AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • DECEMBER 2017

Welfare and Mental Health/Wellbeing

- Post-Traumatic Stress Disorder
- Long Lives. Healthy Workplaces.
- A guide to maintaining trainee wellbeing
- Theories of stress in anaesthesia practice

ASA
Australian Society of Anaesthetists

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Locum anaesthetist program proves vital to rural and remote communities around Australia

Rural and remote health services across Australia make an effort to provide continuity of care to their local communities but often face difficulty in finding a cost-effective temporary solution when health professionals go on leave.

Health services are not immune from requiring short-term locum cover for sudden illness or even burn-out associated with shortages in staff available to cover leave. Maureen Buckley, Admin Manager at Foster Medical Centre in Victoria, explains a number of occasions where their anaesthetists have suffered injuries which prevented their immediate return to the theatre.

"[An anaesthetist] had a serious eye injury and we were forced to replace him at very short notice" Ms Buckley said.

Foster Medical Centre contacted the Department of Health's Rural Locum Assistance Program (Rural LAP) to help find a short-term anaesthetist locum and within minutes the application form was submitted.

"It was a quick and easy application process with good follow-up from the Rural LAP contact. It's also been a great help to us with one of the senior GP Anaesthetists off for many months after an accident.

"We couldn't continue to run theatre sessions at our local hospital without these great locums backed by Rural LAP" Ms Buckley concluded.

Heather Byrne, Practice Manager at Foster Medical Centre, says the program is "a vital component in our planning to cover our procedural GPs during periods of leave. Without the assistance of Rural LAP, our community would have lost procedural services and our existing GP workforce would have been even more overworked."

Since inception, the Australian Government-funded program has helped thousands of health professionals take much needed leave to recuperate and come back

to work revitalised and ready to provide quality health services to their communities. Rural LAP provides a cost-effective service to practices by providing health professionals to rural and remote practices for short periods of time with no extra costs to those practices.

Rural LAP is a component of the Australian Government's rural workforce capacity agenda and aims to provide targeted rural and remote support services to general practitioners (obstetricians and anaesthetists), specialists (obstetricians and anaesthetists), nurses and allied health professionals in rural and remote Australia.

The program is managed by health care solutions provider, Aspen Medical.

Australian Government

rural LAP

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

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

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FEATURES

30 76TH NATIONAL SCIENTIFIC CONGRESS PERTH

INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The March issue of *Australian Anaesthetist* will focus on Overseas Development and Education. If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 6 January 2018.
- Final article is due no later than 17 January 2018.

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

REGULAR

ASA EDITORIAL FROM THE PRESIDENT

A/PROF. DAVID M. SCOTT
ASA PRESIDENT

In this edition of *Australian Anaesthetist* we are focusing on the life and health of anaesthetists. Dr Antonio Grossi, our Chair of Professional Issues Advisory Committee writes on welfare and mental health issues. Dr Tracey Tay informs us about a project the ASA is sponsoring with the Hunter Institute of Mental Health and welfare systems and structures. Drs Scott Popham (past TMG Chair) and Richard Seglenieks (new TMG Chair) write on trainees at risk and trainee perspectives on the profession and speciality. I have also been asked to share my experiences on dealing with PTSD. These articles all speak to the important role of Support that the ASA takes most seriously, and is one of the key planks of our member service.

I also wish to discuss the concept of Professional Citizenship and how it fits in with the speciality. Professional is defined[1] as: a paid occupation, especially one that involves prolonged training and a formal qualification, and citizenship as:
1. the state of being vested with the rights, privileges, and duties of a citizen, and
2. the character of an individual viewed as a member of society; behaviour in terms of the duties, obligations, and functions of a citizen. Professional citizenship was recently described by Jeffery Plagenhoeff MD ASA (US) President as:

- willingness to accept responsibility and ownership for the present and future state of their profession,
- being a team player,
- taking their fair share of the load – ALWAYS,
- leading by example in EVERYTHING,
- standing up for, and doing what is right – ALWAYS,
- giving back, and
- supporting the mission with their time energy and money.

Looking at how professional citizenship fits into ASA membership, I will examine the aims of our society: Support, Represent and Educate:

SUPPORT

A professional citizen will be somebody who will look out for their colleagues, be prepared to ask RUOK. They will be prepared to take their share of the after-hours roster, prepared to sometimes take on the list that maybe doesn't pay quite as well, and to cover their colleagues when they are unwell. When a professional citizen witnesses bullying, discrimination or harassment they respond appropriately to it, and ensure that it is stopped and that the victims are supported.

A professional citizen participates in department activities to support delivery of care. They contribute to preparing rosters, attending multidisciplinary meetings, and assist the director to run the department or practice smoothly. They will encourage their colleagues to attend mortality and morbidity reviews, and be fully prepared to present their adverse outcomes so that both they and their colleagues will learn from mishaps, and our patients will be better cared for.

Supporting also includes being members of professional associations.

If you care about the future of anaesthesia in Australia, indeed in your own future, then ask yourself "who represents my interests with decision-makers, fund holders and government?". Maybe you have the time and the money to travel regularly to Canberra to lobby the Health Minister, and your Local Member, but it's unlikely they will see you. They are busy people and want to meet representatives of larger organisations, not individuals. So, if you care and you want to have your voice heard, then work to become president of the ASA, if you have no political inclination then make sure you support the people who do this work for you by paying your subscription. Professional citizens support the mission with their time, energy and/or money.

REPRESENT

This year the ASA's attention has been quite focused on the MBS review. One criticism that has been levelled at the speciality has been the 'gaming' of the MBS. I work in a rural practice where we all know each other, and aberrant activity such as placing, or charging for arterial lines on every knee arthroscopy, or gastroscopy, or claiming respiratory gas monitoring on every case, would be identified and called out. As such I have not seen this behaviour, but I am told by colleagues that this happens elsewhere.

I know that it's human nature to maximise one's benefit where possible, but activities as I have just described is not professional citizenship.

A professional citizen stands up for and does what's right, always. This must apply to caring for patients, acting in their best interests, and also acting in the best interests of the MBS and fund-holders. A sustainable universal healthcare system relies on the honesty and integrity of the people supplying service and accepting payment. I am almost positive that if you are reading this then you are an ASA member and this doesn't apply to you.

If you are aware of such behaviour it's your responsibility as a professional citizen to help your colleague understand the unsustainable nature of their practice.

The ASA has been and will continue to work hard to represent the Membership in the review of the MBS, and to ensure that our patients continue to have the current good access to surgery and won't lose their rebates because of unsupported cuts.

EDUCATE

The professional citizen will engage with supervisors of training, registrars, residents and medical students to help develop our future anaesthetists. They will be on the lookout for struggling trainees and work with them. Importantly they will also educate them in the values of professional citizenship.

As a profession, we also need to educate our Patients. They should be helped to understand the value of their perioperative care, of their anaesthesia care during their procedure, and the care they receive from us in recovery and after.

The speciality of anaesthesia needs its professional citizens to ensure that they provide the best quality care and the best value care to their patients, this is the best advertisement we have.

Finally, we need to work on raising the profile of the speciality, so that the recurring cycle of attacks on our scope of practice, task substitution and training standards ends. We have become so good at what we do, and the improvements from anaesthesia research has resulted in advances in safety to the point that, to the casual observer it all looks easy. It takes somebody to casually approach anaesthesia and then have a catastrophic outcome (e.g. Michael Jackson) before people, fund holders, and governments stop and consider what we do. Professional citizenship then is also being an ambassador for the speciality and our colleagues, making every encounter an opportunity to enhance our standing in the community.

The speciality of anaesthesia, and the profession of medicine, is currently at a crossroads: we are experiencing intense government scrutiny with the MBS review, the independent review into accreditation systems, the Private health inquiry, and health economists trying to influence governments to forsake quality and safety for cost savings, at the same time we are (correctly) pushing for an expanded role as perioperative physicians and anaesthetists.

If the speciality is to emerge from this intersection with our position secure and enhanced it will take commitment not just from the leaders, but from its citizens as well. To assist your society to advocate for your interests I ask you all to strive to be better professional citizens, support, represent and educate yourself, your colleagues, your patients, your politicians, and the community at large.

Reference

1. http://www.dictionary.com/

CONTACT

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

REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

MEMBERSHIP GROWTH AND GOVERNANCE REFORM REFLECTIVE OF A SUCCESSFUL YEAR

The past year has been in many ways quite a successful one for the Society. Be it in the Policy initiatives, in particular related to the MBS Review, or the financial result achieved, the Society has had a good year.

Two other areas where success has been achieved but may not be immediately evident are in membership and in the new governance structure approved by members at the 2016 Annual General Meeting and implemented over the past 12 months.

The ASA is a membership-based organisation and I am pleased to report that the overall membership of the Society has continued to grow. During the year as noted in the 2017 Financial Statements this growth was 4.5%

At present approximately 55% of the anaesthetic profession (FANZCA's plus trainees) are members of the Society. A percentage figure that has been gradually increasing over the past four years. As of July 2017, overall membership stood at 3,502.

During the year the Society welcomed 320 new members. Of those 120 were new Ordinary Members meaning our largest member category was 2,024 at year's end.

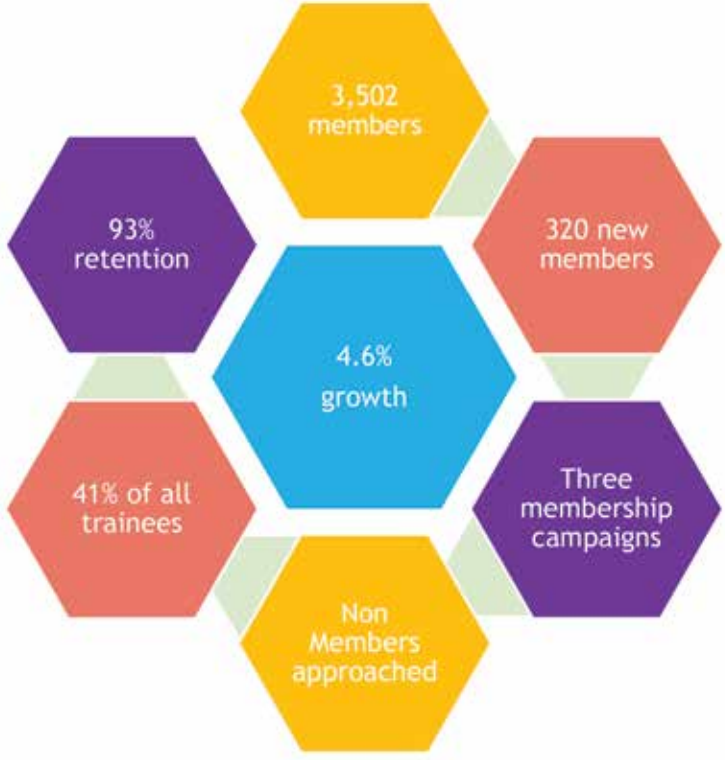
This growth was the result of a number of factors not least the three specific campaigns conducted during the year.

The first of these was through AMPCo the business arm of the AMA where we actively approached those anaesthetists who are AMA members but not Society members. At the same time we reached out to those who had in recent years for whatever reason let their membership lapse or had placed it on hold.

Combined, these three campaigns contributed 40 Ordinary members.

Non-members whose details we hold and who had attended an ASA meeting were approached via a quarterly 'teaser' highlighting the work of the Society and encouraging them to join.

These organised approaches coupled with the tremendous work of our state Chairs and Committee's and the active



Membership

promotion of the Society by existing members have all assisted greatly in building the membership.

A point of some satisfaction has been the continued increase in the number of trainee members.

During the year 100 Introductory/Basic Trainees joined along with 84 Advanced/Provisional Fellow Trainees.

Currently there are 501 trainee members accounting for 41% of all trainees in Australia up from 24% in 2014.

This continued increase in the number of Trainee members is important. It is hoped that a closer relationship with the College will assist in introducing trainees to the Society at the beginning of their training leading to their long-term engagement with the Society.

Like all membership organisations retention is a key aspect. It is pleasing to report that the ASA's overall retention rate remains very strong and sits at 93% (excluding deaths and retirements). In order to aid this extremely high level of retention, the Society through the Membership team is looking establish a direct debit facility for the payment of membership subscriptions. It is hoped that such a facility will be in place by early 2018, and will be well received by members.

The ASA is strong. The challenge remains to show to all the value of membership.

At the Annual General Meeting in 2016 the then President Dr Guy Christie-Taylor put to the membership a raft of motions designed to change the governance structure of the Society. In short, the motions led to the creation of a smaller seven person Board of Directors, four of whom are member-elected and two elected from Council with the Immediate Past President being the seventh director. The goal, and I am pleased to say, the outcome, has been to make the Board responsible for the business aspects of the ASA, covering such matters as finance, risk and overall governance leaving the Council to devote its efforts towards the professional matters such as workforce, revalidation and welfare, impacting on members.

To date this new model has been working well and will continue to evolve over time. The success of Council has been further strengthened by the re-establishment of the Public Practice Advisory Committee, Chaired by Associate Professor Alicia Dennis from Melbourne. As its name suggests this Committee has given a strong voice to those members who are working in the Public Sector, and who face issues specific to that sector.

This model of governance which is reflective of modern business practice, was a point of great interest at the Common Issues Group meeting held in Canada earlier in the year. Our colleagues from both the AAGBI and the ASA USA expressed great interest in what had been achieved through this change. No doubt there will be further follow up at the London meeting in 2018.

It would be remiss of me not to acknowledge the great work of Dr David Law and his organising Committee, in staging the recent 2017 National Scientific Congress in Perth. The feedback from delegates has been exceptional. Comments covering such things as the high quality of the speakers, the tremendous social events, the family-friendly considerations of the meeting, right through to the venue and Perth itself, reflect the success of the meeting. I am sure that the report included in this edition will give all members a flavour of the Congress.

The Society is indeed grateful to David and the Co-Convenors of the Scientific Meeting Drs Dan Ellyard and Dale Currigan and the rest of the team from Sir Charles Gairdner Hospital who put together a wonderful meeting.

