planning to send a representative. I am hoping that our input will be listened to.

I have been away for a few weeks and would like to thank Drs Nicole Fairweather and Chris Breen for filling in for me.

The Queensland Committee of Management is gaining some younger members which is good for our future.

I would like to thank all committee members and Jenn Burgess, who runs our secretariat, for their interest, involvement and assistance this year.

AUSTRALIAN CAPITAL TERRITORY COMMITTEE

Dr Mark Skacel, Chair

The Thomas Lo ASA Registrar's Prize Evening was held on Thursday, 6 November with three presenters currently in the running to win the best paper award and the $500 first prize. The night saw a good attendance from the local anaesthetists on the evening.

The MBS Reviews are about to begin and I would like to thank the following anaesthetists from the ACT for volunteering for the different committees if selected, namely Drs Weber, Viliunas, McInerney, Skacel and Gemmell-Smith. How the committees will be run and the amount of time each will entail is uncertain at this point in time. Suffice to say, the outcome will probably affect anaesthetists for years to come.

The ASA/ANZCA Art of Anaesthesia meeting will be moved back to its usual time slot of September 2016 and the convenors for this event will be Drs McInerney and Palnitkar.

The ACT AMA and Visiting Medical Officers Association, together with ACT Health, are negotiating VMO contracts at present. I understand the first meeting was delayed by six weeks due to differences in opinion. The first meeting was finally held in early October and failed to reach an agreement on the selection of an arbitrator and little else was discussed as regards anaesthetists. No doubt the process will be time-consuming for those involved and will ultimately be divisive for relations between ACT Health and VMOs.

Staff specialist contract negotiations are still continuing with discussion around the Special Employment Agreements which will allow staff specialists to be paid for public joints in the private sector. In the interim, the private hospital will pay the staff specialists for public work.

Recently, there has been some discussion about all public heart surgery from the Canberra Hospital being undertaken in the private sector. Where this will leave ACT anaesthetic registrar training is uncertain at the moment.

The recent hot topic in the *Canberra Times* is bullying of junior doctors at the Canberra Hospital. Speaking to senior clinicians at the hospital, one worries whether a consultant has the right to tell a junior that he or she is not up to standard. I believe that many consultants over the next few years will step away from teaching junior doctors and medical students, so removing themselves from the firing line. We live in interesting and changing times.

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin, Chair

CME

The showpiece of the ASA/ANZCA CME program this year was the special meeting held at Adelaide Oval on 17 September. Professor John West, Adelaide University alumni, and previously an intern at the Royal Adelaide Hospital, was our invited speaker, fresh from the CSC in Darwin. The interest in this meeting resulted in a late change to a larger venue. The Magarey Room reception area looks north over the oval and the lecture facility looks south over the Torrens, Festival and Convention Centres and the new footbridge over the Torrens. This provided a spectacular backdrop. Over 140 attendees enjoyed Prof West's presentation 'A polio epidemic and the birth of clinical physiology'. It was quite remarkable to hear Prof West answering questions from the floor on a range of topics related to his interest in the effects of gravity on the lung and his experience with NASA. My thanks to Kerri Thomas and Teresa Camerelli in the ANZCA office for their help and support in bringing this meeting to fruition. In addition, the support of the industry was greatly appreciated – thanks to MSD, abbvie, Aspen, Hospira, Concordia Medical Financial Solutions, LifeHealthcare and Ferrari Adelaide.

As the ASA's guest, Prof West was kept busy with a program including presentations to the Department of Anaesthesia at the Royal Adelaide Hospital (RAH), the Medical Grand Round at RAH, the Dean's lecture series at Adelaide University and the Australian Thoracic Society Meeting in Victor Harbour. He was also interviewed by ABC 891, for the morning program with Ian Henschke.

Our challenge to provide our CME program to our regional members is in the closing stages, given our loss of a video link, that was detailed in a previous edition of *Australian Anaesthetist*. We anticipate that we will be able to provide a link through the ASA website for our members in the Northern Territory and regional South Australia.

AGM

At the AGM held on 29 July at the Queen Victoria Lecture Theatre, Women's and Children's Hospital, preceding the July ASA/ANZCA CME, the following were elected unopposed:

Chair:	Dr Simon Macklin
Vice Chair:	Dr Tim Benny
Hon Treasurer:	Dr Tim Porter

Vale

It is with great sadness that we note that Tuyen Tran, one of our basic trainee members, lost her battle with serious illness. Our thoughts and prayers are with her family in this troubled time.

Finally and as always, my thanks to the SANT COM members for their support, and to Tracey DiBartolo for her secretarial assistance. The ASA SANT committee can be contacted via Tracey at the ASA SA office on (08) 8361 0105 or tracey@amasa.org.au.

WESTERN AUSTRALIA

Dr David Borshoff, Chair

The year has rapidly disappeared.

Some of the ASA WA-associated events included the very successful GASACT registrar cocktail evening at the former Fremantle Prison. Thirty-five to forty people attended with a small profit made and considered a great success.

The combined ASA St John of God Health (SJGH) Morbidity and Mortality meeting was held at the SJGH Subiaco

Delegates enjoy the Magarey Room at Adelaide Oval.

SANT Chair, Dr Simon Macklin with Prof John West, Dr Nathan Davies, Chair ANZCA/ASA SA CME committee, Dr Perry Fabian, Chair ANZCA (SA).

INSIDE YOUR SOCIETY

auditorium on 22 June – the second for the year. The first was held in March, and both proved very successful with much positive feedback. At the time of writing, we are scheduling the third and final meeting for November – we had hoped to have four for the year but with both the ASA/NZSA CSC in Darwin and the Bunker Bay country conference all occurring around the same time, we decided to miss the third quarter meeting.

The ASA Country Conference at Bunker Bay, the-wine growing (and surfing) area of WA, was held between 16 and 18 October at the Pullman Resort. There were approximately 110 delegates, great sponsorship and 17 health corporates participating in the weekend.

