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THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • DECEMBER 2014

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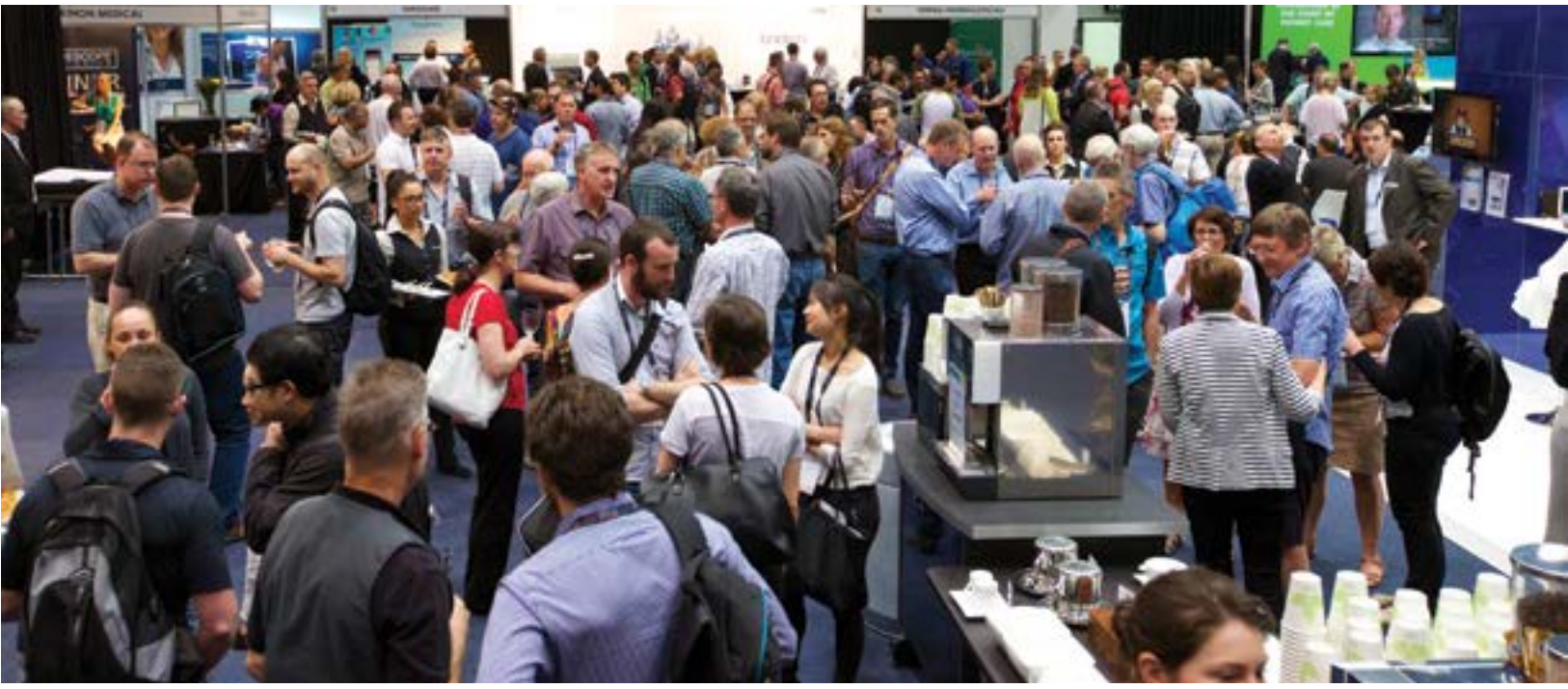

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WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

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

- Intention to contribute must be emailed by 09 January 2015.
- Final article is due no later than 13 February 2015.

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

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ASA EDITORIAL FROM THE PRESIDENT

DR GUY CHRISTIE-TAYLOR
ASA PRESIDENT

Welcome to the final edition of *Australian Anaesthetist* for 2014. Following another successful National Scientific Congress and Annual General Meeting, we are pleased to present your new President, Dr Guy Christie-Taylor, and his first Editorial for *Australian Anaesthetist*.

I am greatly honoured to begin my role as the 44th President of the ASA and to serve the membership and profession to the best of my ability.

The first objective of the Company, as stated in our Constitution, is to "advance the science and art of anaesthesia in Australia and related disciplines to achieve international best practice".

The Constitution admonishes the Company to "preserve, at all times the professional independence of anaesthetists in whatever capacity they may be serving".

The ASA is the professional body for all anaesthetists, whatever their capacity. Private, public, academic, metropolitan, regional, remote and rural and even on foreign shores – all anaesthetists serving in these diverse environments and with variable capacities must have a 'home' within the Society.

Our new Vice President, Dr David M. Scott, brings to the Society his many impressive talents and skills and also his perspective and insights as a regional (no pun intended) private practitioner.

So, in what 'capacity' do I serve? I serve as a full-time staff specialist at the Royal Adelaide Hospital and head of cardiothoracic anaesthesia. In addition, I bring with me the insights gained from having been briefly 'Lost in the Labyrinth'[1] of the International Medical Graduate Specialists/Overseas Trained Specialist process and been compelled to contemplate what the notion of 'citizenship' really means.

It is one thing to become a skilled anaesthetist and it is a further step to become a small business leader, manager and entrepreneur

In addition, I bring to the role an appreciation of the important function of ANZCA in shaping and advancing our profession. I have been supervisor of training at the Royal Adelaide Hospital, a module supervisor, part 1 and part 2 course lecturer, a project supervisor, longstanding member of the Continuing Medical Education Committee and member of the Cardiothoracic, Vascular and Perfusion Special Interest Group executive. More recently, I was a member of the ANZCA Medical Perfusion Working Group.

At the 'coal face', I have had opportunities to improve and enhance the cardiothoracic anaesthetic service at the Royal Adelaide Hospital and we have seen this improve through the endeavours of all our group's members with an anaesthetically-lead intraoperative transoesophageal echocardiography service and cardiothoracic pre-admission clinic. We have enabled our surgeons to explore robotic surgery and minimally invasive mitral valve repairs and have enhanced and improved transfusion with cell salvage and the introduction of ROTEM®. Many of these are now taken for granted and are a standard of care in any unit, however, it should not be forgotten how much energy and effort needs to be expended daily to enact change and improvement.

I have served on the Cardiothoracic Improvement team, the General Manager's Emergency and Elective Surgical Strategy Committee, the Transfusion Committee and the Department of Anaesthesia Management Committee.

Recently I had the opportunity to see first-hand how a national committee functions by serving on the Health Workforce Australia's Project Advisory Group: Advanced Scope of Practice Nurse Endoscopy.

The ASA has given me many wonderful opportunities to expand my understanding of what it is to belong to the wider and broader community of our profession and not just focus on my clinical role in isolation. I have been an ASA member since 4 April 2001 and a member of the SA/NT Committee since 2003. I was also Chair in 2008/2010. In

addition, I serve on the Professional Issues Advisory Committee and was very privileged to have been Vice President of the Society for the last two years.

Richard Grutzner has provided me with a magnificent role model and has facilitated my transition into this position. I have been able to actively participate in the full range of Society business and, in doing so, build a deep appreciation of what a wonderful and vibrant Society we have, as well as gain insight into where some of our challenges lie.

It should not be forgotten how much energy and effort needs to be expended daily to enact change and improvement

In seeking to serve the profession and Society more effectively, I have sought to up-skill some of my previously 'dormant' or non-existent management and leadership skills with some training. In addition to brief weekend courses and conferences, I attended the University of South Australia's program on Principles of Lean Thinking in 2012 and in 2013 became a graduate of the Australian Institute of Company Directors by completing and passing their Company Directors Course.

I believe that the Society has a role to play in assisting its members to acquire the sort of skills and knowledge taught in these types of courses. It is one thing to become a skilled anaesthetist, but it is a further step to become a small business leader, manager and entrepreneur.

Largely due to the energy and effort of a few key colleagues, I have been fortunate in the last few years to begin to appreciate how crucial and vital the role of research is to our profession and how we seem in Australia to collaborate so successfully in multi-centre trials of immense clinical value. I am a Principal Site Investigator for the Aspirin and Tranexamic Acid for Coronary Artery Surgery trial and have already benefitted from its results in my pre-admission clinic. It is certainly far easier and more convenient to simply continue aspirin until cardiac surgery than it was having to work out the logistics of ceasing it. It remains an absolute object of the Society to encourage and support research related to anaesthesia and I would remind members that the Society has funding available to assist their activities.

The unique nature of my work structure has meant that for many years I have had the opportunity to appreciate and understand the nature of private practice in Australia. This area is crucial to service delivery and to maintaining the health and wellbeing of a large and growing segment of the population. As strongly as I believe in maintaining an outstanding public system with its vital role in teaching and training, so too do I believe in the fundamental role of private medicine to deliver efficient, effective and timely care to its many patients. The Society needs to represent and advocate for all anaesthetists, whatever the role or capacity in which they choose to function.

The ASA and ANZCA form the backbone of the anaesthetic profession in Australia and it is by means of their combined resources – human capital, infrastructure and expertise – that the profession can protect its independence, advance its practice and serve its patients.

I look forward to serving you as President in whatever capacity you might serve anaesthesia.

1) Lost in the Labyrinth. Report on the inquiry into registration processes and support for overseas trained doctors. House of Representatives Standing Committee on Health and Ageing. March 2012. http://bit.ly/1ryDXec.

CONTACT

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

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GEOFFREY KAYE ORATION

The anaesthesia workforce 2014: how many is too many and when is enough enough?

DR RICHARD GRUTZNER,
ASA IMMEDIATE PAST PRESIDENT

Everyone at the ASA and *Australian Anaesthetist* offer our greatest thanks to Dr Richard Grutzner for his term as President of the Society. Richard presented his Outgoing President's speech – the Geoffrey Kaye Oration – at this year's National Scientific Congress at the Gold Coast and it is featured below as his final Editorial with *Australian Anaesthetist*.

It is my great pleasure to present the 2014 Geoffrey Kaye Oration. This oration comes at the end of my two-year term as ASA President. In the same way that the Sword of Damocles hangs over the heads of all medical practitioners, the Geoffrey Kaye Oration hangs over the head of the ASA President. Following the death of Dr Geoffrey Kaye in 1986, the President's address at the National Scientific Congress was re-named the Geoffrey Kaye Oration. Former ASA President, Dr Peter Brine observed in 1978 that "the beauty of presenting a presidential oration is that one chooses the subject, speaks without interruption and finishes without question." In my Geoffrey Kaye Oration I will talk of the founding of the ASA, introduce some key participants and go on to relate the beginnings of professional anaesthesia to contemporary issues, in particular the anaesthesia workforce. How many is too many and when is enough enough? This is clearly a rhetorical question, but in this oration I will discuss the issue of the anaesthesia workforce which has been one of the major issues of my presidency over the last two years.

The great American physician, William Osler, said

> *The great possession of any society is its great names. It is not the pride, pomp and circumstance of an organisation which brings honour, not its wealth, not the number of its buildings; but the men and women who have trodden in its service along the thorny road through toil, even through hate.*

I would like to start by introducing you to one great man in the history of the ASA and another great man of significance in my own personal history.

Geoffrey Kaye was born in Melbourne in 1903. He was educated in Britain and returned to Australia where he enrolled in the Faculty of Medicine at Melbourne University. He graduated MB BS in 1926 and MD in 1929. He took an early interest in anaesthesia and worked with Dr Frederick Green, honorary anaesthetist to the Royal Melbourne Hospital, who became one of his mentors. Green was due to present a paper at the British Medical Association meeting in Sydney in 1929. Due to ill health, Green was unable to attend and asked Kaye to represent him at the meeting and to prepare and present his paper called "Pathological Findings in Death during Anaesthesia". This was fortuitous as, at this meeting, Geoffrey Kaye met Dr Francis H. McMechan who was a pioneering American anaesthetist from Ohio. In 1912, McMechan had been instrumental in the formation of the American Association of Anesthetists. In 1925, the American Association of Anesthetists became the International Anesthesia Research Society (IARS), a body still in existence and responsible for the publication of the journal *Anesthesia and Analgesia*. McMechan was a strong believer in international collabo-

Dr Geoffrey Kaye

Dr Francis (Frank) H McMechan

ration long before the word globalisation had been coined. McMechan saw in Geoffrey Kaye a man of great potential and encouraged him to travel to the United States and Canada to meet anaesthesiologists and to attend several meetings as a guest of the IARS.

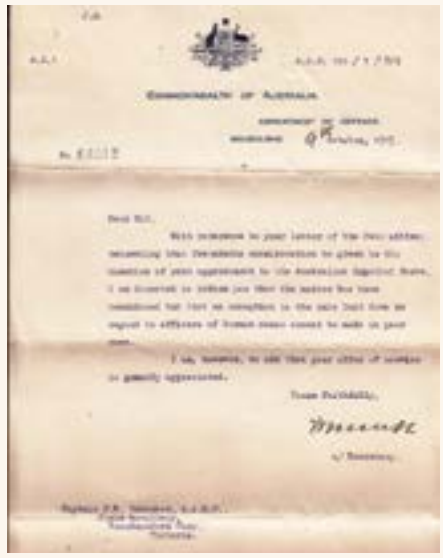
Unbeknown to Kaye, McMechan had an ulterior motive in his encouragement of Kaye. McMechan was impressed by Kaye's strong work ethic and his enquiring scientific mind. His own physical health was deteriorating due to the effects of rheumatoid arthritis and he imagined that Kaye could be a suitable successor for his role as Secretary General of the International Anesthesia Research Society. Kaye returned to Australia in 1931 and, at the urging of McMechan, became involved in establishing the Australian Society of Anaesthetists. Kaye set out to develop the specialty of anaesthesia by a commitment to organisation, publication and research which would underpin the solution of practical problems for practicing anaesthetists. It is these same principles of organisation, publication and research which still underpin the specialty of anaesthesia in 2014.

The British Medical Association meeting in 1934 was held in Hobart and the ASA was founded on or about January 19th 1934 following a meeting at Hadley's Hotel. Prior to the meeting in Hobart, Kaye had been corresponding with anaesthetists throughout Australia and actively developing the case for the establishment of an Australian Society. A provisional committee was elected with Dr Gilbert Brown as president and Geoffrey Kaye as secretary, a role he fulfilled for 12 years.

Geoffrey Kaye worked as an honorary anaesthetist at the Alfred Hospital and the Eye and Ear Hospital in Melbourne. Meanwhile Kaye purchased a grand Victorian building in Mathoura Rd, Toorak which, in addition to his home, became the headquarters to the Society and included an engineering workshop, a library and meeting rooms. He had a particular interest in anaesthesia equipment and his collection of equipment became the foundation for the ANZCA collection housed in the Geoffrey Kaye museum at Ulimaroa in Melbourne. As honorary secretary of the ASA, Kaye almost single-handedly managed the affairs of the fledgling society. His autonomous style was not without problems and Kaye felt that he lacked support from other Victorian anaesthetists who did not share his vision for the specialty. Kaye was somewhat protected from the harsh reality of making a living due to his independent means and was therefore able to do the work of the Society and honorary hospital work. Eventually, in 1954 the secretariat was moved to Sydney and Kaye sadly withdrew from both the Society and the Faculty of Anaesthetists of the Royal Australasian College of Surgeons.

I would now like to introduce you to another man of great importance to my own personal history. My grandfather, Frederick William Grutzner, was born in 1887 and educated at the Geelong College, having been awarded a full academic scholarship. He matriculated in 1905 and entered the faculty of Medicine at Melbourne University, graduating MB BS in 1912. In 1913, he worked as a registrar at the Launceston General Hospital in Tasmania prior to the outbreak of the First World War. Upon the declaration of war, my grandfather applied to join the Australian military forces and was appointed a temporary Captain in the Australian Army Medical Corps. Later, in 1915 he applied for active service but received a reply from the Ministry of Defence denying his application. This was on the basis that his allegiance was questionable on account of his German surname. As a proud second generation Australian, he would have been distressed by this decision but did not speak further of it for the rest of his life. It was only after his death in 1974 that my father discovered the letter from the Department of Defence which he had kept for the next 60 years. In 1914, he moved to Shepparton in rural Victoria and commenced work as a general practitioner. Shepparton is two hours north of Melbourne and set on the Broken and Goulburn Rivers. The rivers and irrigation arising from them was responsible for the

Dr Frederick Grutzner



Ministry of Defence letter, 1915

[Dear Sir,

With reference to your letter of the 24th ultimo; requesting that favourable consideration be given to the question of your appointment to the Australian Imperial Force.

I am directed to inform you that the matter has been considered byt that an exception to the rule laid down in regard to officers of German name cannot be made in your case.

I am, however, to add that your offer of service is greatly appreciated.]

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district's role as a major food producer with orchards and dairy production a particular focus. Amongst the population of Shepparton was a large migrant population, from Italy in particular. A story, maybe apocryphal, is that my grandfather's first patient in Shepparton was a prized greyhound owned by one of the immigrant Italian families. The unfortunate dog had a fractured leg which was X-rayed and put into a plaster cast by my grandfather. We are unsure of the ultimate racing fate of his first patient.

My grandfather practiced in Shepparton for the next 44 years. His first wife died in the Spanish Influenza epidemic of 1919 and this, I believe, spurred his interest in public health issues for the remainder of his career. His second marriage was to Madge Abernethy, who was to become my grandmother.

If we look at a timeline of medical innovation over the last hundred years, there would appear to be an almost inverse relationship between the respect in which doctors were held and their ability to provide effective treatment of a host of conditions. Prior to the major advances of antibiotics, immunisation against Polio, Measles, Tuberculosis, Mumps, rubella and now human papilloma virus doctors were very limited in what they could do. Joint replacements, organ transplants, arthroscopic and endoscopic procedures were still a long way off. Treatments for diabetes, hypertension and a spectrum of mental health disorders were rudimentary or non-existent. Despite the limitations of medical practice of the day, doctors were held in high esteem by the community. My grandfather was a parishioner at St Augustine's Anglican Church in Shepparton.

Dr Frederick Grutzner in Shepparton

The number of anaesthetists has continued to grow at a greater rate than the Australian population

In 1925 as a 38 year old general practitioner, he officially laid the foundation stone for the new church building. This must have seemed a long way from the young doctor refused the opportunity to serve his country on the basis of his Germanic name. He subsequently went on to become a Councillor for the Shire of Shepparton, a role he fulfilled from 1927 until 1951. He also became deputy Mayor and subsequently chairman of the Goulburn Valley Water Board, which was responsible for water supply and sewerage treatment for the district.

Travel in the 1930s was not common and my grandfather's attendance at the 1934 British Medical Association meeting in Hobart involved what, for the time, was a significant trip. He caught the train to Melbourne and then sailed by ship to Hobart where he attended the meeting at which Geoffrey Kaye, Gilbert Brown and others would found the ASA. You will note that the dress code for attendance at the meeting was somewhat more formal than today, as a photo shows my grandfather arriving wearing a suit, full academic gown and university hood. It is most likely that my grandfather sailed to Hobart on board the ship *Mongolia* along with Dr Gilbert Troup, a West Australian anaesthetist and fellow ASA founder. How nice would it be if I was able to say that my grandfather was at the initial meeting at Hadley's Hotel and that here I am, his grandson, presenting the Geoffrey Kaye oration 80 years later? Sadly this is not the case and I am not sure of either my grandfather's interest in, or skill with anaesthesia. Certainly as a country general practitioner he was required to provide both anaesthesia and surgery for the management of emergencies including obstetrics and trauma. As I understand it, the various medical practitioners would "take turns" to provide either anaesthesia or surgery in a particular case.

Dr and Mrs F.W. Grutzner at the British Medical Ass-ociation meeting, Hobart, 1934

I would now like to turn towards a discussion of the medical workforce in the Australia of the 1930s in which Geoffrey Kaye and my grandfather practiced. How were doctors trained and communities serviced in the absence of vast government bureaucracies and the equivalent of Health Workforce Australia? This was a time before the Commonwealth Medical Benefits Scheme,

the Pharmaceutical Benefits Scheme, Bulk Billing and Practice Incentive Payments. For both men, there was a significant amount of pro bono service provided and whilst my grandfather would not have seen himself as a participant in the black economy, he received an enormous amount of farm produce throughout his life. Boxes of fruit, vegetables, eggs, dairy produce and meat would often materialise on his back door in the morning, gifts from patients who may have been unable to pay in more conventional ways. Conversely, his patients who had the ability to pay were charged what would appear on today's standards to be very high fees.

many of the trainees themselves are concerned with the reduction in experience particularly in key areas of obstetrics, paediatrics and advanced airway management

Life for the anaesthetist was not so easy. Many worked in general practice to supplement their incomes and were paid by the surgeon for their services, a situation foreign to most modern anaesthetists due to the enormous work by the ASA in removing the nexus between the surgical and anaesthetic fee. Geoffrey Kaye instituted a survey of ASA members in 1939, five years after the foundation of the Society, asking about the financial aspects of their practice. Of 56 members, only six responded, one of whom only worked part-time in anaesthesia. The average anaesthetist did 312 cases per year, with the highest being 762. Approximately 7% of patients were not charged at all on account of being "unfinancial" or members of the medical or nursing professions or their families. The anaesthetists also provided their own drugs and equipment, which represented around 16% of gross revenue. For the period 1933 to 1938, the average gross income of the five anaesthetists was £818, which is equivalent to $65,670 in 2013. Geoffrey Kaye concluded quite rightly "that the anaesthetist is not over-remunerated and that improvement can only be expected from gradual education of the surgical and lay public". This education process is still relevant today and ongoing.

After the Second World War, the Australian population was growing rapidly, with the birth of the "baby boomer" generation and significant migration from the United Kingdom and war-torn Europe, particularly from Italy and Greece. The number of universities was relatively static up until the 1960s and the medical supply and demand was reasonably in sync. This also was the period before the establishment of elective surgical operating lists and much elective surgery was one-off and not as well organised as it is today. Many of the surgical procedures we take for granted did not exist, such as cataract removal, hip and knee replacements, arthroscopy, any of the multitude of laparoscopic or endoscopic surgical procedures and many other life-changing operations. It is only in the last 20 years that discussion of workforce in medicine generally and in anaesthesia specifically has been happening. Prior to 1996, there had been ongoing shortages of medical practitioners in Australia, including anaesthetists. One of the first articles in the anaesthesia literature is by Professor Barry Baker in *Anaesthesia and Intensive Care* in 1997. In this article, he discusses the concept of an anaesthetist to population ratio and opines that the correct ratio is one anaesthetist for every 8,500 of population. In what was in some ways "back of the envelope" analysis, Professor Baker considers that 9% of the population undergo anaesthesia each year and the average practitioner anaesthetises 1,000 patients per year and arrives at the figure of one anaesthetist per 8,500 population. Professor Baker also considered the possibility that the number of trainees in anaesthesia may need to decrease, possibly by up to 40%.

By 1996, both the ASA and ANZCA were directly involved in the shaping of the anaesthesia workforce by way of membership on the Anaesthetic Workforce Party of the Australian Medical Workforce Advisory Committee (AMWAC). The committee for anaesthesia was composed of the Presidents of ANZCA and the ASA, a medical administrator and the chairman, who was a former president of the Royal Australasian College of Surgeons. Each year the committee would determine the number of accredited trainees for the successive year.

Life for the anaesthetist was not so easy. Many worked in general practice to supplement their incomes and were paid by the surgeon for their services

The principles of the Council included the importance of an adequate community supply of anaesthetists to enable equity of access to medical services, including anaesthesia in metropolitan, rural, regional and remote Australia. Of great importance, the Council recognised that medical standards are best upheld if practitioners maintain a reasonable volume of practice. Another important consideration included the number of unfilled anaesthesia positions in public hospitals. In 1996, there were approximately 95 full-time equivalent vacant positions for anaesthetists around Australia. It was anticipated that 90 new specialists would enter the workforce and 40 would retire. The committee recommended an increase of 2.4% in the number of trainees for that year. Five years later, in 2001, the second AMWAC review indicated that there were still around 90 FTE vacancies in anaesthesia and that the demand for anaesthesia would increase at a greater rate than the population. At this time the committee reduced the rate of increase from 2.4% to 2.2% per annum. The target number of graduates was 128 per year and there were 512 trainee positions nationwide. At a time when the Treasurer of Australia Paul Keating was talking of taking control of the levers of the economy, the anaesthesia community were able to do likewise and the only lever available was the number of accredited training positions.

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These were seemingly simple times prior to the expansion of the commonwealth health bureaucracy and the creation of organisations such as Health Workforce Australia, the Australian Institute of Health and Welfare, the Medical Training Review Panel and others. The number of anaesthetists has continued to grow at a greater rate than the Australian population. Determining the precise number of anaesthetists has not always been easy and it is really only in the last two years that we have had accurate data on the composition of the Australian medical workforce. The Medical Board of Australia now provides annual information on the number of medical practitioners with a break down by specialty. The most recent figures show that there are 4,495 anaesthetists registered in Australia.

Underlying all of the workforce studies has been the notion that increased demand for medical services will be accompanied by increased resources to provide care

The ratio of anaesthetists to population has continued to fall over the last 20 years. Similarly the number of trainees has continued to grow, particularly since 2003 when ANZCA no longer accredited anaesthesia training positions, but training departments. In order to save money and still provide service cover, most departments of anaesthesia employed more trainees on lesser weekly hours. The amount of clinical material to which trainees are exposed has been diluted and many of the trainees themselves are concerned with the reduction in experience, particularly in key areas of obstetrics, paediatrics and advanced airway management.

Following AMWAC, the Productivity Commission report of 2004 was the next significant event. The Productivity Commission was enacted under the Council of Australian Governments (COAG). It was charged with examining the supply of and demand for health services over the next ten years. This was on a background of rising costs and maldistribution of medical services. Another key political concern at the time was patient access for after-hours general practitioner services and, specifically, the provision of such services in or near public hospitals.

The Productivity Commission research report found that the 1996 reduction in medical student numbers by the Howard government had produced shortages of medical practitioners, particularly general practitioners. The report also concluded that the public hospital system had limitations for clinical teaching on account of a shift of patients to private hospitals and reduced lengths-of-stay. When previous generations of medical students were training, patients were admitted well before their procedures. This gave medical students time to interview and examine them before surgery. Now they may arrive only hours before the scheduled procedure. The report also flagged the task substitution of medical roles by nurses. We have seen the conclusion of this suggestion ten years later with the Health Workforce Australia nurse endoscopy project. This project to teach endoscopy to nurses has occurred in the absence of any demonstrable shortage of medically-qualified endoscopists. It was also recognised that university-based nurse education had decreased participation with a 40% attrition rate in the first two postgraduate years. The need for education in the private sector was recognised and national registration, now a reality, was proposed.

The next major anaesthesia workforce activity was the ASA/ANZCA Workforce Study of 2008. This study had a very ambitious time frame of 20 years and predicted an increased demand for anaesthetists based on the ageing of the population, increasing incomes and raised community expectations of access to sophisticated medical care. It considered, but was unable to assess, the effect of improvements in technology and the changes that may bring to the way in which medical care is delivered. The continued mal-distribution of medical services was acknowledged and over the 20-year time frame, a potential worst case scenario of a shortage of 2287 anaesthetists was predicted. This formed the basis of the front cover of the ANZCA Bulletin in March of 2009.

There are some serious concerns... in particular the loss of key personnel and also data generated by the work of Health Workforce Australia

Subsequent to the combined ASA/ANZCA study, Price Waterhouse Coopers were engaged to undertake the National Health Workforce Taskforce. This taskforce found that there had been significant growth in the demand for anaesthesia services, particularly in the private sector, where growth had been of the order of 6.6% per annum. On the basis of this increased utilisation, shortages of anaesthetists were possible by 2020. Underlying all of the workforce studies has been the notion that increased demand for medical services will be accompanied by increased resources to provide care. There is a well-recognised waiting list for elective surgery in all of the various state public hospital systems. The waiting list is politically very sensitive and, to an extent, is managed by the presence of the less acknowledged hidden waiting list. The hidden waiting list is the time taken for patients to see a surgeon in the public hospital system in order to be placed on the official waiting list. For example, in Victoria people may wait up to 18 months to see an orthopaedic surgeon in the public hospital outpatient clinic. Patients on either the official or the hidden waiting list do not require anaesthetists, surgeons, nurses, operating theatres or prostheses.

In Victoria in recent years, budget cuts have resulted in reductions in elective surgical activity with a decreased requirement not just for anaesthetists but for many other procedural medical practitioners. The 2014 Federal Budget has resulted in

reduced financial outlays to the various state jurisdictions and this may result in the same sort of reduction in hospital activity seen in Victoria. The workforce implications of prolonged austerity are profound. We will watch the implications of the budget closely.

The National Health Workforce Taskforce (NHWT) produced a final report which was never published. The activities of the NHWT were then incorporated into the newly created organisation, Health Workforce Australia. Health Workforce Australia was a well-funded body charged with the shaping of policy in this area. Health Workforce Australia was required to quantify the current health workforce and to provide an impetus for reform. It was required to evaluate the effects of different policy options, including but not limited to, measures to boost capacity and efficiency of training systems, productivity and retention of the health workforce, technological change and measures which may reduce the demand for healthcare.

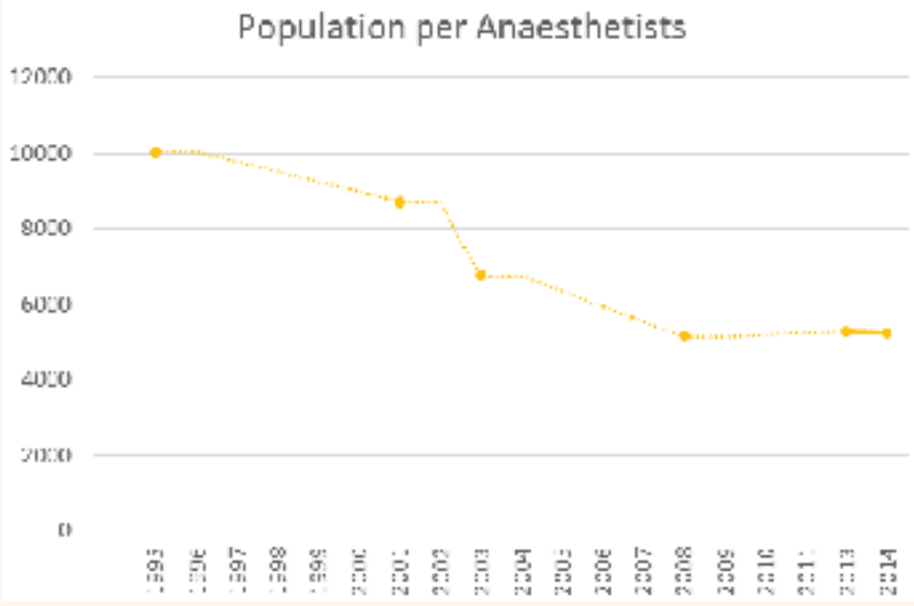
The prospect of medical graduates unable to find employment is real. Why are anaesthetists different from the rest of the graduate population and why is it so important that anaesthetists find suitable employment following graduation?