Looking forward to 2018!

Mark Carmichael
Chief Executive Officer

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AWARD

AMERICAN SOCIETY OF ANESTHESIOLOGISTS RECOGNISES PAUL MYLES MD, WITH ITS EXCELLENCE IN RESEARCH AWARD

The American Society of Anesthesiologists (ASA) recently presented Paul Myles, MD, with its 2017 Excellence in Research Award in recognition of his outstanding research achievements as a primary investigator in perioperative medicine and patient-centered outcomes. Dr Myles' research has led to major contributions to the field of anesthesiology.

Dr Myles is professor and director of the Department of Anesthesia and Perioperative Medicine at Alfred Hospital and Monash University in Melbourne, Australia.

As an academic physician anesthesiologist and clinical investigator, Dr Myles has continued to find conclusive results to important clinical questions. One of his first large trials, which was published in *The Lancet* in 2002, found no adverse outcomes to epidural blocks when used to manage major abdominal surgery and postoperative analgesia, and was the largest randomized anesthesia trial at the time. He has gone on to publish over 275 manuscripts, and his work has been cited more than 13,000 times.

Since 1996, Dr Myles has received 25 research grants totalling more than $35 million in Australian federal funding, and it is still the largest amount for one Australian investigator in the field. The Australian and New Zealand College of Anaesthetists Clinical Trials Network (ANZCA CTN), which he founded, has grown into one of the largest international clinical trial networks. Among the most noteworthy findings to come from ANZCA CTN has been the finding that nitrous oxide does not increase postoperative mortality, morbidity, the risk of heart attack or other negative outcomes; and the finding that the administration of preoperative aspirin resulted in neither a lower risk of death or thrombotic complications, nor a higher risk of bleeding than with a placebo.

"I am honored to present Dr Myles with the 2017 Excellence in Research Award – an extraordinary physician, researcher and mentor," said ASA President Jeffrey Plagenhoef, MD. "Dr Myles' contributions to anesthesiology are unparalleled, and he continues to pass his knowledge and passion on to new investigators."

Dr Myles serves on the editorial board for three of the top anaesthesia and critical care journals in the world – *Anaesthesiology, British Journal of Anaesthesia*, and *Anaesthesia and Intensive Care* – while continuing to serve on the executive committee of the ANZCA CTN. He is actively involved in numerous professional associations and is a founding board member and director of the Australian Clinical Trials Alliance.

Dr Myles received his medical degree from Monash University in Australia in 1981, and completed his anaesthesiology residency at Alfred Hospital in Melbourne, Australia.

From American Society of Anesthesiologists website: http://www.asahq.org/about-asa/newsroom/news-releases/2017/10/excellence-in-research

LETTERS TO AUSTRALIAN ANAESTHETIST

AEROMEDICAL RETRIEVAL

I read the Editorial and the feature articles on Aeromedical Retrieval with a great deal of interest.

I acknowledge that anaesthetists were, and continue to be, at the forefront in the establishment of these lifesaving ventures.

I recently attended the opening of the new Helicopter Rescue Base and Service Centre in Lismore and note that I was one of the first three doctors (two anaesthetists and a general surgeon) to promote the establishment of the local service and flew missions of retrieval and transfer of patients in 1982.

Further, I record that the beginning of the paramedic service was with the impetus and support of anaesthetists in Sydney. Dr Bob Wright and others organised a major meeting at Sydney University in 1978 (I think) to hear Dr Simpson from Los Angeles General Hospital promote the advantages of extended training for ambulance officers to improve outcomes for patients and to discuss a curriculum for training.

The anaesthetists were the people who trained and certified the paramedics from those early beginnings and we are the people who the paramedics come to for maintenance of skills to this day.

Brian Pezzutti
Richmond Hill, NSW

PRIVATE MEDICINE

Simon's feature article (Challenges to private medicine in Australia, *Australian Anaesthetist* September), raises a number of very pertinent issues confronting the affordability of our current health system. Having worked for almost 40 years in both public and private systems, a number of factors strike me as relevant to the issue.

1. Public expectations: These are fed by both politicians and the media.
2. WHO definition of 'Health'. It is so broad that it is doubtful if the entire GDP of the country could actually satisfy everyone.
3. Selection criteria for medical students, combined with high HECS debts on graduating, encourages higher charges.
4. Striving for zero risk, rather than sensible risk management is very costly.
5. Egregious out-of-pocket charges by some doctors.

This is not a comprehensive list by any means, but the pressure on government to act is increasing. If the profession is not proactive, it surely wouldn't be too hard for private hospitals to be required to include constraints on doctors accredited at their hospitals through the By-Laws.

Roger Henderson
Mt Eliza, VIC

HAVE YOUR SAY

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

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

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

FEATURE

POST-TRAUMATIC STRESS DISORDER – A PERSONAL VIEWPOINT

President of the ASA, David M. Scott, writes of his personal experience with post-traumatic stress disorder.

After the celebrations of Christmas Day 2004, with the whole family together around the swimming pool, eating too much good food, drinking too much good wine and telling tall stories from our childhood, it was time to get back to reality. The first reports of the earthquake and subsequent tsunami started to filter through on Boxing Day morning. As is typical, the reports were sketchy but it appeared that it was a serious incident.

I called Air Vice Marshal (AVM) Dr Tony Austin – Head of Defence Health and asked if he wanted a response from the Defence Anaesthesia Consultative Group of which I was Chair. He asked me to communicate with the group and find out who would be available in the event that the Department of Foreign Affairs and Trade (DFAT) wanted to respond. This I did and had about seven colleagues who were prepared to drop everything on Boxing Day and head to parts unknown as part of a DFAT response.

The news was now telling us that there had been a serious earthquake in the Eastern Indian ocean which had triggered an enormous tsunami, and that many countries surrounding the region had been affected. Hundreds, possibly thousands were killed or injured. We were to learn long after we got home that it was a 9.3 magnitude quake lasting for 10 minutes and shifting the sea floor by so much that 7.5 cubic miles (31 cubic km) of sea water was displaced.

The next day AVM Austin called me back and said he wanted four anaesthetists to respond. I was to be one, along with Dr Brian Pezzutti (Army) and Drs Paul Luckin and Paul Dunkin (Navy). We would be travelling and working in 'disguise' as civilians as the place we were going was until recently in open conflict and military uniforms may inhibit people seeking aid, and possibly inflame sentiments. We would be leaving 28th December from Brisbane airport, concentrating at RAAF Base Richmond for a briefing, meeting the rest of our team and departing to the north.

We met at Brisbane, flew to Richmond, met our teams, and departed for

Indonesia. The television said the death toll as it was now being tallied was thought to be as high as 28,000 souls. This was the last news I was to hear until returning to Australia on January 9th 2005.

I do not intend to dwell on the details of our experiences in Banda Aceh following the disaster, suffice to say we spent the next 11 days surrounded by death, decay, destruction and desperation as we battled under very challenging conditions to save as many lives as possible. There were aftershocks of up to 7.3 magnitude, many critically ill patients, intermittent electricity and water, and many dazed and stunned and armed Indonesian soldiers who had lost their families. We were so focussed by our work we barely noticed all the threats to our safety. We operated on over 100 patients while we were there, and saved many lives – not something one usually can say at the end of an average day.

On the 7th of January word came through we were to go home – tomorrow. We were to be at the airport the next morning to catch a flight home. Unfortunately, due to an overnight incident where a jet landing at night had hit a cow on the runway and been damaged, our replacements were delayed. Sadly, we never got to hand over the victims we had been caring for. We waited at the airport all day and were eventually flown to Jakarta in a RAAF Hercules and whisked to a hotel in the city. When the hotel owner found out what we had been doing she opened the bar to our team. So, after our first showers since December 28th we all sat down and caught our collective breath.

Next morning, we had breakfast, were called together for a 'debrief' but really it was all far too raw to even begin to feel anything, so it was a muted and blunted experience. That night we were bussed to the airport and all boarded a QANTAS flight to Sydney.

On arrival, we were allowed to depart the plane first and were taken to a press conference where those lucky enough to have come from Sydney were reunited with their families. I was given a ticket to Lismore and a piece of paper with a phone number which I could call if I was having any 'troubles' adjusting. I did try once to get in contact, I left a message and never got a reply (thus confirming that nothing was wrong). I arrived home to be met by my family and went home, and back to work the following Monday.

I had assumed that with all the news on television I would have no need to explain what I had been doing as we seemed to have cameras in our face most days (this was probably not the case). However, three days after I left, my eight-year-old daughter after seeing the news reports, asked her mother "Is Daddy dead yet?" So, my wife decided that this was too traumatic and took herself and the children to her sister's and turned the television off. We were able to have mobile phone contact most days, but it was intermittent, including being cut off mid conversation during an aftershock.

I was damaged, I just hadn't realised it. I felt I couldn't share my experiences because it was to me impossible to contextualise what happened. I suddenly understood why the Vietnam veterans would say I could tell you but you wouldn't understand. I had many colleagues ask me did I enjoy my break, or did I have fun? The news was now telling us that the death toll was in the order of 340,000.

My wife tried hard to talk to me but I was unable to communicate meaningfully, in desperation she called a colleague for help. Some of my more perceptive colleagues saw that something was wrong, and suggested I needed help. I felt I was ok, but I went to see a counsellor, it didn't help. At the time, I didn't realise that I had post-traumatic stress disorder (PTSD), I was angry. I was angry at everything, and I got angry easily, often over the most trivial things, I got angry at the kids and was scaring them. I felt out of control and had no idea of what to do, but at the same time my brain was saying that I was fine and just get on with it.

One day at work, a year after the tsunami I was in the office and the department secretary asked me if I knew if anybody wanted a locum as one of our past registrars was looking for six months work before starting his contract. I suddenly was struck with the thought that this is what I needed, I rang him up and asked if he would work for me? I then rang an old friend who was working at UC Davis in California and asked if there was any chance of a sabbatical in his department, to which he said that they had just had a six-month vacancy open up. So, in two calls I had organised an escape from my life and all its pressures.

I took myself out of my life, left everything behind including my family and set out to work out what was wrong. I spent my time in California working at UC Davis, alone and contemplating life. While in Sacramento I found a psychiatrist, who was excellent – we clicked and in only three sessions I was on the way to recovery. It wasn't really that easy, but he helped me to understand my anger. For me, and this is typical of many military people with PTSD, the key to recovery is to understand the at-times overwhelming anger.

Anger is the emotion that is permitted in the military, it's the emotion of survival and fight. Trouble is, it's often the only emotion allowed, so anything else you feel gets converted to anger. If I was sad, or frightened, or lonely all I felt was anger. Once I understood this, it was easy: each time I began to feel angry I would stop and feel into what my real emotion was. This was then able to be addressed, and both the anger and the real emotion were confronted and dealt with, or at least accepted. I know I was lucky to figure this out, with help. Not once did my psychiatrist tell me what to do or think, rather he just asked questions.

It was my ownership of my issues that allowed me to move on. For me it was like

FEATURE

a veil had been lifted on my life, I know for others the journey is more difficult, and relapses occur. I know the sight of black plastic bags reminds me of the bodies wrapped on the roadsides everywhere, and the smell of road kill takes me back. I have learned to accept these memories and acknowledge them, recognising symptoms and having a strategy is important.

When I came home my family and friends all noticed the change, and for almost a year after people would volunteer that I was a different person – a most affirming thing for me to hear. Even today when I begin to feel angry I find myself stopping and asking what's the real emotion, a most valuable insight.

I subsequently deployed to Afghanistan with the Air Force in 2008, worked very hard with an outstanding team for nearly two months in the middle of the fighting season, and looked after many trauma patients. About two thirds of our patients were locals, and half of these were children with all sorts of injuries. We saved most, but lost a small number. It was professionally and emotionally challenging. My ritual there involved completing a diary every morning after the gym, shower and breakfast and before morning rounds. I was able to unload each day into my notebook and clear the slate for the next day. This allowed me to live in the moment as much as possible, and to support my colleagues, some of whom were struggling.

After my deployment, when I was back home, I told the Air Force psychiatrist (who I had my compulsory post-deployment interview with) my warts-and-all recount of my life up to that point. He just shook his head and said "it's amazing – you just described the text-book recovery from full blown PTSD, and yet you worked it out by yourself!".

It was a journey, it wasn't easy, but it was worth it.

SUPPORT/HELPLINES

Lifeline – Suicide and crisis support
- **13 11 14**

Beyond Blue
- **1300 22 4636 (24h help line)**

Suicide Call Back Service
- **1300 659 467**

Black Dog Institute
- **02 9382 4530 (9am-5pm)**

Doctors Health Advisory Service
- **http://dhas.org.au/**

2018 MEMBERSHIP

Thank you for your ongoing support of the ASA.

We continue to implement the ASA's vision of '**supporting**, **representing** and **educating**' members to enable the provision of safe anaesthesia to the community.

You would have received your 2018 membership invoice by early December. If you have not received yours, please contact the **Membership Services Team** on 1800 806 654 or email membership@asa.org.au.

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FEATURE

LONG LIVES. HEALTHY WORKPLACES.

An ASA-funded project to support good mental health in anaesthesia workplaces.

The impact of poor mental health in doctors, nurses and other health care providers on the quality and safety of healthcare is no longer just being discussed in hospital tearooms and corridors. Social and mainstream media are asking, on behalf of the community, why there is so little care for those who have to care for others, and why so many smart, high achieving healthcare workers are taking their lives.

Workplaces are an important setting for action in mental health and suicide prevention. Evidence suggests that well-coordinated programs and approaches implemented in workplace settings can improve mental health and wellbeing, reduce mental ill-health and reduce suicidal behaviour. They also have direct benefits in improving productivity and reducing workplace injury, which can deliver substantial returns on investment for organisations that invest in their people's mental health.

Evidence suggests that well-coordinated programs and approaches implemented in workplace settings, can improve mental health and wellbeing, reduce mental ill-health and reduce suicidal behaviour.