Prof Claude Meistelman, Professor of Anaesthesia and Intensive Care Medicine and Chairman of the Department of Anaesthesiology at the University Hospital of Nancy in France, presented on 'Neuromuscular blockade in specific populations' and was well received. He also presented a workshop on 'Anaesthesia of the obese patient' which tied in with National Anaesthesia Day on 16 October.

Dr Chris Acott, a Senior Specialist anaesthetist from the Royal Adelaide Hospital, provided a hands on workshop on different videolaryngoscopes, kindly provided by Western Biomedical, Covidien, Health Technology Supplies and CR Kennedy Medical. He also presented a lecture detailing the advantages of different types of videolaryngoscopes and classifications.

There has been excellent feedback in regards to content of presentations, as well as conference facilities, catering standards and the general organisation of the conference, so congratulations to Sam Hillyard and colleagues at Rockingham Hospital for an outstanding effort. The country meeting at Bunker Bay is an excellent opportunity for our interstate colleagues to experience both a meeting of very high standards and Australia's beautiful southwest, so mark it in the diary for 2016.

Another local initiative instigated by Dr Steve Watts from Hollywood Private and Sir Charles Gairdner Hospitals, has been the Heads of Departments meeting. This provides an opportunity for Heads of Departments from both the major private hospitals and public teaching hospitals in Western Australia to sit down for a few hours together and compare notes on the difficulties and successes in running hospital departments. Issues such as workforce, trainee numbers and varying drug prices have all been subjects of discussion.

Finally, the continuing uncertainty surrounding Western Australia's new hospitals continue. The Fiona Stanley Hospital recently made the news yet again when a local specialist quite publicly voiced his concerns. The government response appeared to be a 'shoot the messenger' approach. The new paediatric hospital's completion date has been moved again, much to the concern of both staff and patients. The uncertainty makes it difficult to plan and execute good patient care, but those loyal to the service are continuing to do their best.

On top of this, it now seems that the state government is planning to cut staffing levels in three major teaching hospitals, including the Fiona Stanley. The health department said hospitals were "overstaffed for their activity levels and exceeding their budgets". It did not say how many jobs would go, but hospital staff fear it could be as many 100 full-time equivalent positions.

This is one perspective. Some more sanguine healthcare workers suggest that the hospitals were built during boom times and significantly exceeded their budgets as a consequence of inflated product and labour costs. Of course, now that the mining boom is considered over, the government revenue stream has significantly diminished. The same workers believe the running costs of these new public hospitals are no longer affordable and that the standard of healthcare could be threatened.

It would appear that for the near future, the unpredictable nature of healthcare management in Western Australia will continue.

NEW SOUTH WALES COMMITTEE

Dr Michael Farr, Chair

Whilst there have been some notable emerging issues at the national level involving Medicare and health funds such as NIB, New South Wales has enjoyed a slightly more subdued last few months. However, there are always issues requiring the New South Wales Committee's attention.

NSW Department of Health

There has been an extensive and ongoing New South Wales Health project to develop model Scopes of Clinical Practice (SoCP) in New South Wales public hospitals, "the goal of the project is to develop model SoCPs for each medical and dental specialty in NSW Health, for Local Health Districts and Specialty Networks to apply when undertaking their credentialing and re-credentialing processes". The ASA, and in particular the PIAC, have been invited to provide comments and feedback during the production of this document (which is entering its final stages). I will report further on the progression of this document in the next edition of *Around Australia*.

Industrial and workplace issues

Public Hospital 'in arrears' payments

New South Wales ASA members were forwarded an email 1 October informing them of the ASA's understanding that the

previously reported 'back-pay' issue for VMO anaesthetists had been resolved. Further instructions were provided so that individuals could verify this in their own case.

Public VMO after-hours loading

The New South Wales ASA continues to observe developments regarding unresolved issues pertaining to after-hours loading, on-call and call back rates for VMO anaesthetists in New South Wales. Though, its looking possible that the New South Wales Ministry of Health may 'retire' these issues at a state-wide level.

GASACT Part 3 course

Since the success of last year's Part 3 Course at the Swissotel in Sydney, we were further pleased after receiving delegate feedback from the most recent meeting held on 14 November. It's popularity continues to gain momentum thanks to the quality of the speakers and their efforts, as well as those of organiser, Dr Callum Gilchrist. I wish to thank the speakers, Drs Harper, Jayram, Loughram, Stone and D'Souza, who unselfishly devoted their time to the day.

In grief and rememberance

It is with deep regret that I report the recent passing of two of our very well respected members. Dr Graham McCleary, an active member of the society for 39 years, passed away on 12 September. Following this, the sudden passing of Dr Andrew Belessis, a member since 1992, occurred on 17 October. On behalf of the Society and its members, I extend our sympathies and condolences to their families.

The ASA New South Wales Committee wishes all members and anaesthetists both a Merry Christmas and a Happy New Year, and would like to acknowledge in particular all those who have made contributions to the greater anaesthetic community this year.

TASMANIAN COMMITTEE

Dr Michael Challis, Chair

The last few months have been busy, as usual, with our winter CME meeting at Freycinet in August and the ASA/NZSA CSC in Darwin (including the ASA Council meeting immediately prior to the CSC). The usual business continues, including our local committee meetings, as well as planning meetings for next year's Tasmanian ASA/ANZCA Annual Scientific Meeting. Membership is also a focus, as we try to increase the society's profile and improve representation for all anaesthetists in Tasmania.

The winter CME meeting at Freycinet on 29 August was well received again. We are considering a change of venue for next year to showcase a different part of Tasmania.