The final key goal was for Australia to achieve self-sufficiency for the health workforce. Health Workforce Australia found that the specialist medical population was heading towards balance by 2025 and that anaesthesia was not of concern, notwithstanding some issues related to maldistribution in rural and remote areas. Health Workforce Australia recognised that the medical training pathways were poorly coordinated and proposed the establishment of the National Medical Training Advisory Network. In relation to emerging models of care, Health Workforce Australia was to address these, including task substitution such as nurse endoscopy. The political landscape is littered with various bodies which are created and then merged or closed down. Such was the case for Health Workforce Australia whose functions were merged with those of the Department of Health and Ageing following the 2013 election. There are some serious concerns around this process and in particular the loss of key personnel and also data generated by the work of Health Workforce Australia. The National Medical Training Advisory Network is ongoing, however it is too early to see what, if any, progress is being made.

The ASA member survey is a rich source of information in the area of workforce. Whilst there has been much anecdotal and qualitative information about the difficulties faced, particularly by recent graduates, there has been a shortage of current quantitative data. The most recent ASA member survey addresses this and I will share some of the information, not just for younger members but for members across the entire life cycle of practice. With the trend towards postgraduate medical degrees and the time taken for specialist training, anaesthetists are slightly older than in previous generations and data for anaesthetists under 35 years of age is less extensive that for the older age groups.

Thirty-four percent of anaesthetists under 35 years of age were wanting more work in the public sector and for 36 to 40 and 41 to 45-year-old anaesthetists the percentages were 11.9% and 12.4% respectively. Sixty-eight point nine percent of anaesthetists under 35 years of age are wanting more work in the private sector. For mid-career anaesthetists aged 41 to 50, there were still 41.1% wanting more private practice work.

Is the situation faced by young anaesthetists any better or worse than that faced by graduates in other disciplines? Professor Judith Sloan, in an opinion piece in our national newspaper, *The Australian*, discussed this issue. Between 2007 and 2013 there had been a 23% increase in the number of domestic university students to a total of 934,000. Course completions over the same time had increased by 21%. Over a longer time frame from 1999 to 2012, the number of course completions



Population per anaesthetist. 1996-2001 Report of the Australian Medical Workforce Advisory Committee, the 2010 Report of the National Health Workforce Taskforce and the Australian Bureau of Statistics.

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had increased by 82%, far in excess of the growth in population over the same time. There are now graduates in law, dentistry, veterinary science, nursing, speech pathology and education unable to find work in their chosen field. The prospect of medical graduates unable to find employment is real.

It is not uncommon for recent graduates to offer to finish lists for senior colleagues and work pro bono in the public hospitals, suggesting a tight employment environment

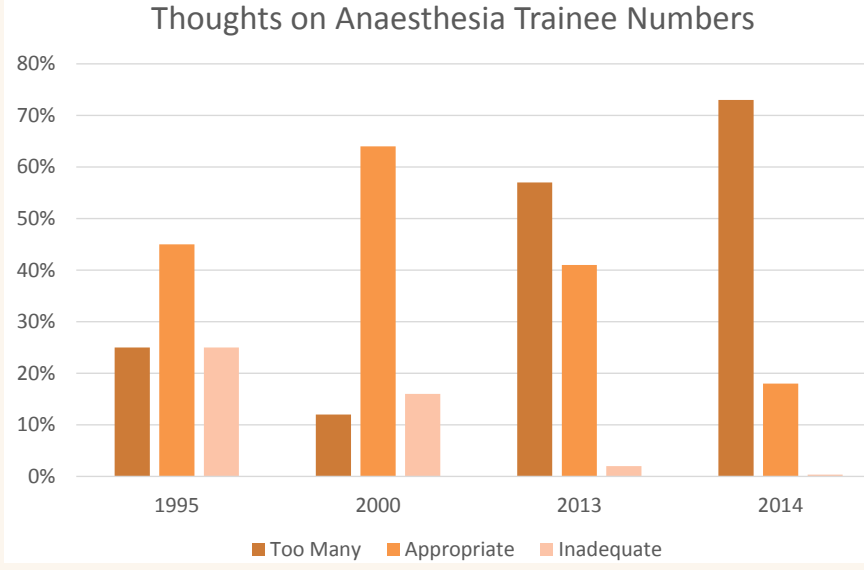
Why are anaesthetists different from the rest of the graduate population and why is it so important that anaesthetists find suitable employment following graduation? The ANZCA Professional Standard 16 (2008) Statement on the Standards of Practice of a Specialist Anaesthetist states that "Regular work in anaesthesia of an appropriate volume and complexity is necessary to maintain clinical skills." Similarly, the ASA Position Statement 11 requires that anaesthetists "Maintain the skill and competence levels required of them." Both ANZCA and the ASA have a commitment to patient safety at the heart of their respective vision statements and this is best served by its members, maintaining ongoing adequate volumes of practice. All anaesthetists maintaining adequate volumes of practice is essential to the specialty and, more importantly, to the community.

In terms of preferred workload, the majority of anaesthetists were happy with the current workload and there were more anaesthetists wanting more work than those wishing to do less work.

One of the concerns that has been expressed is the ability of anaesthetists to do enough work to maintain clinical skills. The importance of adequate volume of practice has been an ongoing theme over the last 20 years of workforce studies, committees and taskforces. We asked members whether their current volume of practice was adequate to maintain clinical skills. For members under the age of 40, 81.1% believed the volume of practice was adequate and 18.9% judged volumes inadequate to maintain clinical skill levels.

Members were asked whether they had felt the need to work outside of their comfort zone due to economic pressures. Of those less than 35 years of age, 29.8% had worked outside their comfort zone as had 15.7% of the 41 to 50 years old bracket. Members were then asked about their capacity to increase the amount of work that they do. The numbers generated by the answers to this question were somewhat surprising. Much of the colour and movement surrounding workforce in anaesthesia has been on the anecdotal cases of underemployed recent graduates and even recent graduates working as baristas or taxi drivers. The numbers however showed that more than 30% of members across all age groups have the capacity to increase workload with no difficulty and the total who could increase workload with no or some difficulty is at least 70% across all age groups. This is a sign of a very large spare capacity in the Australian anaesthesia workforce. Spare capacity will protect against potential shortages were the number of graduates be reduced by too great an amount. One consistent finding related to the prediction of medical workforce is that the numbers will always be wrong. It is just by how much and in which direction. Most of us have met an insurance salesman at some stage who can perform miracles with spreadsheets. By using overly optimistic assumptions over a long time frame, they create some remarkably large numbers which never materialise in the real world. So it is with workforce. Caution is required.

The 2014 ASA member survey confirms the view from our members that there are too many graduates in anaesthesia. This view is strongest amongst younger anaesthetists. Seventy-four point six percent of anaesthetists living in the major regional centres believe there are too many trainees compared with those living in capital cities where 74.1% hold this view. In rural centres with a population less than 100,000 58.8% of anaesthetists believe there are too many graduates. The adequacy of the number of anaesthesia graduates has been monitored over the years by the ASA and ANZCA in their respective surveys. There has been a consistent strengthening of opinion on the number of graduates over the last decade.



Anaesthetist assessment of adequacy of trainee numbers. Source: Australian and New Zealand College of Anaesthetists and Australian Society of Anaesthetists member surveys.

In rural and remote Australia, there is a demand is for a generalist specialist medical workforce in medicine, surgery and anaesthesia. Whilst anaesthesia graduates are generalists this has become less so for physician and surgical graduates. In Australia, as in the rest of the developed world, there is an ongoing trend toward increasingly specialised medical and surgical training. Whilst attempts are being made to train generalist physicians and surgeons, it is too soon to know whether this will be effective. The problem is not as simple as specialists moving to rural locations where the volumes of practice may be marginal and supporting medical infrastructure may be inadequate.

Specialist anaesthetists moving to rural areas will also impact on the incumbent general practitioner anaesthetists, many of whom have been providing an excellent service for a long time, often under difficult circumstances. We also understand that young professionals including anaesthetists are attracted to the capital cities with increased job opportunities for partners and educational opportunities for children. The potential professional isolation and longer working hours in rural practice represent further disincentives for younger anaesthetists to move to rural Australia. The ASA has always maintained that, in order to attract suitably qualified anaesthetists, the industrial conditions on offer and the incentives to compensate for educational and employment issues need to be considered, whilst remaining respectful of the role of the incumbent general practitioner anaesthetists.

For the last two years, the ASA has been hosting a younger fellows' forum for anaesthetists who have graduated in the previous two years. Whilst anecdotal, the experience at these meetings suggest that there are three main groups. One third have found suitable employment, one third are undertaking a second fellowship or further qualification, such as intensive care or pain, and one third are finding conditions tough. It is not uncommon for recent graduates to offer to finish lists for senior colleagues and work pro bono in the public hospitals, suggesting a tight employment environment. Working outside of comfort and geographic zones in areas such as "sleep dentistry" are of concern. Young anaesthetists providing sedation or anaesthesia in facilities which may not comply with ANZCA standards is greatly concerning, and these practitioners may leave themselves wide open in the event of adverse patient outcomes.

If austerity becomes the new "normal" there may be a need to reduce the number of trainee positions and increase the number of positions for recently graduated specialists

The final issue of concern to the ASA is the relationship between anaesthesia workforce, wider economic issues and industrial issues related to the employment of anaesthetists in the Australian public hospital system. The 2014 Federal Budget has reduced outlays to the various state governments. Health is a major source of expenditure and any reduction in funding can be expected to impact on elective surgery in particular. This can be expected to reduce the demand for procedural medical specialists and may result in ongoing pressure on younger anaesthesia graduates. If austerity becomes the new 'normal' there may be a need to reduce the number of trainee positions and increase the number of positions for recently graduated specialists. This will enable younger anaesthetists to consolidate the skills developed during training in the setting of a supportive departmental structure and provide service cover at the same time.

Industrial issues have been of concern to the ASA, particularly in Queensland. Governments may see a perception of excess medical workforce as an opportunity to downgrade industrial conditions. In Queensland, anaesthetists employed in the public hospital system have had their conditions downgraded. Collective bargaining has been removed, there is a requirement to work at another location with only one month's notice and there is a provision to enforce the working of night shifts. The key performance indicators associated with the individual contracts have not been determined and there is certainly the likelihood that new employees will be hired on significantly lower wages. Not surprisingly, morale in the Queensland public health system has been adversely affected. It would be surprising if other states were not watching what is happening in Queensland with some interest.

To return finally to the question at the start of my Geoffrey Kaye oration. The anaesthesia workforce. How many is too many and when is enough enough? The anecdotal evidence, tea room discussions and our own member survey would all concur that there are too many anaesthesia graduates at the moment.

There are more anaesthetists to population than has ever been the case. Most anaesthetists are concerned about the apparent problems faced by young graduates in achieving full-time or significant part-time work in the public hospitals. Our member survey has demonstrated a much more significant spare capacity of the entire anaesthesia workforce across all age groups. The mid-career anaesthetists who are less busy than they would like to be are not complaining publicly about their situation. This may result in older anaesthetists delaying retirement, which may further limit the employment opportunities for their younger colleagues.

In order to address the workforce problem, the first requirement is that all of the key stakeholders recognise that there is a problem with too many anaesthesia graduates. The solutions may involve a number of initiatives, including strengthening the volumes of practice involved

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with the various training modules. In the same way that the Royal Australasian College of Surgeons assesses the log books, supervision and experience of every surgical training position, a similar approach in anaesthesia could be used to ensure that adequate experience is gained in key practice areas.

The first requirement is that all of the key stakeholders recognise that there is a problem with too many anaesthesia graduates

There is a strong demand for full-time anaesthesia positions for recent graduates in the public hospital system. These jobs appeal to recent graduates, as they enable consolidation of the skills acquired during registrar training and occur in the setting of a supportive departmental structure. Increasing the number of full-time consultant jobs for recent graduates in the public system at the expense of training positions will enable service provision to be maintained within the constraints of hospital budgets. One constant in all of the workforce discussions over the last 20 years is the fundamental importance of the maintenance of volumes of practice underpinning the quality of service provided to the Australian community. The role and effectiveness of the National Medical Training Advisory Network remains to be seen, but given the history of bodies in this area a degree of scepticism is probably realistic.

The majority of my oration has focused on the anaesthesia workforce and unfortunately I have struggled to find much cause for optimism. Austere economic times, limitations on hospital spending and excess capacity of the anaesthesia workforce make for difficult times. Anaesthesia remains a popular specialty which would come as no surprise to members of this audience. The 2014 ASA member survey showed that 89% of ASA members enjoy the practice of anaesthesia. Many anaesthetists continue their practice well into their 60s and 70s and enjoy the flexibility that the profession offers. The ASA is committed to advocating on behalf of our younger members so that they too can enjoy as long, productive and enjoyable careers in anaesthesia as the baby boomer generation which precedes them.

We are certainly part of a wonderful fellowship of committed anaesthetists. I have enjoyed working with some inspiring anaesthetists both from Australia and around the world over the last two years, many of whom are here today. It has been my great honour and privilege to be the president of our Society and I thank you for your attention.

Left to Right: Wife, Jane and children, Edward, Kate and Anna Grutzner with their Father at the President's Cocktail Party, Friday, 3 October

Richard with his Mother, Angella at the President's Cocktail Party, Friday 3 October

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ASA EDITORIAL FROM THE VICE PRESIDENT

DR DAVID M. SCOTT
ASA VICE PRESIDENT

"Have you called the right David Scott?" I asked, not for the first time!

After being assured that it was me they were after, I was surprised and honoured to be requested to be the Vice President of the Australian Society of Anaesthetists. I have previously served as Executive Councillor on the ASA in 2004 to 2006 and was very familiar with the processes of the group.

I have been a member of the ASA since 1986, when I joined as a trainee, and firmly believe in the important role that the ASA fills in the professional anaesthesia community in the setting of standards, producing high-quality ongoing education and its strong and effective advocacy in the industrial arena.

My background is different from past Vice Presidents, as I am a senior anaesthesia consultant in private practice in a rural community. I am led to believe that this is the first time a non-metropolitan anaesthetist has held this post. I firmly believe that the ASA is a member organisation whose responsibility is to its members. My primary focus will be to represent the membership to the best of my abilities and to also ensure that my rural colleagues are also not neglected.

I hold other posts including Director of Air Force Health Reserve – Queensland, Vice-Chair of Joint Health Command Anaesthesia Consultative Group and I was formerly Clinical Director of Anaesthesia and Intensive Care Services Royal Australian Air Force.

I received my medical degree in 1985 from the University of Newcastle and obtained my FANZCA in 1992. Following completion of my fellowship I worked as an instructor in anaesthesia with Harvard University at the Beth Israel Hospital in Boston before being appointed as a visiting medical officer at Lismore Base Hospital in 1994.

During my time at Lismore, I have held several posts including supervisor of training and Chair of the Anaesthesia Department. It was during this time that the Lismore anaesthetists entered into dispute with the area health service. After our refusal to renew our contracts, we were able to negotiate, with the assistance of the ASA, a modified contract that significantly improved the conditions of service for our speciality in the region.

In 2006 I took a sabbatical to the University of California, Davis, Sacramento, CA, USA, where I held the position of Visiting Professor in Anesthesia. This was an interesting and challenging time where I was able to hone my trauma anaesthesia skills, which was most useful on subsequent military deployments.

I am the past and founding Chair of the ANZCA/ASA/NZSA Regional Anaesthesia Special Interest Group and have a strong interest in this area. Together with my colleague Alwin Chuan, I have published a book through Oxford University Press on regional anaesthesia and a soon to be released iPhone App on the same topic. I am also on the editorial board of *Pain Medicine*.

I have been an active teacher and I am a senior instructor in Advanced Trauma Life Support and Care of the Critically Ill Surgical Patient, as well as convening the University of Queensland regional anatomy course for the last ten years.

I was commissioned as an officer in the Royal Australian Air Force in 1990.

Since then, I have deployed eight times with the Australian Defence Force, to Bougainville, Solomon Islands, East Timor, Banda Aceh and Afghanistan, have served with the US Navy, Air Force and Army, and on the instructor panel at Uniformed Services University of Health Sciences, Bethesda, USA.

I am looking forward to working with the team at the ASA to continue the outstanding service that our organisation brings to its members.

CONTACT

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

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ASA

Australian Society of Anaesthetists

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ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

In preparing my column, writes CEO Mark Carmichael, I thought it appropriate to reflect in a broad sense on the many activities and initiatives undertaken by the Society throughout the year. While other articles within this edition cover specific aspects of the Society and its work, I will keep mine somewhat general, simply to illustrate how much does occur during a year and the level of activity that surrounds the Society.

As readers will know, the ASA is, by definition, a membership-based organisation. As such, all activities need to be undertaken in order to better serve you, our members. In 2011 the ASA achieved a major milestone, surpassing the 3,000 (net) membership mark. I am pleased to state that, since then, overall membership has continued to grow, and in July 2014, membership numbers stood at 3,194.

While membership represents the financial cornerstone of the Society, of greater importance is that existing members see value in their ASA membership, so they will remain a member and are comfortable in encouraging others to join.

When examining membership, it is important to note that our most significant category – 'Ordinary Member' – continues to grow. In July 2009, there were 1,618 Ordinary Members—at the same time this year, that number stood at 1,880. The challenge remains, however, to maintain growth in this area of membership. If we can ensure that existing members continue to see value in their membership and that those who have not yet joined learn to appreciate what membership represents, growth can continue to occur.

At the same time, it is important to note that we currently have sixty 50-year members, with a further nine reaching that milestone this year. Considering that the Society has been in existence for 80 years, to have so much 'living history' among the membership is a wonderful thing.

Overall, the number of GASACT members continues to build. Between 2009 and 2014, the number of trainee members has risen from 337 to 439. However, retention of GASACT members, in particular during their final years of training, remains an issue.

In short, membership remains strong though, as the number of anaesthetists entering the workforce increases and, as the number of trainees increase, the ASA must ensure that it remains an organisation attractive to join and remain a member of.

The delivery and availability of appropriate and timely services to members and the communities they serve is what the Society is all about. This takes many forms and it is valuable to reflect on the range of such services. What follows is a small sample, which illustrates the diversity that exists when considering the role and work of the Society.

Through the Overseas Development and Education Committee, under the direction of Dr Rob McDougall, the ASA continues to be a leader in the field of humanitarian work. The committee delivers excellent programs in countries such as Laos, Cambodia, Bhutan and a number of Pacific Islands. Such work is greatly valued and the Society should be proud of its significant support for the initiatives undertaken.

If we can ensure that existing members continue to see value in their membership... growth can continue to occur

During the 2013/2014 financial year, members donated over $25,000 to the LifeBox program, allowing Dr McDougall and the Committee to provide much-needed pulse oximeters to areas of great deprivation.

A very different, but equally valuable, service the ASA provided during this year relates to the *Anaesthetic Crisis Manual*, produced by Dr David Borshoff. Recognising the value of this publication, the ASA provided a copy of the manual to each final-year GASACT member, as a way of supporting them as they enter the speciality. This initiative reflects a broadening of the overall offering made available through publications, which

includes the much-respected *Anaesthesia and Intensive Care* journal (and soon to be launched App), the Society's magazine, *Australian Anaesthetist*, and brochures such as *Anaesthesia and You*.

Additionally, the annual awards, prizes and research grants (the winners of which we acknowledged at the Annual General Meeting at the National Scientific Congress), remain a most tangible example of the ASA's continued and ongoing commitment to supporting the specialty. In 2014, awards to the value of $80,000 were made available to ASA members to support their research and reward their achievements.

The ASA has moved to increasingly adopt and utilise the various forms of social media available, most notably Twitter. With regular Tweets covering a multitude of topics, ranging from the now-ceased (but not forgotten) $2,000 cap on education expenditure to the ASA's recent appearance at the Senate Inquiry into out-of-pocket costs, the number of ASA followers has grown to over 1000, up from 521 in April 2013. Clearly, this initiative is meeting a communication need.

All of these activities, along with many others, combine to provide the variety of services made available for members.

Policy initiatives remain central to the ASA's operation. The work of the Professional Issues Advisory Committee, chaired by Dr James Bradley, and of the Economic Advisory Committee, chaired by Dr Mark Sinclair, are pivotal.

Supporting the Committee structure, the Policy staff have been most active throughout the year, engaging on behalf of the membership with bodies such as:

- The now-defunct Health Workforce Australia
- Medical Services Advisory Committee
- Federal Parliamentary advisors
- Private Hospitals Association
- The Medical Board of Australia
- Treasury and a number of other agencies

The Policy Team received in excess of 300 queries during the year on a great variety of topics. These included issues such as appropriate items numbers (reflecting the importance of the *Relative Value Guide*), informed financial consent, practice manager queries, patient questions and a range of industrial matters. While a number of these are handled immediately by staff, many were forwarded to either the Economics Advisory Committee or the Professional Issues Advisory Committee for further consideration and advice. The resource that these two committees provide can never be underestimated in terms of the service provision made available to Society members.

The delivery and availability of appropriate and timely services to members and the communities they serve is what the Society is all about

In October 2013, following the purchase of levels 7 and 8, 121 Walker St, North Sydney and their subsequent refurbishment, the Society relocated from Edgecliff. We now enjoy a most functional, modern work environment, which has ample room for growth and, at the same time, respects the need to retain the important historical aspects of both the Richard Bailey Library and Harry Daly Museum. Visitors to the secretariat have been impressed and I encourage all members who have the time to call in and see it for themselves.

While moving was a time-consuming exercise, it was also tremendously rewarding, and it is hoped that the long-term future of the Society has been secured. At the same time, the Society was successful in selling its Edgecliff premises, doing so in one line. The earlier than budgeted sale, at a price above expectations, certainly contributed significantly to the strong financial result achieved this year.

This last year has indeed been one of continued change for the Society. It is my hope that this will remain the case during 2015. In reflecting on the year, I would like to acknowledge the great support, advice and friendship extended to me by the retiring President, Dr Richard Grutzner, who has assisted me greatly in understanding the issues as presented to the Society. To the ASA Council, the various Committee Chairs and members, thank you. I would also like to thank the ASA staff, who are a most committed group and who work hard to provide the best services possible.

To all of our members, sponsors, advisors and friends, I wish a safe holiday period and look forward to seeing you in 2015.

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LETTERS TO AUSTRALIAN ANAESTHETIST

CONGRATULATIONS

For most of us, a successful career in medicine is a tremendous reward, perhaps enhanced at a specialist level. Two very successful careers at specialist levels must be very satisfying and would be deserving of the praise in Dr Cooper's article ('Forty Years of Service to Medical Publishing', *Australian Anaesthetist*, August 2014).

I would like to add my voice to the loud chorus of praise and appreciation for Jeanette Thirlwell's efforts on our behalf. I found Jeanette wonderful to work with on the Australian Society of Anaesthetists' Council and in organising some National Scientific Congresses. Seeing the article, I realise what a small part of Jeanette's overall contribution I shared.

Best wishes for the future, Jeanette, and thank you for the past.

Dr Dave Fenwick

Aldgate, South Australia

GRUTZNER'S AFR REPLY

Dr Grutzner,

Thank you for your excellent reply in the *Australian Financial Review* to the article "Doctors have a fat co-payment scheme of their own".

Many of us struggle with anaesthetic billing issues – dealing with a government that is fixated on all doctors no-gapping patients, patients that want or expect free health care, the dilemma of no-gapping and terrible indexation of our real wages (indexation of 1.5% of Medicare/Funds over 30 years and more recently 0%!).

On the other hand, if we do charge ASA amounts, which are by definition reasonable, we struggle to try and explain the very large gaps to patients in "top" cover policies given their policies only cover 5% of the total bill (with Medicare covering approximately 20%)!

Every month I am faced with calls from the public asking if I will no-gap, and when I enquire as to what led them to call me, their answer is often that "their fund has asked them to call me".

Similarly, surgeons who no-gap their patients (and still earn $1500+ for a procedure) are asking for the anaesthetist to no-gap and earn $600... An amount significantly smaller than doing the same case in a public hospital with a registrar doing all the work and a system that does most of the post-anaesthetic care.

So once again, I thank you for this reply. I hope there is an ongoing push by the ASA on this issue. With hundreds of new anaesthetists being trained yearly by ANZCA, the market forces will effectively be pushing many of us into lower pay brackets, as everyone clammers for *any* work they can get, taking progressively lower-paid salaried jobs and discounting/no-gapping more to secure work.

Canberra VMO Anaesthetist

FANZCA

HAVE YOUR SAY

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

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

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

TIPS AND TRICKS

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.

BP CUFFS WITH PULSE OXIMETERS

Putting the BP cuff on the arm with the pulse oximeter allows a systolic BP estimation +/- 10 mmHg within seconds as the rising cuff pressure shown on the screen stops the oximeter trace. This is equivalent to how, historically, the systolic BP was estimated by occluding the palpated pulse using a manual anaeroid BP cuff. Most useful in times of unexpected emergencies, in arrhythmias and epidural caesarean section when shivering may interfere with the BP algorithms. The technique works best with a rising cuff pressure, as it tends to underestimate as the cuff pressure falls due to trace display delay.

Dr David Page

Wahroonga, New South Wales

SMS-ING TO YOUR PRACTICE'S ADVANTAGE

Dr Pieter Peach is an anaesthetist and founder of Patientloops, a patient management system for anaesthetists that uses SMS and mobile-friendly patient information websites to deliver preoperative information, obtain informed financial consent and deliver follow-up surveys.

It is generally agreed that SMS is a great tool to contact patients in a non-intrusive way. To improve the effectiveness of the medium, I'd suggest the following:

- Reduce the chance that it will be interpreted as a spam message by including the doctor's name and send it from an Australian number.
- Explicitly instruct them to follow any links and keep the links short to minimise unnecessary characters.
- Have a way of verifying that the mobile phone number is correct. Incorrect contact details are more common than many people realise.
- Include instructions on who to contact if there are any complications related to the surgery so that they don't assume their response to the survey will be sufficient to guarantee follow-up.

Dr Pieter Peach

East Melbourne, Victoria

HAVE YOU GOT A TIP OR TRICK TO SHARE?

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

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

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

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FEATURE

NATIONAL SCIENTIFIC CONGRESS 2014 WRAP-UP

CONVENOR'S WRAP-UP

Convernor of the 73rd ASA National Scientific Congress, Dr Anthony Coorey, has some closing remarks and thanks for a spectacular four days on the Gold Coast.

I would firstly like to thank all of you who attended the National Scientific Congress at the Gold Coast and especially those of you who graciously gave of your time to be fellow presenters and chairpersons. The Congress could not exist without the support of the membership and the broader anaesthetic community. We were graced this year with wonderful invited speakers, Drs Michael Barrington, David Bogod and William Harrop-Griffiths, and I would like to sincerely thank them for their efforts. I would also like to acknowledge Mr Anthony Morris QC, who gave an evocative and inspiring Kester Brown Oration.

Additionally, I would also like to thank those companies that supported our trade display. I hope you found the opportunity to interact and develop rapport, as well as display your products, beneficial. It can only be of great benefit to the community for you to be involved in an ongoing manner with our meetings.

I am pleased to say that there were over 1200 delegates onsite at the Gold Coast Convention and Exhibition Centre throughout the four days of the Congress. The Gold Coast Convention and Exhibition Centre must be congratulated for their excellent catering and the high quality of their facilities.

Of course, our Congress is mainly about the science and I will, at this point, congratulate and thank Dr Stephen Bruce, our Scientific Convenor, for an extensive and informative educational program that responded eloquently to the challenges of our future practice and our new Continuing Professional Development requirements. Steve was most ably supported by his hard working team of Dr Phillip Melksham (workshops), Dr Peta Lorraway (Small Group Discussions) and Dr Patrick See (Refresher Courses). The role of Scientific Convenor is onerous and requires vision, dedication, amazing communication skills and an inexhaustible enthusiasm towards all aspects of the Congress. Stephen brought these qualities and more to the table and I wish to acknowledge and thank him here for the success of the Congress.

Socially, I know many of you enjoyed the welcome drinks, healthcare industry cocktail reception, Kurrawa band bash and Movie World. This year's Gala Dinner at Jupiter's Casino, themed "Casino Royale", was undoubtedly a highlight and many partied

'til late in the evening. I would like to thank, Social Convenor, Dr Cameron Hastie, for his work in putting together this important aspect of the Congress.

And, of course, there are my fellow committee members not already mentioned who deserve a great gratitude. They are Drs Cameron McAndrew (Treasurer), Mitch Morse (GASACT) and Chris Richardson (Trade). On behalf of the committee, I would like to acknowledge the contribution of Dr Piers Robertson (Federal NSC Officer) and Dr David Elliot (Federal Scientific Officer) as well as the secretariat, led by CEO, Mark Carmichael and ably supported by Nicola Morgan, Katie Fitzgerald, and more recently, Alaina Koroday. ICE Australia did a marvelous job as Professional Congress Organisers and I wish to thank Karen Redfern and her team of Danielle, Kristy-Anne and Rebekah for their excellent work and calm demeanor.

On a more personal note, I wish to thank my wife, Millie, and children, William, Charlotte, Grace, Amelia and George. The organisation of such a large meeting has occupied many hours over the last three years and could have not been possible without the support of my family, as I'm sure was the case for all others involved in making this year's Nat-ional Scientific Congress the success it was.

I wish you all a wonderful festive season and look forward to next year's Congress in Darwin.