Organisations such as beyondblue, the Black Dog Institute and Everymind have developed evidence-based frameworks that support good mental health and prevent suicide. In the medical workplace context, the Welfare of Anaesthetists Special Interest Group (SIG) has led the way in raising awareness of the need for prevention, recognition and skilled, compassionate management of mental illness amongst our colleagues. However, in the light of the findings of the National Mental Health of Doctors and Medical Students conducted by beyondblue in 2013, and the continued loss of life through suicide in our profession, it is clear that a more coordinated approach is needed.

LONG LIVES. HEALTHY WORKPLACES.

The Australian Society of Anaesthetists is supporting a new project, supported by Everymind (formerly the Hunter Institute of Mental Health), to develop an evidence-

based response to the mental health and wellbeing of anaesthetists and anaesthetic trainees.

The long-term goal of this project, called *Long lives. Healthy workplaces.*, is to support good mental health and to prevent mental ill-health and suicidal behaviour amongst anaesthetists and anaesthetic trainees.

The initial phase of the project, conducted over 12 months, will provide an opportunity to:

- Develop an evidence-based framework building on existing projects and research in Australian and internationally.
- Develop and provide a toolkit that can be used by anaesthetic departments to:
  - plan responses to staff and peer mental ill-heath or suicidal behaviour; and
  - develop local resources for the promotion of mental health and prevention of mental ill-health and suicide.
- Pilot implementation of the framework in two major public hospital departments in NSW to test early feasibility and to better understand enablers and barriers to implementation.

The long term goal of this project, called *Long lives. Healthy workplaces.* is to support good mental health and to prevent mental ill-health and suicidal behaviour amongst anaesthetists and anaesthetic trainees.

HOW IS THIS PROJECT DIFFERENT?

Experience and evidence tell us that writing frameworks and guidelines is just the first step in achieving change – we need to build a system of support that can be sustained after the project is over. The real work is in implementation, in building the knowledge and skills of individuals and organisations and in changing behaviours and attitudes over time to promote good mental health in the workplace.

To this end, *Long lives. Healthy workplaces.* will co-design the framework and toolkit with frontline anaesthetists and trainees and test its implementation in two real-world contexts – John Hunter Hospital, Newcastle, and Westmead Hospital in Western Sydney. The framework and its implementation will consider current strengths and existing approaches to supporting mental health in these workplaces and identify factors that enable success. The project will also identify current gaps and barriers so that other departments and hospitals can use this information to support their own local implementation.

Long lives. Healthy workplaces. will co-design the framework and toolkit with frontline anaesthetists and trainees and test its implementation in two real-world contexts – John Hunter Hospital, Newcastle, and Westmead Hospital in Western Sydney.

The framework will provide a form of voluntary standard for anaesthesia workplace mental health against which departments can self-assess. The toolkit will provide the learnings from the pilot sites – the steps for implementation and resources for those implementing the framework locally.

Importantly, *Long lives. Healthy workplaces.* aims to encompass the spectrum of mental health, from well-being to poor mental health and mental illness. It will consider promotion of good mental health and prevention of mental ill-health, what we can do to support those with mental illness and how to identify and help those in crisis. No one resource or program will meet all these needs and so this project will bring together the myriad pieces of work in progress to make them available to anaesthetic workplaces.

The safe, high quality delivery of anaesthesia services to our patients depends on healthy, focused clinicians. The *Long lives. Healthy workplaces.* project is a response to the global call for action, to move beyond talk and to drive sustained change in our workplaces.

Drs Marion Andrew, Greg Downey, Jane McDonald, Suzi Nou, Shirley Prager, Prani Shrivastava, Jaelea Skehan and Tracey Tay (Chair)

Long lives. Healthy workplaces. *Steering Committee*

FURTHER INFORMATION

For further information about *Long lives. Healthy workplaces.*, please contact Dr Tracey Tay tracey.tay@health.nsw.gov.au

FEATURE

A GUIDE TO MAINTAINING TRAINEE WELLBEING

Welfare relates to a spectrum of health (with wellbeing not just being the absence of illness). The focus of this article is on maintenance of wellbeing, with some information about common stressors, issues and barriers, writes Dr Scott Popham, Immediate Past Chair of the ASA TMG.

BACKGROUND

Doctors' welfare has been propelled into the spotlight this year with several high profile doctor suicides[1,2]. Anaesthesia has been on the radar for a long time with anaesthetists being over-represented in statistics[3].

Also, a survey conducted by beyondblue[4] (2013) revealed rather alarming statistics around depression and suicidal ideation in doctors and medical students. It is worth bearing in mind that the numbers quoted in the study relate to respondents rather than all doctors (as is sometimes quoted in the general press). This, and similar surveys, are also prone to selection bias.

DOCTORS' WELFARE – WHO'S WHO

The Doctor's Health Advisory Service (DHAS) is an organisation staffed by many well-informed and experienced health care professionals with a wealth of experience in dealing with doctors' health. The DHAS exists for the benefit of all doctors (including those not affiliated with college training).

Colleges are increasingly aware that the welfare of their trainees needs to be a priority and the Australian Medical Council has enhanced the focus on trainee wellbeing[5] in their revised standards (brought into effect from January 2016).

The Council of Presidents of Medical Colleges[6] (CPMC) is an intercollegiate forum where the heads of the specialist Colleges in Australia meet and share information.

Liaison between the CPMC and DHAS may represent a practical solution to the issue of welfare silos and an opportunity for a systemic, unified approach for all College trainees in the form of wellbeing curricula, welfare SIGs, welfare officers/advocates and collections of resources/supports. At the time of writing (October 2017), the Royal College of Physicians is conducting a summary assessment of what each college has in place for welfare support and this will be presented to the CPMC Chair for analysis. I have reinforced advocacy for this approach via email communication with the CPMC CEO, and have spoken directly to senior members

of the DHAS who hope to be involved in a cross-college approach.

Anaesthesia has done a lot of work with DHAS during the formation and evolution of the Welfare SIG, and has led the way with some of the solutions mentioned, however there currently remains potential for trainee-specific resources to be optimised.

WHAT IS CURRENTLY HAPPENING?

Work in this space includes a healthy mental workplace model ('Long Lives, Healthy Workplaces') being investigated and trialled at John Hunter Hospital (Newcastle) and Westmead Hospital (Sydney). This project has received funding from the ASA and other parties including the Hunter Institute. From what I can gather it builds upon similar principles to those advocated by the Beyondblue Headsup program[7].

Mental health is about wellness rather than illness and is not merely the absence of a mental health condition.

There is also a College Trainee Welfare Working Group spearheaded by my good friend and ANZCA Trainee Committee Chair Dr Maryann Turner, which will hopefully see results early next year.

In the meantime in my capacity as Trainee Members Group Chair I have collected and consolidated resources in an online repository, however this is unlikely to be given Board or Council approval for use on the ASA website prior to the college-based trainee project becoming active. However I share the main features/points of interest in this article. It also continues to serve as a resource for my hospital department.

The three main realms of welfare to be considered here are: general wellbeing (which applies to everyone), certain stressors relating to training and being a doctor (which will apply to most trainees), and more serious situations which hopefully apply in a minority of cases (mental health diagnoses, suicidal ideation, substance abuse).

GENERAL WELLBEING

Good mental health

This excellent summary of mental health comes from the Headsup resource document.

- Mental health is a positive concept related to the social and emotional wellbeing of people and communities. The concept relates to the enjoyment of life, ability to cope with stress and sadness, the fulfilment of goals and potential, and a sense of connection to others.
- Mental health is about wellness rather than illness and is not merely the absence of a mental health condition. Mental health exists on a continuum, or range, from positive, healthy functioning at one end through to severe symptoms of mental health conditions at the other. A person's mental health moves back and forth along this range during their lifetime, in response to different stressors and circumstances.
- Some symptoms indicative of people who may be at the 'red' end of the continuum include:
  - disturbed sleep
  - social withdrawal
  - feeling overwhelmed
  - feelings of hopelessness and worthlessness
  - reduced productivity
  - irritability
  - alcohol and drug use.
- Risk factors and protective factors influence mental health and can nudge people back and forth along the continuum.
- Risk and protective factors can be individual or related to family, work or other life circumstances. Risk factors may increase the strain on our mental health, while protective factors can counteract these by helping us to stay or become well.

Own GP

Rates of GP engagement amongst doctors in general is low (<40%[8]) however an *Anaesthesia and Intensive Care* 2013 survey revealed that 78% of the 38% of respondents did have a GP and visited them regularly. DHAS and ANZCA recommend having a GP and seeing them on a regular basis[9]. The fact is that we represent an at-risk group for stress and mental illness and we have a responsibility to ourselves, our patients and our loved ones to seek appropriate professional care as patients.

One issue is finding a GP who is used to dealing with doctors as patients, and the DHAS in your state can sometimes help with this (including working with you until a 'good fit' is found).

Exercise including corporate fitness programs

Regular exercise improves physical and psychological wellbeing and is probably one of the best ways to increase resilience and combat burnout[10]. The College of Intensive Care Medicine Welfare SIG has produced a nice one page summary of the benefits of regular exercise and some strategies for incorporating it into a busy schedule.

Some health services engage with corporate fitness programs where a discounted monthly fee is paid and staff are given access to a range of local health and fitness suppliers. Fitness Passport is one such program and is available in QLD and NSW.

Corporate wellbeing provision

This novel concept has been advertised by one recruitment agency[11] in response to the media coverage of doctors wellbeing this year. It may suit doctors who work in facilities without hospital or health service level supports. Registration with

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the agency grants a discounted rate to access an online survey by a corporate wellbeing company[12]. There is a follow-up phone consultation with a wellbeing coach and an assessment of current habits (diet, exercise, sleep, mood management, stress management) with a focus on patterns of thinking which may be preventing the individual from maintaining wellness. An action plan is discussed along with strategies for completion. The focus is on maintaining wellness, and not 'missing opportunities' for intervention.

Such activity is off the radar of insurance companies and so doesn't have implications for income protection (see later) – you are dealing with wellness coaches/councillors, not doctors or psychologists (however if appropriate they may recommend seeking assistance from your GP or other mental health professional). This sort of approach may be particularly useful during exams – having access to external guidance when studying may help with perspective and mindset[13]. Regular online assessments and a tailored plan to maintain wellbeing would also 'normalise' the concept of accessing help when needed.

Employee assistance programs (EAPs)

Programs for wellbeing likely exist through your hospital or health service and can be accessed by all employees. There may be advice and services to aid with wellness activities, smoking management, alcohol, drugs, mental health, men's and women's health, diet and nutrition, sexual health, staff health screening, emotional and spiritual support (including possible access to free counselling), financial fitness and health insurance.

It is worth noting that these sort of EAPs, while funded by the health service you work for, should be completely separate and confidential.

Income protection (IP)

Income protection comes in various forms from various providers. It's recommended to speak to a financial advisor before embarking on income protection purchases to ensure you are fully informed of the products out there.

Doctors often pay superannuation to a public sector super fund, which will provide limited forms of income protection. These funds often have substantially different benefits to private companies (which in turn tend to be more expensive).

There are four circumstances where you may require an insurance company to pay on a claim[14].

1. Income protection – monthly income payments
2. Trauma/crisis – payout
3. Death – payout
4. Total and permanent disability – payout

1. Income protection

- Replaces your monthly income if you can't work due to sickness or injury.
- Both private insurers and public super funds can provide this but what you want to know is:
  - Whether they look at base salary or tax returns (the tax returns show all the overtime and penalty rates you've worked, so you get more money if they use that).
  - Whether they will cover your whole salary or a percentage of it.
  - Whether there is a time limit for payments (e.g. two years vs until retirement).
  - How long you have to wait until you start receiving money.
  - Who administers the claim? A financial advisor? You?

2. Trauma/crisis

- Rather than referring to specific 'physical' trauma this actually encompasses a wide variety of events; the idea being that you receive a one-off lump sum if you are diagnosed with a serious medical condition (i.e. malignancy, MI, CVA). It also includes accidents resulting in physical injury.
- The payment permits you to take time to recover and not have to worry about finances.
- Note that public super funds may not provide this.
- Also note that not all policies will cover HIV/Hep B/Hep C contracted via needlestick injury.

3. Life insurance (death)

- This provides a one-off payment in the event of your death.
- It provides your family with financial support if you die and your income to the household is lost.

4. Total and Permanent Disablement (TPD)

- This provides a one-off payment in the event that you're rendered unable to work.
- For anaesthetists this means that if you are afflicted by a condition meaning you can't work as an anaesthetist, you could receive a payout (which, combined with your income protection, would assist you with living expenses until the age of retirement).
- Note that some public funds have vague definitions about being 'unable to work', meaning that although you may not be able to work as an anaesthetist, you may still be able to pack boxes for example.

Income protection and mental health discrimination.

An issue for trainees is seeking help around exam time (e.g. trouble sleeping, performance anxiety, even engagement with a performance psychologist if this is done via the GP) and then being penalised under 'mental health' clauses by the insurance provider. The simplest way to avoid this is to apply for income protection when you are healthy however there are avenues to pursue if you feel such restrictions are unjustified (see box on the right).

Online tools/apps

There are a raft of online and app-based mental health tools which cover everything from mood journalling and management and cognitive behavioural therapy to mindfulness. The efficacy of these apps is still being studied although the REEACT trial[15] found that computerised cognitive behaviour therapy to be no more effective than routine GP care. Some examples are "Treat" (mindfulness app developed by Alfred Health and aimed at healthcare professionals) and MyCompass from the Black Dog Institute – an online program designed to address mild-moderate stress, anxiety and depression.

ANAESTHESIA TRAINEE-SPECIFIC STRESSORS

A recent article[16] in *Anaesthesia and Intensive Care* summarised the top eight causes of moderate to severe stress for ANZCA trainees as being:

1. Studying for exams
2. Concern about future job prospects
3. Critical clinical incidents
4. Fear of making errors at work
5. Workplace-based assessments
6. Conflict with staff
7. Carrying out volume of practice
8. Conflict with patients

PUBLIC INTEREST ADVOCACY CENTRE (A STATEMENT FROM THE ORGANISATION)

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit law and policy organisation that since 2012, has provided legal advice and representation to people who have experienced discrimination, or otherwise been treated unfairly, by general and life insurance providers on the basis of a mental health condition.