Our 2016 Tasmanian ASM, 'Anaesthesia in the Extreme', is shaping up to be another great meeting. Topics include thoracic anaesthesia and severe lung disease, 'extreme' airways, anaesthesia in the elderly, hyperbaric medicine, massive transfusion and retrieval medicine. Speakers include Prof Peter Slinger (keynote speaker), A/Prof Reny Segal, A/Prof David A. Scott, and A/Prof Larry McNicol. Delegates will also have the opportunity to attend 'can't intubate, can't oxygenate' or major haemorrhage workshops for emergency response CPD points. The meeting is shaping up, yet again, to be a high-quality event, with a good social program as well. We hope to attract a significant number of interstate delegates. For more details and registration, please go to: http://www.acecc.org.au/Events/EventDetails.aspx?E=3515. At the time of writing, it is anticipated that registrations will open in mid-November.

'Public-in-private' operating lists are currently ongoing, and look set to continue, at least in the short to mid-term future. Some welcome workforce relief has occurred in terms of public positions for anaesthetists across the state. However, Tasmania has not been spared from the workforce maldistribution seen nationally. There is an excess of anaesthetists affecting both public and private practice in Hobart, but Launceston and the north-west have less issues, and sometimes the opposite problem. It will be interesting to see how the increase in public positions affects the overall supply/demand issues across the state.

The redevelopment of the Royal Hobart Hospital continues to move forward slowly, with building works still in their infancy. A long road lies ahead with the issues of running a tertiary referral hospital on a building site yet to fully manifest themselves. Interesting times are ahead on many fronts.

VICTORIA COMMITTEE

Dr Peter Seal, Chair

Gender Equity Officers

Dr Vanida Na Ranong has accepted an invitation to join the Committee of Management as a Gender Equity Officer. In addition, Dr Zoe Keon-Cohen has also taken up this role. This ground-breaking portfolio has been added as a response to a need that has become apparent to address any issues related to gender. We pledge our support to Vanida and Zoe in an area of ever-increasing importance.

Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM)

More than a year ago, the VCCAMM was disbanded for an indefinite period by the Andrews Labor Government. Only the Chair, Assoc Prof Larry McNicol, has been retained, while all the other members of this crucial council have been invited to reapply for their positions. It is unclear when the VCCAMM will be reconvened, but the Victorian Health Minister, Ms Jill Hennessy, has been reminded of the

INSIDE YOUR SOCIETY

situation by the ASA. Her office has replied that this issue is being deliberated upon by the Victorian State Cabinet.

Postoperative accessibility

In recent months, two of the more prominent inner-city private hospitals have identified a problem in not being able to contact a small number of individual practitioners during the early postoperative stage. Anaesthetists understandably have been advised to be more diligent in monitoring their phone at this time so that they can field queries regarding their patients.

Kyneton District Health

A dispute between the administrators at Kyneton District Health and visiting medical officers looks to have been resolved. Seventeen anaesthetists provide an excellent service to the rural hospital, which is just over an hour's drive north of Melbourne. Initially, they were told that they would be receiving a cut to their pay of approximately 50% – far greater than what their surgical counterparts were being offered. A deal has been reached which now involves a drop in remuneration that is more comparable to that being given to the surgeons and other craft groups.

GASACT Part 3 course

Drs Andrew Schneider, Debra Leung and Greg Bulman put together the annual valuable Part 3 meeting at Kooyong Lawn Tennis Club on November 14. The day-long course included many presentations offering sage advice about establishing a professional practice career on a sound financial footing.

ANZCA/ASA Combined QA Meeting

On October 17, ANZCA House hosted another proceeding in which many practitioners took up the opportunity to share and discuss challenging cases. Dr Shiva Malekzadeh, on behalf of the ANZCA Victorian Regional Committee (VRC), is to be congratulated for convening a well-attended and productive program.

ANZCA/ASA VRC Combined CME Meeting

On September 8, a most informative evening took place on the ANZCA premises. Drs Ben Slater and Roman Kluger delivered erudite accounts about the 'Role of Tranexamic Acid in Perioperative Haemorrhage'. Many took advantage of the opportunity to attend this beneficial educational event, which is becoming more of a rarity on the learning landscape.

Ballarat Health Service/ASA Rural Meeting 2016

Dr Fred Rosewarne, Ballarat Health Service Director of Anaesthetics, is organising a comprehensive schedule for what will be a reinstatement of the Rural Meeting. Once more, the venue will be the Novotel Forest Resort, Creswick, and it will occur on the weekend of March 5 to 6, 2016.

ASA NSC Melbourne 2016

The website for the NSC is now live and the academic and social programs are gathering pace. The Organising Committee is now meeting on a monthly basis.

Vale Dr Patricia Mackay OAM

In early September we experienced the sad loss of a true mentor and friend to many of us, Dr Patricia Mackay OAM. A fitting tribute to Pat can be found in this edition of the Australian Anaesthetist.

Committee of Management changes

Dr Andrew Schneider has retired from his role as Executive Councillor. The federal ASA is indebted to him for his many years of tireless service on the Executive. Andrew remains as our AMA Representative. We are most fortunate to have someone of the calibre of Dr Suzi Nou to replace him on the Board. Suzi has been joined by Dr Grace Gunasegaram as a New Fellows Officer. As already noted, Drs Vanida Na Ranong and Zoe Keon-Cohen become the inaugural Gender Equity Officers.

As stated, we mourn the passing of Dr Patricia Mackay OAM. Also, Dr Elliot Rubinstein has resigned from the Committee after many years of loyalty and accomplishment, particularly as a former State Chair, during which time he was instrumental in obtaining significant increased reimbursement for Victorian anaesthetists from Workcare and the Transport Accident Commission. We wish Elliot well in the coming years.