CASINO ROYALE GALA DINNER

NSC Committee: Cameron Hastie, Anthony Coorey, Stephen Bruce, Cameron McAndrew, Peta Lorroway, Philip Melksham, Patrick See, Chris Richardson, Mitchell Morse, Guy Christie-Taylor

Ted Hughes, Margaret Blakely, Renu Borst, Genevieve Goudling, Guy Christie-Taylor, Jane Harrop-Griffiths, Sue Chrstie-Taylor and William Harrop-Griffiths

Anthony Coorey, Guy Christie-Taylor and Stephen Bruce

Andrew Mulcahy drinking Casino Royale style

William Harrop-Griffiths and David Bogod generating some giggles

FEATURE

SCIENTIFIC PROGRAM CONVENOR'S REPORT

Blue skies, warm weather and the smell of the ocean greeted delegates as they entered the Gold Coast Convention and Exhibition Centre to attend the opening of the 73rd ASA National Scientific Congress, writes Scientific Convenor, Dr Stephen Bruce.

The meeting's theme was 'Practice, Precision and Professionalism', a deliberately broad series of topics for speakers to consider.

Opening the meeting, renowned Queensland barrister, Mr Anthony Morris QC, delivered the Kester Brown Lecture. Working on the theme of 'Professionalism in medical practice' his witty and erudite "The Bureaucrat's Bikini: Professionalism in a Crisis" was a Congress highlight and memorable start to the meeting.

Not to be outdone in the entertainment stakes, our two International Speakers, Drs David Bogod and William Harrop-Griffiths delivered a shared plenary lecture. Drawing on a combined experience of nearly 60 years of public speaking, they presented their secrets on how to, and how not to, deliver effective educational presentations.

This was followed by a heated debate designed to decide whether 'Obstetric Anaesthesia is Indeed an Anaesthetic Subspecialty or More a State of Mind'. Who won? You had to be there!

Over the following days, delegates enjoyed Dr Bogod's clever presentations on a wide variety of topics: Research Publication, Nerve Block Complications, Antiseptics and the Neuraxis and the Consent Process.

Dr Harrop-Griffiths similarly entertained us with dissertations on Patient Safety, Incident Reporting and the highly topical Revalidation in the United Kingdom.

We were honoured to have Dr Michael Barrington as our Australasian Visitor. With his vast expertise in Regional Anaesthesia practice and research and a focus on patient outcomes, he delivered two important lectures: "Postoperative Neurologic Sequelae – How Our Understanding Has Evolved" and "Does Regional Anaesthesia Improve Outcome Following Major Orthopaedic Surgery in the Modern Era?".

The meeting was well represented by nine Special Interest Group sessions, all well attended and covering contemporary issues within our specialty.

Seven Refresher Sessions were organised by Dr Pat See. This part of the program continues to be very popular with delegates. Experts in their field summarised important aspects of governance, perioperative medicine, paediatrics, obstetrics, electroconvulsive therapy, ophthalmic anaesthesia, pain, post-anaesthesia care unit and dilemmas we share with the surgeons.

The Congress continues to foster and encourage the presentation of anaesthetic research. Preceding the Gilbert Troup ASA Prize session this year, we were treated to an overview of some key aspects of contemporary research. The session covered directions in future Australian anaesthetic research, the ethics committee approval process, translational research and publication issues.

Congratulations must be extended to the successful NSC Research Prize winners for their hard work. The Gilbert Troup Prize was awarded to Dr Paul Stewart, the ASA/Smiths Medical Best Poster to Dr Victoria Eley and the GASACT/Smiths Medical Best Poster to Drs Brigid Brown and Chelsea Hicks.

A Practice Managers Forum was held over three sessions on the last day of the meeting. Workplace contracts, bullying and social media issues and networking were discussed amongst the enthusiastic group.

I would like to express my thanks to Drs Piers Robertson and David Elliott for sharing their wealth of experience and offering restrained supervision during the often daunting phases of organising the meeting.

To those colleagues who attended the Congress, on behalf of the Scientific Program committee, I hope you enjoyed the sessions.

To those who did not, I hope you have planned your leave and flights for the Combined (ASA/NZSA) Scientific Congress to be held in Darwin on 12 to 14 September 2015. The scientific content and weather both promise to be hot!

My final and most important vote of thanks must be extended to the many colleagues who lectured, facilitated, demonstrated, organised and supervised at the meeting – without your efforts there would be no NSC!

SGD CONVENOR'S REPORT

The SGD component of the scientific program for the NSC in 2014 was very well supported, writes Small Group Discussions Convenor, Dr Peta Lorraway.

We ran a total of 29 sessions with a capacity for 470 delegates. The broad range of topics reflected the meeting's theme of 'Practice, Precision and Professionalism'. All sessions attracted enough interest from attendees to proceed as planned, with many fully subscribed to, at 15 participants.

Facilitators approached their topics enthusiastically and many commented on positive feedback received from those attending these sessions. This will be encouraging for those involved in the organisation of future meetings.

It was felt that capping numbers at 15 preserved the vital interactive nature of these sessions.

It should also be noted that technical support from the Gold Coast Convention and Exhibition Centre staff was excellent.

It was a rewarding experience to be involved with, as it would seem that both facilitators and attendees enjoyed participating in this element of the program.

WORKSHOP CONVENOR'S REPORT

When first asked by Stephen Bruce to help convene the workshops for the ASA NSC 2014, little did Workshop Convenor, Dr Phil Melksham, realise what was involved.

As the newly formed conference committee sat around Anthony Coorey's kitchen table eating pizza, lightheartedly we began brainstorming for the (as it then seemed) distant conference. Many meetings, emails and phone calls later, deadlines coming and going constantly, that distant future was hard on our heels. Would these new Continuing Professional Development workshops get approval from the College? It would be a disaster if they didn't. We were too determined to create refreshing and out of the ordinary, non-medical workshops, all the while wondering – would anyone register for them? As the larger pieces fell into place and the right people were found to facilitate the right things, it became the little things that created the biggest problems. Would this one socket survive powering these six ultrasound machines? How did we forget that it's probably best just to use the male students for the transthoracic echoes!

But on the day, all ran smoothly. Thanks to everyone, there are too many to name, who contributed so generously in the spirit of teaching and sharing of knowledge. Conferences such as the ASA NSC are carried by these individuals and I am very grateful to them for making my experience as Workshop Convenor both survivable and rewarding.

A total of 47 workshops with a potential for 890 delegates were offered at the meeting. Fifteen ANZCA Continuing Professional Development approved Emergency Response workshops were attended by 350 delegates. These workshops were fully booked very early in the registration process (unsurprisingly). The majority of the other 32 workshops were well subscribed.

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FRIDAY WELCOME RECEPTION


Welcome Reception at the GCCEC


Welcome Reception at the GCCEC


Welcome Reception at the GCCEC


President's Cocktail Party


Attendee, Dr Nicole Fairweather, Prof. Michael Steyn


Dr Jeanette Thirlwell and the newly named *Jeanette Thirlwell AIC Best Paper Award*


Drs Gerald Turner, Linda Weber and Mark Sinclair


Drs Stephen Bruce, Kim McLennon, Anthony Coorey and wife, Millie


Drs Anna Granger, Greg Deacon and James Bradley


Drs Genevieve Goulding, Vida Viliunas and Anna Granger


Dr Andrew Schnieder, Ms Nikki Barnes, Dr Andrew and Ms Leonie Mulcahy


Dr Ted Hughes and Ms Margaret Blakely


International Speaker David Bogod (centre) with cocktail party attendees


ASA CEO Mark Carmichael and Dr Robert McDougall


Dr David M. Scott (centre) with cocktail party attendees

SATURDAY OPENING CEREMONY, THE KESTER BROWN LECTURE & THE GREAT DEBATE


Mr Anthony Morris QC, Kester Brown Lecture


Welcome to the country


Drs William Harrop-Griffiths and David Bogod at the conclusion of their debate


Outgoing ASA President, Dr Richard Grutzner


ANZCA President, Dr Genevieve Goulding


Debate audience


Proposed: Dr William Harrop-Griffiths


Opposed: Dr David Bogod


The audience considers both sides of the debate

WORKSHOPS, SMALL GROUP DISCUSSIONS AND THE TRADE FLOOR


Small Group Discussion/workshop


Workshop


Workshop


Workshop


Trade floor


Drs Kate Brunello, Peter Cook, Nicole Fairweather and Ms Kate McDowell

SUNDAY PLENARY SESSION AND MEETINGS

Plenary session audience

Dr Ted Hughes presents New Zealander, Dr Michael Barrington, with a Wallabies' jersey

Plenary session audience

ACECC Meeting

Drs Nicole Fairweather, Andrew Mulcahy, Danielle Moses and Andrew Miller at the Professional Issues Panel

Chair for Professional Issues Panel, Dr James Bradley

WORKSHOPS AND THE TRADE FLOOR

Airways workshop

Trade demonstration

Airways workshop

Sunday trade floor

ASA booth

Dr Vida Viliunus discussing the new ASA CPD compendiums

SUNDAY A NIGHT AT THE MOVIES... NSC ATTENDEES TAKE OVER WARNER BROS. MOVIE WORLD

















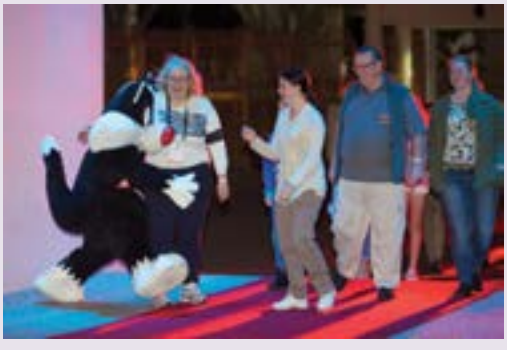


MONDAY

GEOFFREY KAYE ORATION


Geoffrey Kaye Oration audience


Dr Richard Grutzner giving his Geoffrey Kaye Oration


Geoffrey Kaye Oration audience

REGIONAL ANAESTHESIA SESSION


Dr Adrian Chin


Regional Anaesthesia session audience


Audience interaction at the Regional Anaesthesia session

COMMUNICATIONS SIG SESSION


Dr David Bogod


Ms Vivienne Anthon


Communications Special Interest Group session audience


Dr David Elliott

SYMPOSIUM – TO DO OR NOT TO DO: AVOIDING FUTILE SURGERY


Symposium panellists


Symposium panellists


Symposium Chair, Dr Carl Scott

MONDAY ASA ANNUAL GENERAL MEETING

Outgoing ASA President, Dr Richard Grutzner, hands over to Incoming President, Dr Guy Christie-Taylor

Drs Richard Grutzner and Guy Christie-Taylor

Drs Neville Gibbes, Antonio Grossi, Mark Sinclair, Mr Mark Carmichael and Dr Andrew Miller

AGM audience

CEO, Mark Carmichael, presenting at the AGM

AGM audience

GALA DINNER: CASINO ROYALE

Jane and Richard Grutzner with David M. and Rachel Scott

Sue and Guy Chrstie-Taylor

Tearing it up on the dancefloor

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2014 Awards, Prizes, Research Grants and Scholarships

WINNERS ANNOUNCED

ASA PhD Support Grant

Dr Victoria Eley

Anaesthetic guidelines concerning management of obese parturients: specialist anaesthetist knowledge of the guidelines and their experience of caring for obese pregnant women

Kevin McCaul Prize

Dr Matthew Aldred

Can anaesthesia influence long term outcomes after gynaecological surgery? Is there an 'ideal' cancer anaesthetic?

Gilbert Troup ASA Prize

Dr Paul Stewart

Comparison of Kinemyography and Electromyography During Spontaneous Recovery from Non-Depolarising Neuromuscular Blockade

Smiths Medical/ASA Best Poster Prize

1st: Dr Victoria Eley
What is the failure rate in extending labour analgesia in patients with class three obesity compared with normal weight or overweight patients? A retrospective pilot study

2nd: Dr James Trumble (pictured)
Informed consent for labour epidurals: an observational study

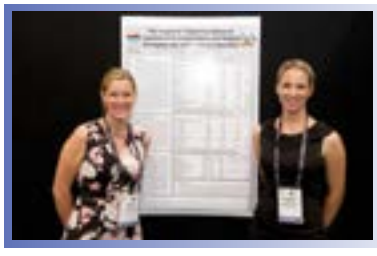
3rd: Dr Paul Stewart
Inadvertent Post-operative Hypothermia in Adults: A Prospective Cohort Study of Predictors and Outcomes

Jeanette Thirlwell *Anaesthesia and Intensive Care* Best Paper Award

Dr Ting-Ting Lu (pictured), with Drs Arvind Raju, Tillman Boesel, Allan Cyna and Suyin Tang

Chronic pain after caesarean delivery: an Australian cohort

Smiths Medical/GASACT Best Poster Prize



Drs Brigid Brown and Chelsea Hicks

The Impact of Indigenous Status on Perioperative Complications and Length of Hospital Stay after Cholecystectomy

On behalf of the ASA NSC 2014 Organising Committee, we would like to thank all the sponsors who supported this year's NSC. We look forward to welcoming you all to Darwin in 2015.

PROUD MAJOR SPONSOR OF THE ASA NSC AND GASACT NSC

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2014 AUSTRALIAN SOCIETY OF ANAESTHETISTS NATIONAL SCIENTIFIC CONGRESS

For 2015 sponsorship enquiries please contact the Events team at sponsorship@asa.org.au

FEATURE

THE 2015 AUSTRALASIAN SYMPOSIUM ON ULTRASOUND AND REGIONAL ANAESTHESIA

Sunny and summery Perth is set to host the fantastic Australasian Symposium of Ultrasound and Regional Anaesthesia (ASURA) from Friday 20 to Monday 23 February 2015, writes committee member Dr Simon Zidar. Convenor, Dr Steve Watts, invites you to attend an exciting program of best practice focused sessions from beginner to master class, with international speakers well-published and energetic in focus on ambulatory analgesia, regional anaesthesia education and patient outcomes.

VENUE

Perth's premium facilities at the Hyatt Regency and Clinical Training and Evaluation Centre at the University of Western Australia will host sessions geared to boost the confidence of beginners and provide tips and techniques from masters to a wide audience looking to gain practical and salient regional anaesthesia skills and development. Cadaver and simulation experiences will allow course participants to gain skills and practice techniques, while discussing the nitty gritty of practice with skilled faculties from local, interstate and international establishments.

SPEAKERS

With an emphasis on early recovery after surgery goals and the associated ambulatory analgesia regimes, ASURA offers attendees the chance to hear from Dr Mike Fredrickson of New Zealand about practical ambulatory regional techniques to incorporate into your current practice. Dr Jens Borglum from Denmark will present on his interest in

truncal blocks and provide experience in this popular and emerging area of regional anaesthesia, particularly within the context of the laparoscopic to open rescue analgesia dilemma, and as an alternate to epidural analgesia. Dr Svetlana Galitzine from the United Kingdom will be presenting her insights on regional anaesthesia education and training and Dr Milton Raff is bringing pain management expertise and advice on practical regimes in which regional anaesthesia can improve outcomes.

WORKSHOPS

An innovative opportunity at the 2015 ASURA will be the delegates' ability to be able to opt for a tailored experience stream. Upon registration, delegates can match their goals for the meeting by choosing from beginner, intermediate and advanced streams. This will provide attendees with enhanced opportunities to achieve learning and skills morely closely aligned to what participants wish to take home from the meeting. Simulation sessions will also deal with cardiac pulmonary resuscitation for LAST (Local Anaesthetic Systemic Toxicity), obstetric crises with regional anaesthesia, anaphylaxis and other scenarios, as refreshers for those looking to update their skill set in resuscitation and critical care management.

LOCATION

Known as a vibrant, energetic, cosmopolitan city only kilometres from vast stretches of some of Australia's most beautiful, untouched beaches, Perth offers attendees the best of both worlds. This west coast city is nestled between the Swan River and one of the world's largest inner city parks—and don't forget the Margaret River is only a three-and-a-half hour drive away! Plus, in the evenings, you can discover Perth's flourishing new bar, restaurant, shopping and cultural scene.

February is an appealing, warm time of year, when ASURA attendees can sample the delicious local produce and wine. The Swan riverfront offers great jogging, cycling or segway experiences and rivercruises to historic Fremantle or to the Swan Valley for wine tastings are popular outings. The ASURA social program will incorporate indoor and outdoor events popular with families and individuals alike.

The enthusiastic ASURA committee is looking forward to welcoming you to Perth for an exciting program that hopes to influence your practice in a positive and practical way. Save the date and book leave now as this conference will have much to offer academically, clinically and socially.

Top Ten things to do in Perth

Activity	Distance from the Hyatt Regency	Opening hours	Admission
Kings Park & Botanic Garden	3.1 km	N/A	Free
Perth Zoo	7 km	9:00am–5:00pm	Adult: $27.00 Child: $13.00
Scitech Discovery Centre	3.6 km	10:00am–5:00pm	Adult: $17.00 Child: $11.00
Museum of Western Australia	2.1 km	9:30am–5:00pm	Free
Perth Mint	1 km	09:00am–5:00pm	Adult: $25.00 Child: $8.00
Swan Bell Tower	1.8 km	10:00am–4:00pm	Adult: $14.00 Child: $9.00
Caversham Wildlife Park	22.6 km	9:00am–5:30pm	Adult: $23.00 Child: $10.00
Adventure World	21.2 km	10:00am–5:00pm	Adult: $51.90 Child: $42.90
Freemantle Prison	23.5 km	10:00am–5:00pm	Adult: $60.00* Child: $40.00*
Shoalwater Islands Marine Park	47.7 km	10:00am–3:30pm	Multiple tours available

*Highest price advertised.

REGISTER FOR ASURA 2015

To register visit:

www.asura2015.iceaustralia.com and follow the prompts.

Note: Early Bird registrations close 10 December 2014.

For enquiries:

Contact Sabrina Lewis at:
asura2015@iceaustralia.com

INVITED SPEAKERS

DR MILTON RAFF
SOUTH AFRICA

Dr Milton Raff is an anaesthetist and pain management practitioner. He also has a BSc degree majoring in biochemistry and genetics.

Milton comes to the Symposium as the Director of the Christiaan Barnard Memorial Hospital Pain Clinic since 1998. He is also a Councillor of the College of Anaesthesiologists of South Africa, which is the part of the College of Medicine of South Africa, the examining body for medical specialists in the country.

Milton is a past President of the South African Society of Anaesthesiologists, as well as of PAINSA – the South African Chapter of the International Association for the Study of Pain. He is currently the Chairperson of the Acute Pain Committee of the World Federation of Societies of Anaesthesiologists and is a current member of the Developing Countries Working Group of the International Association for the Study of Pain, as well as a member of the committee of the NeuP (Neuropathic Pain) Special Interest Group.

He is the Editor of the *PAINSA* Journal and is the author of many peer reviewed publications and book chapters.

Session times

- **Intermediate Workshop**

  Sunday, 22 February, 2015
  Clinical Training and Evaluation Centre at the University of Western Australia
  8:00am–12:00pm

- **Can we make Opioids Obsolete?**

  Monday, 23 February, 2015
  Plenary session 3
  10:30am–12:00pm

DR MIKE FREDRICKSON
NEW ZEALAND

Dr Michael Fredrickson works full-time as a specialist anaesthetist in the Auckland private sector.

Michael completed his undergraduate and postgraduate education in Auckland, New Zealand, before undertaking fellowships at the Royal Children's Hospital in Melbourne and later, the Hospital for Sick Children in Toronto. His current practice consists of a mixture of predominantly paediatric anaesthesia and adult orthopaedic anaesthesia. His clinical and research interests include ultrasound-guided peripheral nerve blocks, especially those involving perineural catheters, and he has authored several journal publications and book chapters on these topics.

He has recently completed two doctoral theses investigating the use of ultrasound for perineural catheter placement, and the management of continuous perineural infusions in the ambulatory setting. He has consequently published extensively on these subjects and also serves as an editor for the journal *Regional Anesthesia and Pain Management* and for the Ultrasound Guided Regional Anaesthesia educational resource, ultrasoundblock.com.

Session times

- **Advanced 1 Workshop**

  Saturday, 21 February, 2015
  Clinical Training and Evaluation Centre at the University of Western Australia
  8:00am–12:00pm

- **Bang for your buck: Economics of Regional Anaesthesia**

  Monday, 23 February, 2015
  Plenary session 3
  10:30am–12:00pm

DR JENS BØRGLUM
DENMARK

Dr Jens Børglum graduated MD from Aarhus University, Denmark in 1990 and successfully defended his PhD thesis in 1997.

In 2002, Jens graduated from Henley Management College, London (MBA(ex.)) and since 2006, he has been employed at Copenhagen University Hospital: Bispebjerg as a Consultant Anaesthetist with special responsibility for the implementation of ultrasound-guided peripheral nerve blocks in daily clinical practice.

In addition, Jens has been employed as an Associate Professor at Copenhagen University since 2012.

Not long after starting employment with the hospital, Jens and members from his research group published several papers and book chapters dealing with ultrasound-guided peripheral nerve blocks and ultrasound in airway management. Jens has been part of the scientific faculty in many meetings, most recently: ESRA 2010–2014, ASRA 2014, ACA 2013, ESRA Winterweek 2013–2015, AAGBI 2013–2014, UZ Leuven 2014–15, 27th Annual Carolina Refresher Course: Update in Anesthesiology, Pain and Critical Care 2014.

Session times

- **Advanced 2 Workshop**

  Saturday, 21 February, 2015
  Clinical Training and Evaluation Centre at the University of Western Australia
  1:00pm–5:00pm

- **Epidural Alternatives in Major Surgery**

  Monday, 23 February, 2015
  Plenary session 2
  8:30am–10:00am

DR SVETLANA GALITZINE
UNITED KINGDOM

Dr Svetlana Galitzine graduated with a MD in Russia, where she first developed an interest in regional anaesthesia at a time when thoracic epidural anaesthesia with no sedation was a safer option for abdominoplasty in the morbidly obese.

She later completed anaesthetic training in the UK and, since 2002, has been a Consultant Anaesthetist in the Nuffield Department of Anaesthetics, Oxford University NHS Hospitals Trust, and an Honorary Senior Clinical Lecturer at Oxford University.

Svetlana is particularly interested in developing and evaluating high-quality regional anaesthesia services for epidural anaesthesia with sedation for prolonged orthoplastic surgery, audio-visual distraction as an adjunct for regional anaesthesia, standardised documentation within the practice area and better regional anaesthesia for high-risk patients.

She has been a Training Lead in Oxford and has initiated and co-organised numerous courses in Oxford and St Petersburg as well as the RA-UK "Top to Toes" Cadaveric Anatomy course.

Session times

- **European dop regional anaesthesia for Australasia**

  Monday, 23 February, 2015
  Plenary session 2
  8:30am–10:00pm

- **Novice 4 Workshop**

  Sunday, 22 February, 2015
  Clinical Training and Evaluation Centre at the University of Western Australia
  1:00pm–5:00pm

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FEATURE

SOUTH AUSTRALIA CORONER'S REPORT

In April 2008 and February 2010, two patients were admitted to a private hospital in Adelaide. Tragically, neither patient survived the postoperative course and as a result were referred to the South Australian Coroner. The Coroner's report was released in February 2014 and in total runs to 88 pages. It can be read in full at: http://bit.ly/1xMstcl.

What follows is the initial statement and introduction from the Coroner's Report, followed by the Coroner's recommendations.

SUMMARY

The said Court finds that John William Ryan aged 54 died as a result of hypoxic-ischaemic encephalopathy following ventilator failure and cardiac arrest in the context of morbid obesity and opiate medication, complicating post-operative recovery from right ankle arthrodesis.

The said Court finds that Patricia Dawn Walton aged 66, died as a result of hypoxic-ischaemic encephalopathy following cardiac arrest after developing cardiac syndrome precipitated by myocardial ischaemia as a consequence of uncontrolled hypertension, fluid overload, ongoing pain and coronary artery disease, post left total hip replacement.

The said Court finds that the circumstances of [their deaths] were as follows.

Introduction

1.1. This Inquest concerns the deaths of John William Ryan and Patricia Dawn Walton, separated by two years, but in circumstances which give rise to similar issues about admission practices of small private hospitals for higher risk surgical patients. Both deceased were morbidly obese and underwent orthopaedic procedures at [XXX] Hospital. [XXX] is a small private hospital which does not have medical practitioners within the hospital overnight. Mr Ryan deteriorated during the first night following surgery, whilst Mrs Walton collapsed during the night after her fifth post operative day.

1.2. Whilst there are significant differences between the circumstances leading to their deaths, both Mr Ryan and Mrs Walton posed predictable and continuing risks during the post operative phase which required a higher level of care than was provided at [XXX]. In addition to the known risks, Mrs Walton had severe coronary vessel disease which had not been detected in routine preoperative assessments.

1.3. Both patients received opioid analgesia which is said to have played a role in their deterioration. The degree of obesity in both cases complicated their post operative management, as well as the attempted resuscitation, following their collapse. Despite the increasing prevalence of obesity in the community, the link between opioid medication and respiratory depression in this type of post operative patient is said to be poorly understood by nursing staff and some medical practitioners. This latter point is particularly relevant to the death of Mr Ryan.

1.4. The evidence received in this Inquest leads to a compelling conclusion that Mr Ryan's death could have been avoided if more frequent and adequate monitoring had taken place during the night following his surgery. I find that Mr Ryan suffered acute respiratory failure, secondary to a combination of the opiate medication received post operatively, in the context of his morbid obesity. Had his deterioration been detected in a timely manner, the anaesthetist could have been contacted to formulate a plan which may have involved intravenous (IV) administration of naloxone to reverse the effects of the opioid medication.

1.5. Additionally, there is a question as to whether Mr Ryan suffered from undiagnosed sleep apnoea and how this might have contributed to his respiratory failure. This question remains unresolved, but has application more generally to preoperative assessment of morbidly obese patients.

1.6. Mrs Walton had suffered severe hip pain for some years and had become opioid tolerant. Pain management was always going to be a challenge following her surgery. She also had hypertension as well as sleep apnoea, which required a continuous pressure device overnight (CPAP).

1.7. Throughout the post operative period Mrs Walton's pain and high blood pressure proved difficult to manage. When early signs of cardiac ischaemia emerged during an overnight shift, it was attributed to asthma because the deceased had suffered asthma in the past. There was no medical officer on site to confirm the diagnosis or to investigate the matter.

1.8. The evidence supports a conclusion that, notwithstanding the unknown cardiac disease, Mrs Walton's known medical challenges were such that she should have had her surgery in a hospital which had the medical and nursing resources to handle her complex pain requirements and labile hypertension. I find that this important issue was not appropriately addressed pre-operatively. What was required to maximise her safety throughout her hospitalisation for hip surgery was a facility with Intensive Care Unit (ICU) backup and medical emergency team capability, for early intervention in the event of deterioration. I find that had she been managed in this environment, her death may have been prevented.

1.9. Despite the predictable anaesthetic challenges which both Mr Ryan and Mrs Walton posed, neither had the benefit of a pre-anaesthetic consult. In Mr Ryan's case, the surgeon did not think of arranging it. In Mrs Walton's case, it was overlooked because of a system failure in the surgeon's rooms. As a consequence, the respective anaesthetists had to deal with the situation under pressure, moments before surgery. Despite the challenges posed, the surgery for Mr Ryan and Mrs Walton was completed without incident, however, during the post operative phase, both patients deteriorated during the night when there were no medical officers on site. Both patients were evacuated to [YYY] Hospital by ambulance but passed away in the ICU once testing confirmed that irreversible hypoxic cerebral damage had occurred.

1.10. The major focus of the Inquest has been on how patients with significant medical co morbidities, including morbid obesity, are screened pre-operatively. Whilst the degree of screening required will depend in part on the type of surgery contemplated, the evidence indicates that an informed decision should be made in a timely manner about whether the procedure ought to take place in a hospital which offers a higher level of nursing and medical care than that available in smaller private hospitals such as [XXX]. Medical practitioners who have a financial interest in a preferred facility are obliged to disclose that fact and prioritise patient safety.

1.11. The Court was assisted by evidence from a number of medical practitioners to consider how Mr Ryan and Mrs Walton might have been better managed, with the

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benefit of hindsight. Opinions from independent anaesthetists and intensivists during the Inquest were generally critical of the systems and facilities available at [XXX] to cope with the predictable challenges posed by both deceased post operatively. The evidence supports a finding that in both cases there was a failure to detect or recognise early signs of deterioration. By the time nursing staff at [XXX] reacted in both cases, the situation had become catastrophic. Without the support of highly trained emergency team staff, both patients were unable to be effectively ventilated at [XXX] and valuable time was lost before the ambulance was called.

1.12. Questions surrounding the competency and resourcing of nursing staff at [XXX] have been examined during the Inquest, together with the protocols which were in place at the time for monitoring patients following surgery and particularly for patients who have received opioid medication post operatively.

RECOMMENDATIONS

1. That the Minister for Health, the Australian Commission on Safety and Quality in Health Care and the Australian Council on Healthcare Standards, consider as a requirement of accreditation that small private hospitals which have no on-site medical practitioners overnight, and no ICU backup, develop robust pre-admission processes in which higher risk patients are screened to ensure that they are not accepted for overnight admission unless they have been assessed as suitable for that facility by a medical specialist or anaesthetist, well in advance of the planned admission date;
2. That the Medical Board of Australia, the Australian Medical Association, the Australian Medical Council, the Australian College of Nursing and Australian Nursing Schools attempt to raise awareness amongst medical practitioners and nurses about the inherent risks of post operative respiratory depression occurring in obese patients in particular, who may or may not have a diagnosis of sleep apnoea and who are receiving, or have received, opioid analgesia;
3. That the Medical Board of Australia consider formulating a code of conduct which stipulates that medical practitioners who practise preferentially in a facility in which they have a financial interest, should disclose that fact to the patient appropriately and specifically raise the issue concerning suitability of that facility with other specialists to whom they refer the patient for pre-admission assessment;
4. That the Australian and New Zealand College of Anaesthetists (South Australian branch) consider reaching an understanding with the Royal Australasian College of Surgeons (South Australian branch) and the Australian Society of Orthopaedic Surgeons to streamline the process by which higher risk patients are referred for pre anaesthetic assessment and to avoid last minute changes to operating lists where this would result in a different anaesthetist taking over immediately before surgery;
5. In the interests of patient safety, that Board Members and Chief Executive Officers of hospitals with staff and facilities similar to, or less than those at [XXX], consider implementing policies whereby those hospitals decline to admit higher risk patients to their facilities.