Under federal and state disability discrimination laws, insurers cannot discriminate against a person on the basis of their mental health condition, including past, present, future and imputed mental health conditions, unless the discrimination is:

a. based on actuarial or statistical data that is reasonable for the insurance provider to rely on; and

b. the discrimination is reasonable having regard to that data and 'other relevant factors'.

If there is no statistical or actuarial data available or the data cannot reasonably be obtained, the discrimination must be reasonable having regard to 'other relevant factors'.

PIAC has identified systemic problems in the insurance industry, including a widespread practice of offering insurance with blanket mental health exclusions (that is, policies that refuse to pay in the event of a claim arising from mental illness) or declining to offer insurance on the basis of mental illness. PIAC argues that insurers must design, price and offer policies in a manner that is founded on robust evidence and contemporary understandings of mental illness.

If you think you may have been discriminated against or treated unfairly by an insurer on the basis of your mental health, PIAC may be able to assist you. Please contact Mary Flanagan, Senior Solicitor at PIAC on 02 8898 6509 or mflanagan@piac.asn.au for further information.

Potential strategies are outlined in the article with some suggestions below.

Exam preparation

Exam preparation can be assisted by having a study group, attending exam preparation courses[17] and planning for failure (i.e. formulating a plan B and ensuring that a strategy is in place for both potential outcomes – this may help reduce stress experienced on the day and the catastrophising that accompanies an unsuccessful result[18,19]). Maintaining a work-life balance is important as outlined in the Welfare of anaesthetists SIG document[20]. Some people find engagement of a performance psychologist helpful. Some trainees may find it beneficial to engage with a performance psychologist who can help with ensuring the best performance on the day.

Job prospects

The oversupply of graduates to the training medical workforce remains a problem and is the focus of ongoing discussion. Maldistribution has contributed to the perceived need for more doctors, but isn't necessarily remediated by the oversupply[21].

Both ANZCA and the ASA have dedicated portions of their respective websites which advertise jobs across Australia. Locum and recruitment agencies can also be a useful resource when gauging which regions require consultant anaesthetists.

Incidents or errors at work, WBAs and VOP

Ultimately department-based approaches are required to ensure that registrars are

FEATURE

well supported by senior colleagues, exposed to appropriate list variety (rostering) and consideration given to simulation training to train for crises which may be experienced out of hours (depending on the resources of the hospital).

Mandatory notifications

Fear over mandatory reporting is a current issue which can be a barrier to seeking help.

Some media reports[22] surrounding mandatory reporting of doctors imply that any doctor who seeks help regarding mental illness may be reported under the 'impairment' category.

The reality is that threshold for mandatory reporting is high. Being diagnosed with a mental illness, seeking support, substance misuse, etc are not in themselves reportable. Simply seeking treatment does not mean a practitioner's registration is at risk[23].

The process of mandatory reporting is under review at the time of writing this article.

MORE SERIOUS ISSUES

There are specific issues that can develop at the 'red' end of the wellbeing spectrum. These may not affect everyone, but they are important for all to be informed about.

Mental illness including mood disorders, depression, anxiety and burnout

In the beyondblue Survey 2013 doctors reported substantially higher rates of psychological distress, depression, anxiety and attempted suicide compared to both the Australian population and other professionals. They also suggested that doctors have more resilience to the negative impacts of poor mental health on their work.

It is interesting to note that the common scales used to assess depression or distress symptoms such as the Kessler and ProQOL scales aren't validated in doctors[24]. Kessler is validated for the general population and ProQOL for medical professionals in general.

The issue still stands that barriers to seeking treatment and support for a mental health condition exist including a fear of a lack of confidentiality or privacy, embarrassment, impact on registration and right to practice, preference to rely on self or not seek help, lack of time, and concerns about career development or progress.

Signs to look out for in yourself and others include certain verbal cues and behavioural signs.

Burnout (a syndrome with three core components: emotional exhaustion, depersonalisation and perceived lack of personal accomplishment) featured more highly in younger doctors and female doctors in the beyondblue survey[25]. It occurs early; medical students (when surveyed at the start of their studies) demonstrate better general wellbeing than the general population (when idealism is at it's highest[26]). Medical students have been shown to demonstrate symptoms of burnout within months of commencement of study[27] and the transition from study to work is another difficult time[28]. Senior peers sharing their experiences at the beginning of placements, and normalising the concept that "it's ok to struggle" at times may help combat this phenomenon[29]. There are also psychologists who specialise in helping doctors with burnout – again these can be difficult to find although a Canadian-based psychologist, Jason Brooks[30], has a variety of online resources accessible to all.

A brief history of doctor suicides

On the face of it there appears to be an increase in doctor suicides but it difficult to draw firm conclusions given that past and current evidence is patchy.

Difficulties faced in gathering data about suicides are:

1. Doctors who suicide aren't always recorded as suicides.
2. Doctors who suicide aren't always recorded as doctors.
3. The unregistered doctor is not always officially recorded as a doctor.
4. Subcategorisation of specialist doctors doesn't always occur (i.e. anaesthetists) as well as distinction between trainees and consultants.

These issues have been recognised from the time that epidemiological data began to be collected. Durkheim (1897) noted difficulties when trying to define what constituted suicide. In 1886 William Ogle presented to the Royal College of Physicians a report on the epidemiology of the health of doctors; this revealed the higher prevalence of suicide in the UK medical profession. P.H. Blachly published research on the topic of physician suicide in 1963 (USA) with a subsequent article by the *JAMA* in 1977 on strategies in prevention. In Australia, and more recently, the *beyondblue National Mental Health Survey of Doctors and Medical Students* (2013) and *Suicide by health professionals: a retrospective mortality study in Australia, 2001-2012* have been widely publicised.

Sadly a doctor's suicide may represent the first manifestation of a crisis, however in retrospect there may have been warning signs. Signs to look out for in yourself and others include certain verbal cues and behavioural signs[31]. Healthy workplace models advocate the awareness of these signs and strategies for intervention so that help and support can be given early on in the spectrum rather than 'opportunities missed'.

A major risk factor for suicide is the diagnosis of mental illness or substance abuse[32].

Substance abuse

Traditionally, opioids have appeared

to be the substance of choice for anaesthetists. Australian data from 2015 indicates that propofol and alcohol abuse have increased[34]. Female trainees had higher incidences of abuse in this survey. Psychiatric illness as well as family or financial problems were identified as being present in 70% of cases.

A major risk factor for suicide is the diagnosis of mental illness or substance abuse.

I don't claim to be an expert in mental health or substance abuse and a detailed outline of the interventions and treatments are beyond the remit of this article. However it is important to recognise that assistance and support come from multiple sources. As mentioned before there are state and national helplines. There are hospital and health service assistance programs. Departmentally there is the SOT, and allocation of welfare advocate roles are becoming more common. Mentor schemes are available to some, in various forms of evolution. Some specialities have a welfare special interest group, with the Welfare of Anaesthetists group probably being the most evolved at this time.

Welfare of trainee doctors at large needs a cohesive approach from colleges (top down), but it also requires a 'bottom up' culture of awareness and change to ensure that collegiality isn't replaced with Darwinism as competition for metropolitan jobs increases.

I would like to thank Associate Professor Alicia Dennis for her support of the concept of the 'welfare wiki' which was presented at the Perth NSC Council meeting, and my colleague Dr Simone Fagan whose ongoing commitment to trainee welfare and contributions to the wiki have been invaluable.

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SUPPORT/HELPLINES

Lifeline – Suicide and crisis support

- **13 11 14**

beyondblue

- An Australian, independent non-profit organisation working to address issues associated with depression, anxiety disorders, and related mental disorders.
  1300 22 4636 (24h help line)
  Also provides interactive online chat facilities between certain hours
  Online forums and email responses within 24 hours.

Black Dog Institute

- A translational research institute that aims to reduce the incidence of mental illness and the stigma around it, to actively reduce suicide rates and empower everyone to live the most mentally healthy lives possible.
  Not a crisis support service

Doctors Health Advisory Service
http://dhas.org.au/

- Offers state based telephone helplines for doctors and medical students.

FEATURE

THEORIES OF STRESS IN ANAESTHESIA PRACTICE

There are several member enquiries to Professional Issues Advisory Committee throughout the year that relate to welfare issues and the stress of anaesthesia practice. People often feel isolated and vulnerable, and reach out for help. These issues have been considered extensively in the occupational health and safety literature and it may be useful to review these theories and the concept of resilience, writes Antonio Grossi.

Stress is the physical and emotional reaction to a perceived demand or threat that exceeds the ability to respond regarding something considered important[1]. The body of knowledge of occupational stress has arisen in the sociocultural context of the human experience over the past fifty years. Stress is a recognised component of anaesthesia practice[2]. Describing and evaluating theories of stress may lead to an action plan to research ways to reduce, mitigate and manage stress in the anaesthesia workplace.

IMPORTANCE

The importance of occupational stress is reflected by its widespread prevalence and the increased costs due to lost productivity and managing stress related illness[3]. Individual consequences include impaired health and performance manifesting as mental illness[4], hypertension[5], coronary heart disease[6] and job insecurity[1].

It follows that in anaesthesia, where expectations of perfect outcomes prevail[7], occupational stress would be significant[8]. Professional burnout[9], disproportionate drug addiction[10] and suicide[8], have been attributed to the high stress levels in anaesthesia. One should not confound the effects of stress with the sources of stress[11].

HISTORICAL SOCIOCULTURAL CONTEXT

As work practices evolved from industrialisation utilising production lines, through to service, and then knowledge based industries, the notion of occupational stress also evolved. Through the 1960s and 1970s the Western world enjoyed material prosperity, which allowed questioning of social values, the rise of social justice, feminism, democratisation and other social reforms[12]. This permitted people to question work-life balance and occupational stress. At the plenary session of the 76th ASA NSC in Perth (2017), Professor Bruce Robinson discussed the importance of making adequate time for family, self and community in addition to work, to maintain a psychologically healthy life.

RECOGNISING STRESS

The physical, psychological and behavioural symptoms and signs of stress are well described[13]. Eustress describes positive states where some stress can improve the physiological, psychological and cognitive state to improve performance and well-being. Beyond a certain point, increased stress is known to decrease performance, impair cognition, recall, communication and produce errors and adverse outcomes[14]. Identifying this 'tipping point' and appreciating that it varies depending on the person and their environment remains important.

THE RISE OF INDIVIDUALISM AND PERSONALITY THEORIES

The role of people's self-efficacy and predetermined attitudes, behaviours and dispositions were studied in the 1970s in relation to work stress[12]. Friedman[15] described the type A personality as hurried, impatient, aggressive and prone to cardiovascular disease. Type B personality types tend to be more relaxed. Type A people were more likely to be stressed. It has also been suggested that having a moderately internal locus of control is most protective as a stress buffer[16]. Work was seen as a human endeavour that overloaded some people's capacity because they lacked resilience.

RESILIENCE AND COPING

The notion of resilience allowed researchers in the 1980s to look at coping strategies that could be employed to deal with occupational stress. This progressed to several studies aimed at preventing occupational stress in healthcare workers. Routsalainen[17] found "low-quality evidence that cognitive-behavioural training and mental and physical relaxation reduces stress more than no intervention and… changing work schedules may reduce stress." This is possibly the best evidence available summarising 58 studies, including 7,188 patients. It highlights the difficulties of comparing different populations assessed by different tools and interventions. There may be some elements of anaesthesia such as professional autonomy, job challenge and high satisfaction that mitigates stress[11].

THE NORDIC AND EUROPEAN EXPERIENCE

In contrast to this individualistic perspective, throughout Northern Europe there was a progressive research agenda coupled with a social democratic movement from the 1960s and 1970s, which focused on social equality[12]. Collaboration between social, psychological and health sciences, lead to the concept of 'worker alienation' resulting from being under-stimulated, not participating in decisions and not being meaningfully engaged, reducing occupational pride[18]. Extending this humanistic approach, the 'holistic workplace' would ideally provide task variation, continued professional development, autonomy, social support, meaningfulness and future security. Anaesthetists are fortunate that as autonomous professionals working in a complex adaptive system[19], many of these requirements seem to be fulfilled. However, closer examination reveals that lack of control, production pressure, lack of resources, inadequate support and job insecurity are substantial sources of on-going stress[11].

Throughout the 1980s and beyond, workplace stress became less of a political issue and more of an occupational health and safety issue. The focus shifted to maintaining a healthy workplace and productivity.

PERSON-ENVIRONMENT FIT: THE COGNITIVE-MOTIVATIONAL-RELATIONAL THEORY

Maintaining productivity may have been why the US air-force supported Lazarus' original research into occupational stress[12].

Increased stress is known to decrease performance, impair cognition, recall, communication and produce errors and adverse outcomes.

This notion proposes that stress is due to the dynamic nature of the 'fit' between the individual and their environment or job. It goes beyond identifying potential stressors, personality types or socio-political systems, which may promote stress. Lazarus[20] describes three key elements: transaction, process and personal meaning. Transaction refers to the dynamic nature of the environment's effect on the person, the person's effect on the environment and the fluidity of this interaction. For a situation to be stressful the individual needs to have something important at stake. This is consistent with Hobfoll's conservation of resources theory[9]. There must also be an ongoing appraisal process that evaluates the external and internal demands compared with the resources available to meet those demands. The process involves a person's psychological state, which changes over time and across different situations. The personal meaning attributed to these challenges and threats are contextually dependent. The primary appraisal relates to what is personally and professionally at stake. The secondary appraisal relates to the balance of power between demands and coping mechanisms[21].