2016 MEMBERSHIP

Thank you for your ongoing support, we value your membership and continue to support and represent our members through:

- Advocating and representing your speciality through our dedicated policy team,
- Providing you the *Anaesthesia & Intensive Care* Journal and ASA *Relative Value Guide* in both print and App formats,
- Offering access to a variety of state and national events, including our successful National Scientific Congress in Melbourne in 2016,
- Our member magazine *Australian Anaesthetist* (soon to be available as an App)
- Member specific resources and merchandise,
- Ongoing support to our ASA trainees, and
- Other resources and services such as our ASA Advantage Program, access to the Harry Daly Museum and Richard Bailey Library collections, the opportunity to train in developing countries and access to a number of awards, prizes and research grants.

2016 invoices were posted out to members in the first week of December. If you have not received yours please contact the Membership Services Team on 1800 806 654 or email membership@asa.org.au.

To pay online simply log in to the member section of the ASA website and go to the Billing information section under the Membership tab.

ASA

Australian Society of Anaesthetists

INSIDE YOUR SOCIETY

DR GREGORY WOTHERSPOON 1943–2015

The *Australian Anaesthetist* was sad to report on the passing of Dr Greg Wotherspoon earlier this year. Long-time friend and colleague, Professor John Overton, has kindly passed on a transcript of the eulogy he presented at Dr Wotherspoon's funeral.

There is sadness speaking about the loss of a great friend and colleague but it is balanced by the privilege of recalling Greg's great achievements, his endearing characteristics and his courage in facing the challenge of his last illness.

His last letter, requesting me to deliver his eulogy, brought the realisation of how precious friendships are, and leaves time to ponder on how much special friends add to one's life – a thought we all share today.

The wide spectrum of people here today attests to the many lives Greg has touched across our community – family to whom he was devoted, colleagues, younger doctors in many disciplines who have learned their skills from him (both technical and in compassionate care), patients and friends.

In reflection of Greg's life, I spoke to close friends. Let me tell you the words they used – able, affable, calm, competent, compassionate, efficient and always willing, no matter how inconvenient. The added extra case was always accepted with grace and done in the best interests of the patient, perhaps this latter reflects his philosophy which has passed to the next generation. His elegance in dress was widely acclaimed and he was never seen with a hair out of place.

I first met Greg in 1973 as a Registrar when his immense potential was readily apparent. It was also observed by a very beautiful nurse who he had met when she was on rotation from the Children's Hospital. She was admired by all the junior staff. I was, however, able to tell them all that she was taken and they didn't have a chance!

What a wonderful union theirs was! Greg would often say "I wouldn't be where I am without Deb!". They left for the UK in 1974 for further training both at Great Ormond Street in London and at the Toronto Children's Hospital. Greg returned with so much to teach us.

At the RPAH (Royal Prince Alfred Hospital), he made major contributions to cardiac and obstetric anaesthesia and we all rejoiced the day he accepted an appointment at the Children's Hospital.

He worked with Bruce Benjamin and together they explored and investigated the airways of small children. He shared this ground-breaking work with the late Verlie Lines and managed the whole program after her death in 1986. They were pioneers and a unique team. I remember registrars fighting for the chance to do their lists. I even thought about charging them for the opportunity!

Many in private practice find little time to contribute on the bigger stage. Being a most efficient person, Greg became a College examiner, well remembered for his fairness and kindness. And if that wasn't enough, he then became Secretary and President of the Australian Society of Anaesthetists. In this position he, with Richard Walsh, organised the World Congress of Anaesthetists – arguably the best meeting of its kind ever held. With Deb at his side they graced every event and, like ambassadors, dealt with overwhelming numbers of foreign dignitaries. Their accomplishment is always remembered.

As President of the ASA, Greg pioneered and developed the highest standards of education, resulting in

the early recognition of Continuing Medical Education programs to raise the standards of practice and the recognition of anaesthesia as a critical and vital specialty. The rare accolade of life membership was awarded as recognition of this extraordinary achievement.

Bob Hare, as another ASA President, remembered Greg as an efficient manager, able to handle even the most irascible with kindness and tact. His humour was always on display and never disparaging – everyone was treated with dignity. Bob recalled that he rang regularly on a Sunday morning with new and innovative ideas. Greg knew the best time to secure agreement on his new ideas was early Sunday morning before the coffee had kicked in!

These talents made him an outstanding Head of Department at Sydney Adventist Hospital, where he moulded many diverse characters into a cohesive department. His passion for high standards resulted in his membership on the Quality Review Committee and provided a template for many other departments to follow.

His skills and vision were instrumental in the establishment of Sydney Anaesthetics – one of the biggest practices in Australia. There, his colleagues remembered him and drank a toast to his memory.

In meetings he could convince those with often aggressive, opposite views to agree in the best interests of the patients and the hospital – what a man to have on your side! But, how did he do it? He was ably supported by a wonderful wife and three beautiful daughters; one, Edwina, who is my Goddaughter. They were a united family, an example to us all.

Bob Hare summed it up by saying "he would have excelled as a career diplomat but that would not have outshone his achievements as a doyen of his profession". We who knew him would agree unreservedly!

It is at times like this that we reflect on the great legacy a colleague has left. Greg was a self-effacing man, but his achievements beyond his successful private practice are remarkable. Let me enumerate the highlights – he was a founder of Day Surgery in Australia and Principal of Sydney day surgery, a recipient of the Pask Certificate of Honour, a member of the Association of Anaesthetists of Great Britain and Ireland, was awarded Life Membership of the ASA and, of course, was ASA President during the most successful World Congress of Anaesthetists. He was a part of, or authored, many publications – one especially, *A clinical review of a free-standing day surgery unit*, was widely quoted as an authorative reference! It is not often realised that Greg spent a year lobbying politicians, both here [Sydney] and in Canberra to set the benchmark and gain approval for day-stay surgery in Australia. Now accepted as standard practice, we owe this, in large part, to Greg. His international standing resulted in his advice being sought in other countries, especially Singapore, while they established their day-stay services.