For a full copy of the South Australian Coroner's Report go to:

http://bit.ly/1xMstcl

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INTERPRETING THE CORONER'S REPORT

The 14th of February 2014 may represent a watershed moment in the model of care provided in the private sector in South Australia, if not nationwide, writes Dr Simon Macklin. On this day, the South Australian Coroner released her Finding of Inquest into the deaths of two patients who were retrieved from a private hospital to a nearby tertiary referral centre[1]. These deaths occurred in 2008 and 2010. The cause of death was given as:

1. "hypoxic-ischaemic encephalopathy following ventilatory failure and cardiac arrest in the context of morbid obesity and opiate medication, complicating post-operative recovery from right ankle arthrodesis";
2. "hypoxic-ischaemic encephalopathy following cardiac arrest after developing cardiac syndrome precipitated by myocardial ischaemia as a consequence of uncontrolled hypertension, fluid overload, ongoing pain and coronary artery disease, post left total hip replacement".

In response, the Australian Commission on Safety and Quality in HealthCare (ACSQH) published Advisory Note A14_02 entitled "Pre-Admission Requirements and Responding to Deterioration in Small Health Facilities"[2]. Both this document and the Coroner's report warrant scrutiny.

It is not the intention to dissect the Coroner's report, which is readily available, but to draw attention to the recommendations that are made at the end of the report "that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the events that were the subject of the Inquest."

Are these two cases isolated incidents in an otherwise extremely safe environment? Circumstantial evidence would suggest that the incidence of significant morbidity and mortality in the private sector is small. A concern is that the safety mechanisms that have been developed over the relatively short lifetime of modern anaesthesia are quietly being eroded as a direct result of the low morbidity and mortality that these safety mechanisms have produced.

Private hospitals in Australia are required to collect information according to the Australian Council on Healthcare Standards (ACHS) Clinical Indicator Program. The data collected is compiled and the ACHS released its "Australasian Clinical Indicator Report 2004-2011" in 2012. It is of note that it makes reference to six factors associated with preventable mortality. Of these six factors, postoperative complications, suboptimal critical care and delays in responding to deteriorating patients are relevant in this instance.

A REPONSE TO THE CORONER

Firstly, is there a need for a more robust approach to pre-admission assessment of patients to ensure that they are suitable to be cared for in the proposed healthcare facility, having undergone the proposed surgical procedure? The SA Coroner believes this to be the case. Modern surgery has developed to such a high level of skill and technology that the intraoperative course of events has become almost irrelevant.

However, we need to benefit from the lessons learned from the mistakes of others

What has changed, however, is the comorbidity profile of the patients presenting themselves for surgery. For example, the incidence of obesity has risen dramatically; and with obesity comes the risk of diabetes, heart disease and sleep disordered respiration, among other conditions. According to the Australian Bureau of Statistics, the percentage of adults who were overweight (BMI 25 to 29.9) or obese (BMI 30+) has risen from 56.3% in 1995 to 61.2% in 2007/2008 to 62.8% in 2010/2011[4]. In spite of the increasing health burden of the patient population, the expectation created by the success of modern anaesthesia and surgery is that any patient can be managed anywhere and without complication. A report from the National Confidential Enquiry into Patient Outcome and Death in 2011 titled "A Review of the Perioperative Care of Surgical Patients" is illuminating and should dissolve this complacency. Twenty percent of patients were assessed as being high-risk. Seventy-nine percent of the deaths were in this group. The overall 30-day mortality in the general

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surgical population was 1.6%. In the low-risk group of patients it was 0.4%, in the high-risk group 6.2%. Only 22% of high-risk patients were managed in a critical care facility and 48% of high-risk patients who died never went to a critical facility[5,6]. These are figures from the National Health Service, and so may not be directly applicable to the Australian model of care.

Modern surgery has developed to such a high level of skill and technology that the intraoperative course of events has become almost irrelevant

However, we need to benefit from the lessons learned from the mistakes of others. Not all private healthcare facilities in Australia have the capacity to offer intensive care or high dependency facilities. Not all private hospitals have resident medical officers available to answer the call to attend the deteriorating patient. Implementing the National Safety and Quality Health Service Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care (October 2012), therefore presents a major challenge. Detection is the first step but rapid response to acute deterioration, in the smaller private health care facility is not so easy[7]. It is, therefore, incumbent upon us to exercise vigilance when selecting patients for surgery at specific hospitals. A principle specifically identified in the Australian Orthopaedic Associations Code of Conduct/Standards of Clinical Practice/Principles 1.1 a) "The surgeon will ensure the patient is cared for in an institution capable of providing the appropriate level of care"[8], and in the Royal Australasian College of Surgeons Code of Conduct 2011 2.2 Specific Issues Pertaining to Operative Procedures "The surgeon will ensure elective and scheduled urgent procedures are performed in an institution capable of providing the appropriate level of perioperative care"[9].

The other significant change to have taken place over the last 15 years is the widespread adoption of day-of-surgery admissions. Many of the private hospitals laid down their bricks and mortar before there was the need for an appropriate day-of-surgery admission facility with the result that many such facilities have been 'shoe-horned' into existing spaces. This can be successful, but there is a requirement to provide confidential space for the anaesthetist to conduct the pre-anaesthetic assessment, including physical examination. The burden at the start of the day can be heavy. Is the magic 'privacy curtain' adequate for detailed history taking? Managing a large volume of patients arriving early in the morning places enormous logistical strain on these facilities. Add in the mantra of "Patient-centred care" which has resulted in the expectation that there will be minimal delay between admission and surgery, and we have a recipe for shortcuts and compromise. To ease the administrative burden, staggered admission times have been adopted and whilst, on the face of it, this seems the logical solution, it presents its own dilemma. As anaesthetists, we are expected to obtain both procedural and financial consent to comply with the requirement to be open and transparent. This is morally and ethically correct. Managing this in the setting of a high-volume, rapid turnover list with 'unseen' patients with often suboptimal facilities is more challenging. There are numerous examples of ways in which this can work more efficiently with preadmission questionnaires and financial consent information sent out prior to admission.

However, these measures are not always the answer, particularly if there is a short lead-time between booking and surgery. A confounder is the widely held misapprehension that a minor surgical procedure is associated with a minor anaesthetic, irrespective of patient factors. Therefore, managing a patient's expectations in the brief window available for the pre-anaesthetic assessment of the day patient can be challenging and creates an environment that can mitigate against best practice.

Managing [procedural and informed financial consent] in the setting of a high-volume, rapid turnover list with 'unseen' patients with often suboptimal facilities is more challenging

It is perhaps time for the anaesthetic community to accept that more of the working week needs to be devoted to pre-anaesthetic assessment, possibly with the introduction of the pre-anaesthetic clinic run within a private group. Whilst most anaesthetists will feel professional 'ownership' of 'their' patient seen preoperatively by them, is this achievable in 2014? Is a privately run pre-anaesthetic clinic, run by each private group where anaesthetists allocate themselves to staff the clinic a viable solution?[10]. Is a thorough telephone assessment that precedes or replaces a traditional face-to-face assessment a solution?[5] It could be suggested that a higher rate of pre-admission assessment would improve theatre throughput by reducing turn-around time that is necessarily created by the requirement for anaesthetists to conduct the pre-anaesthetic assessment of an 'unseen' patient. Does the current manpower dilemma open a window of opportunity to develop a private practice model of pre-anaesthetic assessment?

The role of the general physician in preoperative assessment and postoperative care needs to be analysed. In my view, the general physician has a role in optimising the pre-existing medical conditions that have been identified by the specialist anaesthetist and deemed to require optimisation. It may be that the general physician is more available for consultation, as a result of work practices, and is, therefore, referred patients for pre-anaesthetic assessment.

The question for the general physician should be "Can this patient's medical comorbidities be improved?" and not "Is this patient fit for anaesthesia?"

It is estimated that nearly 20% of the obese population will suffer from obesity hypoventilation syndrome

Fitness for anaesthesia is determined by a specialist anaesthetist, but the specialist anaesthetists must make time to provide this service, otherwise alternatives will be found. ANZCA PS 57 clearly states under section 2 – Clinical Duties – 2.1 "Provision of anaesthesia and medical services for patients as required" and 2.2 "Clinical management and organisation of pre-anaesthesia assessment clinics and preparation of patients for surgery". These seem clear and unambiguous statements. Many patients have a lead time of weeks between booking and surgery. Surely, this is sufficient time for an anaesthetic assessment, by an anaesthetist, to take place? The expectation should be that patients are referred for assessment with all their recent investigations and an up-to-date health care summary from their local family practice specialist such that further delays to their surgery, for the purpose of information gathering, can be avoided.

In regard to postoperative care, ANZCA has published Professional Statement 53, promulgated in 2013, entitled "Statement on the Handover Responsibilities of the Anaesthetist". The exact point in time that the patient ceases to be the primary responsibility of the anaesthetist is difficult to pin-point. Suffice to say, the anaesthetist has "responsibility for ensuring the patient recovers safely from surgery and anaesthesia in an area appropriate to that purpose, as defined in ANZCA Professional Statement 04. Ideally, all patients will receive a postoperative visit from their anaesthetist and many anaesthetists extend their role into the postoperative period if complex pain management strategies have been employed. Sadly, circumstances often prevent this ideal practice being extended to all postoperative patients. It may be more appropriate for a general physician to manage the complex medical conditions e.g. diabetes or heart disease (for which they have received specific training in acute medicine) in the postoperative period, but anaesthetists need to be available to provide advice on post-operative pain management. Again, is this a role that could be filled with our current workforce issues? I believe that a more coordinated model of care needs to develop, with specialists in Acute Pain Management available in the private sector, in addition to the general physician and surgeon.

Secondly, patients are anaesthetised in the expectation of a nursing workforce that is experienced, qualified and present in appropriate numbers to manage a diverse range of postoperative patient requirements that may not be consistent from day-to-day. The private hospitals are effectively paid by the health funds to provide patient care, but remuneration is poorly related to patient casemix. High dependency units, as opposed to intensive care units, are poorly remunerated by the health funds, which forces higher acuity patients either into an intensive care scenario or to the general wards. Nursing staff levels for Intensive Care Units are set in accordance with guidelines, established by the Australian Council on Healthcare Standards and Australian College of Critical Care Nurses.

Sadly, circumstances often prevent this ideal practice being extended to all postoperative patients

A nurse to patient ratio is set at 1:1 for intensive care and 1:2 for high dependency care. In addition, it is stipulated that there is one Senior Critical Care trained nurse who is supernumerary, to act as coordinator, plus a number of nurses, in addition to the 'bedside' nurse; and with numbers varying according to the skill mix (critical care versus non- critical care nurses) to act in supporting roles. On the general wards, however, the situation is not so clear with overall ratios of Registered Nurses to Enrolled Nurses, nominally set at 70:30, being skewed by the higher number of Registered Nurses in higher acuity wards[11]. It is additionally recognised that not all Registered Nurses are equal when experience is considered. The tools used to determine nursing levels in the public healthcare system vary from state to state, but broadly speaking a ratio of one nurse to five patients during the day and one nurse to eight patients at night are 'ball-park' figures.

Thirdly, staffing numbers alone are not the whole solution to enhanced postoperative recovery. Knowledge and insight are required from surgeons, anaesthetists and nurses to understand the implications of postoperative pain management, especially if opioids are the mainstay. Many institutions will have a policy mandating the use of supplemental oxygen for patients using a self-administered opioid analgesia system. However, opioid-induced ventilatory impairment is not confined to those patients on intravenous opioids. There is the belief that opioid-induced ventilatory impairment only occurs in the obese, or those with sleep apnoea, but there are increasing concerns that many patients suffer with opioid-induced ventilatory impairment and as such all patients in the postoperative period should receive supplemental oxygen and be suitably monitored. It is important to understand that pulse oximetry gives valuable information regarding the oxygenation of peripheral blood. It does not give a good indication of ventilation in the presence of supplemental oxygen, as can be remembered by many who have performed the apnoea test as one of the range of tests to establish brain death. It is also crucial to understand the role and impact of opioids on respiratory depression. These are important lessons

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that seem to have been forgotten. It is estimated that nearly 20% of the obese population will suffer from obesity hypoventilation syndrome (previously Pickwickian Syndrome)[12]. There will be others that suffer from central sleep apnoea. These patients are at high-risk as the combination of hypoxia and hypercarbia provides a fertile ground for cardiac arrhythmias and myocardial ischaemia.

It is of concern that the drive for 'patient centred care', which provides single room hospital accommodation (reduced risk of cross infection, increased privacy), increases the risk of undetected postoperative hypoventilation and hypoxia. Indeed, managing all opioid-receiving postoperative patients in a high dependency unit is unrealistic unless there is a dramatic change in the health fund remuneration to the private hospitals. The role of the health funds has already been mentioned, so a discussion between funds and hospitals needs to take place to ensure that the hospitals are adequately remunerated to manage postoperative care to the highest possible standard. as defined by the ACSQH. The alternative is to ensure that adequate monitoring and observation is available to all these patients. This has important ramifications for surgical ward nursing staff levels. The focus is currently on the 'high risk patient', but as Macintyre et al[13] outline in their paper, there are many 'non-high-risk' patients at risk of postoperative morbidity and mortality as a result of sleep disordered breathing compounded by opioid medication. We simply cannot afford to 'drop the ball' with these patients.

AND SO, WHAT OF THE FUTURE?

1. The current state of play in surgical training is that the public sector has transferred much of the responsibility for pre-anaesthetic assessment from the junior surgical staff to the anaesthetic department, through pre-anaesthetic assessment clinics. Similarly, postoperative pain management has become the role of the Acute Pain Management team, often run by the Department Of Anaesthesia. Therefore, having graduated from the highly supervised public hospital, is the recently qualified modern surgeon equipped to identify preoperative comorbidities and manage postoperative pain in the private sector? ;
2. Education needs to improve to ensure that all staff, medical and nursing, are aware of potential postoperative complications and we need reassurance that the hospitals are adequately resourced to:

    a) monitor the postoperative patients and

    b) detect/respond to the deteriorating patient.

Greater collaboration between surgeon, anaesthetist and private hospital to appropriately match patient, procedure and hospital is urgently required. The development of a 3D matrix that incorporates these factors would be of benefit.

To summarise, the South Australian Coroner has identified potential gaps in the management of patients in smaller healthcare facilities. It is incumbent upon the entire healthcare system to close these gaps to minimise unnecessary postoperative morbidity and mortality. This can only be achieved if comorbidities are identified early and optimised by preoperative management; the complexity of the surgery is matched to the hospital's' facilities and the facilities are staffed with the numbers, experience and knowledge of nursing staff for the task required of them.

Right patients, right surgery, right facility.

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

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The ASA is hosting a one-day symposium

When: Saturday 7 February

Where: Adelaide Convention Centre

The symposium will address the concerns expressed by the SA Coroner. Representatives of the major players in private healthcare will be invited to attend and present such that the profession can respond to the directive. Let us be part of the solution, not part of the problem.

BOOJUMS OF ADVERSE EVENTS: CAN WE PREVENT THEM?

In Lewis Carroll's nonsense poem "The Hunting of the Snark", Boojums are sinister variants of the more benign Snark.

Similarly, postoperative mortality is a rare outcome of postoperative complications following elective surgery. Following the findings from the South Australian Coroner, issued in February 2014, and the Advisory Notice A14-02 from ACSQHC, we invite you to join us at this one-day meeting to discuss the Coroner's recommendations and the impact these might have for the future.

The purpose of the day is to engage leaders in medicine and the private health industry in developing guidelines that will enable safer perioperative management of patients and understand some of what might be needed to reduce the risk of significant morbidity or mortality.

Speakers include representatives from the ASA Professional Issues Advisory Committee, SA Orthopaedic Association, Drugs of Dependence Unit at SA Health and the Royal Australasian College of Surgeons.

When:	**Saturday 7 February 2015**	
Where:	**Adelaide Convention Centre, Adelaide**	
Registrations:	**Fee for Early Bird registration***	**$285**
	Standard registration	**$330**
	Trainee	**$240**

For more information and to register, please visit http://bit.ly/Boojums

***Early Bird registration closes 19 December 2014.**
Contact Alaina Koroday at events@asa.org.au
or phone 1800 806 654.

We encourage all Specialists, Chief Executive Officers, Directors of Nursing, Private Hospital representatives and other interested parties to join us for this event and discussion.

ASA
Australian Society of Anaesthetists

FEATURE

2014 WORKFORCE SURVEY REPORT

The Professional Issues Advisory Committee (PIAC) and Policy Team at the ASA sent out the 2014 Member Survey earlier this year. After collating the results and comparing them to current stats, Dr James Bradley reports on what you, our ASA members, have had to say about a range of professional issues.

The ASA has surveyed its members on a number of occasions over the years. The 2014 Member Survey is the latest through the online host, SurveyMonkey®, and was targeted only at members in active specialist anaesthesia practice – Medical Board of Australia (MBA) registration as a specialist was required for participation in the survey. A total of three emails with links to the survey achieved completed responses from 961 members. This was the best response to a member survey we've had in 12 years. The survey was promoted without inducements. We believe that the possible reasons for the improved response rate include the more 'user-friendly' format (the survey was also smartphone compatible), targeted reminders during the survey period and perhaps a perception that participation was important during what might be perceived as professionally challenging times. However, given that by one measure, only 21% of Australia's 'registered specialist anaesthetists' (4,495 as of 30 June 2014 according to the MBA – though according to the Australian Institute of Health and Welfare [AIHW], there were, in 2013, only 3,616 'employed clinician specialists') completed the survey, the question that is bound to be asked is: do these responses from at least 21% of anaesthetists in fact represent the views of the specialty?

Information regarding the age distribution of registered specialists provided by the MBA as of 30 June 2014 aligns reasonably with the specialist age distribution in our survey and so, it is felt to be reasonable to say, yes, 21% does represent the speciality. Furthermore, 'sneak-peeks' at the responses at the one- and two-week points showed consistent response patterns across the questions. And finally, consistent response patterns across the states were observed in responses to questions that might be expected to be 'national' in their focus

(e.g. "a reduction in anaesthesia caseload or a narrowing of one's case-mix could result in deskilling"). Information from other sources in relation to working hours etc. remains to be confirmed with 'publication lag' currently obscuring this data.

What we can say is that this 2014 survey has asked questions and obtained answers not available to others and that our data can be used to qualify and expand on the information obtained through the MBA registration/re-registration process and subsequently used by National Medical Training Advisory Network (NMTAN) and the AIHW.

All data is available to members with an interest, perhaps with a view to 'researching' the Australian anaesthesia workforce.

FINDINGS

The following observations are included for information, with further, more detailed analysis underway.

Refreshingly, 90% of members enjoy practising anaesthesia, 9% have 'neutral feelings' and 11 members do not enjoy practice.

The descriptive demographics (the age distribution of members, gender, state or territory of practice, site of practice and practice profile [public, private or both]) were as anticipated and in line with previous surveys. The questions addressing years since commencement of practice and intentions in relation to retirement were designed to enable analysis of subgroup intentions and concerns and have been reported to the Group of ASA Clinical Trainees (GASACT). Questions asked in relation to a desire for more work in the public and private sectors were a consequence of concerns expressed by younger members in relation to skills acquisition and maintenance. Younger members did report that they desired more public work, more private work and more work in total than more established members.

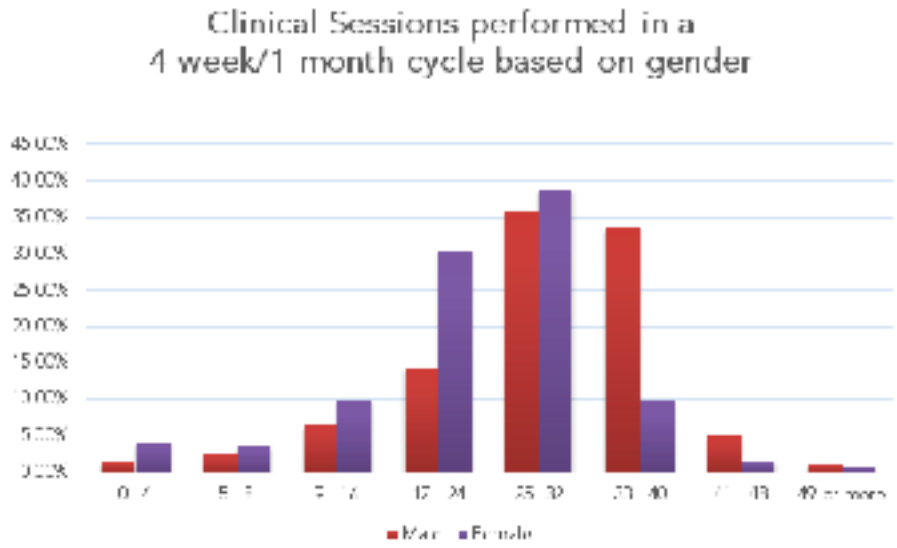

Figure 1: Clinical sessions performed in a 4 week/1 month cycle.

Thirty-six percent of members worked six to eight sessions per week (where one 'session' could be three (3) to six (6) hours or a 'half day' and for afternoon 'sessions', even longer) and could be classed as 'busy', and a further 27% (with a significant male preponderance) up to ten sessions per week, a workload consistent with long days and late nights. Members in non-metropolitan areas were also somewhat more likely to report these latter workloads. Perhaps a quarter of all responders (say, those working fewer than 24 sessions per four weeks – call this three or fewer days per week – might be termed 'part time' (Figure 1).

Fifty-two percent were satisfied with their current workload but 30% would like more work (compared with 54% and 19% respectively in 2012). Seventy-five percent could increase their professional caseload without difficulty or with some difficulty, with 12% working at 'full capacity'.

Members were asked to comment on a number of aspects related to the anaesthesia workforce. More than 85% believed that both the ASA and ANZCA have pivotal roles to play in relation to determination of anaesthesia workforce numbers, with a third of respondents identifying both the State and Federal Departments of Health as further key bodies. Only 22 responders of a total 920 responding believe that there is a shortage of anaesthetists in Australia and three believe that an inadequate number is being trained. In relation to a maldistribution or otherwise of anaesthetists; it is only in areas serving a population of less than 100,000 that a significant group (41%) believe that there is an inadequate number of practitioners, with cross-tabulation showing that 46% of the anaesthetists who actually practice in these areas concur.

In relation to vocational anaesthesia training in the private sector, there is a clear diversity of views with one third somewhat or strongly opposed, and 54% somewhat or strongly supportive (Figure 2). Parallel to this, one third believe that training should be restricted to the public sector, with only 9% in favour of 'substantial exposure' to private hospitals. Only 15% believe that vocational training does not decrease private-sector productivity (Figure 3).

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Figure 2: Level of support for vocational training in the private sector.

Figure 3: Views on the relationship between vocational training and private sector productivity.

Questions were asked in relation to further aspects of practice. Seventy percent of responders do not feel that they understand the concept of 'revalidation' in the context of current discussions. On the other hand, a large majority understand the process of 'informed consent' and the concept of 'material risk'; but interestingly, while 94% 'inform and discuss until satisfied that the patient has consented for anaesthesia', only 9% obtain a written statement of consent.

A large majority of respondents support the activities of the ASA in the areas of workforce, industrial and economic issues. There is also solid support for the need for the specialty to work to increase the availability of work for young consultants in public hospitals, though there is a dichotomy of views in relation to whether or not specialists, rather than trainees, should be employed to perform more 'out of hours' work in public hospitals.

In relation to anaesthesia for obstetrics in the private sector, a majority of respondents practising obstetric anaesthesia reported that there was no difficulty in maintaining anaesthesia cover in the facility with which they were most familiar, approximately half of which made some form of payment to anaesthetists for participation in a roster.

FUTURE ACTIVITY

The 2014 survey has identified at least one dozen areas suitable for detailed further study, including a number that may be suitable for assessment for peer-reviewed publication. There is also the capacity for comparison with earlier member surveys (2004, 2010 and 2012 in particular) and an increasing confidence in defining what information we most need.

The ASA now has the ability to explore in detail the responses and concerns of new specialists and those specialists

in non-metropolitan areas, particularly within the context of anaesthesia training numbers and the often reported 'maldistribution'. It may also be that differences in practice profiles and patterns are more related to where one actually practices rather than age or gender; and that whether a responder is the 'principal breadwinner' or otherwise is more important than gender in predicting the work capacity of the specialty.

Sequential information is now also becoming available from the MBA and AIHW in relation to the anaesthesia workforce and ANZCA itself has surveyed Fellows in 2014, with several of its findings likely to provide interesting comparisons with this survey. The MBA registration/re-registration process currently has limitations (e.g. the MBA was not able to quantitate the actual numbers of specialist anaesthetists entering as opposed to exiting the Register during the latest registration cycle) and offers little in relation to practitioner perceptions of the workforce or satisfaction with existing workload. This is a deficiency that needs to be rectified. Likewise, ANZCA data would need to capture the responses of Fellows in active practice to be complementary.

SUMMARY

The survey suggests that anaesthesia is a specialty that enjoys what it does, but one that has some capacity for extra work. There is solid support for the activities of the ASA in the workforce, industrial and economic areas and significant concern with both the number of active practitioners and the numbers entering the specialty.

While conceding the methodological issues with online surveys (sampling, response/non-response issues) it is felt that this was the ASA's best survey yet and, with the exception of several questions which we could delete in the future (relating for example to perceptions of the value or otherwise of other health workforce providers in the anaesthesia context), the further information that we most need in the future relates to the gender versus 'major breadwinner' question, rather than gender split per se. Other society activities and 'products' which have been assessed in earlier surveys, for instance *Anaesthesia and Intensive Care, Australian Anaesthetist*, emails and other broadcast activities etc., can be canvassed in future surveys to allow optimal alignment of resources with member needs and values; and it may be that these should be brief independent surveys, in the interests of achieving a high response rate without 'e-exhaustion' of the membership. Recent experience has shown that topical, short and sharp online surveys are comparatively successful.

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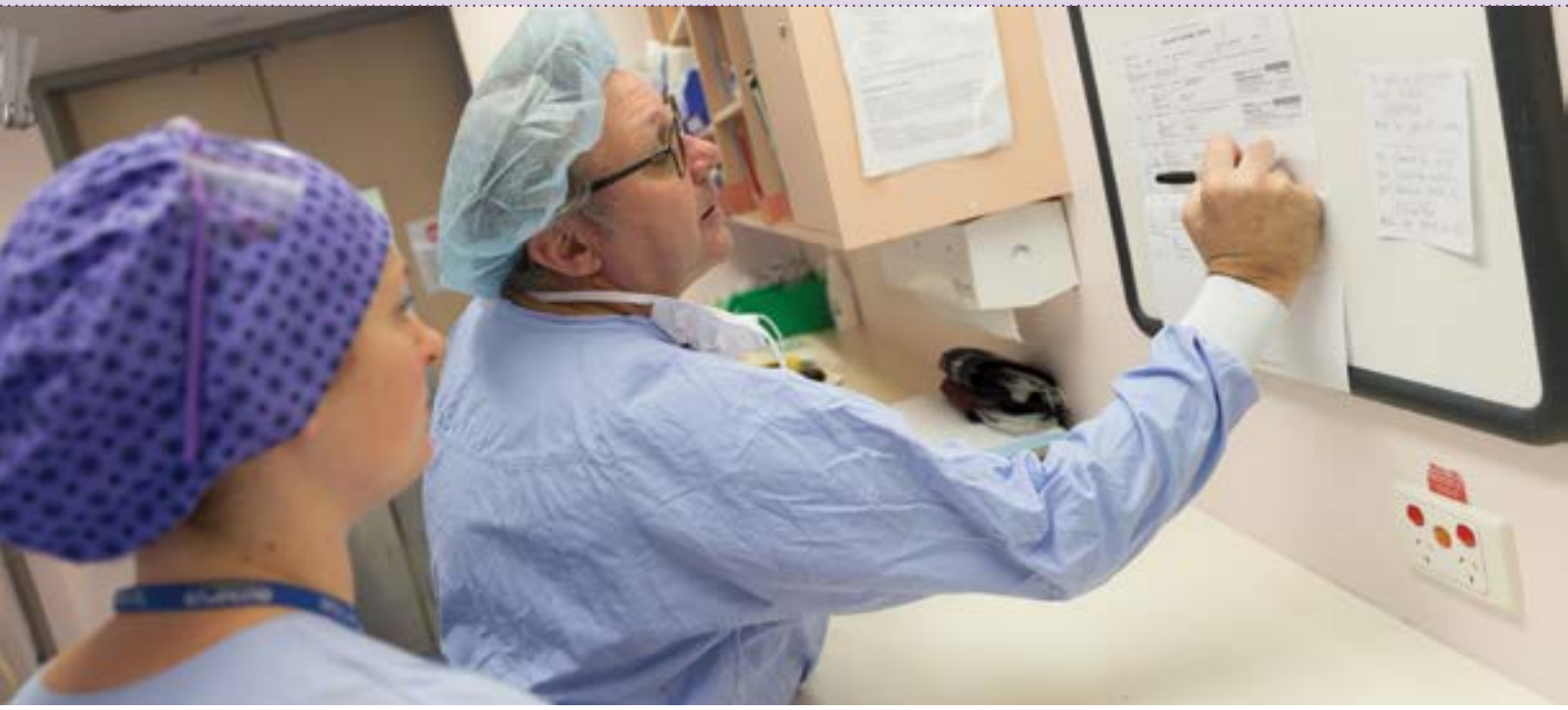

FIVE YEARS' NOTICE

Attending the Canadian Anesthesiologists' Society (CAS) Annual Scientific Meeting (ASM) in June, GASACT Common Interest Group (CIG) scholarship winner Dr Benjamin Piper has returned home with valuable insight into international developments in medical certification and revalidation.

In June, I was granted the opportunity, as a GASACT CIG scholarship recipient, to attend the CAS ASM at St Johns, Newfoundland. Through the support of the ASA, I was invited to travel, learn from international leaders and interact with trainees from the CAS. The ASA offers these opportunities annually to three GASACT members.