COPING AND OTHER OCCUPATIONAL STRESS THEORIES

Coping has been defined as the cognitive and behavioural efforts to manage excessive demands[20]. It is a dynamic, problem-focussed and emotionally invested strategy. It can involve avoiding the source of distress or dealing with its significance. The meaning of stress can be dealt with by denial, distancing or positive mindfulness. Adaptive coping can have positive long-term emotional, social and physical effects. Anaesthetists may require

FEATURE

different coping mechanisms as they transition through their careers[7].

The 'Beehr-Newman model'[3] describes various environmental stressors acting on the individual strains through time being influenced by various environmental and personal moderators, which lead to adaptive responses and organisational consequences. Some of the key stressors studied include uncertainty, role ambiguity and conflict, job demands, job security, organisational culture and structure, relationships and external factors.

Developing strategies to deal with the anaesthesia workplace has the potential to benefit the patient, the anaesthetist, other staff and be cost-effective.

A SYSTEMS APPROACH TO OCCUPATIONAL STRESS

LaMontagne[4] postulates that protecting and promoting mental health in the workplace requires a comprehensive, systems-based preventive approach, rather than isolated individual efforts. This includes: a) primary interventions to reduce stressors such as correcting demand-control imbalance and improving social supports; b) secondary interventions that alter the way people perceive or respond to stressors including cognitive behavioural therapy, relaxation techniques, anger management and screening for physical disease and; c) tertiary interventions that treat, compensate and rehabilitate for stress-related illnesses. This multidisciplinary approach incorporates organisational psychology, occupational health and safety, medicine and health promotion. Directing the interventions upstream and targeting healthy behaviours such as physical activity, nutrition, reduced alcohol consumption and smoking are effective ways to reduce people's further vulnerability to stress and its consequences. Participation by those directly affected permits a meaningful, contextually appropriate intervention and is consistent with international guidelines[22].

CONCLUSION

It is important to consider the emotions and behaviour involved in the individual's response to environmental stressors, not just the stress itself. The complexity of dealing with occupational stress is reflected by the multidisciplinary theories that have evolved in their sociocultural, historical and political context. Developing strategies to deal with the anaesthesia workplace has the potential to benefit the patient, the anaesthetist, other staff and be cost effective.

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BRIDGING THE ELEMENTS

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FEATURE

OUR STATUS – A TRAINEE'S PERSPECTIVE

Anaesthesia is relatively young as a medical specialty. In Australia, we've had a Society for 83 years, formed a Faculty 65 years ago, and our College is currently celebrating 25 years. Over this short time, we have grown into one of the largest specialist medical colleges in the nation. It's not surprising that this process has presented numerous professional challenges.

While I'm far from an expert on the issues facing our specialty, my views as a trainee looking forward to a long career in anaesthesia may differ somewhat from other voices. I find it's easy to subconsciously assume that after a tumultuous past, we have reached the final stage in our professional evolution and that the nature of our working lives now is essentially how it will look for the rest of our careers – in much the same way as it's easier to accept how different I was as an individual 5 years ago than to accept that I am will likely to be just as different five years into the future. It would be naïve to think that our biggest challenges are behind us. By anticipating the problems awaiting us, we can be prepared and mitigate their impact – or prevent them from arising at all.

I recently attended the 2017 Association of Anaesthetists of Great Britain and Ireland Group of Anaesthetists in Training Annual Scientific Meeting in Cardiff. Between sessions I had the opportunity to discuss with trainees from across the pond the current and future roles of anaesthetists. In many areas, healthcare in Australia has historically tended to follow the British system, thus providing us with a window into potential challenges and opportunities we may face down the track. A trainee from the European Society of Anaesthesiology also shared some particularly interesting insights into the differing status of anaesthetists internationally, many of which tie into current discussions regarding the future of our profession.

EDUCATED EXPERTS

It's no secret that anaesthetists are still not universally recognised as highly-qualified medical specialists. While this attitude may have arisen historically, from the nature of our work being more practical than academic, alongside our youth as a truly independent specialty, it's disappointing that it persists today. Surgeons have successfully risen above their former brutal reputation and many still use titles other than 'doctor' with pride. Even small, subtle behaviours reflect the pervasive views of our status – yesterday I transported a patient to recovery with completed anaesthetic charts, medication charts and fluid orders, only for the nurse to comment that there were "no doctor's notes", referring to the surgeon's postoperative

orders. I don't find this to be a particularly uncommon occurrence.

The importance of perceptions highlights the vital importance of our pursuits beyond the operating theatre. Not only can these advance anaesthesia and medicine in general, but they are also vital in reinforcing our image as educated experts. If we treat our work as though we are simply technical service providers then that's how we will be seen, both by our colleagues and the wider community. A Croatian colleague shared with me his frustrations at the lack of respect anaesthetists receive in his country, where anesthesiologists tend to be viewed and treated as technicians rather than medical specialists. This undervaluing is associated with a disregard for their medical expertise; they are frequently removed from perioperative decision-making processes and serve at the whim of surgeons. He described multiple cases of facilitating surgery he knew to be futile, and rather alarmingly of being unable to convince surgeons to perform necessary procedures. To elevate our standing above that of technical service providers, it's critical that we continue to engage in activities that highlight our roles as specialist clinicians, academics, educators and managers.

We are fortunate that the Australian anaesthetic community is seen as a world leader in this regard. Throughout the meeting I attended in Cardiff, speakers made repeated references to research and advocacy work undertaken in Australia. We are definitely punching above our weight on a global scale, which helps strengthen our image both internationally and locally.

WHAT'S IN A NAME?

Our UK colleagues are having the same discussions I have seen locally, regarding a potential name change from anaesthetist to anaesthesiologist. The rationale behind this is sound – to highlight the academic nature of our discipline, it seems logical to adopt a suffix derived from the ancient Greek '*logía*', denoting the study of something, in place of simply '*-ist*', indicating 'one who does or makes.' Such a change would bring us into line with naming conventions across most of the international anaesthesia community (even though the spelling of anaesthesiologist can't be agreed on) and most other specialist medical colleges. It would also differentiate physician anaesthetists from non-physician anaesthetists, which is how the terms are often used in settings where anaesthesia is commonly delivered by nurses or technicians.

As practical as this may seem, it begs the question – does it matter? Would it actually impact on public perceptions? The association of '*-ologists*' as the most educated in a field is far from consistent. People understand the difference between astronomers and astrologists because those are standard terms, not because of any conscious etymological considerations. Likewise for psychiatrists and psychologists, or pharmacists and pharmacologists. Indeed, it is well understood that scient-*ists* are educated academics despite being physic-*ists*, chem-*ists*, biolog-*ists*, and so forth. Changing a name is reasonable where good reasons exist to do so, however, we should keep our expectations realistic. Should we suggest that intensivists rebrand as intensivologists?.

NON-PHYSICIAN ANAESTHESIA PROVIDERS

The role of non-physician anaesthetists varies greatly around the world. From the anaesthetic technicians and nurses who are vital for anaesthesia provision in the developing world, to the sizeable and influential body of Certified Registered Nurse Anesthetists in the US, and the few hundred Physicians' Assistants (Anaesthesia) in the UK. The potential merits and drawbacks associated with various approaches to the role of non-physician anaesthetists is too large a topic to deal with in this brief piece, however, it is clearly a topic worthy of careful consideration. Whether we embrace it, oppose it, or cautiously observe its progress, we can't ignore its development. Given that modelling predicts the anaesthetic workforce in Australia is "in balance, with the potential to shift into oversupply,"[1] perhaps it will remain an unrealised possibility in the foreseeable future.

WHAT NOW?

Trainees should be as interested as anyone in the evolving role of anaesthetists. The changes currently occurring in our profession will impact on our working lives for decades, for better or worse. If we want to have a say in how our practice will look in five or ten years' time then we need to be active and involved today. I encourage everyone to think about these issues and others, such as the potential shift towards greater anaesthetist involvement in perioperative medicine, our environmental impact and the mental health of anaesthetists. In particular, I encourage other trainees to engage with issues of importance to you – voice your opinion and influence the direction in which we move.

Richard Seglenieks
BMedSc(Hons) MBBS MPH

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FEATURE

ASA Economics Advisory Committee Chair, Dr Mark Sinclair presenting to a full house of PMC delegates

ASA PRACTICE MANAGERS' CONFERENCE – BRISBANE

This year's ASA Practice Managers' Conference (PMC) was held on 14 September 2017 at the Oakwood Hotel in Brisbane. With 48 delegates, it was a record-high turnout for a PMC in Brisbane.

The meeting began with the Chair of the ASA Economics Advisory Committee Dr Mark Sinclair, thanking the sponsors: Avant Mutual Group, MillerBiller, Medical Business Systems, Direct Control and MediTrust, for their support of the PMC.

In his opening lecture, Dr Sinclair provided a significant update on the MBS Review and highlighted the tremendous advocacy efforts of the ASA so far, for a fair and equitable review of the anaesthesia RVG. Not surprisingly, this sparked lots of discussion and questions from the delegates – about the potential implications of the MBS Review Taskforce's recommendations.

Developments in the realm of private health insurance were talked about. These included various publications about surgical variance by Medibank Private, in conjunction with the Royal Australasian College of Surgeons; the rise of doctor-rating sites like 'Whitecoat' (a joint initiative between nib, Bupa and HBF); and the ASA submission to the current parliamentary senate inquiry into the value and affordability of private health insurance and out-of-pocket medical costs.

The policy team delivered a presentation on the busy and dynamic nature of the work handled by the ASA policy team – providing micro and macro insights.

Firstly, we reflected on the commonly asked RVG item number queries received during the past year, by providing case studies on the appropriate use of items for consultations, after-hours emergencies, time, nerve blocks, epidurals and caesarean. The delegates came away with a better understanding of how to proceed with billing MBS items in-line with their descriptors and associated rules. On a macro-level, we briefed attendees on the changing attitudes towards the private health insurance industry – especially of the younger demographic. Considering the high publicity given to the value of rising health premiums, we discussed current ACCC allegations against nib and Medibank Private for their alleged unconscionable and misleading conduct.

Special attention was also given to recent achievements spearheaded by the ASA policy team. Engagement with key stakeholders has been a paramount

endeavour for the ASA, especially in light of the MBS Review, as well as for various professional and economic issues faced by our members. These efforts culminated in numerous face-to-face meetings with Federal Health Ministers (Sussan Ley and now Greg Hunt), the Commonwealth Department of Health, and the Australian Competition and Consumer Commission. In expanding our focus on local state and territory issues, we have set out to establish links with all the health ministerial offices around Australia. This led to a face-to-face meeting with the NSW Health Minister, Brad Hazzard, with whom we discussed topical matters related to mandatory reporting, workforce and public/private hospitals.

Moreover, numerous submissions have been lodged throughout the year that have advocated a safer and fairer deal for our members and their patients. These were directed to the Senate inquiries into the medical complaints process and the value of private health insurance; the skilled occupations list for the removal of anaesthetists from the eligible occupation visa programs; and the Medical Board of Australia consultation on revalidation.

The mid-morning session commenced with a presentation by Annabel Herron from Avant Mutual Group. She discussed the rising trends in identity theft and privacy breaches. We were further briefed on the upcoming changes to the privacy laws, which includes the mandatory reporting of any serious breach of confidential patient medical records.

Emma Norman from Associated Anaesthetists, on behalf of Mark LaForest from Medical Business Services, outlined her experiences in using SMS messages to communicate with patients at her practice. She explained how the SMS system can be used in setting up payment reminders for pre- and post-operations, as well as provide informed financial consent to patients.

Lilian Kikuvi from Medibank Private described the extensive work her team has done, in partnership with the Australian Association of Practice Managers – creating new tools to assist with billing practice management. These include the introduction of 'Live Chat' (a web-based communication tool); development of a PHI training manual (generic overview of pre- and post-hospital topics) and the national launch of their Eclipse campaign (electronic claims management system).

The afternoon Q&A session was conducted by Lexie Harris (Wesley Anaesthesia and Pain Management); Cheryl Wood (Associated Anaesthetists) and George Sotiris (AMA Queensland – Workplace Relations). Delegates were well engaged by open discussions about staffing their practices; addressing bullying and harassment; training opportunities and changes in award rates.

Presentations from the day can viewed in the 'Education and Events' members section of the ASA website.

Overall, the feedback from delegates about the PMC has been resoundingly positive. Many took delight in the social networking opportunities, and praised the variety of topics covered during the PMC. Acknowledgement must be given to Jade Melville, for her superb efforts in organising an excellent conference that was enjoyed by all. We look forward to hosting more practice managers at next year's PMC.

Elaine Tieu
ASA Policy Officer

Practice managers Lexis Harris (Wesley Anaesthesia and Pain Management), Cheryl Wood (Associated Anaesthetists) with Dr Mark Sinclair (EAC Chair), George Sotiris (AMAQ), Chesney O'Donnell (ASA Policy Manager) and Elaine Tieu (ASA Policy Officer) at the afternoon Q&A session

Annabel Heron (Avant Mutual) pictured left, presented on recent privacy law changes

Lilian Kikuv introduced new initiatives by Medibank Private to assist practice managers

FEATURE

ASA 76TH NATIONAL SCIENTIFIC CONGRESS PERTH 2017

The 76th National Scientific Congress (NSC) was held in Perth in October – 10 years since the last NSC was held in Perth. Convenor Dr David Law reflects on a very memorable and educational meeting.

The ASA NSC, themed 'Bridging the Elements' of Anaesthesia, took place at the Perth Convention Centre from the 7th-10th of October 2017. The Scientific Convenors, Dr Daniel Ellyard and Dr Dale Currigan, along with the Local Organising Committee, did a marvellous job of covering as many topics of anaesthesia as possible over the course of three-and-a-half days, with outstanding plenary sessions, three lecture streams consisting of 'Bridging Science and Outcomes', Refresher and Special Interest Group sessions, as well as Workshops and Small Group Discussions.

The Invited Speakers were Professor Michael Avidan (University of Washington, St Louis), Dr Philipp Lirk (Harvard University), Professor Avery Tung (University of Chicago) and Professor David Story (University of Melbourne). Associate Professor Marjorie Stiegler (University of North Carolina) was one of the initial invited speakers, but she could not attend due to family illness. Professor Avery Tung, a collaborator of Associate Professor Stiegler, was her able replacement.