Facing his last illness, his family were there by his side – the model of a devoted and loving unit. His courage and fortitude, combined with dignity, is not just an example, but a reflection of his strong character.

Today, like you, I mourn a friend, a mate and a loyal and supportive colleague who has brightened all our lives, whose company and fine hospitality was so enjoyed.

He will leave warm memories for us all – his devoted family, colleagues, patients and those who learned from him the art of the caring physician.

Not stone or brass tablet will be his legacy, but rather a light on the path of those who follow as he set the standards of care.

He has touched our lives with warmth, humour, a genuine nature and great enthusiasm.

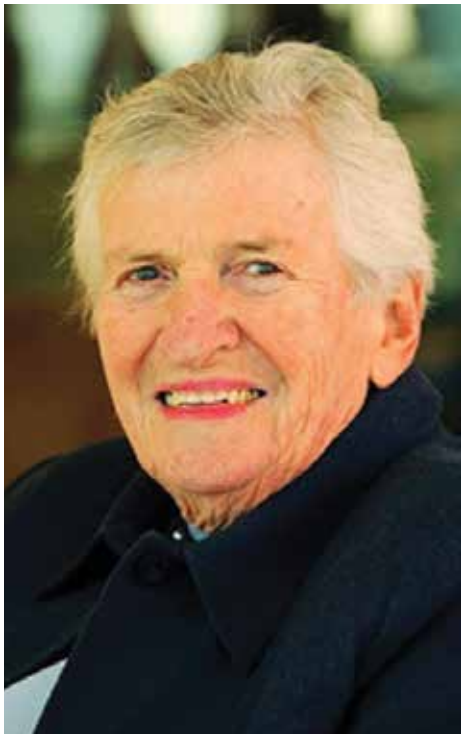
To Deborah, Edwina, Charlotte and Georgia and their families, we offer sympathy and support as he would for us.

What is greatness? For some it is medals, titles, wealth or status. But if it is integrity, love of family, respect of friends and colleagues and leaving a lasting legacy – and I believe it is – then Greg was a great man.

He has touched all our lives, we are better for having known him and the memories will help soften the loss. He has left his mark. Farewell old friend, we will miss you.

INSIDE YOUR SOCIETY

DR PATRICIA MACKAY, OAM 1926–2015



The ASA was saddened to hear of the passing of Ex-President, Dr Patricia Mackay, OAM. Dr Christine Ball was present at Pat's funeral on 7 September and gave a beautiful eulogy which has been reproduced below for those that were unable to make it to the ceremony.

Pat Mackay won a scholarship to study medicine at Otago Medical School in the closing years of World War II. Entrance into medical school was purely academic then; the barriers to women studying medicine had been broken down by the previous generation, but there were still only a handful of women choosing the profession. About 10% of her graduating year were women. Specialist anaesthetists were also unusual then and junior doctors were expected to deliver anaesthesia with very little experience or supervision. Pat discovered a love for anaesthesia almost immediately and remembered one particular case which defined her career – as a junior doctor she anaesthetised a woman for a caesarean section whose baby was believed to be dead. She told me that the survival of this baby was the thing that crystallised her desire to study anaesthesia.

There was no way to become a specialist anaesthetist in New Zealand at that time and so she travelled to Australia to obtain a Diploma in Anaesthesia at Melbourne University. Not content with one qualification, she then moved to Oxford in the UK where she obtained their anaesthesia diploma and studied with Dr Robert Macintosh. She also became a fellow of the relatively new Faculty of Anaesthetists at the Royal College of Surgeons in England.

Back in Australia, the world of anaesthesia was changing rapidly. The Faculty of Anaesthetists at the College of Surgeons was founded in the early 1950s and the first faculty members were inaugurated in 1952. This was the beginning of what is today known as our independent College of Anaesthetists.

Pat returned to New Zealand in early 1954, working as a specialist anaesthetist for six months at Otago Hospital. But there were other things drawing her back to Melbourne and she moved there in mid-1954. There she quickly obtained a position with Dr Norman James at the Royal Melbourne Hospital where she was appointed as the Assistant Director of Anaesthesia, a fairly stellar rise through the ranks. She also joined the new Australian Faculty of Anaesthetists in the same year and was awarded the Fellowship the following year. To put things in perspective, there were 44 Fellows of the College in 1954; today we have over 3000. These inaugural Fellows built the foundations of our profession.

As we know, she married Ian in Melbourne in 1958 and had five children. She told me she managed to "keep her hand in during these years" and gradually returned to full-time work. But her curriculum vitae tells a slightly different story. Her life has been one of continuous service to the profession as a clinician, as an administrator, as a committee representative and as an educator, all whilst being a wife and mother. Throughout her early years in Melbourne, she held appointments at various hospitals, mainly the Royal Melbourne, but also hospitals like Footscray and the Repatriation Hospital.

She also became very active within the Australian Society of Anaesthetists.

Starting as Treasurer, she then rose to Federal Secretary from 1956 to 1961 when the Society was going through some particularly turbulent times. The stability she brought to the organisation was invaluable and led to her becoming President of the Society from 1966 to 1968. In her capacity as President, she travelled to London, representing Australia at the World Federation of Societies of Anaesthesiologists conference.

The College also received her attention, and by 1956 she was on the State Committee of the Faculty. Later, she was to serve for 14 years as an examiner, as well as holding various teaching appointments at the University of Melbourne.

Throughout this time she also managed to conduct research within anaesthesia, writing scientific papers and presenting her findings at various meetings. Her earliest publications reflect her growing skills in anaesthesia, with articles about the management of tetanus and the role of hypothermia in neurosurgery. It was these clinical skills which she was to impart to generations of registrars passing through the Royal Melbourne Hospital where she worked for her entire clinical career. As Chairman and Head of the department throughout the late 1980s and early 1990s she brought wisdom and vision to the profession, convincing management that anaesthetists were important to the running of a successful hospital and had important roles to play in places other than the operating theatre. As a result, the department grew in numbers and in stature. Importantly, Pat believed in quality assurance and the changes she brought to the Royal Melbourne Hospital Anaesthetic Department were to also redirect her career. She instituted a teaching program for the registrars on Friday mornings, where consultant anaesthetists began the operating lists so the trainees could go to the departmental meetings. The dedicated teaching time and quality assurance was something quite new – now our trainees take it for granted.