On a personal note, the ability to travel to a location that has been referred to as "the Canadian equivalent of Tasmania", in view of the isolation and pristine wilderness, was a real privilege. St Johns is the most easterly tip of the American continent, with foundations in fishing for the hallowed cod and, more recently, drilling for offshore oil deposits. The rich history of the indigenous Inuit peoples transposed with early European settlement, primarily from Ireland, could not help but sound familiar to a visiting Australian. On arrival, I was greeted by a local taxi driver who, upon learning that I had never before seen an iceberg, promptly turned off his metre and escorted me on a thirty minute tour around the town of about 100,000 people before dropping me at my lodging – a friendly welcome that would set the tone for the rest of the week.

Professionally, I was afforded the opportunity to attend seminars where international leaders discussed topics on perioperative echocardiography, blood transfusion and regional anaesthesia to name but a few. One of my particular interests in attending the St Johns meeting was the forum on the topic: 'International Approaches to Maintenance of Certification: How Do We Manage Maintenance of Competence?'. In this forum, leaders from the United States, United Kingdom, Canada and Australia described processes and experiences of

the anaesthetic community in their own jurisdiction. Revalidation is an important issue emerging in our own profession locally and, over the next few years, will be a topic debated at the highest levels. As such, I would like to offer a summary to the ASA membership on the current state of affairs abroad and the challenges and learning points they may offer us as we venture into this complex administrative environment.

CERTIFICATION AND REVALIDATION

The need to assure the community of the competence of their medical professionals is at the very heart of any revalidation or maintenance of certification process. The need for this to be achieved via a transparent and fair process is the minimum requirement and the complexity of how and by whom this is undertaken is where the real contention lies. It seems that the debate surrounding the 'if' it should occur has been had, with the Chair of the Medical Board of Australia stating that revalidation is likely to be in place within the next five years. This does present the profession with a unique opportunity, in that we have been granted five years' notice to develop and enhance our own professional self-regulatory framework. We don't need to start from scratch, as there are lessons that can be learned from our international colleagues and a brief summary of these systems follows.

The United Kingdom operates a system that is administered by the Graduate Medical Council and has only been running since 2013. The historical background of the British revalidation program is interesting, as it was developed within the context of an undermining of public confidence in the health system and its practitioners. High-profile cases such as the Bristol heart scandal (1998), the Shipman murder trial (2000) and the Ledward abuse trails (2001) were proof that previous policies of self-regulation had failed. From these beginnings, the Graduate Medical Council overhauled its revalidation procedures and the current system was born.

The CPD system is based on three layers:

- core knowledge: basic science and medicolegal principles,
- knowledge and skills for day-to-day practice: airway management, regional anaesthesia etc. and
- subspecialist interest areas: bariatric, neuro, cardiothoracic etc.

The United States operates a system known as Maintenance of Competence in Anesthesiology. It is administered by the American Board of Anesthesiology and is the only example of a self-regulated

Requirement	US (MOCA)	Canada (MOC)	UK (Revaladiation)	Australia (CPD)
Professional standing	✓	✓	✓	✓
CPD/continuing medical education	✓	✓	✓	✓
Simulation of critical event(s)	✓	✓	✓	✓
Reflective practice	✓	✓	✓	✓
• Colleague-based	✓	✓	✓	✓
• Patient-based	×	×	✓	✓
Examination: theory	✓	×	×	×
Subspecialty requirement	✓	×	Optional	×
Cycle duration (years)	10	5	5	3
Administrator	Specialist medical (ABA)	Medical (RCPS)	Medical (GMC)	Specialist medical (ANZCA)
Current model initiated (year)	2000	2001	2013	2014
Backed by legislation	✓	✓	✓	Not yet!

MOCA=Maintenance of Competence in Anesthesiology, MOC=Maintenance of Certification, CPD=Continuing Professional Development, ABA=American Board of Anesthesiology, RCPS=Royal College of Physicians and Surgeons, GMC=Graduate Medical Council.

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and self-certifying specialist body. Its major difference from other programs is in its high-stakes, multiple choice question exam—you don't pass, you don't practise.

Maintenance of Competence in Anesthesiology is based on:

- lifelong learning and self-assesment,
- cognitive examination and
- practice performance, assessment and improvement.

The Canadian equivalent, called Maintenance of Certification (or MOC), is grounded in a points-based Continuing Professional Development (CPD) system (similar to our current CPD system in concept). It is maintained by the Royal College of Physicians and Surgeons and is used by all specialist practitioners. It too is based on three categories:

- group learning,
- self-learning and
- assessments.

WHERE TO FROM HERE?

Having listened to the presenting speakers, including the ASA's own Dr Richard Grutzner, a few things have become clear, but so too have questions been raised.

What has become clear(er)

- The days of gaining a fellowship and then ad hoc accumulation of CPD points to justify our currency of competence are gone. The public and governing bodies now require more of us – and so, perhaps, they should. Evidence strongly suggests a steady decay in competence after the age of 35, which is the typical age that a consultant is generated. The common mindset (and mine prior to this meeting) was that our competence plateaus early as consultants, with a steady increase in ability with experience. Unfortunately, this notion is being shattered by the accumulating body of evidence suggesting otherwise.
- It is very likely that within the not too distant future we will have a non-optional requirement (likely legislated) to regularly demonstrate competence.
- We, as a professional body of anaesthesia providers, are in a unique position to 'get our house in order' before it is done for us. Let us learn from others and retain a self-regulated body that instils public confidence in our practice.

Questions that are yet to be answered

- How do we define what the "minimum level of competence" is in a profession that differs so widely in its day-to-day tasks, particularly in regional and remote settings?
- Who is going to create, maintain and administer such a system? At which level should self-regulation occur: subspecialist (e.g. cardiothoracic anaesthetist), specialist (anaesthetist), vocation (e.g. the Australian Health Practitioner Regulation Agency) or government (whether state or federal)?
- What problems are revalidation/certification aiming to fix and will it work? Will a self-administered, third party developed concept of self-directed teaching and third party assessment pick up the very few practitioners that have difficulties? It has been suggested that the few anaesthetists that have problems are often the same as those that are very poor at self-assessment and reflection.
- How should we set the 'sensitivity' and 'specificity' of this process? That is to say, do we want a very sensitive system that picks up ALL problem colleagues but results in many false positives (i.e. high numbers of non-problem colleagues being inadvertently flagged) or a highly specific system that has few false positives but runs the risk of missing those with potential problems (which some may argue we already have in place).

The future of our professional regulation has been placed in our metaphorical laps. We would be unwise not to take this opportunity with both hands and have the conversations that these questions prompt. We should take on the experiences of our international colleagues and build a system that will aid our ongoing requirements in lifelong learning, as well as help to offer the public confidence in its medical providers.

SELECTED REFERENCES AND FURTHER READING

Revalidation:

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Maintenance of competence over time:

Choudhry NK, Fletcher RH, Soumerai SB. Systematic review: the relationship between clinical experience and quality of health care. Ann Intern Med. 2005 Feb 15;142(4):260–273.

Baxter AD, Boet S, Reid D, Skidmore G. The aging anaesthesiologist: a narrative review and suggested strategies. Can J Anesth. 2014 June (ePub ahead of print).

ASA CPD FOLDER NOW AVAILABLE

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

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

FEATURE

Anaesthesia and Intensive Care has joined the App revolution!

The ASA, on behalf of the Editorial Board of *Anaesthesia and Intensive Care*, is thrilled to announce that our Journal is now available as an App.

HOW TO ACCESS

Anaesthesia and Intensive Care (AIC) is now available free of charge for all members to download from either the App Store or the Google Play store (depending on your device).

Simply search 'Anaesthesia & Intensive Care'

To read an article or issue you'll need to login to the App using the same details you currently use to access the ASA and AIC websites. When a new issue of the Journal is ready for you to view or download via the App you'll be sent a notification that the new issue is available.

HOME SCREEN

The first screen you'll see when you view the App features all the Journal cover images since January 2013. Journals appear in date order with the latest issue always appearing at the top of the screen – so you won't need to go searching for it – and the oldest version displaying in the bottom right.

MAIN MENU

To view the main menu tap on the icon at the top left of the screen (the three horizontal lines). From there you can either view the 'Issues' page, your favourite articles, search for an article or contact us.

To search for an article from 2013 onwards, select the Search function and type in the appropriate fields.

TO VIEW AN ISSUE

There are three options to view an issue. When you tap on the cover image of the issue you will be given the option of downloading the full issue as a PDF or view each article individually as plain text or as individual PDFs. Each issue will only need to be downloaded once and will remain in your App unless you clear the cache.

NAVIGATING A FULL ISSUE

Once you've opened an issue, you can access each article through the Issue contents by clicking on the menu item in the top left of the screen – this is the easy way to view the contents for the full issue. From here you can choose to read the plain text or PDF version. You can also download the full PDF and access a drop down menu table of contents within the issue. Skipping forward through an issue has been made easy by tapping the page icons at the bottom of the screen. Alternatively, there is a grid view option of each issue within the full PDF. You can access this view by tapping on the top right icon.

VIEWING INDIVIDUAL ARTICLES

To view individual articles click on the relevant navigation item i.e. Original Paper, Case Report, Editorial etc., then select the article you want to view. Articles can be viewed in either PDF or plain text format, as with the current AIC website.

If you start reading an individual article and find yourself taken away, or want to refer back to it later, simply select the 'star' icon to favourite the article. To view all your favourites simply return to the main screen menu and select favourites. This will display all your starred articles. To remove an article from your favourites list, simply deselect the 'star' icon.

VIEWING REFERENCES

Rather than scrolling to the very end of an article to see the item the reference number refers to, with the new App, you merely need to tap the reference number and a pop-up will display showing you the reference details.

STEPS

1. **Download the app**
2. **Enter your member ID and password**
3. **Happy reading**

Your free *Anaesthesia and Intensive Care* app is available to download now!

ANDROID APP ON Google play

Download on the App Store

Free to ASA, NZSA members, and ANZICS and individual subscribers, simply use your ASA website logon details to access.

For any queries, contact membership@asa.org.au

NZSA

ASA Australian Society of Anaesthetists

ANZICS

REGULAR

REGISTRATION STANDARDS AND REGULATIONS

TressCox LAWYERS

Dominique Egan, Partner at TressCox Lawyers, explains to *Australian Anaesthetist* the Registration Standards that all Australian medical practitioners are required to meet.

Health practitioners registered under the *Health Practitioner Regulation National Law* 2009 ('the National Law') or seeking registration under the National Law should ensure that they are familiar with the requirements of the Registration Standards developed by the applicable National Board. The Registration Standards concern:

- professional indemnity insurance arrangements,
- matters about the criminal history of applicants for registration, registered health practitioners and students registered by the Board,
- requirements for continuing professional development for registered health practitioners,
- requirements about the English language skills necessary for an applicant for registration and
- requirements in relation to the nature, extent, period and recency of any previous practice of the profession.

The obligations to comply are continuing, that is, not just at the time of initial registration but throughout the total period the health practitioner is registered. Failure to comply with the Registration Standards may be evidence of unsatisfactory conduct.

All current Registration Standards (together with other applicable codes and guidelines) may be found on the relevant National Board website.

The National Law states that when making a determination in relation to application for initial registration (or the renewal of registration), the relevant Board must refuse to grant the registration if the applicant does not meet the requirements for registration outlined in a Registration Standard.

In an application for renewal of registration, a practitioner must provide a declaration accompanying their application, confirming that the registrant:

- does not have an impairment,
- has met any recency of practice requirements,
- has completed continuing professional development requirements and
- has not practised and will not practise without appropriate professional indemnity insurance.

The registrant must also provide details concerning:

- any change in the registrant's criminal history (convictions, pleas and charges, whether in Australia or elsewhere),
- the withdrawal or restriction of rights to practise at a hospital or other facility because of the registrant's conduct, professional performance or health,
- the withdrawal of restriction of billing privileges under the *Medicare Australia Act* 1973 (Cth) because of the registrant's conduct, professional performance or health,
- any complaint made about the applicant to a registration authority or another entity having functions in relation to the professional services provided by the registrant and
- any other information required under a Registration Standard.

Providing false or misleading information in the statement is a ground in itself for which a Board can refuse to renew a practitioner's registration. In *Nursing and Midwifery Board of Australia v FH* (2010, Queensland Civil and Administrative Tribunal 675), the Board brought proceedings before the relevant tribunal on the grounds that an applicant for re-registration had made a false statement on his application and had failed to disclose a number of charges (and, on the grounds of the applicant's subsequent conviction as a result of the indictable offences, the subject of the charges):

> *The statutory declaration goes to a fundamental issue for registration as a nurse, the applicant's fitness to hold a position of significant trust. It is a key component of the protective function of registration. The importance of accurate and comprehensive disclosure is reflected in the significant penalty the Tribunal has imposed on FH.*

A false declaration to the National Board may also have criminal implications. A practitioner who makes a false declaration to the Board in their statutory declaration may be found guilty of an offence under the *Statutory Declarations Act* 1959 (Cth), which is punishable by up to four years' imprisonment.

The Registration Standards are relevant in professional conduct proceedings. The National Law provides that a Registration Standard can be admissible in proceedings against a health practitioner as evidence of what constitutes appropriate professional conduct or practice for the health profession. More specifically, Registration Standards can also constitute behaviour for which health, conduct or performance action may be taken in relation to the following, for example:

- failure to undertake the continuing professional development required by an approved Registration Standard or
- practising without appropriate professional indemnity insurance arrangements in place.

A practitioner who has any concerns or queries in relation to the above should seek professional advice about his or her particular circumstances.

For more information, please contact:

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GROW AND PROTECT YOUR WEALTH

LOMAX FINANCIAL GROUP
Integrated financial advice

More than 75% of Australians will be diagnosed with a serious illness in their working life (ABS Statistics), writes Financial Planning Manager for Lomax Financial Group, Ian Gibson.

Given the above, it is a concern that research indicates Australians are consistent in NOT taking out adequate levels of insurance to protect themselves and, in most cases, their family. In fact, Australia is one of the most under-insured nations in the developed world, ranking 16th for life insurance density and penetration (Swiss Re: Economic Research and Consulting, 2007).

WHILE YOU WORK TO GROW YOUR WEALTH, DO NOT FORGET TO PROTECT IT

A quote from Canadian economist and humourist Stephen Leacock (1869 to1944):

> *"I detest life insurance agents; they always argue that I shall someday die, which is not so."*

To protect the financial assets earned through your hard work, you will need to insure against various risks that could potentially undo all that you have achieved.

Through your profession, you will no doubt be well aware of the many personal risks experienced, not only by your patients but also, by your work colleagues.

While taking out personal risk insurance is a step towards protection, it is important to structure the insurance in a way that it will be most tax-effective. In some cases, the structure may increase your available cash flow.

The table on the following page helps you understand the various types of Insurance, under what circumstances they are appropriate and how the ownership should be best structured to achieve those tax savings and possible cash flow benefits.

There are several 'simple' ways of determining how much cover you actually need, however it is important that you discuss your wishes with your family (they are the ones who may suffer financially the most) and then seek help and clear advice from a professional financial planner.

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

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

For more information, please contact:

Web: www.lomaxfinancial.com.au

Email: lfg@lomaxfinancial.com.au

Address: Suite 1, Level 2, 1 Spring St Chatswood 2067

Phone: 02 8404 6700

What are the different types of personal insurance and what is the most tax-effective structure?

Types of cover	What does it pay?	What the benefit could be used for?	What is the ideal ownership structure for maximum tax benefit?	Can you or the super fund claim a tax deduction on the premiums?	
Life Insurance	Pays lump sum in the event of death or if the insured person is diagnosed with a terminal illness	Repay: Mortgage Other loans Credit cards Provide income stream for: Family living expenses Children's education	Superannuation fund Because: a) the superannuation fund pays the premium b) it potentially frees up personal cash flow c) premiums may be automatically deducted d) some funds automatically accept you for cover without requiring a health check	Super Yes* * Typically, the super fund gets a tax deduction for the insurance premiums paid. * You will need to speak to a financial adviser on how you can claim a tax deduction on life insurance premiums.	You No
Total & Permanent Disablement (TPD)	Pays a lump sum if the insured person is (depending on the TPD definition selected) unlikely to work again or suffers a loss of ability due to a permanent disability	As above PLUS: Meet rehab and home modification costs Ongoing medical and nursing costs Pay for nursing/respite care Pay for childcare	Both personally and through super-annuation	Super Yes *Similar to above, you will need to speak to a financial adviser on how you can claim a tax deduction on TPD insurance premiums.	You Yes*
Trauma/Health Events (Also known as Critical Illness/Living insurance)	Pays a lump sum	Pay for medical costs, and meet short financial needs to get you back to good health as soon as possible	In your name, outside of super	Super No	You No
Income Protection	Pays a monthly benefit to replace a portion of the insured person's monthly earnings if they are unable to work due to sickness or injury	Replace your current income	In your name to obtain the best tax deduction and be able to access the benefits at claim.	Super N/A	You Yes
Business Overheads	Pays a lump sum benefit if the Insured Person is unable to work due to sickness or injury	Any ongoing business expenses that would need to be paid even though you are not active in the business	Normally, in your name	Super N/A	You Yes
Key Person Insurance	Pays a monthly benefit to the business in the event the insured person (owner or employee) is unable to work due to sickness or injury	Minimise financial impact to business cash flow Pay for recruitment and training to replace a key person Assist paying off short term debt Protect business assets Assist key person's gradual return to work	In the name of your business* * If you are self employed, you will need to speak to your financial adviser to discuss the ownership depending on what business structures you have in place.	Super N/A	You Yes

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CAREERS IN ANAESTHESIA
ACADEMIC ANAESTHESIA EDITOR

Dr Michael Corkeron, from Townsville, Queensland, is an Editor for academic journal, *Anaesthesia and Intensive Care*. Along with his typical working week, Michael manages to fit in academic work with the Journal, processing over 130 papers last calendar year! Michael tells *Australian Anaesthetist* what it is like to be an editor.

"Mike, would you be interested in becoming an Editor for the Journal?". That call from the then Chief Editor, Alan Duncan, has proven a key point in the academic side of my career as an anaesthetist and intensivist. Reflecting upon the five years since I joined the team at *Anaesthesia and Intensive Care*, being an editor has been an unexpected turn that has proven stimulating, demanding and, at times, challenging, but the chance to contribute in this somewhat specific way to the academic and intellectual life of the disciplines of anaesthesia and intensive care medicine is invariably rewarding.

What does being an editor entail? Assessing papers, finding relevant reviewers and getting papers into shape for publication – sounds relatively simple, no? The reality is, it can be a convoluted process, especially when multiple iterations are required or a major issue is detected after peer-review. Add to that the need to find editorialists, write editorials myself, organise book reviews, plan strategic directions for the Journal and keep abreast of issues in publication in general and I can well understand why a number of journals have full-time staff editors. My overall take on this, which I believe is shared by my fellow editors, is that we strive to balance producing a journal that is interesting and relevant for the readership, supporting authors and maintaining high academic standards in our publication. Possibly one of the hardest parts of the processes of working in academia is time. Articles are submitted on a certain date, and it is expected that that paper is assessed, critiqued and responded to in a timely fashion (at *Anesthesia and Intensive Care*, we advise authors of an approximate eight week turnaround period). However, that can be hard to achieve when you are not only relying on your own assessment, but also the feedback from our reviewers. Our reviewers are crucial to the peer review process, central to publication and are of course also fitting this in amongst the many other demands placed on clinicians. And above all, you are managing authors who often have a lot riding on their paper being published.

So where do journals fit in these days? With 'Dr Google' and internet-only publications, there are many alternative sources of medical information and media, and the role of the paper journal is diminishing. That means an adaptive and proactive approach is needed to embrace new forms of publication (in *Anaesthesia and Intensive Care*'s case, we are excited to be launching the new journal App at the start of 2015). That said, the role of robust peer-review remains, despite its difficulties, as nothing genuinely better seems to have been developed thus far. So, even with changes in media, some aspects of publication will remain. In an era of rapid separation of the disciplines of anaesthesia and intensive care in larger centres, but anaesthetists being central to intensive care provision in many areas, the need for a journal covering both disciplines is greater than ever, at least in my opinion.

The world of medical publication is dynamic and much has changed, even in recent years

The advent of electronic manuscript submission means that journal work can be done anywhere with an internet connection. This in turn means that some editorial work has been done in far-flung and 'interesting' locations such as various islands in the Pacific and even the often-seen-in-media 'Poppy's' recreation lounge in Tarin Kowt. Electronic systems invariably bring their downsides and the ASA staff are well used to emails about my IT issues, not to mention that the Journal website is only a click or three away when on holidays and an "I'll just be a few minutes", is to the annoyance of significant others!

For those who have been published, you would be acutely aware that every

paper is the result of considerable effort on the authors' part. Junior colleagues embarking on their publishing careers tend to attract a degree of special support. Seeing a trainee's first publication make it to press, sometimes after many iterations and corrections, is something I find particularly satisfying.

A major issue is one of maintaining standards in an author-pays system and... [we] are reminde[d] of the challenges that lie ahead in this field

Being an editor has been interesting at every turn. The world of medical publication is dynamic and much has changed, even in recent years. There is a body of knowledge that has to be acquired and maintained in relation to publishing itself, something that, ten years back, I would have said was rather derivative but now consider essential. Readers will be aware of the research fraud scandals of recent years and mechanisms to detect such activity are an active topic of discussion. Plagiarism detection has been something of an eye-opener and the issues of what to do when plagiarism is detected, which can include reporting to employers and registration authorities, loom large at times. These issues are not isolated to medicine – scientists of all types can be liable to such behaviour, so cross-discipline groups offer much to learn. The advent of Open Access journals has dramatically changed the dynamics of publication and the implications of this major shift are still being felt. A major issue is one of maintaining standards in an author-pays system and papers such a "Who's Afraid of Peer Review?"[1], an extremely worthwhile read for any clinician, are reminders of the challenges that lie ahead in this field. On the other hand, moves toward electronic publication of journals will bring information to the operating theatre and bedside in new ways and we will, I am sure, have to modify how publication is done to make these changes work for readers, authors and ultimately patients. It's an area that will bring changes that are, right now, difficult to fully predict, but are very exciting in terms of where they may lead.

Of course, there are downsides to being an editor. It is time-consuming and occasionally frustrating. I am in awe of my fellow editors who maintain active research programs, as I seem to run out of hours in the day far too quickly. These are minor compared with the benefits of having a birds-eye view of a great deal of research activity and the chance to interact with an outstanding group of authors, reviewers and colleagues through the Journal.

The editorial team at *Anaesthesia and Intensive Care* is comprised of a group of clinicians led by Chief Editor, Neville Gibbs, supported by the hard-working, diligent and enthusiastic publishing staff at the ASA, the eagle-eyed sub-editors and the Editorial Board. Without their support and help, and that of my fellow intensive care editor, Kwok Ming Ho, I certainly could not do the job and I would like to take this chance to express my gratitude to them all.

To our reviewers and of course our authors, I offer my heartfelt thanks. For those who aren't yet reviewers and would like to take this on I'd like to invite you to contact the Journal staff at the ASA and come aboard.

'Being an editor' has been a fascinating journey. I am looking forward to the challenges that lie ahead and hope I can ever better serve the Journal, its readers and our authors in future.

References

Bohannon J., Who's afraid of peer review? Science. 2013:342, 60-65.

CONTACT

To get in touch with Michael, or any of the editors at *Anaesthesia and Intensive Care*, send an email to aic@asa.org.au.

AIC JOURNAL

Or, if you'd like to know more about the Journal, you can read past issues and articles at www.aaic.net.au.

JOIN THE TEAM

Like to see your name in print? Want to contribute to the peer-review process? Visit the AIC submissions website at: www.submissions.aaic.net.au and create a user profile to start your academic career.

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ANAESTHETISTS IN TRAINING
ACING A SKYPE INTERVIEW WITH "BRAND U"

John Coleman is the Strategic Recruitment and Candidate Care Advisor at Central Queensland Hospital and Health Service, a Queensland Health affiliate. As a recruitment specialist in a medical environment, *Australian Anaesthetist* asked John for some tips on how members can ace the increasingly prevalent and popular Skype interview.

Your resume and cover letter have done their task. You've created awareness and generated interest by showing relevant qualifications and skills in your application. You've succeeded in gaining an interview. Your confidence is high until you find the interview will be on Skype.

Face-to-face, you approach an interview or networking situation with ease. Why is it that in front of a camera you appear flat and awkward?

The pragmatic voice in you head screams "enough!".

You've always been professional and never been one to shrink from a challenge. Motivated to get this job, you decide it's time to ace Skype interview techniques.

QUESTIONS TO ASK YOURSELF AS YOU PREPARE

What will make me stand out in a competitive job market?

While you thought you understood the job market, you discover that in an era of social media and computing technologies, it's now important to build a consistent "Brand U".

What are the differences when interviewing with Skype?

It can be challenging to prepare for a Skype interview. First of all, you will need to have a professional Skype name and picture. A cheeky or irreverent name or picture might be fun with your friends but will send an unwanted impression to the potential employer.

You will need to test your technology in advance. Your camera, connection speed, lighting and microphone will need to be adequate and reliable. De-clutter your location background including avoidable interruptions. A dedicated microphone will work best to isolate you from distracting background noise. Good lighting will help produce a clear image. This will allow you to project that all important positive body language and showcase "Brand U".

The advantage of Skype is that you can locate cue cards with your most important key points off camera. Make them large enough and brief enough to read at a glance.

Travelling to interviews and negotiating traffic doesn't have to be a hassle with good planning with Skype you can allow yourself the luxury of time to find that inner composure that will help you present your confident "Brand U".

What does my audience seek from the interview?

When building your "Brand U", consider what it is about you that will be of interest to the employer. Research the company, talk to the contact person and review their competition.

A Google search of reputable marketing, recruitment and communication sources provides common themes for success. This checklist will help maintain your "Brand U" during your Skype interview:

- Dress the part – one notch above the company's day-to-day standard will show respect for the process. Feel the part.
- Have your key strengths and benefits prepared from the perspective of what you can offer the company. Analysing the company needs and culture will help you to better align your message and demonstrate your fit.
- Highlight how your transferable talents will make you immediately productive.
- Back yourself up with prepared short stories relating a clear objective, action you took and the results achieved.
- Don't overlook past project failures. What did you learn? What do you now do better to avoid repeating those mistakes?
- Smile and ensure you actively listen. What are the points that must be

highlighted in your response? Make dot points if it helps you to be more thorough. Clarification questions are better than missing the point and the interviewer being disappointed.

- Avoid distractions that may block your message – don't over-gesture – and maintain your position relative to your camera. Having your own small in-picture image on screen will help.

Is my strategy aligned with the needs of the role and the company?

Having a "Brand U" strategy ideally starts with your initial application and is maintained throughout the whole recruitment process. Planning to make the best of the Skype technology and interview process takes focus. The traditional interview success factors still apply, however, the firm handshake takes a back seat to the ability to engage with and respond to your audience. Don't forget the follow-up 'thank you' email.

Do I have a Plan B?

Rehearse so that you don't need to rely on notes. Preparation adds to your flow and flexibility.

Don't forget though, Murphy's Law has a nasty way of bringing the ideal plan to a screaming halt. Using Skype and other digital communication platforms does not make you immune from the outside world. On the day, should the council decide to dig up your street or your computer decides that it is time for a glitch, you need a Plan B.

Have you alternative arrangements, such as going to the library or using a friend's computer, should any last-minute problems arise? Can you contact the interviewers by an alternate means?

Having a planned fall back position means that you can maintain your "Brand U" and show resilience under changed circumstances.

All of this preparation is to position your "Brand U" as the best fit for your chosen opportunity.

For more information, please contact:

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LinkedIn: https://www.linkedin.com/company/central-queensland-hospital-and-health-service?trk=affco

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WEBAIRS NEWS

In this issue, Adjunct Professor Martin Culwick reflects on the growth of webAIRS in 2014 and the data collected from reported incidents.

ANZTADC has had a successful year, with an increase in both the number of sites registering and the rate at which incidents are reported.

Sites registered	Sep-2014	Jun-2014	Nov-2013
Australia	54	49	39
New Zealand	24	24	22
Total	**78**	**73**	**61**

There are currently 78 registered sites, which is a 28% increase since November 2013. Twenty-four of the sites are in New Zealand and 54 are in Australia. One of the barriers to registering a site in Australia is the need for ethics approval. Where a hospital has its own ethics committee, then the advice of that committee should be sought regarding the best avenue for ethics approval, though smaller hospitals, private practices, day surgeries and individual practitioners may accept the ethics approval of an external human research ethics committee. ANZTADC plans to simplify the approval process by allowing this to be accepted online. There is also the need for permission to be obtained for the data to be used for analysis by ANZTADC. While this might seem obvious, a formal approval process is still required. This has previously been conducted by a signed agreement but, in future versions of the program, this agreement will also be able to be completed online.

ANZTADC has now received 2,772 incident reports (as of 26 September 2014), which represents a 41% increase since September 2013. Some of this growth may be a result of successful promotion and the increased recruitment of sites, while some of the growth might be related to the use of webAIRS as a tool to facilitate practice evaluation and obtain Continuing Professional Development credits.

Presentations at national and international meetings this year have included the NZSA Asian Australasian Congress of Anaesthesiologists (February 2014), the Airway SIG Meeting (May 2014), the ANZCA Combined Scientific Meeting (May 2014) and the ASA NSC (October 2014).

During the interim analysis of the data, one of the interesting points that has been noticed is that, in some cases, there is an initial difficulty in reaching the correct diagnosis. At the time an incident is evolving, the clinical signs observed may vary and the anaesthetist may be performing other routine tasks. There is a natural tendency to treat the most likely cause of the initial sign before formally looking for alternative diagnoses. The anaphylaxis data presented at the recent ASA NSC supported this conclusion.

The first sign of anaphylaxis was stated in 81 of the 82 incidents that were analysed. The most common sign was hypotension, but it was interesting to note that this was observed first in less than half the cases. Respiratory events, including desaturation, bronchospasm and high ventilation pressures, were noticed as the first sign in 27 cases, which is almost as frequent as hypotension. A rash was noticed first in 12 (14.6%) cases and arrhythmia, which

Incident reporting summary	Sep-14	Jun-14	Sep-13
Respiratory/airway	732	644	485
Neurological	160	142	107
Medical device/equipment	377	361	304
Medication	456	400	323
Infrastructure/system	174	156	124
Cardiovascular	462	403	329
Assessment/documentation	176	155	127
Other organ	48	41	32
Miscellaneous/other	187	156	126
Total	**2772**	**2458**	**1957**

included two cases of cardiac arrest in seven (8.5%) cases. This resulted in other interventions, such as salbutamol, steroids or alternative vasopressors, being used prior to the use of adrenaline in many cases. However, vasopressors were used first in 56 of the cases and adrenaline was used first in 32.