The NSC took off to a flying start with two inaugural pre-Congress workshops on Friday morning. Both ACWA (Airway Cadaver workshop of WA) and CRASH (Critical care Resuscitation Airway Skills Helping you return to work) were well subscribed and highly successful. Feedback from these courses was overwhelmingly positive and both will be held annually in WA in the future.

Associate Professor David M. Scott, President of ASA officially opened the NSC on Saturday morning. We were also welcomed to the country by Alton and Olman, Noongars from the local Pinjarra tribe.

Professor Bruce Robinson, a respiratory physician, founder of the 'Fathering Project', author of the best-selling book *Fathering from the Fast Lane* and former

West Australian of the Year delivered a memorable and heart warming Kester Brown Lecture. He gave insights and strategies for attaining and maintaining a balance between work and family life commitments. With many delegates travelling across the country or overseas to attend the NSC it was a timely reminder of how the nature of medical work can slowly envelope other aspects of our lives.

All the invited speakers also delivered very interesting and insightful lectures in their respective plenary sessions.

Professor Avidan identified the cognitive fallacies in research and strategies for debiasing techniques whilst highlighting the importance of reproducibility of methods, results and inference. He encouraged open research practices with involvement of academic adversaries in the development of robust study protocols to drive quality practices.

Dr Lirk highlighted how digital technology has entered every aspect of life and its potential to change anaesthesia and medical practices for the future. With the growth and development of wearable data collection devices, patients are now able to contribute to their own data collection. He stressed the 4P's of the medicine of tomorrow – Predictive, Preventative, Personalised and Participatory.

Professor Tung spoke on 'Non-rational Factors in Medical Decision Making', discussing how powerful gut feelings and instincts are in our everyday medical decision-making. He described how regret and responsibility influence our decisions, especially in situations where no evidence exists, and may explain differing priorities between surgeons and anaesthetists. He stressed the importance of metacognition ("thinking about thinking") in your decision making process.

Professor Story gave a stimulating and thought provoking plenary titled 'Wot I Learned in Books'. No doubt an avid reader, Prof Story provided important lessons and wisdom from his own bookshelf that apply to the contemporary practice of anaesthesia.

Clinical Professor Neville Gibbs, immediate past Editor-in-Chief of *Anaesthesia and Intensive Care* presented the Pioneer Lecture on Monday morning, in honour of Dr Peter Brine, a past ASA president and local pioneering paediatric anaesthetist in Perth. In his lecture titled 'Truth, the Whole Truth, and Evidence Based Medicine', Professor Gibbs was able to show that most anaesthetists in Australia and New Zealand are not named "David", despite the ASA, ANZCA and NZSA Presidents, NSC Convenor and one of the invited speakers sharing that name. Congratulations to Professor Gibbs who was awarded the Ben Barry Medal for his many years of contribution to *Anaesthesia and Intensive Care* as editor and Editor-in-Chief.

There were also many local, interstate and overseas speakers and facilitators involved in making the NSC a very successful one. The topics presented were highly varied and interesting, making it nigh on impossible to decide which session to attend everyday. The workshops and SGDs also allowed many delegates to complete their CPD requirements.

The social program, designed by Dr Divya Sharma and Dr Paul Kwei, was the talk of the NSC and arguably the best one ever. The Friday evening welcome reception was well attended with delegates enjoying scrumptious food (shucked oysters were in abundance and greatly appreciated!) and WA wine whilst taking in the expansive views over the Swan River and catching up with old friends.

On the Saturday evening the Health Care Industry Drinks were held in the very well designed and intimate Exhibition Hall. A local providore, The Blue Cow Cheese Company, also provided an impressive smorgasbord of delicious WA cheeses, quince paste and artisan biscuits in the centre of the hall. A jazz trio serenaded delegates and industry personnel as they socialised in the relaxed atmosphere.

This was the first NSC to hold the Gala dinner on the Sunday evening, which was inclusive for weekend registrants. As a result, over 600 people enjoyed a spectacular extravaganza – A Song of Fire and Ice. Guests were greeted by an ice sculpture of a dragon head, a roving pair of 'ice' and 'fire' stilt walkers – complete with a flaming torch – and cocktails to match the theme. Two drummers, dressed as Dothraki fighters, accompanied by the *Game of Thrones* theme music, led the guests into a ballroom bedecked like the banquet hall of a medieval castle, complete with a dragon, wrought iron candelabras and banners from the great houses of Stark, Lannister and Targaryen. Guests were entertained by two fire-eaters, although there was some disquiet about the possibility of an airway burn in one entertainer! The medieval throne-styled photo booth proved popular and the amazing 'Little Belle' Band kept the crowd on the dance floor, boogying the night away.

Rohan Jewellery generously designed, sourced and donated an exquisite pink diamond and pearl pendant worth $10,000 for a raffle draw. Thanks to delegates who bought 250 tickets, raising $25,000 for Lifebox Australia and New Zealand. A very lucky Dr Deborah Watson was the winner of the pendant.

On Monday, A Night in the Park was held in the State Reception Centre, Kings Park with magnificent views over the city of Perth and the Swan River. Preceding this event, guests were able to take a tour of the Botanical Gardens and enjoy the iconic wildflowers in their spring bloom. This was also a well-attended function with guests of all ages enjoying the interaction with the koala, lizard and two snakes. Children were kept entertained with a face painter and balloon artist, while the magician mesmerised everyone with his tricks.

FEATURE

Guests enjoyed the delectable Indonesian and Spanish cuisines as well as substantial canapés and, of course, wine as they watched the sunset across the river in a convivial atmosphere.

This NSC achieved a few 'firsts' and some new records as well. It was the first time the CRASH workshop ran in Perth. It was also the first ever anaesthetist-led cadaver airway workshop in Australia. To encourage delegates with young families to attend, this was also the first NSC with a parents' and baby room as well as on-site crèche facilities. We also achieved the equal highest number of trainee delegates, equal to that seen in Hobart in 2012. A further $10,000 was donated in lieu of speakers and delegates' gifts, providing Lifebox Australia and New Zealand with a sum of $35,000 in support of their work in Developing World Countries.

On behalf of the Local Organising Committee, I want to thank everyone who attended and supported the NSC. The NSC also could not have happened without the amazing support of the many speakers and facilitators who freely and generously gave up their time to educate all the delegates. Thanks must also go to our medical student volunteers from Notre Dame University and University of Western Australia, who played a key role in the workshops as models.

I also want to thank our Gold Partner Seqirus, session sponsors, equipment sponsors and exhibitors for making the Exhibition hall a very lively place during the breaks. A meeting of this size does not run smoothly without the logistical support of our Professional Conference Organisers, Mr Taylor Bow, Ms Kristi Parker and the team from Encanta Events Management.

My thanks also go to Dr Piers Robertson (NSC Officer), Dr David Elliott (Federal Scientific Program Officer and ACE Chair), Ms Denyse Robertson and the ASA Events Team.

Finally I want to acknowledge the wives, husbands, partners and children of the Local Organising Committee. We would not have been able to organise this Congress without their continual unwavering support in the last three years. I want to make special mention of my wife Maryann, who has almost single-handedly raised our three-year-old boy whilst I attended to the organisation of the NSC.

It was great fun convening the NSC with an amazing group of people from the Anaesthetic Department at Sir Charles Gairdner Hospital who have become my very good friends over the course of the last three years.

ASA President David M. Scott officially opens NSC 2017

Welcome to Country, Alton and Olman, Noongars from the local Pinjarra tribe.

David Law, convenor, NSC 2017

David M. Scott presents Bruce Robinson with the Kester Brown Medal

Invited International Speaker Michael Avidan

Invited International Speaker Philipp Lirk

Invited International Speaker Avery Tung

Invited Australasian Speaker David Story

Neville Gibbs presents The Pioneer Lecture

Zeev Goldik, President of the European Society of Anaesthesiology

Jeffrey Plagenhoef, President of the American Society of Anesthesiologists and David Kibblewhite, President of New Zealand Society of Anaesthetists

Scientific convenors Dale Currigan and Daniel Ellyard

2017 AWARDS, PRIZES & RESEARCH GRANTS

WINNERS ANNOUNCED

Kevin McCaul Prize

Dr Julie Lee

Rotational Thromboelastometry (ROTEM) in Obstetrics.

Jackson Rees Research Grant

Dr Alwin Chuan

A coordinated bundle of clinical and educational interventions, led by anaesthetists as perioperative physicians, reduces the risk of delirium in at-risk hip patients by 40% compared to existing care.

Gilbert Troup ASA Prize

Dr Rochelle Ryan

Does cefazolin prophylaxis during elective bariatric surgery achieve therapeutic concentrations in plasma and interstitial fluid?

ASA Best Poster Prize

Associate Professor Philip Peyton

Performance of a latest generation prototype capnotracking system for non-invasive cardiac output monitoring in major surgery.

ASA Trainee Best Poster Prize

Dr Dinushka Kariyawasam

Post-operative outcome among patients undergoing elective hip and knee joint replacements – impact of pre-operative anaemia.

The Ben Barry Medal

Dr Neville Gibbs

Dr Neville Gibbs has been an Editorial Board member and Editor since 2003, and the Chief Editor since 2009. He retired from his Chief Editor role on June 30, 2017, but will be continuing as an Editor and Board Member of the Journal.

During his tenure as Chief, Neville has overseen very significant and positive evolution in various aspects of the Journal's production and management, and has successfully navigated some very significant challenges. He has maintained and strengthened both the national and international profile of the Journal, while continuing to be a very fair and effective editor, leading by example.

Neville has contemporaneously served in a number of other prominent and busy roles including Head of Department at Sir Charles Gairdner Hospital, Clinical Professor in the School of Medicine and Pharmacology of the University of Western Australia, Chair of the Australian and New Zealand Tripartite Anaesthesia Data Committee, Chair of the WA Anaesthetic Mortality Committee and Chair of the ANZCA Mortality Subcommittee. Any one of these would be impressive enough, but to be simultaneously involved in so many leadership and research activities is truly remarkable.

Jeanette Thirlwell *Anaesthesia and Intensive Care* Best Paper Award

Y.C. Bong, J. Walsham

Systemic anticoagulation related to heparin locking of non-tunnelled venous dialysis catheters in intensive care patients.

FEATURE

ASA WELCOME DRINKS


Guests at the welcome drinks


Christopher Bryant, Sue Lawrence, Lorraine and Graham Bruce


Immediate past chair of the ASA TMG Scott Popham with trainee anaesthetists


Jim Troup with fellow delegates


New Zealand visitors


Exhibitors enjoying a catch-up


Having a chat


Fiona Sharp, Fiona Kilpatrick and Matt Sheminant


Industry reps chatting to attendees


Cheers!


Scott Ma and Andy Pybus


Exhibitors mingling with guests

PRESIDENT'S COCKTAIL RECEPTION


Michael Avidan, Avery Tung, Guy Christie-Taylor and Simon Macklin


Vice President of ASA Peter Seal with CEO Mark Carmichael


Rod and Margot Westhorpe, Joanna Macklin, Libby and Piers Robertson


David Law, David Borshoff and Alwin Chuan


Simon Reilly and Jim Bradley


Matt Brbich, Kate Wessels and Diyva Sharma


Marc Gheeraert, Executive Manager, European Society of Anaesthesiology, David Story and Zeev Goldik President of the European Society of Anaesthesiology


Lynaire Kibblewhite, Georgia, Monica and John Loadsman and Liz Feeney


ASA President David M. Scott, President of the AMA Michael Gannon, past president ASA, Richard Clarke and President of ANZCA David A. Scott


Guy and Sue Christie-Taylor, Neville and Jane Gibbs


Jane and Richard Grutzner


Chris Bowden, Suzi Nou and David Prescod

FEATURE

ASA GALA DINNER


ASA President David M. Scott with the NSC 2017 Organising Committee


Performer with dinner guest


Pre-dinner drinks


Delegates mingling


Congratulations to Dr Deborah Watson who won the diamond necklace in the Lifebox raffle


Making a grand entrance


Admiring the ice sculpture


Setting the scene


Fire eaters


Guests enjoy the atmosphere


Having a laugh


Mark and Anita Sinclair


Dressed for the part


Jim Bradley, Carolyn Crabb, David Borshoff and Gail Bradley


Visitors from Singapore

Catching up with friends


Greg Deacon and Anna Granger with fellow delegate


Smiles all round


Guests with Dothraki fighters

FEATURE

Catching up with friends


Ice sculpture


Simon and Jo Macklin


Victor Fesaitu and wife Luisa Bula from Fiji


Guests mingling


David Knott and Jenny King with their daughter Maddie


Relaxing with colleagues


Wai Nung Tong, James H.W. Lui with fellow delegate


Trainee members enjoy the evening


All smiles at the gala dinner


Delegates hit the dancefloor

A NIGHT IN THE PARK


A friendly face


Getting hands-on


Watch closely!


Delegates enjoying a chat


Family fun


Jenny King, State Chair for Victoria with fellow delegate


Families enjoying the day


Stewart and Gaye Booth and Godfrey and Janine Williamson


Pick a card


Delegates with Ali Ammar Beck, NSW State Chair


Neil and Ann Warwick


Executive editor AIC journal Linda Weber and Peter Harbison

FEATURE

SESSIONS & WORKSHOPS


Michael Avidan


Stephan Schug asks 'Are all opioids created equal?'