Pat's interest and commitment to patient safety is her most enduring legacy. She was involved with the origins of the Australian Patient Safety Foundation in the late 1980s and was invited to become the chair of the Victorian Consultative Council on Anaesthetic Morbidity and Mortality (VCCAMM). She had never been a member of this council, which had been operating for around ten years, and initially had some doubts. But she told me her internal conversation concluded with "Well, after all, you always take on more than you think you can do and you usually manage." She was proud of the achievements of this committee and her years as its Chair. The committee is now an integral part of the safety profile of anaesthesia, and under her direction, reporting increased with some significant recommendations resulting – including the removal of a problematic intravenous fluid from the market and a greater awareness among anaesthetists of the dangers of intraoperative hypotension. Her work on this council has promoted the highest standards of anaesthesia and perioperative care through adverse events reporting.

I have spoken with many people over the last few days who had memories of Pat that they wished to share. All spoke of her ability to sum up a situation and quickly get to the heart of the matter; some spoke of her fairness and support. She was also apparently very good at making things happen. One colleague told me "She would tell you she had a little job for you, and that was it, you would do it". Dr Phil Ragg was one who knew her very well through their years together on the VCCAMM committee and I would like to quote from the email he sent me:

Her role on VCCAMM has been where I have had most opportunity to be impressed by her. She was the first Chair and established a relationship with the Coroner's Office that has not been emulated since. She would visit the Coroner on a monthly basis and was so respected and trusted by the department that she had unrestricted access to coronial inquests and deaths that had not been reported directly. This opportunity and relationship has long been extinguished.

Sitting at VCCAMM meetings was always a pleasure with Pat, and I would try to sit beside her if possible to get some insightful comments under her breath that were often not for the minutes. As Chairman, she would always encourage deep discussion, giving every representative the opportunity to speak and if she noticed someone sitting quietly she would invite comment from any member she believed would contribute. She was instrumental in building a committee with an incredible versatility and wide representation of expertise including lawyers, intensivists, GPs, health department epidemiologists and, of course, anaesthetists from many specialties both public and private. She was an honorary member of this committee until last year and a very active and vocal contributor. I would like a cent for the number of times Pat would recall a similar case 20 years ago or would sit and listen to 15 members struggling with a case and then summarise the key issues in two sentences to make it clear to us all. She was a very clear thinker and always supportive of anaesthetists that had volunteered their cases no matter how difficult or revealing.

For the last few years, Phil has been regularly driving Pat home from these meetings. As well as being impressed by her communication and organisational skills, he was particularly in awe of her ability to get in and out of his ultra-low sports car. He cherishes the memories of their conversations on the way home, often about football, sometimes about local politics, but also, often, about her family, who she always spoke of with great pride.

It was her great wisdom and skill as a communicator which meant that Pat was never really able to retire. In 2006, she was an inevitable selection for the new Quality and Safety Committee at the College and took on the communication role. She established the quality and safety section of the College bulletin and was also quick to take advantage of new technology with contributions to the electronic newsletter. She served on that committee until 2012, her last official appointment at the College. In summing up her contribution, Professor Alan Merry, himself an international expert on safety in anaesthesia, stated "quality and safety in anaesthesia can only be built on the foundation of sound clinical expertise and experience, and through effective administrative and organisational skills. Pat brought all of these attributes to the committee, and a great deal more".

Pat obtained many official honours throughout her career, including the ANZCA medal, life membership of the World Federation of Societies of Anaesthesiologists, the Australian Medical Association Women in Medicine Award, the Centenary Medal of the Order of Australia and, in 2008, a Medal of the Order of Australia. All these honours are a reflection of the honour and respect with which we, as a profession, had for Pat. Her knowledge, wisdom and expertise were legendary; she gave generously of her time to the profession as a whole and to individuals who remember her with love and affection. She lived an extraordinary life. It was my very great privilege to record some of her reflections in an oral history at the College two years ago and to stand here today to tell you how much we valued this wonderful woman and what a privilege it was to know her.

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

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

TRAINEE MEMBERS

Dr Daniel Reece Alban	VIC
Dr Mitchell David Blake	NSW
Dr Gregory Britton	NSW
Dr Sebastian John Corlette	NSW
Dr Sandra Marie Derry	NSW
Dr Eliza Jane Doneley	QLD
Dr Thomas Druitt	QLD
Dr Kate Elizabeth Dummond	TAS
Dr Mohamed Elkashash	ACT
Dr Richella Lea Falland	SA
Dr Wai Mee Foong	QLD
Dr Andrew Bryan Gillard	SA
Dr David John Hargreaves	NSW
Dr Ben Kave	VIC
Dr Adam Lindsay Bacchi Keys	QLD
Dr Elise Maree Kingston	SA
Dr Gary Leung	NSW
Dr Avery Lim	NSW
Dr Alfred Tanaka Mahumani	NSW
De Erin Belinda McCabe	VIC
Dr Peter Michael Mulcahy	TAS
Dr Lauren Pilz	NSW
Dr Kajan Hajumeanin Pirapkaran	NSW
Dr David Brian Reid	SA
Dr Nikitha Vootakuru	NSW
Dr Sarah Wallis	VIC
Dr Vamshi Yatham	ACT