First sign of anaphylaxis	
Not stated	1
Desaturation	2
Arrhythmia	7
Rash	12
Respiratory event	15
High ventilation pressure	11
Hypotension	34
Total	**82**

The final outcome of the cases were generally good. Fifty-eight cases were admitted to either intensive care or high dependency units, though cardiopulmonary resuscitation was required in nine cases and, unfortunately, the outcome was fatal in two. The take-home message from this interim analysis was that, whilst anaphylaxis is an uncommon event, unexpected falls in blood pressure, the development of difficulty in ventilation or the occurrence of arrhythmias should trigger a search for other signs of anaphylaxis. The observation of a rash is also important, but in general this does trigger an immediate search for other signs of anaphylaxis. It should also be noted that, in severe anaphylaxis, a rash may not emerge until blood pressure has been restored.

ANZTADC would like to thank everyone who has submitted incidents and is contributing to the wealth of data that is being collected. The contribution and analysis of incidents are eligible for two Continuing Professional Development credits per hour. If you wish to register, you can do so online at www.anztadc.net or, if you would like to be involved in the analysis of incidents already collected, then please contact ANZTADC at anztadc@anzca.edu.au.

For more information, please contact:

Adjunct Professor Martin Culwick, Medical Director, ANZTADC

Email: mculwick@bigpond.net.au

Administration support: anztadc@anzca.edu.au

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

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

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INSIDE YOUR SOCIETY

MEMBERSHIP UPDATE

Membership Services Manager, Veronica Pardey, reflects on another fantastic National Scientific Congress and looks toward what you can expect from your Membership Team in the new year.

The end of 2014 marks the close of the ASA's 80th year – a proud milestone for a Society that has long offered support to members in anaesthesia practice in Australia. We exist as on organisation that is focused purely on representing, connecting and educating members and this strength was reflected in the recent success of the 2014 National Scientific Congress held on the Gold Coast, which had over 800 delegates in attendance.

The overarching theme of the congress, 'Practice, Precision and Professionalism' was thoughtfully articulated by Mr Anthony Morris QC who, in delivering the Kester Brown Lecture at the opening plenary session, noted a number of key attributes of professionalism. Captured in no particular order, they included:

- **Be a broad-based thinker:** take an interest in the human condition in a holistic sense. Having an appreciation of history and philosophy enables you to be well-rounded, thoughtful and responsive.
- **Maintain fierce independence:** be available to all people, not a servant to any one government or corporation.
- **Safeguard the welfare of the community:** speak up for the health of the nation.
- **Uphold strict professional standards:** as overseen by peers. Show integrity, be conscientious.
- **Demonstrate absolute commitment to the patient.**
- **Insist on sufficient remuneration:** at a level that enables rest and recreation, with rewards commensurate with one's abilities and experience.
- **Respect:** the best way to earn respect is to give it.

As anaesthetists, you are called upon to wear many hats in your practice, remaining mindful of many of the points above, which are often overlapping. At the core, you are medical experts, but also collaborators, communicators, health advocates and scholars. These competing demands make the profession immensely interesting and rewarding, but also at times challenging. It is the ASA's mission to support you with services to assist with these challenges, with a primary focus on the economic, workforce and professional interest of our members.

It is with optimism that the ASA's Council and staff continue to work towards the future, with a strength of purpose established in our foundation: for the dissemination of knowledge, for scientific research and for the protection of the status and welfare of anaesthetists. As Dr Donald Maxwell, former President of the Society (1982 to 1984) stated, "The Society's sound beginnings sprang from a deep desire to further the best interests of anaesthesia and anaesthetists and the firm conviction of its members that they were furthering the interests of a medical speciality which would have a major impact on the health and welfare of all mankind"[1].

Being the independent voice for Australian anaesthetists, we remain focused on addressing matters that are practical, relevant and represent your concerns as a profession.

We look forward to your ongoing engagement and involvement in 2015 and thank members for their valued loyalty to the ASA.

1) Wilson G. *Fifty Years, The Australian Society of Anaesthetists 1934 – 1984*, Foreword by Donald Maxwell. 1987:ASA, Sydney.

2015 Membership Renewals

Please keep an eye out for your 2015 renewal letter in the coming weeks, with 2015 membership fees due before 28 February 2015.

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

INSIDE YOUR SOCIETY

POLICY UPDATE

The Policy Team has had an active few months, particularly in the lead-up to the National Scientific Congress.

Assistant Policy Officer, Josephine Senoga, assisted greatly with the development, pre-testing, data gathering and, finally, data analysis of the 2014 ASA Member Survey which was a great success. Policy Manager, Chesney O'Donnell, had a productive meeting with the new General Manager of Policy at ANZCA, Mr Jonathon Kruger.

This period has also been a busy time for submissions, ranging from the Senate Select Committee on Health to Australian Commission on Safety and Quality in Health Care's Clinical Practice Guidelines discussion paper and research conducted in the area of National Registration and Accreditation for the Health Professions. Queries have been quite diverse with no one overarching theme outside of general billing enquiries. Our Economics and Professional Issues Advisory Committees continue to do great work in helping us assist our members with the many complex and varied issues they face.

INFORMED FINANCIAL CONSENT AND PATIENT QUERIES

Every now and then the ASA Policy Team receives calls from the general public. More often than not these calls concern issues of informed financial consent. The ASA advises such callers that is it not a government regulatory body. The ASA guides patients towards having this discussion with their anaesthetist. Informed financial consent is not legislated like cost agreements for lawyers are (*Legal Practitioners Act* 2004, Division 5, ss322-328). Where possible, it is strongly encouraged to provide patients reasonable notice as to the cost of their procedure.

For further information on informed financial consent, you can visit the Economic Update section, under News on the ASA website.

MEDICAL INDEMNITY

In September, Chesney O'Donnell attended the 2014 Medical Indemnity Industry Association of Australia Forum in Melbourne. Of particular interest was the examination into the Australian Health Practitioner Regulation Agency complaints process.

This relates to how the process could be more equitable for all parties involved, more timely, less rhetorically bureaucratic and ultimately cutting out unnecessary red tape. By streamlining the system via more reconciliatory means, it has been argued that it will lessen the likelihood of a complaint reaching the courts. This is an ongoing discussion.

MANDATORY NOTIFICATIONS

Mandatory notifications are under review and discussions on several levels have been made as to whether it should be harmonised and in line with the Western Australian model.

The Western Australian Health Practitioner Regulation National Law exempts doctors from mandatory reporting when they are providing a health service to another doctor or to a medical student (*Health Practitioner Regulation National Law (WA) Act* 2010, s4). The argument here is that the current common model across Australia may in fact discourage doctors from seeking help for conditions such as depression, which may or may not have an immediate impact on their ability to perform as a medical professional and specialist.

CONTACT US

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

Email: policy@asa.org.au

Phone: 1800 806 654.

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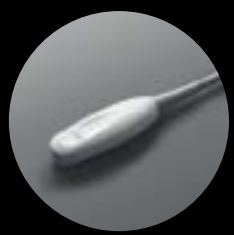

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INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

Dr Mark Sinclair, Chair of the Economics Advisory Committee (EAC), reports on a wide range of economic issues facing the ASA and its members.

MEDICAL SERVICES ADVISORY COMMITTEE (MSAC) ULTRASOUND APPLICATION

Application 1183, for Medicare funding for the use of ultrasound guidance to assist nerve block and major vascular access procedures, is nearing completion. As previously discussed, detailed assessment of the economic aspects of the Health Technology Assessment (HTA) group report was beyond the capacity of the EAC. After liaising with several groups involved in healthcare economics, the company Deloitte Access Economics was engaged to assess the report.

The Deloitte Access Economics report lists a number of errors in the HTA assessment, with numerous examples of underestimation of the economic benefits of the use of ultrasound for the procedures in question. Unfortunately however, the economic benefits still remain uncertain, due to a lack of available evidence in the literature. The MSAC requirement for high-level clinical and economic evidence will be very difficult to satisfy.

The ASA has replied to the HTA report, and included the Deloitte Access Economics material. Strong emphasis was placed on the inappropriateness of simply ignoring any potential economic benefits not backed by detailed evidence. An example is the fact that ultrasound guidance has been proven to decrease the incidence of inadvertent carotid artery cannulation during attempts at jugular venous access. The probability of the catastrophic complication of a cerebrovascular accident is therefore decreased. MSAC has made no consideration of the economic benefits of preventing strokes by using ultrasound guidance, due to a lack of definitive economic evidence (which is virtually impossible to obtain).

At the time of writing, the Evaluation Sub-Committee of MSAC is about to meet to discuss this (and other) applications and a recommendation for or against funding should follow soon. ASA members will be updated as further information comes to hand.

OTHER MSAC APPLICATIONS

Application 1308, for the introduction of Medicare Benefits Schedule items to cover all nerve blocks used for postoperative analgesia (rather than the limited range covered by Items 22040–22050) is now being assessed by HTA. It is hoped this assessment will be completed, and the HTA paper published, in early 2015. Again, we anticipate a positive finding for the claim for clinical benefits, but uncertainty regarding the economic aspects.

As previously discussed, the MSAC application for improved funding for complex initial attendances in the practice of pain medicine is no longer with MSAC. The submission to the Department of Health (DoH) is still being drafted. Again, the main problem is the lack of definitive evidence for economic benefits. Cost savings afforded by better initial assessments of patients with complex problems are almost certainly real (less ordering of investigations or procedures, for example), but are hard to prove to the level required by the DoH. The EAC is grateful for the assistance of ASA member Dr Roger Goucke, Past Dean of the ANZCA Faculty of Pain Medicine, and also Dr Tim Semple, Immediate Past President, Australian Pain Society, and Ms Lesley Brydon, CEO, Pain Australia, for their ongoing advice.

FEDERAL BUDGET 2014

The first budget handed down by the current Federal Government had a number of implications for health funding. At the time of writing, there is still uncertainty as to which measures will be passed by parliament. The proposed $7 co-payment for bulk-billed GP services has been withdrawn for now. However, the freeze in Medicare rebates for specialists' services (until at least July 2016) is definite, as is the removal of the office of the Private Health Insurance Ombudsman and the Private Health Insurance Administration Council. The Ombudsman role will be absorbed by the general Commonwealth Ombudsman, and the Council by the DoH.

The response of private health insurers to the rebate freeze has been mixed, with some providing small indexations and others following the government's lead and not indexing. The implications for out-of-pocket expenses for medical services remains to be seen, but this of course entirely depends on the response of the profession.

PRIVATE HEALTH INSURANCE

As members are by now aware, on 1 July 2014, Bupa introduced a 'known gap' product for doctors other than those of first referral. The reason for this remains uncertain. The only explanation from Bupa was that it was in response to "advice, comments and concern from the medical profession". As the ASA (and other groups) have been enthusiastically expressing "advice, comments and concern" for many years, with no result, this sudden change in direction came as somewhat of a surprise.

The Bupa product, like that of Medibank Private, limits the co-payment to $500 per doctor, per admitted episode of care. Any fee resulting in a higher co-payment will result in the rebate dropping to 100% of the Medicare Benefits Schedule. Initially, communications from Bupa indicated that anaesthetists agreeing to use the new scheme had to commit to either a 'no gap' or 'known gap' fee (with its $500 limit) for 100% of Bupa patients. This was later overturned.

In a more worrying development, Bupa and Medibank Private/AHM have developed policies that could interfere in the doctor–patient relationship, with concerns that a USA-style 'managed care' agenda is gradually being established. Medibank Private/AHM have apparently concluded that the use of a Medicare Benefits Schedule item may not indicate medical necessity and Bupa wishes to implement a system in which surgeons must provide a report to insurers in advance of at least ten working days for certain procedures that may have a 'cosmetic' component. As a result, at least one private hospital group has decided to charge these patients in advance for their hospital fees, in case the insurer refuses to pay the full hospital benefit.

Representatives of the Australian Society of Plastic Surgeons intend to meet with the Federal Minister for Health and Sport to discuss this issue. The Society have indicated that they are keen to maintain close contact with the ASA on this issue.

The Australian Medical Association is also actively working with surgical groups as well as the DoH and health insurers, with the aim of developing definitions of "medically necessary" versus "cosmetic" surgeries.

RELATIVE VALUE GUIDE

The 17th edition of the *Relative Value Guide* booklet is currently being edited. The EAC is grateful for the assistance of Drs Rob Storer, Tim Wong, Callum Gilchrist and Renald Portelli, who, along with myself and the Policy and Publications teams, have again formed a sub-committee to work on updates to the booklet.

SCARC

In March 2014, the Senate referred the matter of out-of-pocket healthcare expenses to this committee. The ASA made a detailed submission. Overall, approximately 100 submissions were received from medical and other healthcare groups, consumer advocate groups and individual consumers. Of course, the inquiry looked not only at doctors' fees, but also at all possible sources of costs to consumers, for example, hospital costs, pharmaceuticals and prostheses.

Numerous submissions referred to 'gaps' for doctors' fees but, disappointingly, very few submissions referred to the reason for the existence of gaps, namely, poor rebates and poor indexation of rebates. Notably, some such submissions came from medical groups or individual professionals and were critical of their colleagues for any charges resulting in any gaps whatsoever. Unfortunately, the terms "unjustified" and "greed" were used.

ASA Policy Manager Mr Chesney O'Donnell liaised extensively with the Senate Community Affairs References Committee (SCARC) secretariat, and, as a result, the ASA was asked to send representatives to the face-to-face Senate hearing in Melbourne on 3 July. Our President at the time, Dr Richard Grutzner, appeared along with Chesney O'Donnell and myself. We placed strong emphasis on the arguments regarding poor rebates and poor indexation, as well as the implications of 'no gap only' insurance policies on out-of-pocket expenses and the lack of information provided by insurers to their customers. Fortunately, the senators seemed very interested in our opinions and we were given ample time address these matters in detail.

The SCARC released its report in late August. Much of this document simply summarised important points made in the various submissions and in the face-to-face hearings. The legitimate concern that patients forego health interventions due to cost was expressed. Our positions on poor indexation and poor insurance company policies were mentioned, but no opinion was offered. The final recommendations of SCARC are basically that further reviews of costs to healthcare consumers are needed and that the $7 GP co-payment should not be implemented.

THE ASA IN THE MEDIA

In recent months, there have been two articles published in the mainstream media by Mr Terry Barnes, who was advisor to Mr Tony Abbott when the latter was Health Minister in the Howard government. Mr Barnes currently works as a consultant in the private sector and was the chief architect of the $7 GP co-payment plan.

The first article, published in *The Australian*, was chiefly aimed at the Australian Medical Association's criticism of the GP co-payment plan, but included sarcastic remarks about anaesthetists' low level of bulk billing. A second article also appeared in the *Australian Financial Review*, severely criticising specialists' fees and charges and again specifically mentioned anaesthetists, describing us as showing "blatant disregard" for patient rights, as well as "stubborn, arrogant and contemptuous" behaviour. Both articles contained several examples of basic factual errors (for example, the fact that bulk billing and inpatient no gap billing are entirely separate statistics). Fortunately, after discussions with the editor of the *Financial Review*, Dr Grutzner was able to have a response to the second article published.

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MEDICARE EXPENDITURE 2013–14

The table to the right shows the total amount of Medicare claims and expenditure for the 2013–14 financial year, as well as specific expenditure on anaesthesia and surgical services. The figures for anaesthesia and surgical expenditure do not include consultations (approximately $91 million for anaesthesia—publicly available data do not specifically list expenditure on attendances by surgeons). The continuing growth in Medicare expenditure shown in this table has been described as "unsustainable" by the government, hence the freeze in indexation. However, this description has been criticised by bodies such as the Australian Medical Association. An analysis by the Australian Institute of Health and Welfare revealed that, in real terms, total national spending on health grew by a record low of 1.5% in 2012–13 (significantly less than inflation) and that Federal Government expenditure fell by 2.4%. The Commonwealth Budget expenditure on health has fallen from 18% to 16.1% over the last seven years. Unfortunately, those in power apparently continue to see health expenditure as 'lost' money, rather than an investment in the health (and therefore economic productivity) of the population.

Service	Number	Expenditure	1-year growth	5-year growth
Medicare (total)	358 million	$19.3 billion	4.2%	22%
Anaesthesia	2.26 million	$390 million	5%	34%
Surgery	9.04 million	$1.6 billion	6.2%	38%

ANAESTHESIA WORKFORCE

The wide range of issues arising from the current medical workforce situation has been dealt with in detail elsewhere, including an article by Dr Antonio Grossi in this edition of *Australian Anaesthetist*. Unfortunately, the EAC has been made aware of numerous instances of anaesthetists feeling pressured to enter into unpalatable workplace arrangements in order to maintain steady employment.

Members will of course be aware of the difficult situation faced earlier this year by our salaried colleagues in Queensland. There has since been a case in another state, in which a salaried anaesthetist was pressured to sign a new contract, similar to those on offer in Queensland. If the contract was not signed within 24 hours the anaesthetist was advised not to show up for work the next day. Anaesthetists should be aware that other state governments will be watching these developments with interest.

The private sector is certainly not immune to such pressures. The EAC continues to receive queries from members in private practice who have been required to enter into certain agreements in order to obtain or retain regular work. Examples include a guarantee to charge 'no gap' fees to 100% of patients, or the payment of a 'facility fee' for each patient anaesthetised.

Members subject to such pressures are encouraged to contact the ASA for advice. However, it must be recognised that the only way around such problems is for the anaesthetists involved to refuse to participate in such arrangements, and to negotiate better terms. The ASA is always prepared to assist members with this.

Economics Advisory Committee 2014–2015

Position	Name	State
Chair	Dr Mark Sinclair	SA
EAC Immediate Past Chair AMA Craft Group Representative TAS EAC Officer	Dr Andrew Mulcahy	TAS
PIAC Chair ASA Past President and Life Member	Dr James Bradley	QLD
PPAC Representative	Dr Mark Colson	VIC
GASACT Representative	Dr Brigid Brown	SA
NSW and ACT EAC Officer	Dr Callum Gilchrist	NSW
QLD EAC Officer	Dr Timujin Wong	QLD
VIC EAC Officer	Dr Renald Portelli	VIC
SA/NT EAC Officer	Dr Tim Porter	SA
WA EAC Officer	Dr Robert Storer	WA
Committee Member	Dr Graham Mapp	QLD
Committee Member	Dr Ian Woodforth	NSW
President (ex-officio)	Dr Guy Christie-Taylor	SA
Chief Executive Officer (ex-officio)	Mr Mark Carmichael	NSW
Secretariat Contact/Policy Manager (ex-officio)	Mr Chesney O'Donnell	NSW
Secretariat Contact/Assistant Policy Officer (ex-officio)	Ms Josephine Senoga	NSW

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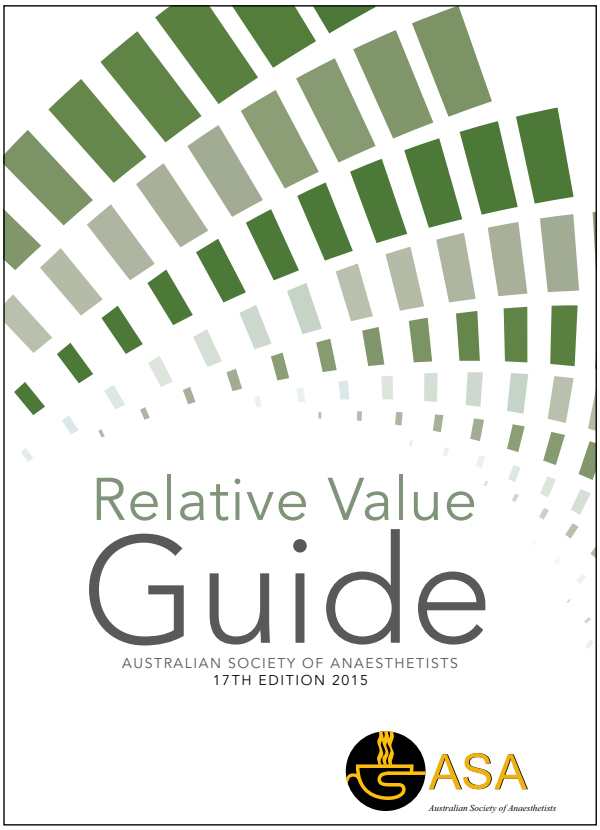

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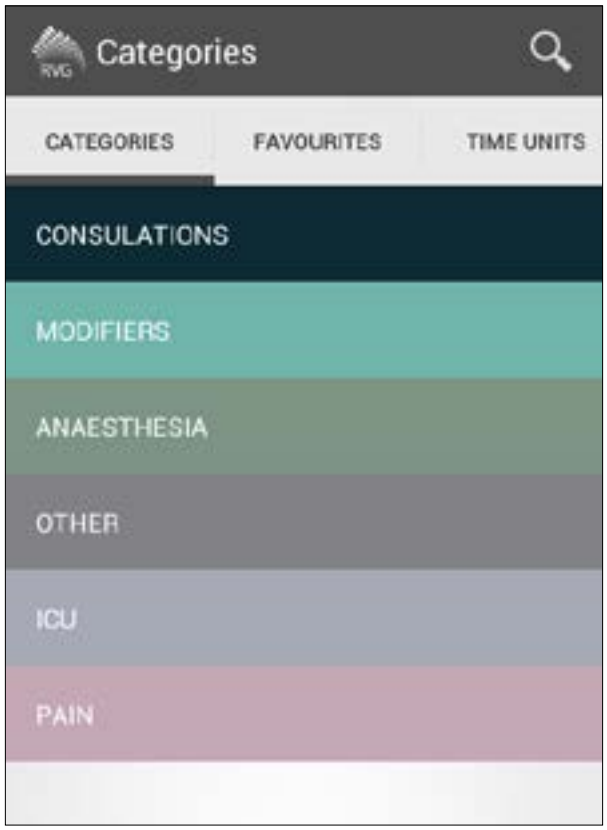

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PROFESSIONAL ISSUES ADVISORY COMMITTEE

The most rewarding activity of this committee is rendering assistance to members. In reports to Council throughout the year, writes Professional Issues Advisory Committee (PIAC) Chair Dr James Bradley, a variety of difficulties including contracts, rostering and credentialling encountered by members have been highlighted.

ACTIVITIES & ACHIEVEMENTS

Late last year, on 7 December 2013, the ASA convened a Workforce Summit which was held at the North Sydney head office. The attendees comprised of members of Executive and Council, including those who are members of PIAC, plus guests from the ASA, the New Zealand Society of Anaesthetists and ANZCA. The program consisted of a number of presentations followed by discussion sessions. The intent of the summit was to define the concerns in relation to the present and emerging anaesthesia workforce and, in doing so, delineate the possible future roles of the ASA, the Australian Medical Association and ANZCA in relation to this workforce.

The proceedings of the Summit and subsequent activity have been reported to members throughout the year through the President's e-news and *Australian Anaesthetist*. It has been noted that the issue is 'long on sentiment and short on data', but better information is now becoming available, particularly through the registration/re-registration process of the Medical Board of Australia and the associated reports of the Australian Institute of Health and Welfare.

The ASA's periodical member surveys are intended to augment the above information, with a further Member Survey conducted during July and August this year. This survey further explored our priorities in the area of workforce issues, as well as re-examining some other ongoing areas of interest. Constructed through the site – SurveyMonkey® – it has, for various reasons, produced our most gratifying response rate for quite some years.

PIAC continues to promote the interests of members through its various submissions to external bodies and attendances at meetings, conferences, forums and project groups, as reported throughout the past year. The submissions include those to the Australian Competition and Consumer Commission (ACCC) regarding Medicines Australia, the New South Wales Agency for Clinical Innovation (in relation to the proposed *Minimum Standards and Toolkit for Safe Procedural Sedation*), the Royal Australian and New Zealand College of Radiologists (in relations to the *Standards for Diagnostic and Interventional Radiology*, version 10) and the Select Committee on Health (19 September).

As PIAC Chair, and on behalf of the ASA, in March 2014 I attended the annual meeting of the Australian Private Hospitals Association as well as the Royal Australasian College of Surgeons/ Royal Australasian College of Physicians symposium on revalidation. In June, the Australian Council on Healthcare Standards met to revise its anaesthesia clinical indicators during the year, with the ASA contributing to the process. ASA Policy Manager, Chesney O'Donnell, met with advisors to the Assistant Acting Treasurer and the Productivity Commission. Finally, the then Vice President, Guy Christie-Taylor, represented the ASA throughout the year on Health Workforce Australia's project on the *Expanded Scope of Practice – Advanced Practice in Endoscopy Nursing*, and coordinated the ASA's feedback to Health Workforce Australia.

A number of the Mi-tec patient information brochures (which help to address 'material risk' considerations in the patient consent process) have been revised this year. They include *Anaesthesia for Oral Surgery*, *Anaesthesia for Weight-Loss Surgery*, *Anaesthesia for Children*, *Anaesthesia for Major Joint Replacement Surgery*, *Anaesthesia for Endoscopy* and *Anaesthesia for Cataract Surgery and Other Eye Operations*. In addition, the ASA's patient information brochure *Anaesthesia and You* underwent minor revisions and is available for purchase by members. Its content parallels the general patient information posted on the Society website. Finally, the ASA's Position Statement – PS10 *The Medical Specialty of Anaesthesia* – was revised this year. If you have any queries or comments regarding any of this, please forward them to policy@asa.org.au.

GOVERNMENT

The Coalition federal government is now in its second year in power. At this time, we are reminded of the plans that were expressed for 'certainty' in relation to funding ('support for activity-based funding, a determination [sic] to cut administration and bureaucracy, support for more local, as opposed to centralised, management and support for private health insurance once fiscal circumstances allow'). At this stage, Health Workforce Training has been folded into the Department and various other bodies have had their activities altered. The Pharmaceutical Benefits Advisory Committee was to have its 'independence restored' but the implications of this are uncertain. Money was to be provided to support up to '100 additional intern places each year in private hospitals and non-traditional settings'; information in this regard is still to come.

The ASA has, on a number of occasions, expressed concern that some bodies established by the previous Federal government had the capacity to conflict with the activities of the established stakeholders in the quality and safety area. The bete noire in this context is the Australian Commission on Safety and Quality in Health Care. It is unclear if there could be a significant change in this area during the term of the current government, but certainly there is Federal government awareness that the private hospital sector is unhappy, with concern expressed by that sector that there is a lack of appreciation of its interests by the Australian Commission on Safety and Quality in Health Care.

It is interesting to observe thatit has now been six years since Nicola Roxon, then Health Minister for the incoming Rudd government, gave her 'Light on the Hill' address which, while affirming the 'sanctity' of Medicare, canvassed amongst other things the 'false contest' between doctors and nurses, which is still being explored in the context of workforce change (e.g. the *Expanded Scope of Practice – Advanced Practice in Endoscopy Nursing* project, and the proposition that there was 'no true private health system'. These debates are still being played out, with monies previously allocated to various projects still underwriting activities that the Society is having to address.

INTENTIONS

A number of face-to-face meetings with key personnel in national stakeholder organisations are planned for the coming year. These include the Australian Private Hospitals Association and the Department of Health. Certainly, the national meeting of the former earlier this year demonstrated how their political ground has shifted in

Professional Issues Advisory Committee 2014–2015

Position	Name	State
Chair	Dr James Bradley	QLD
ASA Immediate Past President	Dr Richard Grutzner	VIC
State Representative	Dr Paul Cook	QLD
State Representative	Dr Elizabeth Feeney	NSW
State Representative	Dr Simon Reilly	VIC
State Representative	Dr Stuart Day	TAS
State Representative	Dr Simon Macklin	SA
State Representative	Dr Richard Clarke	WA
State Representative	Dr Phil Morrissey	ACT
Committee Member	Dr Michelle Horne	VIC
Committee Member	Dr Antonio Grossi	VIC
Committee Member/Past President	Dr Andrew Mulcahy	TAS
President (ex-officio)	Dr Guy Christie-Taylor	SA
Chief Executive Officer (ex-officio)	Mr Mark Carmichael	NSW
ANZCA Q&S Committee nominee	Dr Lindy Roberts	WA

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relation to government support for private health care and for privately operated provision of public healthcare. As a hospital-based specialty, it goes without saying that this different focus is very important to anaesthetists.

Anaesthesia drug shortages have been an irritant in this country during the year, but are of greater concern overseas, especially in America. The ASA has been party to discussions concerning these shortages, especially within the Common Issues Group. Coronial inquests in both Queensland and South Australia have recently addressed the inadequacy of preoperative assessment and postoperative patient care in the particular context of smaller private facilities and patients who might have sleep disordered breathing conditions. In part, the ubiquitous 'Day of Surgery Admission' process is inextricably linked with these issues. It is planned to canvass these issues within the short term.

As was foreshadowed, and as addressed above, 'workforce issues' have been the major focus of PIAC throughout 2014. There is continuing concern with with the size of the anaesthesia workforce, the number of vocational trainees in the specialty and the access of newer specialist members to a case-mix and caseload that enables 'consolidation' of skills hard gained during advanced vocational training.

I wish to thank all PIAC members for their support over the last 12 months. At the Secretariat, I have been supported by Chesney O'Donnell (Policy Manager) and Josephine Senoga (Assistant Policy Officer) and I thank them both. I would note also the enthusiasm and support of Danielle Ashford (Policy Assistant), who has now left the ASA. Dr Lindy Roberts (Past President of ANZCA) has taken over from Dr Rod Mitchell as ANZCA nominee. My thanks and welcome.

Suggestions from members of the Society in relation to any professional issue are always welcome.

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EAC AND PIAC SPECIAL REPORT

BRAVE NEW WORLD

The Professional Issues and Economics Advisory Committees continue to receive a number of enquiries relating to deteriorating economic and working conditions for anaesthetists, writes Dr Antonio Grossi.

These range from unfair contracts in the public sector, including reduced sessional payments, to exploitative entrepreneurial day case hospitals charging exorbitant service and facility fees and price capping anaesthesia fees. Because of the oversupply of anaesthetists in some areas, many anaesthetists feel pressured to agree to these oppressive conditions. The anaesthetist providing the service assumes the clinical and medicolegal risk even if the fee for this service is distributed to others.