Philipp Lirk


Ben Piper speaks on Anaesthesia and Technology


Off to another workshop


Major Daniel Weber speaks about AME on the battlefield


Getting hands-on


Jeremy MacFarlane talks about teaching in private practice

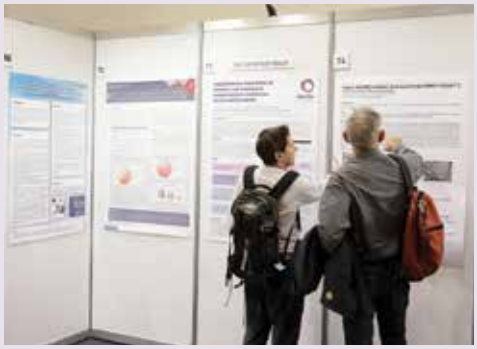
Hannah Seymour


Interested audience at a session

Sponsored session presented by Marcus Skinner


Michael O'Hanlon, Welfare SIG session


Workshop


Checking out the posters


David Story


Avery Tung


Concurrent session


Stephanie Phillips


Andrew McGregor

Lindy Roberts, Bob Smith, Philipp Lirk


Cat Goddard

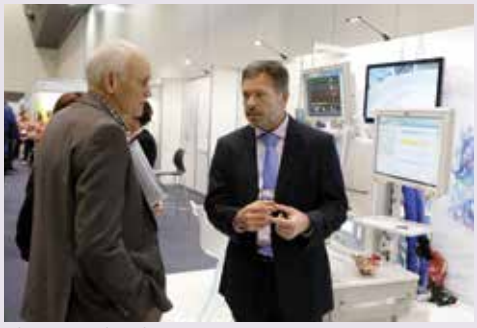

Prani Shrivastava


Rob Nicholls


Audience participation

FEATURE

EXHIBITION & EXHIBITORS' DRINKS


Chatting with industry rep


Getting hands-on


Australian Defence Force recruiting


Checking out some new products


New products on display


Checking out the booths


Entertainment at exhibitors' drinks


Time for a chat


Catching up with friends

Kameel Marcus, winner of the travel voucher


Enjoying exhibitors' drinks


American Society of Anesthesiologists President Jeffrey Plagenhoef with delegates

AAGBI GROUP OF ANAESTHETISTS IN TRAINING

ANNUAL SCIENTIFIC MEETING 2017

Dr Andrew Klein lectures prospective primary examination candidates

Sunny, warm, and even 'too hot' is not how one usually describes Cardiff, yet I heard all of these within my first hour at the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and Group of Anaesthetists in Training (GAT), Annual Scientific Meeting (ASM) – in July.

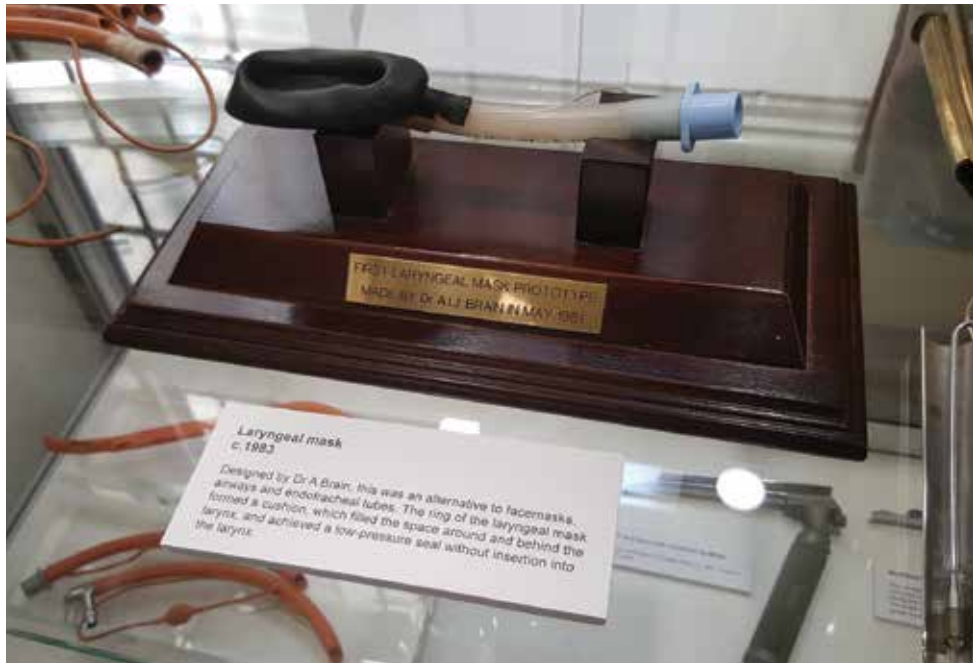
Set in historic Cardiff City Hall, the meeting was a fascinating three-day journey through some of the key topics for anaesthesia trainees and anaesthetists today. I was surprised by the attendance and level of engagement at an entirely trainee-focussed meeting, particularly given the long list of competing demands on trainees' time and finances.

I started the first day by attending the GAT Committee strategy meeting, alongside representatives from the British Medical Association (BMA), the Association of Surgeons in Training (ASiT), and the European Society of Anaesthesiology (ESA). We each gave short presentations about our respective groups, which highlighted that many of the issues faced by anaesthesia trainees, and junior doctors in general, are shared across the developed world. There was a particular focus on the ongoing disputes in Britain, regarding the unilateral imposition of an unpopular junior doctor contract and the potential impacts this could have on trainees; as well as discussions around ways for professional organisations to better engage trainees, and how to strengthen international links between trainee groups.

The scientific program opened with a brief overview of 'What's new in sepsis?' (the short answer was 'nothing and everything') and continued with lectures on a number of common themes,

FEATURE

Historic anaesthesia textbooks



First LMA prototype

including quality improvement, trauma, doctors as people, and academia.

Individual lectures ranged from an engaging talk on the unique challenges involved in delivering anaesthesia in a war zone – to a surprisingly detailed presentation on how the singing voice is produced. There was even a neurosurgeon who presented his opinions on when and why we should be intubating patients with traumatic brain injury.

It was evident that the Australian anaesthetic community and wider Australian medical community are generally held in high regard – a fact that we should all be proud of.

I was pleasantly surprised that almost every second speaker referred to Australia – from the high-profile research produced by the ANZCA Clinical Trials Network, to the leading work by the AMA, ANZCA and the ASA/NZSA – on issues regarding health and wellbeing, and the historic role played by John Flynn, in founding the Royal Flying Doctor Service – the world's first air ambulance. It was evident that the Australian anaesthetic community and wider Australian medical community are generally held in high regard – a fact that we should all be proud of.

In amongst the industry exhibition hall was a fascinating selection of items from the AAGBI Anaesthesia Heritage Centre. This included Dr Archie Brain's original 1981 LMA prototype, Boyle's 1917 nitrous oxide/oxygen/ether apparatus and a range of other historic airway devices, ventilators and vaporisers. There was also a Carlens Tube – the initial double lumen tube which was invented in 1949, by the Swedish ENT surgeon Dr Eric Carlens and first used in thoracic surgery by the strikingly-named Dr Viking Björk. I am sure that the full collection at the AAGBI headquarters in London would be well worth a visit for anyone with an interest in the fascinating history of anaesthesia.

Perhaps one of the most useful talks of the meeting featured the editor-in-chief of *Anaesthesia*, Dr Andrew Klein, discussing the 'Top 5' papers of the year in his journal. This included the two most cited papers:

- 'Recommendations for standards of monitoring during anaesthesia and recovery 2015: Association of Anaesthetists of Great Britain and Ireland'[1].
- 'Secondary analysis of outcomes after 11,085 hip fracture operations from the prospective UK Anaesthesia Sprint Audit of Practice (ASAP-2)' [2].

The top two papers by 'altmetrics' (a fascinating novel method of measuring research impact):

- 'International consensus statement on the perioperative management of anaemia and iron deficiency'[3].
- 'Complete relinquishing of anaesthetic conscientiousness, optimisation and nuance (CRAC-ON) trial'[4].

And the most downloaded paper:

- 'Data fabrication and other reasons for non-random sampling in 5087 randomised, controlled trials in anaesthetic and general medical journals'[5].

Dr Klein held the audience's attention well with carefully timed comments that "This will definitely be asked about in the exam" – particularly regarding the first two papers.

On the final day, Dr Peter Maguire, the specialty lead for anaesthesia on the BMA consultant committee, outlined the history and future of anaesthesia training in Great Britain and Ireland. I was glad to be an outsider as he painted a concerning picture of the evolving issues around Brexit and the NHS funding shortfall. For those unfamiliar, these issues include an increased cost and uncertainty of supply of pharmaceuticals and medical equipment, loss of EU funding for medical research, potential weakening of regulations around working conditions, and more after-hours shift work for consultants.

Dr Klein held the audience's attention well with carefully timed comments that "This will definitely be asked about in the exam".

Fears of an exodus of health care workers are also high – largely to the Republic of Ireland and mainland Europe – though Australia is an increasingly popular destination. Perhaps our discussions around the detrimental effects that skilled migration can have on developing countries should also include a growing 'brain drain' from the United Kingdom? With the NHS predicting a one-third shortfall in anaesthetists and intensivists by 2033 – without the effect of Brexit[6] – and Australian modelling indicating a risk of anaesthetist oversupply if international medical graduate numbers are not reduced[7], it appears difficult to justify supporting further movement of anaesthetists from the UK to Australia – no matter how much nicer our weather is.

The meeting concluded with a lively debate titled 'Everyone needs a speciality: The death of the general anaesthetist?'. By the end, even the speakers seemed to agree (along with 81% of the audience), that the general anaesthetist is still very much a necessity and the backbone of the anaesthesia workforce. With our smaller workforce and greater distances between population centres, this is likely to hold even more so in Australia and New Zealand. A general drift some see towards increasing 'specialisation' is perhaps simply a growth in the popularity of identifying with 'areas of interest', rather than a move away from generalism in practice.

I left the meeting highly impressed at the planning and organisation, that ensured it ran smoothly and maintained interest throughout. I was truly surprised at the level of attendance and engagement from trainees across Great Britain and Ireland and wonder whether we could replicate the same enthusiasm in Australia. A dedicated event like the GAT ASM would be difficult to sustain; with fewer trainees spread over much greater distances, and I suspect that the major political and economic challenges facing the UK healthcare system are a strong motivating factor in mobilising time-poor and money-poor trainees.

I would like to thank the ASA for providing me with the opportunity to gain this invaluable experience, and I strongly encourage other trainees to apply for the trainee member international scholarships in future. It's more than a holiday!

Richard Seglenieks
Chair, ASA Trainee Members Group

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FEATURE

CANADIAN ANESTHESIOLOGISTS' SOCIETY – 2017 ANNUAL MEETING

NIAGARA FALLS, ONTARIO – 23 TO 26 JUNE

The annual meeting for the Canadian Anesthesiologists' Society (CAS) was held from 23 to 26 June 2017, in the iconic destination of Niagara Falls, Ontario. The Scotiabank Convention Centre was the epicentre of the conference, providing a fantastic environment for interaction and learning.

CONFERENCE TOPICS

The meeting theme was 'Competence by Design: The Future of Education and Assessment in Anesthesiology – From Residency to Retirement'.

Saturday started for me with a symposium on neuroanaesthesia relating to the management of coagulopathy during neurosurgical procedures. A fantastic up-to-date review of the pathophysiology and clinical management strategies of early trauma coagulopathy in traumatic brain injury patients was presented. Dr Katerina Pavenski then discussed the implications of novel oral anticoagulant drugs and the management and reversal of these agents in traumatic brain injury – providing excellent insight into what is a relatively new issue faced by anaesthetists.

The symposium on chronic pain management delved into the somewhat controversial and topical issue regarding medical cannabis. The symposium explored the clinical evidence, pharmaceutical relevance and its use in the perioperative and hospital setting. It was interesting to relate this topic to our current stand on the issue in Australia. Some provinces in Canada have legalised medical cannabis, not just for the management of chronic pain but many other medical issues. While some of the evidence presented did demonstrate improved pain relief and sleep; it was highlighted that the area still needed significant research in determining the overall efficacy and clinical acceptance.

Sunday brought many interesting sessions, with a symposium in ambulatory care being a stand-out. The session reviewed aspects of anaesthesia which may improve outcome in ambulatory care. For me the most interesting talk was from Dr Anil Patel, discussing the evidence and efficacy of apnoeic nasal oxygenation, in patients at high risk of hypoxaemia, including patients with morbid obesity and respiratory disease. Dr Patel was instrumental in the development of Optiflow Thrive™, the same technology we are currently using in our hospital. Having used it a few times prior to this session, I had some idea of the concept; however the data presented demonstrated the incredible implications this has for the obese or high-risk patient. Following the session I have implemented Optiflow Thrive™ into my practice on a regular basis – seeing great results.

Dr Matthew Chan presented a review on 'Depth of Anaesthesia and Patient Outcome'. I found this talk particularly interesting as he talked about the upcoming publication of the *Balance Trial* – looking at a comparison of 'light' and 'deep' anaesthesia (measured by BIS) and long-term patient outcomes. My interest from this stems from the fact my current hospital is enrolled in the study, and I have personally contributed many patients to the study. It was great to see it being discussed at such a meeting and being greeted with enthusiasm from the audience.

Sunday afternoon provided the closure to the academic program with a refresher course, 'Update in Obstetric Anaesthesia'. Two major topics were discussed: the current recommendations for the airway management of the obstetric patient, and the use of programmed intermittent epidural bolus (PIEB) in labour anaesthesia. The concept of PIEB was new to me, coming from an institution rigid in continuous epidural infusion (CEI) and only recently beginning to experiment with PCA epidurals. The outcomes demonstrated that with PIEB compared to CEI there was a lower incidence of motor block, lower rate of instrumental delivery, decreased total local anaesthetic used and improved maternal satisfaction.

To my delight there was a fellowship fair where many major teaching hospitals were present to discuss fellowship opportunities. For some time I have been interested in spending my provisional fellowship year in Canada and this was a great chance to network and explore the institutions and fellowships offered across the country.

A new concept I found exciting was the 'residents' olympics'. This was a simulation-based competition putting groups of four residents against each other in a scored simulation event. Teams moved into progressive rounds until an eventual winner was crowned. While in its first year – and having some slight teething issues – it was a great idea and received well, by not only the resident

cohort, but the entire conference. In the current era of extensive simulation based training; I feel this is something that could be experimented with at our ASA meeting.