ORDINARY MEMBERS

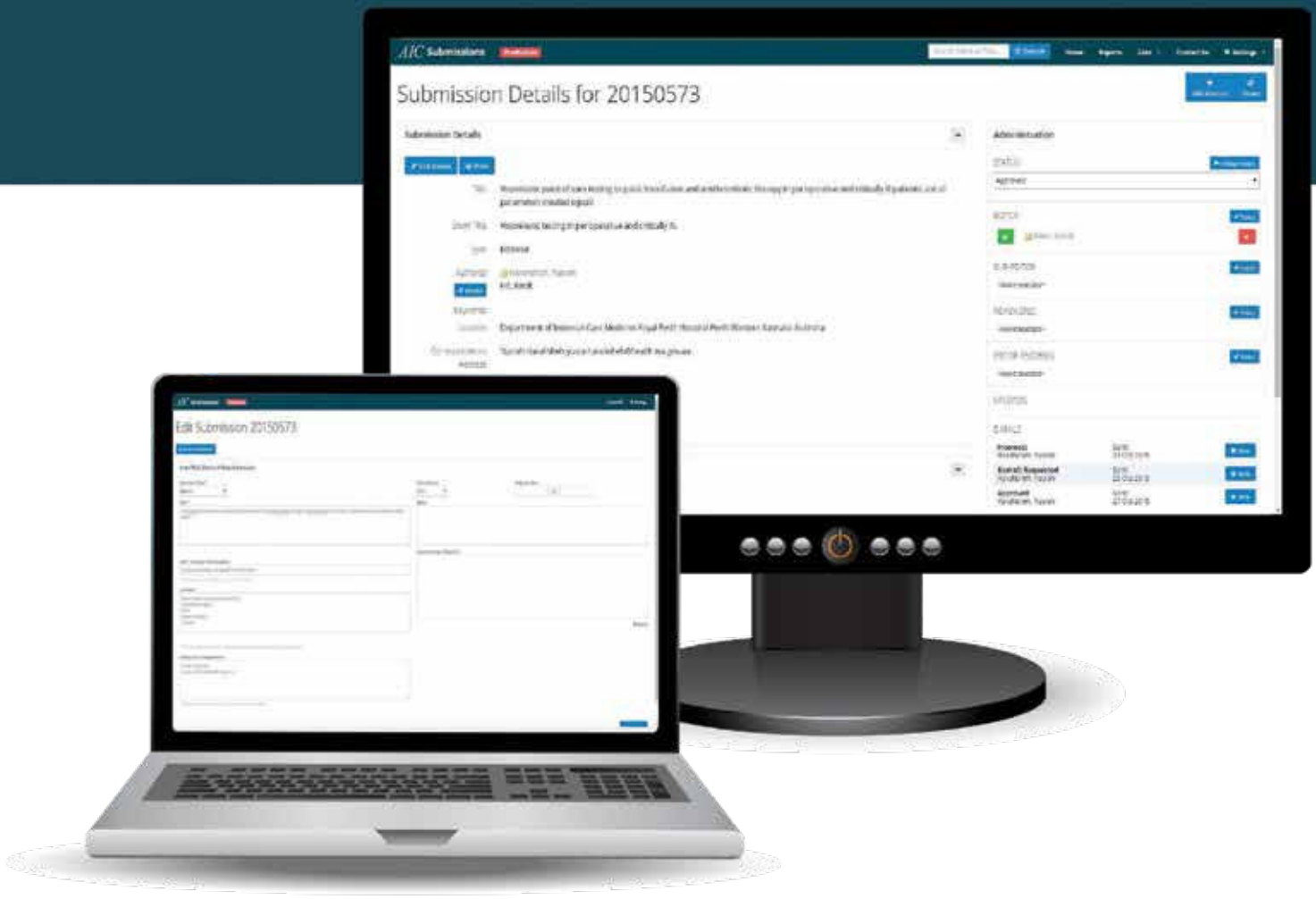
Dr Lauren Maree Bourke	VIC
Dr Alan Grayson Bullingham	NSW
Dr Philip Bruce Cornish	SA
Dr John Edington	VIC
Dr Raymon Tasman Gadd	NSW
Dr Leslie James Grene	NSW
Dr Ben Greenhalgh	NSW
Dr Philip Gribble	SA
Dr Anna Hallett	QLD
Dr Ross Colin Henderson	WA
Dr Mark Joseph Heynes	VIC
Dr Dinuk Arshana Jayamanne	ACT
Dr Indra Sujeewa Kumarasena	NT
Dr Sophie Liang	NSW
Dr Stephen John Lightfoot	NSW
Dr Alison Margaret Lilley	VIC
Dr Mark Stephen Markou	SA
Dr Vanida Na Ranong	VIC
Dr Wendy Anne Olden	NSW
Dr Usha Padmanabhan	VIC
Dr Vanessa Greta Percival	WA
Dr Edney Richardson	NSW
Dr Peter Squire	VIC
Dr Arpit Srivastava	NSW
Assoc Prof Kersi Jalejer Taraporewalla	QLD
Dr Monika Katalin Tecsy	ACT
Dr Melanie Sonya Van Twest	VIC
Dr Beth Michele Veivers	QLD

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Drs Graham Roy McCleary (NSW), Henry Paul Dyer (QLD), Desmond Patrick Dineen (SA), F James Reid (VIC) and Patricia Mackay (VIC).

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

The *Anaesthesia and Intensive Care* Submissions website has had a make-over!



As part of our continuous endeavours to improve ASA services to our members, the publications team has been working with the AIC Editors to update and re-invigorate the submissions website in order to provide authors and reviewers with a sleeker, more intuitive experience when working on a paper for the journal.

As with all new projects, we have endeavoured to ensure there are no issues when the site goes live, but if you do come across a glitch, let us know at aic@asa.org.au and we will rectify them as quickly as possible.