From a quality and safety perspective, there is a real danger that patients will be at risk of receiving inferior anaesthesia care. The anaesthetist is no longer regarded as a specialist health professional, an integral part of the healthcare team and an advocate for the patient. Instead, anaesthetists are often regarded as 'a necessary evil', an imminently replaceable commodity and a source of revenue whose services can be exploited for a profit margin for others.

The maintenance of professional standards such as minimum requirements for staff, space, equipment, drugs, emergency procedures, governance and accreditation policies are all threatened by environments that do not respect the integrity of the anaesthesia profession. This can only translate to increased risk for the patients. Recently, the South Australian Coroner has highlighted deficiencies in perioperative care as being responsible for two deaths in a doctor-owned facility. From a consumer perspective, one wonders whether patients are fully informed about the lack of process and short cuts taken in some of these centres. A number of women were recently exposed to Hepatitis C in a day-case hospital. Could this have been prevented with more robust professional and governance policies in place?

Ultimately, ANZCA and the ASA put much effort and resources into producing and promulgating professional documents, minimum standards of practice, continuing professional development activities and good corporate governance. Due to the changes in training places from around 2004, there is now a significant oversupply of anaesthetists in several environments. This is leading to deteriorating economic and workplace conditions for anaesthetists. This will inevitably lead to a downward spiral in the anaesthesia care being delivered to patients and compromises on quality and safety.

HAVE YOUR SAY

Agree with Antonio Grossi and the Professional Issues and Economic Advisory Committees?

Write to editor@asa.org.au and tell us what you think about this 'Brave New World'.

You can also speak to the committees via the ASA Policy team at policy@asa.org.au.

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INSIDE YOUR SOCIETY

OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

The challenges facing Pacific anaesthetists were highlighted at the recent ASA National Scientific Congress, writes Overseas Development and Education Committee (ODEC) Chair, Rob McDougall.

Dr Pesamino Une, Head of Anaesthesia in Samoa, reported that due to a shortage of qualified anaesthetists in his small nation, the two specialist anaesthetists would work continuous 1:2 on-call rotas making holiday or professional development leave very difficult. Workforce studies have demonstrated that five specialist anaesthetists are required to manage the clinical demand in Samoa (population 194,000). There are two Samoan doctors who are nearing the end of their anaesthesia training and one, just commencing training, in Fiji. So there is some light at the end of the tunnel for Pesa and his colleague but until the end of 2015, Samoa will need a hand!

Dr Jocelyn Christopher, who is a final year Fijian trainee in anaesthesia, gave a thorough account of the working day and week of Pacific trainees. Six day weeks, complex patients and busy emergency loads madk the life of a Pacific anaesthetist exhausting, but she described a sense of satisfaction in the job and an enthusiasm for being part of a strong Fijian anaesthesia team in the future. Jocelyn praised the hard work of Dr Sereima Bale, the long-time Senior Lecturer in Anaesthesia at Fiji National University and expressed appreciation of the role of the two visiting ASA Pacific Fellows for 2014, Drs Bruce Newman and Ann-Maree Barnes.

Drs Une and Christopher were the 2014 ASA Pacific Visitors and were sponsored by the ASA and Sydney Anaesthetics.

Pesamino Une, Jocelyn Christopher, Simon Hendel, Michelle Chan and Tom Mohler

They both gave excellent presentations at the ODEC scientific session, which had the theme "Sustainable Development – Is it really possible?"

HOW CAN ASA MEMBERS HELP?

If you are interested in volunteering for a short-term locum in Samoa, please go online and register for the ASA Volunteer Database. The database members will be notified of any requests for assistance in the form of locums, service or teaching trips to the Pacific and South East Asia. For those already registered, expect a request from Samoa soon!

Fiji National University currently has a vacancy for a Lecturer in Anaesthesia. The role involves teaching the enthusiastic Pacific trainees in and out of theatre and some clinical service work. Please contact the ASA for more information.

LIFEBOX NEWS

In recent months the ASA has purchased Lifebox oximeters for Timor Leste, Nauru, Mongolia, Vanuatu, Solomon Islands and Indonesia. Further substantial requests have been received from Myanmar, Papua New Guinea and Indonesia. These purchases have only been possible due to the generosity of ASA members. It is anticipated that over $30,000 of donated monies will be spent by the end of this financial year.

LIFEBOXES IN NAURU

Anaesthetist Dr Christian Leepo and Acting Director of Medical Services Dr Samuela Korovou with the two Lifeboxes received at the Republic of Nauru Hospital

The Republic of Nauru Hospital entrance

The Republic of Nauru Hospital operating theatre

Greetings from the Republic of Nauru, an island state just below the Equator, that was settled by Polynesian and Micronesian peoples at least 3000 years ago.

The country was once rich with phosphate, a natural resource that, in the 1960s and '70s, put it on the map as the sovereign state with the world's highest per capita gross domestic product. By the turn of the millennium however, Nauru was struggling financially as phosphate mining ran dry. This put a lot of the national infrastructure in jeopardy, with limited to no maintenance being done. Moreover, most skilled workers on the island were from neighbouring Pacific countries and their repatriation when ongoing phosphate mining was no longer viable placed great strain on the remaining local workforce. Nevertheless, the ongoing support of donor countries has helped Nauru and her population of about 10,000 to maintain the functioning of essential services.

Health services in Nauru, however, still need a lot of work. While awaiting the construction of a new national hospital, the current hospital in use is an old 40 to 50-bed infirmary built by the British Phosphate Cooperation in the 1950s. It still has asbestos roofing and, despite impressive maintenance efforts over all these years, its condition is certainly deteriorating. Non-government organisations including local enterprises have, for a long time, been generous in donating consumables and vital medical equipment such as monitors. Sadly, with no biomedical service available on the ground, most medical equipment including pulse oximetry tends to malfunction and is rendered useless. Furthermore, while such equipment is tucked away in storage, the island's high humidity and heat often cause corrosion of electronic parts, making them difficult for a visiting biomedical engineer to fix.

The Republic of Nauru Hospital has just one operating room, which is situated in a refurbished X-ray room of the former Phosphate Cooperation hospital. It contains adequate standard patient monitoring, including capnography/end-tidal CO_2. It has vital functional anaesthetic and resuscitation equipment, including a robust Ulco anaesthetic machine and ventilator. The recovery unit has two beds and a portable oxygen concentrator. Recently, the operating room received two robust pulse oximeters with extra paediatric and neonatal probes for each from the Lifebox Foundation, made possible by the kind financial support of the ASA. These Lifeboxes have made a significant difference in patient monitoring, as the old monitor in recovery was given to the emergency unit. The Lifeboxes have increased the number of functioning pulse oximeters in the entire hospital to six. Hopefully the other monitors and medical equipment awaiting spare parts can be fixed soon.

Lifebox has made anaesthetic and surgical procedures safer for patients, not only with equipment featuring sensitive alarm settings and other specifications, but also through the foundation's promotion of the World Health Organization surgical safety checklist. The Republic of Nauru Hospital has now implemented a modified surgical safety checklist that is mandatory for all surgical patients. The hospital operating room staff wish to thank all parties involved in procuring these robust pulse oximeters.

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ODEC MEETING AT THE NATIONAL SCIENTIFIC CONGRESS 2014

ODEC meeting

ODEC Chair, Dr Rob McDougall

Dr Sereima Bale

OVERSEAS ISSUES: SUSTAINABLE DEVELOPMENT - IS IT REALLY POSSIBLE?

Overseas Issues, Chair, Dr Rob McDougall

Drs Pesa Une, Tom Mohler and Simon Hendel

Dr Tom Mohler presenting 'Partners in Education - Has it worked in Laos?'

Dr Pesa Une presenting 'Managing Samoan Anaesthesia'

Dr Michelle Chan presenting 'This is an Anaesthetic Emergency! Empowering anaesthetists through education in Myanmar'

Dr Jocelyn Christopher presenting 'A day in the life of a Fijian register'

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INSIDE YOUR SOCIETY

GROUP OF ASA CLINICAL TRAINEES UPDATE

GAT/AAGBI ASM 2014 – DR TIM SULLIVAN

Thanks to generous funding assistance from the ASA, I was able to attend the recent Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT) Annual Scientific Meeting (ASM) held in Newcastle-upon-Tyne in June of this year. In addition to a stimulating clinical program, the meeting provided an opportunity to engage with fellow anaesthetic trainees, consider current issues facing anaesthetic training and discuss the direction of future training.

Prior to commencement of the ASM proper, I was invited to attend the combined GAT/AAGBI Board of Directors meeting, a relatively new initiative designed to facilitate greater integration and collaboration between the two bodies. Anecdotally, this combined format seemed to provide an informal collegiality, breadth of perspective and sense of common purpose. The board meeting served to emphasise the degree of common ground shared by the AAGBI/ASA and their respective trainee groups, illustrating the value of the Group of ASA Clinical Trainees' (GASACT) Common Issues Group (CIG) and the potential for further utilisation of this alliance. While complicating logistical factors are significant, I do believe that further collaboration, particularly at a trainee level, would be met with much enthusiasm. The meeting also examined the challenge of identifying exactly what trainees want and need from GASACT/GAT, stimulating consideration of the GASACT niche and current areas of need that it could address. The opportunity cost of limited resources necessitates strategic prioritisation. Duplication in the provision of educational resources also offered by multiple other organisations could be minimised through a shift by GASACT to a collating, rather than providing, role. Given the similarities between the Australian and UK exams, this could even be a joint project between GASACT and GAT. Conversely, relatively few organisations provide leadership and professional development opportunities. One initiative that has recently been offered to UK trainees with great success is mentoring. During the conference a number of mentees shared their experiences, while potential mentors were made available throughout the conference to illustrate the process. Given the range of experience represented within the ASA, mentoring could be a great help to trainees as they begin a career in anaesthesia.

The major complication of the conference itself proved to be the process of navigating the dense schedule and choosing which sessions to attend. The three-day scientific program encompassed a wide range of anaesthetic topics and, in an attempt to cater to a broader spectrum of trainees, the final day was divided into primary, fellowship and post-fellowship exam streams. The lecture sessions on challenging patients and communication were particularly helpful. That said, the keynote addresses proved to be the highlights. Hamish McLure's aptly titled 'Charge of the knight brigade' provided insight into the changing landscape of trainee supervision requirements, while Kevin Fong drew on experience from the aeronautical industry and military for his talk on 'Life, death and mistakes'. The didactic lecture program was punctuated by optional workshops and I chose to attend 'Anaesthetising the morbidly obese patient' and 'Difficult airways'. Both workshops provided an intimate environment with ample opportunity to discuss scenarios with expert consultants and simulate different practical techniques. Consequently, I came away from them with approaches and techniques that I plan to incorporate into my clinical practice.

Arguably the most valuable component of the conference was the opportunity to foster relationships and build networks with UK consultants and trainees. The AAGBI/GAT board dinner and the conference dinner, held at the historic Assembly Rooms, greatly facilitated this process. In addition to a crash course in traditional cèilidh dancing, these events provided time to reflect upon training, life and future plans. It was a great privilege to be welcomed as I was and to meet the range of people that I did. I look forward to continuing many of these relationships and utilising the networks formed in the future.

Receiving the GASACT/ASA CIG scholarship afforded me an opportunity that I would not otherwise have had and

for which I am most appreciative. My time in Newcastle provided an added breadth to my training. From a clinical viewpoint, I have discovered resources and learnt concepts and techniques that I will integrate into my practice and share with fellow trainees. From a non-clinical viewpoint, I have gained perspective and initiated ties that will provide future opportunities for my colleagues and myself. The ASA/GASACT CIG scholarships provide unparalleled opportunities and have significant benefits for both the recipients and Australian trainees in general. I would like to express my gratitude to the ASA/GASACT/CIG for their support and encourage continuation of the scholarship program and additional programs promoting collaboration with our overseas colleagues.

UPCOMING COURSES

South Australia/Northern Territory: Part 3 course

When: 17 January 2015

Where: AMA House, 161 Ward Street, North Adelaide

CIG Scholarships open January 2015 to the following meetings:

- Association of Anaesthetists of Great Britain and Ireland GAT
  17–19 June 2015, Manchester, England
- Canadian Anaesthesiologists' Society
  19–22 June 2015, Ottawa, Ontario
- American Society of Anasetheiologists
  24–28 October 2015, San Diego, California

Applications are open to all GASACT members from January 2015.
To join contact gasact@asa.org.au or call (02) 8556 9700.
For further information visit GASACT.com.au or for enquiries contact visit www.gasact.org.au

GASACT
AUSTRALIAN SOCIETY OF ANAESTHETISTS

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RETIRED ANAESTHETISTS GROUP

NATIONAL

Prof. David Gibb

As of 28 August 2014, the national membership of RAG stands at 342. There have been three recent changes in regional representation in South Australia, Western Australia and the Australian Capital Territory. In South Australia, Dr John Crowhurst has taken over from Dr David Fenwick and has been actively maintaining David's momentum. In Western Australia, Dr Wally Thompson has been instrumental in revitalising the local branch of RAG. Drs Hugh Lawrence and George Jerogin have only recently accepted appointment as Australian Capital Territory representatives following the sad passing of Dr James Purchas OAM. As usual, the Victorian Branch of RAG has been very active under the Chairmanship of Dr Patricia Mackay OAM, with a program that included four formal dinners featuring distinguished guest speakers.

This year's high honours have been awarded to two of our members for services to anaesthesia: Professor John Overton AO and Professor Barry Baker AM.

RAG Luncheon Meetings were held over the last year at the ASA National Scientific Congress 2013 in Canberra, the ANZCA Annual Scientific Meeting 2014 and the ASA NSC on the Gold Coast. These were well-attended and we were honoured to have as guests, our Presidents, Drs Richard Grutzner and Guy Christie-Taylor. At the Canberra luncheon, Dr John Paull announced the publication of his new book *Not Just an Anaesthetist*.

This year retired anaesthetists were offered the opportunity to participate in the Personal Biography Project. This project, sponsored by the Society, is aimed at establishing an extensive historical record of professional anaesthetists who have been members of the ASA. All members are encouraged to submit a biography. These will be filed by the Society's Curator, Ms Anna Gebels, and stored in the ASA archives for future reference.

Finally, I regret to report that over the past 12 months, ten of our retired colleagues have passed. These deaths have been reported in the 'In Memoriam' section of the *Australian Anaesthetist* throughout the year.

Left to Right: Prof. John Russell, Dr John Crowhurst, Ms Linda Sorrell and Dr Ian Rechtman at the RAG Singapore Luncheon

SOUTH AUSTRALIA

Dr John Crowhurst

Our Group in South Australia now meets for lunch on the second Monday of each odd month at the Kensington Hotel. More than 70 colleagues from anaesthesia, intensive care and pain medicine comprise the Group, and usually some 20 to 30 of us attend each meeting.

In September, we began to meet in a private dining room, which is fully equipped with a large LED screen suitable for guest speaker presentations and screening of relevant notices, such as recent publications. Presently, these include the following books authored or edited by members: *Inside God's Shed – the Memoirs of an Intensive Care Specialist* (Dr L.I.G. Worthley); *Intensive Care Medicine in Australia – Its Origins and Development* (Prof. G.D.Phillips.); *Blood, Sweat and Fears – Medical practitioners and medical students of South Australia who served in World War 1* (Drs Christopher Verco, Annette Summers, Tony Swain and Michael Jelly [Eds.]).

I was fortunate enough to be the guest speaker at our September meeting and presented an update of my lecture 'The Historical Significance of the Anaesthesia Events at Pearl Harbor', first given to the joint Annual Scientific Meeting of ANZCA and the Royal Australasian College of Surgeons in Singapore last May, a précis of which was published in the History

Supplement of *Anaesthesia and Intensive Care* this past July.

At the November meeting, Lindsay ('Tub') Worthley provided more insight and discussion of his recent book cited above.

If any retired or semi-retired colleagues from other states, New Zealand or elsewhere happen to be in Adelaide, you are most welcome to join us on the second Monday of each odd month.

Please contact myself at: jacrow@optusnet.com.au

VICTORIA

Dr Pat Mackay

The speaker at our September meeting was Dr Rod Westhorpe who gave an outstanding talk on the history of Anaesthesia in China, from early days along with many fascinating illustrations. A record number of 34 attended this meeting. We would like to thank Dr Westhorpe and his skills in historical exploration.

The November meeting included the Annual General Meeting and election of new office bearers as well as a talk by Sherene Hassan, Director of the Islamic Museum of Australia. Sherene presented on "The experience of an Australian Muslim Woman".

GET IN TOUCH

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

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

RAG LUNCHEON AT THE 2014 NSC

Back Row, Left to Right: John Lauritz, Guy Christie-Taylor, Richard Grutzner, Alan (John) Board, unknown, Paul Bellhouse, Andrew Boman;
Front Row, Left to Right: Graham Smith, John Hains, Jennifer Parslow, David Gibb, Donald Maxwell, Sankarara (Sam) Epari, David McConnel

Left to Right: Andrew Boman, David Gibb, John Hains and Guy Christie-Taylor

David McConnel with Donald Maxwell

unknown, Graham Smith and Dorothy Smith

Sankarara (Sam) Epari

John Hains chatting with Jennifer Parslow

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INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

HARRY DALY MUSEUM

ASA Curator, Anna Gebels, tells *Australian Anaesthetists* about a new donation to the Harry Daly Museum.

The Harry Daly Museum is grateful to Dr Neil Street for his donation of a hand-blown glass syringe (pictured below). The syringe is in excellent condition, with a cork stopper and cotton washer encased inside its original cardboard tube. The makers mark, 'HAE' or 'HAL', is stamped on the glass plunger tip. The bulbous tip indicates that it may be a urethral syringe c.1900.

The syringe will feature in our new exhibition. If anyone has information to add, please visit the object's individual eHive page and make a comment at http://ehive.com/account/4493/object/478668/Syringe.

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

RICHARD BAILEY LIBRARY

ASA Librarian, Peter Stanbury, gives us an update on the Richard Bailey Library.

The Richard Bailey Library, comprised of around 3,000 items, is now more accessible than ever before in its new premises on the seventh floor of the ASA head office.

Members can now access and search the Library catalogue from home as the Richard Bailey Library has joined the Harry Daly Museum on eHive. Simply visit the ASA website, click on the links "About us" and "Library", or alternatively, visit www.ehive.com/account/5441. One can search under a number of categories including title, author and subject.

The books are arranged under the American National Library of Medicine system. A list of the more important categories for anaesthetists can be found at http://1.usa.gov/ZYuMNI or, if you are visiting the Library, the list can be found immediately inside the door.

The shelves are labelled for easy reference and each book has its catalogue number on an inserted tag and written on the front endpapers.

Pamphlets (slim volumes without

Hand-blown glass syringe

The American National Library of Medicine cataloguing system used is indicated on the shelves with a complete list just inside the Library doors

The Mesmerism and the pamphlet collections are held in the adjoining Board Room

Search the catalogue on the Library's eHive account – a lap top computer is available in the Library

a spine) are kept in drawers in the adjoining Board Room, together with the ASA's unique and separately housed mesmerism collection.

The mesmerism tiles have been arranged by date of publication as given Crabtree's standard bibliography (Crabtree, A. 1988, *Animal magnetism, early hypnotism, and psychical research, 1766-1925: an annotated bibliography*, Kraus International Publications). This very useful volume for historical research can be consulted in the Richard Bailey Library or viewed online at http://bit.ly/1tJgWf7

The ASA's collection of pre-2010 journals are housed on level eight within the HALMA section of the ASA head office. They include the *British Journal of Anaesthesia*, *Anesthesiology*, *Anesthesia and Analgesia*, *Survey of Anesthesiology*, *Anaesthesia*, *Canadian Journal of Anesthesia* and *Acta Anaesthesiologica Scandinavica*. Although they are available for reference and a list of the numbers held is available, they will not be incorporated into the eHive until early 2015.

Changing periodically is our Library's exhibition space featuring books and articles of note.

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).

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HARRY DALY MUSEUM & RICHARD BAILEY LIBRARY

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

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

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

ASA

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

NEW SOUTH WALES COMMITTEE

Dr Michael Farr, Chair

There have been some changes to our ASA NSW Committee of Management recently. Following the Annual General Meeting at the Hilton, Sydney on 21 June, I have taken over the State Chair role. Dr Ammar Ali Beck has been elected Vice Chair. I wish to acknowledge our immediate past NSW State Chair, Dr Murray Selig, not only for his contribution as State Chair, but also for his ongoing commitment for well over ten years in a number of roles within the ASA NSW Committee, and as Treasurer for the ASA National Scientific Congress in Sydney in 2011.

We also welcome Dr Helen Leggett to the Committee and unfortunately farewell Dr Catherine Downs, who has made a very large contribution, particularly to our Iamonline Continuing Medical Education Modules, but also with regard to many of the NSW Continuing Medical Education meetings in recent times.

Industrial and Workplace Issues

The NSW Committee is mindful of the changing topography in both the public and private sectors. Emerging issues across Australia are somewhat similar as opportunities for new anaesthetic consultants diminish and the public sector (both staff specialists and visiting medical officers) face difficult negotiations with state governments regarding remuneration for anaesthetic services. Negotiations are ongoing but a vital point to note when approaching government ministers and salient bodies is that the more members the ASA represents, the more influential the anaesthetic voice will be. With a view to handling industrial and workplace issues for our members, Dr Ammar Ali Beck (ASA NSW Vice Chair) has taken over the role as NSW representative on the Public Practice Advisory Committee, a position previously held by Assoc. Prof. Stephen Gatt.

Continuing Medical Education

Whilst the ASA enjoys ongoing joint commitments with ANZCA within the ACECC committee, we still look to provide our members with independent Continuing Medical Education opportunities in NSW. The major Continuing Medical Education focus currently is with regard to the planned ASA National Scientific Congress to be held in Sydney in 2019. The Committee would enthusiastically receive expressions of interest regarding participation on the organising committee for this event. Please contact Sue Donovan at sdonovan@asa.org.au.

GASACT

We thank Trylon Tsang and Adam Hill for their ongoing contributions and commitment to the NSW GASACT.

After considered input and discussion with our GASACT members, we are looking forward to what we expect will be our most effective GASACT Part 3 Course yet. By the time this has gone to press, the event will have been held on 29 November at the Swissotel in Sydney's CBD (with a social event to follow). I look forward to reporting on the event in the following Issue.

TASMANIAN COMMITTEE

Dr Michael Challis, Chair

There has been a lot happening over the last few months to keep us busy. We had a successful winter Continuing Medical Education meeting with a fantastic Advanced Life Support refresher component. This was well subscribed to and proved popular with registrants while counting towards Continuing Professional Development (CPD) for emergency responses. At the time of writing, we also have a fully subscribed multi-disciplinary airway management course coming up on 7 November that will allow participants to satisfy their CPD requirements for Can't Intubate Can't Oxygenate activities. This will be repeated in an altered format at our Tasmanian combined Annual Scientific Meeting next February, along with an anaphylaxis workshop. These activities will assist local anaesthetists to satisfy their category 3 CPD requirements without being required to travel interstate. A GASACT Part 3 Course will also have run in late November and will have hopefully been useful for (and well attended by) senior trainees.

On the industrial front there has been little outward progress with regard to renegotiation of the Salaried Medical Practitioner's Award. Fortunately, submissions in the Industrial Commission

are scheduled to be completed at the end of October and hopefully a ruling will be made soon after that. Our Australian Medical Association team have been negotiating on behalf of all salaried medical practitioners and I would like to thank them for the enormous amount of work they have put in. Hopefully the outcome is positive for all medical staff covered by the agreement.

Many of our members, most notably younger members and new fellows, continue to be affected by workforce issues. The impact of governmental policies, budgetary restraints and the current uncertainty regarding the future structure and function of the Tasmanian public health system don't make life any easier for those battling the current workforce issues. Hopefully a clear sense of our future direction will appear soon and I hope this will be positive for our Tasmanian members.

In the meantime we carry on as usual.

QUEENSLAND

Dr Nicole Fairweather, Chair

Areas of interest for Queensland members continue to be those involving public hospitals and public patients.

Members should be aware that if they are on any form of paid leave from Queensland Health and they undertake a Surgery Connect patient at a private hospital that they will not be paid for this patient by Surgery Connect. It is the position of the department that the anaesthetist is already being paid by Queensland Health for their time. As another round of Surgery Connect patients is about to begin, members may find these patients on their private lists without any warning.

The Mater Hospitals continue to expand their system of undertaking surgery on their public patients at the Mater Private Hosptial. These patients are not 'Mater Broker' patients and fees will need to be negotiated individually with the Mater Adult Hospital administration.

The opening of the Lady Cilento Hospital is expected soon. All staff that previously worked at the Mater Children's Hospital will need to undertake the same contract consultation process that other Queensland Health staff from the Royal Children's Hospital have previously undertaken. The Royal Children's Hospital will need to sign new contracts. Please remember that very little is actually negotiable in the new contract model and that all staff should have an educated support person with them at their personal meeting. I would encourage all staff to join a union to facilitate this process.

Whilst on the issue of medical contracts, members should remain vigilant to administrative attempts to use the contracts in creative ways. This continues to happen and members should communicate and network amongst specialties, across specialties and across the state in order to alert their colleagues to suspect practices. Members should not feel compelled to undertake work practices or conditions they are not comfortable with without utilising the existing grievance processes.

Finally, I would like to congratulate Drs Coorey and Bruce along with their entire Organising Committee for the smashing success that was our most recent National Scientific Congress, held on the Gold Coast.

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin, Chair

Combined ANZCA/ASA CME Meeting: Update on Regional Anaesthesia

This meeting continued on from the successes of previous meetings held so far this year, with local experts presenting their tricks of the trade to a near-packed house. Thank you to Drs Jim Dennis, Justin Porter, Richard Church and Chien Wei Seong for their time and effort in making this another excellent Continuing Medical Education evening. Thanks also to Dr Adam Badenoch for exposing some flesh for a live demonstration of sonoanatomy!

ASA member, Dr Jim Dennis, illustrates the popliteal sonoanatomy of ex-Senior GASACT rep, Dr Adam Badenoch. These meetings are videolinked to Darwin, Alice Springs and Mount Gambier (as seen in the background)

By the time this edition of *Australian Anaesthetist* has made it to publication, there will have been two further Combined ASA/ANZCA Continuing Medical Education meetings. On 29 October, Dr Debbie Knight presented 'NAP 5: Accidental Awareness under General Anaesthesia'. This is a joint audit conducted by the Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland and provides interesting insight into awareness and anaesthesia. 'Anaesthesia Allsorts' was the title of our combined ASA/ANZCA Annual Scientific Meeting, held on 29 November and brought together a wide range of speakers covering a broad range of topics including 'Allsorts of Locations and Research, Assorted Providers and Subspecialities'.

My thanks go to the hard-working Continuing Medical Education committee, Chaired by, Dr Nathan Davis, who have provided an excellent program throughout the year. We look forward to another exciting schedule in 2015 that will include the ANZCA Annual Scientific Meeting in Adelaide in May.

INSIDE YOUR SOCIETY

Boojums of Adverse Events: Can we Prevent Them?

Another date for the calender is a meeting to be held on 7 February at the Adelaide Convention Centre. Entitled 'Boojums of Adverse Events: Can we Prevent Them?', this meeting will bring together the major players in the delivery of private healthcare in South Australia to respond to the directives of the South Australian Coroner, which were handed down in the report published in February of this year. This report is featured in more detail elsewhere in this edition of *Australian Anaesthetist*. The primary goal of the meeting is to initiate a collaborative approach to improving perioperative care. Discussions will include the specific problems associated with postoperative opioids, the current colleges guidelines on perioperative care and possible solutions to the challenges faced. The target audience includes senior administrators of the private hospitals in Adelaide, Directors of Nursing, Chairs of Medical Advisory Committees, surgeons, anaesthetists, gynaecologists and perioperative physicians.

Wine, Wheels and Where to go

The inaugural social event hosted by the SA/NT Committee was held at Adelaide Motors on Friday 29 August. The event was enjoyed by 47 members, non-members and partners at the excellent facility at Adelaide Motors showroom on West Terrace. Local wine expert, Paul Henry from Winehero, sourced an interesting selection of wines for us to enjoy during the evening and spoke about each of them as they were released throughout the night. Jane Thesinger and Anna Massei from Thesinger & Turner Travel Associates generously supported the event and were present with an enticing array of holiday destinations. Congratulations to Dr David Jarvis who took home a magnificent travel book, donated by Thesinger &Turner, for winning the travel heads and tails quiz and to Dr Peter Rischbieth for being the lucky draw winner for the use of a BMW vehicle for the weekend, donated by Adelaide Motors.

WESTERN AUSTRALIA

Dr Ralph Longhorn, Chair

Our local CPD officers remain busy on many fronts:

The Bunker Bay Updates at the end of October were fully booked and work is under way for the Perth NSC in 2017.

We are also looking forward to hosting the ASURA conference next February in Perth.

The ASA has launched regular morbidity and mortality meetings in conjunction with Saint John of God Hospital, which have been very popular.

At the time of writing, we are looking forward to our Part 3 Course in November, which is usually an entertaining and informative event for our senior trainees.

Progress continues on the Fiona Stanley Hospital, with the incredible challenge of starting a new department for the anaesthetists to be employed there. However, there are complexities for the anaesthetist in the other public hospitals, with the contraction of services, some long-standing and loyal visiting medical officers are not having their contracts renewed.

Dr Mike Soares from our committee has been keen to set up a new fellows group, with the aim of supporting our members in the first five years of practice. This should be a great way for our local committee to find out the issues new consultants are facing so they may be better represented by the ASA. Mike can be contacted through our local ASA office and has specified that he'd like to get the ball rolling a soon as possible.

Dr Ian Forsyth has stepped forward to be our local Public Practice Advisory Committee representative and will take concerns of our local members to the federal sub-committee.

Any local members employed in public practice with issues they'd like to discuss with the ASA can contact Ian, again through our local office.