NZSA SALUS PER SCIENTIAM

ASA Australian Society of Anaesthetists

ANZICS

RVG 18th edition
Exclusive to ASA members

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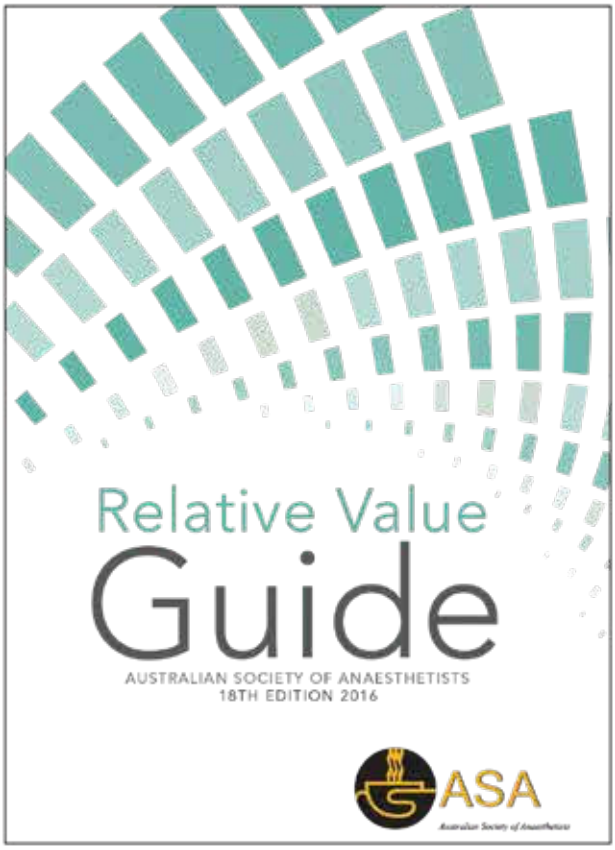

ASA APP VERSION AVAILABLE DECEMBER

The app can be accessed using your ASA member logon details.

Search for "ASA RVG" and look for the ASA RVG fan icon.

For any queries, contact policy@asa.org.au
Members will be emailed once the app is available to download.

RVG

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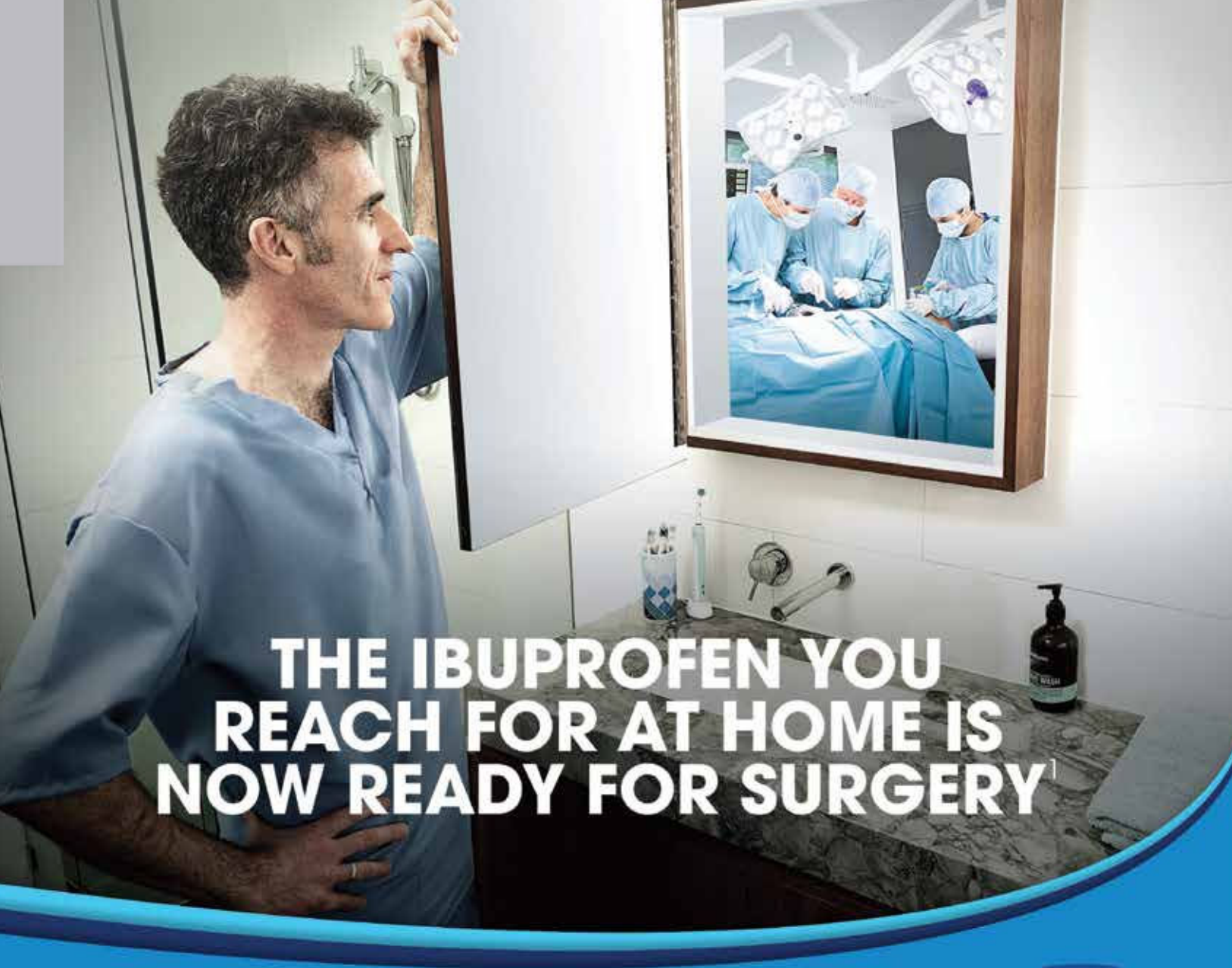

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