Anaesthesia Continuing Education Coordinating Committee (ACECC)

- ✓ Local and international anaesthesia-related events
- ✓ 17 special interest groups open to members
- ✓ Great resources to organise or promote anaesthesia-related events.

www.acecc.org.au

ACECC
Anaesthesia Continuing Education Coordinating Committee

INSIDE YOUR SOCIETY

DR STEPHEN KEITH SWALLOW 1957–2014

Stephen climing Mt Aspring

Family, friends and colleagues were saddened by the recent death of Hobart Anaesthetist, Dr Stephen Swallow, aged 57. He will be missed by many.

Stephen went to school in Liverpool, England and attended medical school in Cambridge, with his clinical years spent at the Middlesex Hospital Medical School in London. After two weeks in general practice, Stephen's career was decided and he sought anaesthesia training at the University Hospital of Wales in Cardiff.

As with so many United Kingdom trained anaesthetists, Stephen found his way to the Antipodes, firstly to the Department of Anaesthetics in Dunedin, New Zealand where he obtained his FANZCA; and then to take up a Staff Specialist position in Townsville, Queensland. Stephen always spoke highly of his time in the Dunedin department under Professor Barry Baker and Townsville with the charismatic leadership of Vic Callahan.

But it was in Tasmania where Stephen was to spend the majority of his professional career, firstly in Launceston and then, from 1999, at the Royal Hobart Hospital. His contribution to medicine and anaesthesia was remarkable. Stephen often joked about excelling as an underachiever. This could not be further from the truth. His was a sharp intellect that would not tolerate fools. He expected more from his professional world than most ordinary mortals could give. But Stephen was equally exacting of himself. His long history of service in teaching hospitals saw many cohorts of trainee anaesthethetists benefit from his teaching and his unique view of the medical model and the bigger world around it. His consultant work in Townsville, Launceston and Hobart covered a breadth of domains from Intensive Care to Neuroanaesthesia, as well as all the more mundane service duties of large public hospitals.

But it was in his extracurricular activities that Stephen really excelled. Whether it was mountaineering in Nepal, competing in International Frisbee competitions, or teaching on Early Management of Severe Trauma (EMST) courses, Stephen was always conspicuous in his contributions. He was an early member of the Primary Trauma Care (PTC) movement, which spread into over 60 countries around the world. Stephen co-authored the PTC Instructor Manual and, through his teaching trips, helped develop trauma management in Mongolia, Myanmar and China. He was an active member of the Australian Society of Anaesthetists' Overseas Development and Education Committee and took seed money for a China project which became an enormously successful endeavour, training over 25,000 Chinese doctors in 1,250 PTC courses. He chaired one of the Special Interest Groups (the Neuro SIG), as well as inaugurating the Royal Hobart Hospital's Global Outreach.

Whilst Stephen had a conventional, team-based approach to clinical anaesthesia, his approach to non-clinical activities could be unconventional. He was not afraid to speak his mind and expected his colleagues to do the same. This had the potential for teleconferences to run well into the night! He once threatened to resign as Chair of the Neuro SIG when the ANZCA's Bulletin published his name against a photo of a colleague, after he had refused to provide a picture of himself for the article. Unknowingly, a few weeks later, the ASA newsletter published a PTC article with a large photo of a topless Stephen, acting as a mock patient for chest tube insertion demonstration, on the front page. ODEC nearly lost a valuable member!

Prior to the ASA AGM in 2008, Stephen decided to enlist support for major ASA constitutional change. He campaigned vigorously, outside the meeting venue, dressed in ASA white cycling lycra, a size too small. Not surprisingly, he failed to enlist many, if any, signatures of support and withdrew his challenge to Council but sat through the ensuing meeting still in costume.

Whilst Stephen could be an imposing presence in an English-speaking world, he had tremendous understanding for those of different backgrounds and would always trust the local coordinators in less affluent countries. This made him an excellent PTC instructor and program manager.

He had the ability to calmly diffuse tense situations – in 1999 he found himself in the middle of a significant disturbance in the main market in Honiara, Solomon Islands. In spite of only arriving in the Solomon Islands the previous day, he deftly negotiated safe passage through the riot using local politics and rugby as discussion points.

Stephen's outdoor adventures took him far and wide. From Federation Peak in South West Tasmania to the Annapurna Circuit in the Himalayas. With his daughter Stephanie, he visited Machu Picchu in Peru, the volcanic mountain Cotopaxi in Ecuador and the Galápagos Islands. With his son Oliver, he travelled to Mongolia for a horseback expedition into the mountains. He returned to New Zealand on several occasions for mountaineering and ice climbing including summiting Mt Aspiring and traversing the Olivine Ice Plateau. Often whilst perched on a summit or anchored to the side of an ice cliff, he would remove a piece of paper from his jacket and recite a poem relevant to the moment. In the tent in the evenings, following a day's climbing with fellow mountaineers and guides, he would lead discussions on a wide variety of subjects whilst giving commentary on a single malt whiskey or a red wine he'd carried in and shared. He was a true Renaissance man.

Stephen was always a stimulating colleague both in and out of the operating theatre and it was a real pleasure to work with him on his overseas teaching trips. His hands off the wheel approach to life seemed to work well in Mongolia and he returned to Ulaanbaatar many times. Was he possibly looking for his ancestry in the turbulent history of the great Ghengis Khan?

Stephen made enduring friendships everywhere he worked, from the United Kingdom, Hong Kong, China, the Pacific and Australia.

His career was tragically shortened and Stephen's last years as an anaesthetist were not without their difficulties. The medical future he had foretold for himself unfortunately came to pass. He bore his infirmities with dignity and equanimity. He sought refuge in his various and many alter egos, as writer, poet, cook and social commentator.

Many will have their own stories of Stephen Swallow. We celebrate his life, we give thanks for his friendship and we treasure the opportunity to have shared some of life's mystery with this remarkable man. He has left behind his partner Angela and two children, Oliver and Stephanie, who will be his ongoing spirit. But, in fact, everyone who knew him will carry a little bit of Stephen with them.

We mourn his passing, but we are richer for having known him.

Vale Stephen.

Dr John Madden, Calvary Hospital, Dr Haydn Perndt, Royal Hobart Hospital, Tasmania and Dr Rob McDougall, Royal Children's Hospital, Victoria

This obituary has been concurrently produced in the ANZCA bullletin.

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INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

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

TRAINEE MEMBERS

Dr Alexandra Barratt	SA
Dr Samantha Bigg	VIC
Dr Rodney James Cansdell	QLD
Dr Christopher Raoul Clemens	VIC
Dr William Bret Curtis	SA
Dr Karen Ann Hungerford	NSW
Dr James London	SA
Dr Richard Samuel Lumb	SA
Dr Adele Grace Macmillan	VIC
Dr Peter Malcomson	QLD
Dr Keir McIlmoyle	VIC
Dr Olivia Millay	VIC
Dr Ross Mortimer	NSW
Dr Gabrielle Papeix	NSW
Dr Louis Thomas Papilion	SA
Dr Rajdev Toor	WA

ORDINARY MEMBERS

Dr Jeremy Abbott	WA
Dr Pragya Ajitsaria	NT
Dr Christine Aynsley	QLD
Dr Anders John Bown	TAS
Dr Pierre William Bradley	VIC
Dr Rajesh Brijnarayau Brijball	QLD
Dr Gabriel Yee Hui Chong	NSW
Dr Daniel Martin Clarke	QLD
Dr John-Paul Cotter	NT
Dr Marie Christiane Hadassin	NSW
Dr Amelia Harricks	NSW
Dr Graham Hocking	WA
Dr Brendan Alexander Irvine	NSW
Dr Antony Leaver	VIC
Dr Vaishali Londhe	VIC
Dr Ian Mackay	VIC
Dr Andrew J. Mitchell	QLD
Dr Nagesh Chowahalli Nanjappa	SA
Dr Xuan-Phuong Nguyen	NSW
Dr Agnieszka Paulina Szremska	SA
Dr Jonathan Colin Kersley Taylor	SA
Dr Bindu Vasu	SA
Dr Edith Bodnar Waugh	NT
Dr Kerstin Wyssusek	QLD

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Drs Colin James Friendship (NSW), Paul Steward (NSW), Kenneth Peter Wilson (QLD), Sally Elizabeth Drew (SA), Stephen Keith Swallow (TAS) and Timothy John McCarthy (VIC).

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

UPCOMING EVENTS

JANUARY 2015

GASACT Part 3 SA/NT

Date: 17 January 2015

Venue: AMA House, 161 Ward Street, North Adelaide

Contact: Samantha Pascoe, ASA, events@asa.org.au

FEBRUARY 2015

GASACT Part 0 WA

Date: 5 February 2015

Venue: TBA

Contact: Samantha Pascoe, ASA, events@asa.org.au

Boojums of Adverse Events: can we prevent them?

One day meeting to consider the implementation of the South Australian Coroner's recommendations

Date: 7 February 2015

Venue: Adelaide Convention Centre, Adelaide

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

Australasian Symposium on Ultrasound and Regional Anaesthesia

Date: 21–23 February 2015

Venue: Hyatt Regency, Perth

Contact: Samantha Pascoe, ASA, events@asa.org.au

Website: http://asura2015.iceaustralia.com

SEPTEMBER 2015

ASA & NZSA 2015 Combined Scientific Congress

Date: 12–15 September 2015

Venue: Darwin Convention Centre, Darwin

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

Website: http://www.csc2015.com

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

ACECC
Anaesthesia Continuing Education Coordinating Committee

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OPINION: FOR EVERY GENERATION, THERE'S A GAP

Following on from his contribution to the August edition of *Australian Anaesthetist*, provisional fellow, Dr James Miller, argues that anaesthetic expertise risks being devalued under private health insurers' 'no-gap' and 'known gap' policies.

In a recent opinion piece I wrote for the August edition of *Australian Anaesthetist* (a response to the April workforce issue), I raised the point that we, as a profession, need to actively resist accepting the unit rate rebated by private health insurers. This essentially means that we need to charge a gap.

Since leaving the world of commerce for that of medicine and anaesthesia, I have been entertained by the willingness of doctors to speak openly about how much money they earn and subsequently spend. On the other hand, most report disliking having to discuss bills with their patients and often bulk bill the health fund. Therefore, they avoid gapping. While the reason for this is often cited as the belief that they 'already earn enough money', it also enables doctors to avoid the financial consent process, which is perceived as being awkward.

This has both personal and professional impacts. On a personal level, medical professionals are forgoing the opportunity to earn larger incomes, which they could be spending just as fast as they do their smaller ones! They are also, without realising it, devaluing their unique skill set, knowledge and services. I believe this is having a negative impact on the anaesthesia profession. This devaluation is occurring in the eyes of patients and also in those of surgeons, private insurers and the greater health sector. It enables and encourages talk of 'nurse-anaesthetists' for example, and is resulting in private insurers freezing or lowering their rebates, rather than adjusting them for the national consumer price index.

Health insurance companies are businesses like any other – their ultimate goal is to make profits. They do this by charging customers premiums and, ultimately, rebating less than those

premiums. In order to increase profits, they either need to increase their income or decrease their costs. If they're really smart they do both. To increase income they need to increase their customer base or the amount of money they charge for premiums. To appeal to customers they often promote 'no-gap' policies or, in the case of Bupa, a 'known gap' scheme. The easiest way to decrease costs (assuming they have maximised their efficiencies elsewhere in the business) is to reduce the rebates they offer us, the medical practitioners. Put these two policies together and the result is the 'preferred provider' system, where insurance companies pay marginally higher rebates to practitioners who agree to either bulk bill or charge a fixed gap (no more than $500 in the Bupa example). They promote these providers and create negative impressions in the minds of their customers about practitioners who set their own fees which therefore, results in a gap.

Health insurance companies are businesses like any other – their goal is to make money

Regrettably, we are seeing increasing numbers of practitioners, especially anaesthetists, enabling such schemes. Beyond the ability to avoid the financial consent process, other benefits for practitioners include a reduction in the number of bad debtors and, arguably, a more consistent income stream. Unfortunately, these short-term gains will seem negligible as time goes on and insurers' rebates fail to keep pace with inflation and will, I believe, ultimately fall to levels approaching the base Medicare rate (as I am sure any notes from the long-term planning divisions of these organisations would uncover!).

By not individually determining and charging a fair and reasonable fee, anaesthetists leave themselves open to accept a unit rebate dictated by patients' health insurers, which, as we know, can vary greatly. This allows private health insurers to not only lead the discussion with regard to what our skills are worth, but also to control it – and this is a disaster. Ultimately, ithis means our professional autonomy is being lost along with our earning potential. It means that our unique skill set is devalued and may be devalued to a point where the idea that our services can only be provided by qualified medical specialists loses its gravitas. Furthermore, it means that the narrative is set by the insurance companies. I would argue that few, if any, privately insured patients understand that almost half the rebate for anaesthesia services is actually paid for by the government and that the rebate offered by most companies is less than half that deemed a fair and reasonable fee by the Australian Medical Association. Many specialist anaesthetists may not even be aware of this, nor most registrars.

Let us take the NIB 'no-gap' scheme as an example. Assuming the anaesthetist complies with all of the insurer's policy rules, charging no gap and therefore, accepting the dictated rate, NIB will rebate $30.50 per *Relative Value Guide* anaesthesia unit. Of this, $14.85 per unit is actually paid by the Medicare Benefits Schedule, i.e. NIB really only rebates $15.65 per unit. The current Australian Medical Association/ASA unit value, which is recognised as a fair reflection of the financial value of anaesthesia services, is $77.00. Although unit rebates differ between insurers, the same argument stands for every health insurance policy currently in the market.

Similarly, 'known gap' policies set a ceiling price for both the gap component and the unit rebate. While these policies appear to provide an admission that the unit rebate offered by the company is not adequate compensation for the services provided, they still effectively control the rates we charge, as the gap cannot increase above a fixed rate ($500 in the case of Bupa's 'known gap' scheme). Therefore, the unit rebate effectively decreases in any case that becomes extended or complicated in unforeseen circumstances.

Our professional autonomy is being lost along with our earning potential

I firmly believe that anaesthetists need to set their own unit rate. In doing so, they need to resist the temptation to sign onto 'no-gap' and 'known gap' products that dictate the value of anaesthesia services and reduce the autonomy of individual practitioners and the profession. Furthermore, they need to take charge of the dialogue and educate patients on why anaesthesia services are worth the money charged and why a bill may be more than the rebate received from a health insurer. Anaesthetists need to explain to their patients that a gap between the cost of the anaesthesia service and the amount an insurance company rebates indicates that the insurance company has chosen profit over adequate reimbursement for the services that the customer has paid good money for, in the form of both insurance premiums and taxes to the Medicare Benefits Schedule. This is not a difficult conversation to have with your patients, however it will become more so if we allow insurance companies to continue to control the conversation without us.

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LIFE ON THE RUN

Dr Eugenie Kayak, an anaesthetist who works at the Alfred Hospital and Austin Health in Melbourne as well as being Victorian Chair of the health advocacy organisation Doctors for the Environment Australia (DEA), tells *Australian Anaesthetist* that making time for a sporting life is not only personally gratifying – it also contributes to a healthy planet.

In the recent Melbourne Marathon Festival (12 October 2014), 75 doctors and medical students, along with family and friends, ran for DEA under the banner 'Healthy Planet; Healthy People'.

I'm proud to say I was one of the doctors involved in that run. As a very amateur, but keen, runner, being part of Team DEA was an ideal way to combine two vitally important, non-anaesthetic aspects of my life: exercise and raising awareness of the important and relevant role to us as medical professionals of 'protecting health through care of the environment'.

I've been interested in physical activity for many years. As a student at Melbourne University (where I completed a Masters of Science in Biochemistry before moving to the University of Queensland to do my Bachelor of Medicine and Bachelor of Surgery), I became very involved in rowing and represented the University at national and international inter-varsity level.

Over the last five years, I have had the good fortune of being able to combine practicing anaesthesia, raising two young sons, chairing the Victorian branch of DEA and, more recently, recreational running.

I have run a grand total of two half marathons (21 km each) in the Melbourne Festival event, a challenging but very doable distance, requiring surprisingly less training than one might expect. While I almost consider myself an expert of the event, I am reminded of my amateur status when true runners learn of my time aspirations and politely nod their heads without really knowing how to comment!

Perhaps this is a reflection of my training regimen for the Melbourne Marathon, which involved no more than two to three runs per week (usually on the way

Drs Steve Fowler, Eliza Beasley and Eugenie Kayak for Team DEA at the 2014 Melbourne Marathon event

DEA runners in scrubs. From L–R: Claire Felmingham, Hugh Murray, Dr Kristen Pearson, Brigid Skipper, Laura Beaton, Ozge Tanrikut, Dr Jo McCutcheon and Dr Jane FitzGerald

home from school drop-off) and 8 to 10 km at most each time. The longest distance I ran before the race was 15 km, accompanied by by nine-year-old son on his bike. This was a great way to spend an active morning with him and to listen continuously for 90 minutes about the details of the computer game 'Minecraft' – we had a deal that he would do the talking and I would do the listening!

Engaging in physical activity...was a great reminder of the numerous immediate health benefits that can be gained with decreasing our greenhouse gas emissions and protecting our local environments

Knowing that family and friends have sponsored your run is a wonderful motivating factor, especially when the inevitable niggling injuries begin to surface and you are reminded why you don't run more than three times a week, even if you did have the time. However, perhaps more than the sponsorship obligations and the obvious benefits of physical fitness and strength gains that come with consistent training, running on off-road tracks (without music or audio) enables a unique time and space for mental relaxation, thinking and problem solving – the things that often seem unobtainable in the incredibly full and unrelenting pace that tends to accompany living in the 21st century as we try to juggle the professional, personal and volunteer aspects of our lives.

Also being part of such an amazing team of medical professionals running for DEA was incredibly motivating as well as inspiring. In particular, it was great to run with DEA members of all ages and specialties, including two anaesthetic colleagues, Drs Steven Fowler and Eliza Beasley, with whom I work with – even if they both significantly outran me!

This year was the first time DEA participated in the Melbourne Marathon Festival and it was an ideal way for myself and other members of the organisation to participate in a healthy, fun activity together, while supporting the organisation's increasingly important and ever-expanding advocacy work.

DEA is the only Australian medical organisation focused entirely on raising awareness and taking action to protect our environment for the health of present and future generations. It has been significantly involved with education and advocacy work for over a decade in Australia.

As medical doctors, we are in a unique position to promote the need for action concerning our environment

DEA works to prevent diseases – local, national and global – caused by damage to the Earth's environment and to raise awareness of the absolute dependence of our wellbeing on healthy, natural ecosystems, or 'life-support systems', namely, clean air and water, biodiversity and a stable climate.

As Margaret Chan, the Director-General of the World Health Organization, has stated, "The real bottom-line of climate change is its risk to human health and quality of life". According to the Organization, climate change will affect, in profoundly adverse ways, some of the most fundamental pre-requisites for good health: clean air and water, sufficient food, adequate shelter and freedom from disease. In Australia, in particular, we are already becoming familiar with the devastating health implications, trauma and destruction that extreme weather events bring, whether they be heatwaves as 'silent killers', or bush fires, droughts

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and storms. Ban Ki-Moon, the United Nations Secretary-General, has said "Climate change threatens all our goals for development and social progress" and "it is a true existential threat to the planet".

So what better way of promoting the importance of a healthy planet for healthy humans and the urgent need for action than having one of the largest teams in the Melbourne Marathon raise awareness about these issues?

Organising the team was a significant, welcome change of focus from our standard DEA activities, which are so often sobering, confronting and incredibly serious. Our team was coordinated by University of Melbourne graduate medical student, Laura Beaton, who demonstrated superb leadership, integrity and organisational skills throughout the months leading up to the event.

Furthermore, engaging in physical activity as an organisation, team and individual was a great reminder of the numerous immediate health benefits that can be gained with decreasing our greenhouse gas emissions and protecting our local environments. For example, increased active transport with associated activity and less use of our cars leads to less CO_2 and local air pollution emissions (the latter of which is widely accepted to contribute to almost double the number of Australian deaths per year than traffic accidents), while helping to maintain fitness and healthy body weight.

As medical doctors, we are in a unique position to promote the need for action concerning our environment. We have a proud history of service to the community and have been instrumental in encouraging policy development to protect and improve health, such as tobacco, drink driving and bicycle helmet legislation. We are also ideally placed to educate and raise awareness of the adverse health implications presently associated with, and predicted from, our current trajectory of anthropogenic global warming and associated changes to our climates and environments.

Advocacy organisations can speak out when others may be constrained. DEA was the first medical organisation in Australia to provide advice to the government and the public about the potential health impacts of coal seam and shale gas developments, submitting reports to, and appearing before, both federal and state (NSW) coal seam gas parliamentary inquiries. We have also briefed members of both state and federal parliaments on the health impacts of coal developments, climate change, air pollution, biodiversity/forestation, preparedness for extreme weather events and environmental design (amongst other topics) and were the first health group in Australia to challenge the Environmental Protection Authority (on public health grounds) for approving a new coal-fired power plant in Morwell, Victoria in 2011.

Doctors for the Environment Australia is already making plans for next year's Melbourne Marathon Festival and hopes that perhaps our team will be even bigger than this year's by encouraging a wider group of medical professionals, family and friends to participate.

Please consider running with us and/or joining the organisation and our efforts to maintain a healthy planet for present and future generations.

DOCTORS FOR THE ENVIRONMENT AUSTRALIA

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Postal address: 67 Payneham Road
College Park, South Australia 5069

LIFESTYLE

CRAFTING A LIFE AFTER PRACTICE

Tempus fugit! It has been over seven years since Dr Dave Fenwick retired and during that time he reckons he's learnt a thing or two.

The first is that this is a golden time of life, but it requires some planning. Financial planning is needed to put the lustre on the gold. One must have care in the accumulation phase and this persists into the consumption phase. Financial security is a wonderful comfort.

In my first year of retirement, I completed my boat, *Emm Dee*, a play on the names of our grandchildren and an erstwhile career. Its construction was a good education, from reading plans to translating them into a finished boat, and it required many skills learnt along the way. My wife, Nan, and I had many happy cruises on the Murray River, from Renmark in South Australia to Devils Elbow in New South Wales. Later, we had the idea of a cruise from Goolwa to Wentworth and back. That involved twenty lock transits, 1,800 river kms and 33 days aboard. The river was fascinating and navigating it was an art and science in itself, which was enhanced by observing the geology, palaeontology, flora, fauna and the people along the way. One example of this was exploring the Queens Sandhill at marker 628 km, said to be an ancient burial ground. Here we found many kangaroo bones, but it was the discovery of a human left tibia that really stood out. The anterior surface of the bone had weathered away, but the posterior surface was intact, allowing identification. Alongside it, we found a jasper core, from which, unmistakably, flakes had been struck for stone tools. Notably, jasper is found in southern Queensland, but not in that area of the Murray River, and I surmised that it could have been brought there for trade in return for ochre, which was highly prized. This interest stemmed from being taught anatomy – and much else – by Professor Phillip Tobias, who was at the forefront of investigating the early hominids, such as *Australopithecus*. As members of the Archaeology and Anthropology Society of Wits University (the University of the Witwatersrand, Johannesburg),

we were taught comparative anatomy, the rudiments of geology, excavation techniques, botany and zoology, which all made for a wonderfully broad education in topics outside the narrow confines of pure medicine.

There were indeed many magic moments given only to those gliding along the waters of the river, even if being awake at the crack of dawn was the price to pay for some. The evenings were easier with a glass of wine.

I found that, eventually, attention needed to be paid to the retention of grey capital

Modelling in clay has been a lifelong interest, though the rigours of a medical career precluded any formal education in the art of sculpting. While a Councillor for the ASA, I crafted a crude bronze statuette called 'Just Checking', which the Society was kind enough to accept. Later, while Education Officer, I made a bronze called 'Ether', which again the ASA accepted. I suppose the Department of Anaesthesia at the Royal Adelaide Hospital had seen these works when they commissioned me to make a floating trophy for the winner of the annual Painter Debate. I made a small bronze called 'Difficult Airway' for them. Since then, I have made a piece called 'The Teacher', which has just been accepted by the New Medical School of the University of Adelaide. Clay is delicate, but bronze is enduring and hopefully will be around when the sculptor has gone. The clay has to be encased in a mould, which is made in several pieces. The mould is then dismantled, the clay taken out, the mould reassembled and molten wax is poured in. The wax model is taken out of the mould, refined and, in its turn, encased in another mould. As the mould and wax are heated, the wax melts and runs out, leaving space for the bronze to be poured in. When the bronze has set, the mould is broken away from the sculpture, giving the name to the process: lost wax, broken mould. I only make the clay sculpture and then hand it over to a specialist mould maker and metal caster for the final phases. 'The Teacher' certainly gave the mould maker a few problems, but his skill produced a good outcome.

'Difficult Airway', 2007, bronze

'The Teacher', created to commemerate the opening of the New Medical School at the University of Adelaide

Dave and Nan make it to Wentworth, NSW, at the confluence of the Darling and Murray Rivers

As readers of *Australian Anaesthetist* may know, I am also keen on the art and culture of writing letters. As such, I wanted to write a specification sheet to explain the symbolism of 'The Teacher',

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which I thought would be easy enough. Well, I wrote one and it looked terrible! So, I took myself off to the Calligraphy Society of South Australia, where they politely described my efforts as "fancy writing" and took me in hand to teach proper calligraphy. My ability is awful, but the study is fascinating.

Over the last seven years I found that, eventually, attention needed to be paid to the retention of grey capital. Thus, I went to the Medical School of the University of Adelaide to be a tutor in the Case Based Learning program. Initially, I taught the preclinical years one, two and three, in order to see where the students had travelled. Now, I just teach year three and find that enough of a commitment. This entails five hours a week contact time and about ten hours a week preparation time, with four hours of assessment time per term, of which there are four a year. I find that preparation is needed because specialist practice allows general knowledge to slip away and, while that happens, progress is made in other fields. I have two groups of nine students and I teach each group for two hours a week. Classes are followed by an hour long tutor briefing on the next week's case. Tutors are meant to be facilitators of the self-learning system, but I find that some tuition is still required during the tutorials. The preparation has taught me a lot and it is a privilege to engage with bright young minds, plus both elements of the role help to retain that vital grey capital!

Valuable time is also spent with family, gardening, reading, contributing to RAG and drawing, but never wondering what to do next!

(Head photo provided courtesy of Discover Murray River www.murrayriver.com.au)

A magic moment on the Murray-Darling

The *Emm Dee*, moored 30 km up the Darling River

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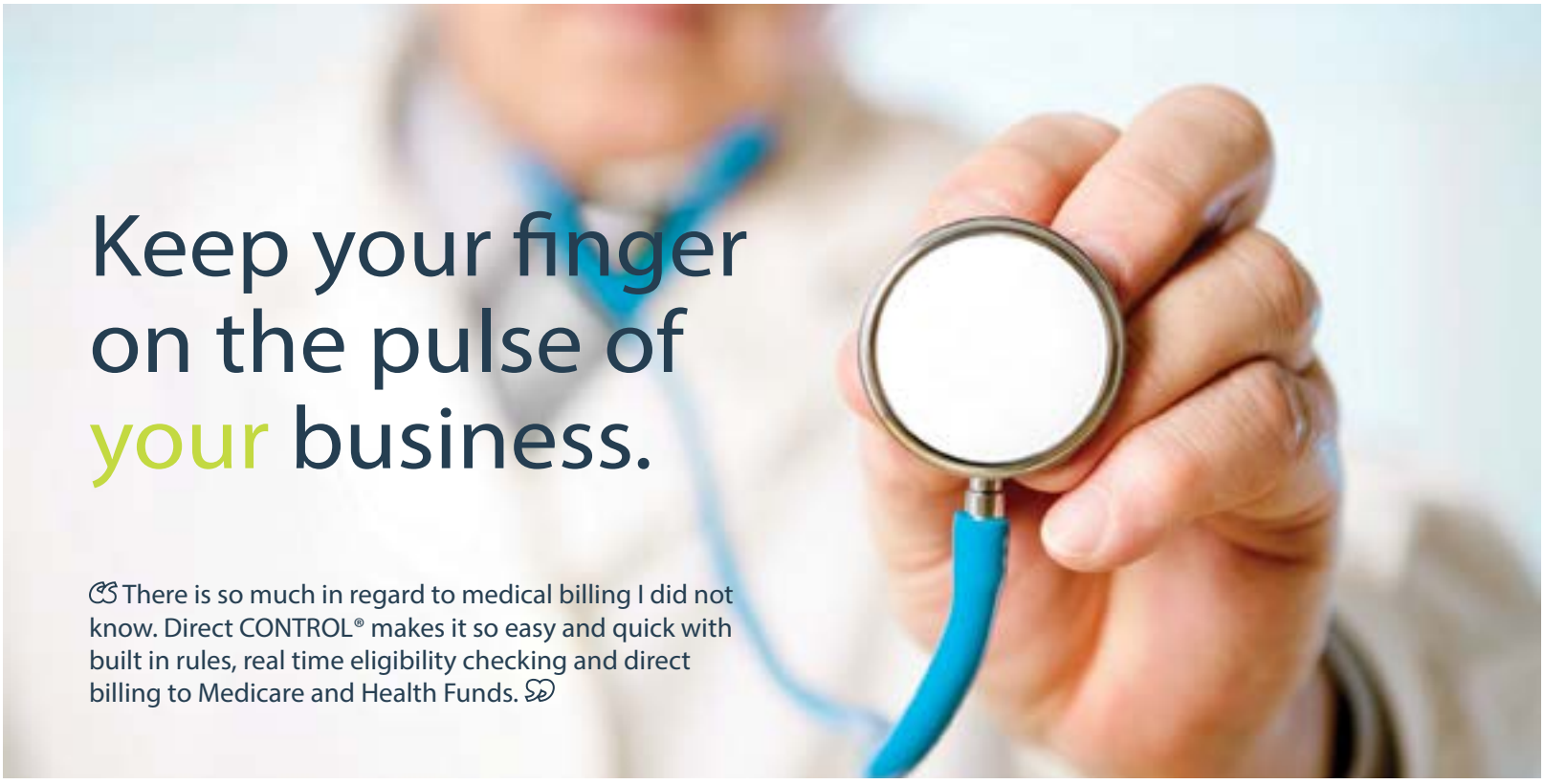

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  Ambulatory Nerve Blocks
- **Jens Borglum, Denmark**
  Trunk Blocks & Outcomes
- **Svetlana Galitzine, UK**
  Education & Training