I found the academic program excellent, giving me an in-depth view of many new concepts and technologies, along with reviews of topics highly relevant to my current training and exam preparation.

SOCIAL EVENTS

Prior to arriving in Canada I had been contacted and welcomed by Dr Kait Duncan, Chief Resident for the University of Ottawa, who extended an invite on behalf of the CAS Residents' Section to attend a social event on the Friday evening – exclusive to the registrar cohort attending the conference. This was a great opportunity to introduce myself to fellow trainees and gain insight into the similarities and differences of our training and career pathways. The event itself was at a local bar which provided a casual environment for everyone to have a few drinks, laugh and get to know each other.

The premier event dinner took place on the Saturday night – the President's reception and dinner – in the ballroom of the Marriott on the Falls. This was a fantastic night and a great environment to network with a large group of anaesthetists from across the country (and world). The entertainment was electric, with a Beatles cover band providing the background for a good time.

The Sunday morning started early with a slightly sore head for the fun run for CARF – a fun run to raise money for anaesthesia research in Canada. The route was picturesque; I was able to see the majestic falls prior to the onslaught of tourists that would be there later in the day.

The CASIEF Gala Fundraising Dinner was held on the Sunday night, at the Queen Victoria Place terrace restaurant, overlooking the colourfully lit-up Niagara Falls. The backdrop set the scene for what was an inspirational night. Dr Chris Charles – a resident whom I had spent some time with over the course of the weekend, was the guest speaker for the evening. Chris talked in-depth about his endeavours working in rural Cambodia, inventing a dissolvable iron fish that infused their cooking with iron, and preventing and treating anaemia at minimal expense. It truly was inspiring hearing such an incredible story from someone so young and passionate.

While the conference was busy – taking up most of the day, I stayed on a couple of extra days to explore the town of Niagara Falls and its surrounds. It was an incredible place with a lively atmosphere. Obviously driven heavily by tourism – there was never a shortage of places to eat or wet the palate.

THANKS

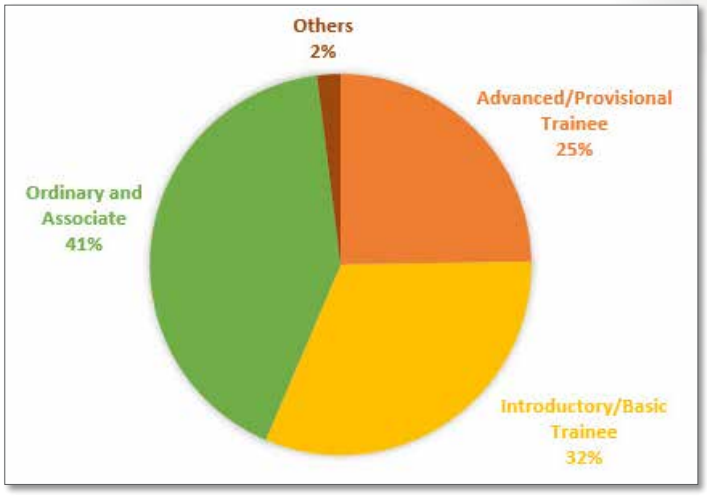
This amazing experience wouldn't have been possible without the ASA CIG scholarship program. It provided me a great chance to network, learn and explore, and one I would highly recommend to other trainees. I would also like to thank the CAS Residents' Society for their welcome and hospitality throughout the weekend.

Dr Pete Mulcahy
Royal Hobart Hospital

2017 IN REVIEW

MEMBERSHIP UPDATE

New Member Statistics



ASA APPS

Downloads increase

AUSTRALIAN Anaesthetist

160 to **246**

Anaesthesia and Intensive Care

AIC

89% increase from

6,094 to **11,492**

Relative Value Guide

RVG

32% increase from **1,344** to **1,776**

POLICY UPDATE

- Government Submissions:
  8 submissions + **4** MBS Review submissions available to membership
- Government Engagement:
  10 MBS review related meetings

134
policy queries
with
94%
resolution rate

2017 IN REVIEW

MARKETING & COMMUNICATIONS

ASA website

- **82%** increase in page views
- **88%** increase in new users

President enews

> 58% open rate

> 20% click rate

Harry Daly Museum

8,000 + visits to online collection

>1.3k likes
>1.3k followers

>2.8k followers

>1.4k followers

EVENTS UPDATE

26 events including trainee, state, social and combined ANZCA & CMEs

50 attendees at the annual Practice Managers Conference

265 attendees ASURA 2017

Note: All information and statistics for the period of 1 January to October 2017

REGULAR

HOW TO CHOOSE THE BEST SUPER FUND OR MANAGED FUND

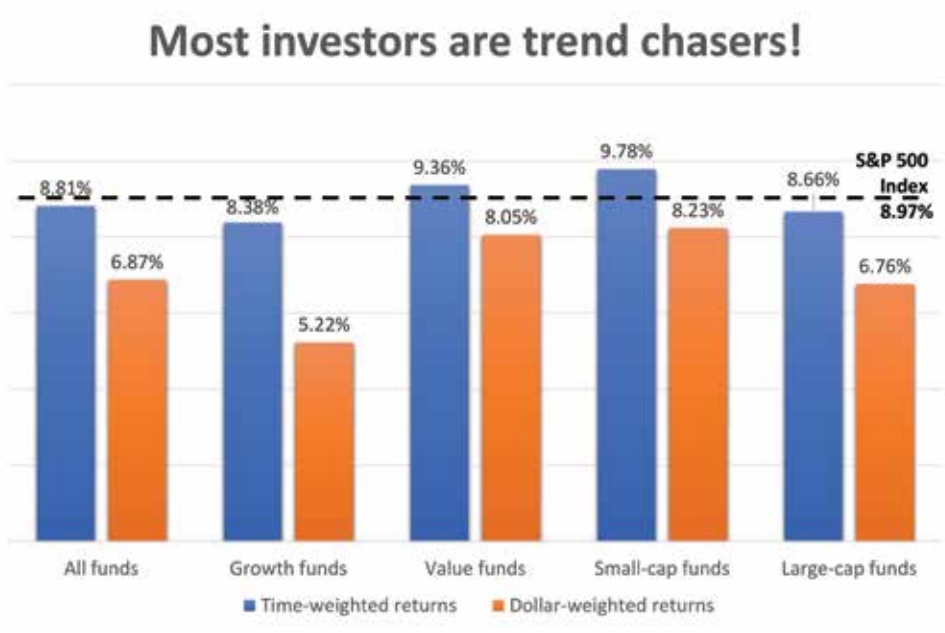
How do you identify the best superannuation fund or managed fund?

It would seem logical to compare the net investment returns (after fees) over various periods of time and select the one that has produced the best results. But you would be wrong. This approach will not necessarily identify the funds that will produce the best returns in the future. I will use this article to outline a more successful approach.

YOU MUST REALISE THAT MOST INVESTORS ARE LATE TO THE PARTY

If a managed fund or super fund has a few good years, investors tend to flock to those funds – in the hope that the good investment performance will persist and they can enjoy high returns. However, research shows that most investors are too late – they invest in the fund towards the end of a "good run" and end up generating ordinary returns.

For example, a research report[1] published last year compared the investment returns generated by all managed funds in the US between 1991 and 2013. They compared the published time-weighted returns with the actual dollar-weighted returns that the investments produced. For example, Fund X might have a time-weighted return of 20% p.a. for the 2016 calender year – which, for example, might be made up of 15% in the first half of 2016 and only 5% in the second half. If most people invested mid-way through 2016 (after they produced outstanding returns), they would have only earned a small return of 5% – this is the dollar-weighted return.



Source: "Timing Poorly: A Guide to Generating Poor Returns While Investing in Successful Strategies", *Journal of Portfolio Management*, Winter 2016.

CHASING RETURNS: LIKELY TO COST YOU 2% P.A.

The dollar-weighted returns (in the research mentioned above – see chart below) were about 2% p.a. lower than the time-weighted returns. This is because most people invested monies after the 'good performance' had already occurred – this is called 'performance chasing'. Vanguard arrived at very similar findings in its research[2] too. By the way, note that the index beat most of the managed funds!

In conclusion, we know that selecting managed funds and super funds based on past performance isn't the right approach.

CAN'T BEAT THE MARKET IN THE LONG RUN

These findings reinforce our belief that actively managed funds cannot beat the market on a consistent basis. Therefore, the strategy that has the highest probability of maximising your returns is to invest in low-cost, index funds.

NO ONE KNOWS WHICH ASSET CLASS WILL DO WELL

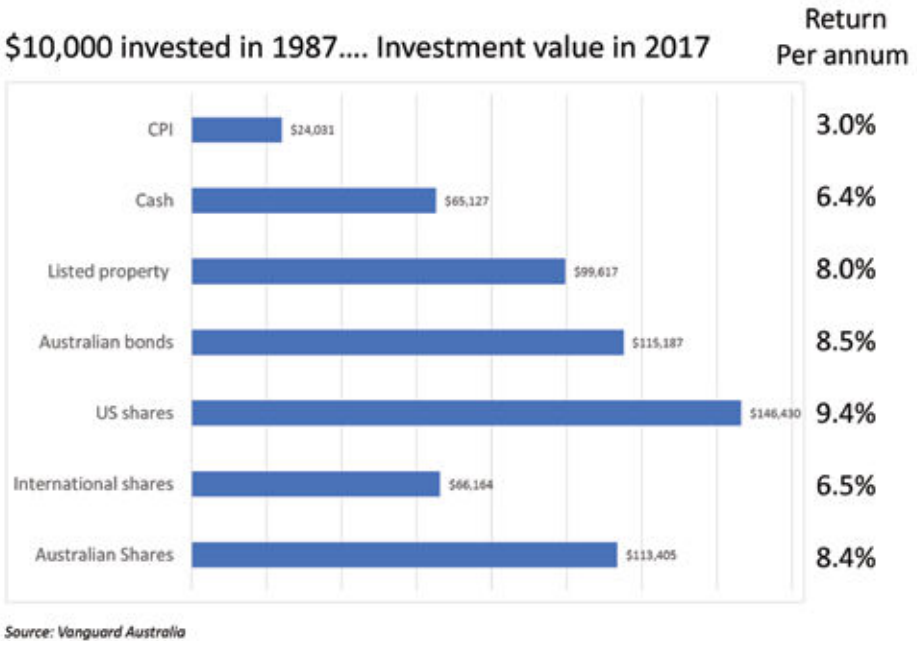
No one in the world has developed a reliable and repeatable methodology for predicting which asset class will perform

the best in the short to medium term. Vanguard produced the chart below which sets out how much a $10,000 investment made in 1987 would be worth today. You might be surprised to see that Australian bonds come in second. That's not to say we should invest in bonds – but more importantly it's wise to adopt a long-term asset allocation based on the fundamental assumption that no one knows which asset class will work and when.

AND THE WINNING APPROACH IS…

So far, we know that comparing (chasing) returns isn't the right approach – nor is trying to pick the next "winning" asset class. Instead of these approaches, I recommend the below 3-step approach will produce the best results:

1. **Pick your methodology** – you either believe that passive investing will produce superior returns (compared to active investing) in the long run, or you do not – there isn't really any middle ground. If you believe in passive investing, then you must select an investment/super fund manager that invests passively. Also, this means you no longer need to worry about whether you have picked the "right" fund manager or super fund – because you know that you will always get the market return – and beat the vast majority of active managers in the long run. Comparing your returns against other (actively managed) funds is meaningless – as research demonstrates that long term results matter the most. From year to year you will always find a handful of funds that will beat the market (index) – but picking these in advance is like finding a needle in the haystack – instead, invest in the haystack (i.e. index).
2. **Pick your desired asset allocation** – once you have decided to adopt a passive methodology, the next thing to choose is which asset classes you want to invest in. Maybe it's a small investment for your kids and you only want to invest in the Aussie market. Or, if it's your super, then it is almost certainly better to have a diversified asset allocation.
3. **Identify the lowest-cost way of implementing above (steps 1 & 2)** – the final step is to identify the lowest-cost avenue to implementing your desired asset class exposures. For example, if it's a small investment in one or two asset classes, the lowest-cost avenue is probably to set up an online trading account and invest in ETFs. If it's your super, then setting up a wrap/platform account will give you full control, a huge investment menu and allow you to minimise investment fees.



Source: Vanguard Australia

NEED HELP? OR A SECOND OPINION?

Investing in index funds is a relatively simple strategy. However, not all index funds are created equal – so you must be very careful to understand what you are investing in, how it is managed and the risks involved. Keep away from synthetic ETFs for example. It is wise to seek independent advice – even if it's just a second opinion – to ensure you are on the right track.

Stuart Wemyss
Prosolution

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2. "Quantifying the impact of chasing fund performance", July 2017, Vanguard.

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WEBAIRS NEWS

At the ASA NSC in Perth a session was allocated to webAIRS. This was chaired by Dr Gregory Deacon and featured presentations by the ASA International Speaker Dr Avery Tung as well as by Professor Neville Gibbs and Dr Martin Culwick. The topics covered included why we should report incidents, results from the first 4,000 incidents reported to webAIRS and how to make effective changes following report analysis. The session also saw the launch of the new landing page which incorporates interactive links to several other new pages including the Incident Dashboard, News, Events, Publications and Frequently Asked Questions.

The new landing page may be viewed at www.webAIRS.net

The publications button [as per landing page screen shot, above] is a particularly valuable resource as it lists all of recent ANZTADC analysis reports. The page features a summary of the abstract together with an additional link to the original article on the corresponding journal website.

Other webAIRS improvements include updated pages for reviewing incidents and the creation of bar charts of bi-national as well as local results. The programming extensions fine tune reviewing of incidents, as well as providing the capability to analyse incidents by type at a departmental level. Further information about these features will be added to the frequently asked questions page which is accessible from the home page.

ANZTADC welcomes feedback on all aspects of the website and reporting process. You can get in contact via email: ANZTADC@anzca.edu.au

S. Walker
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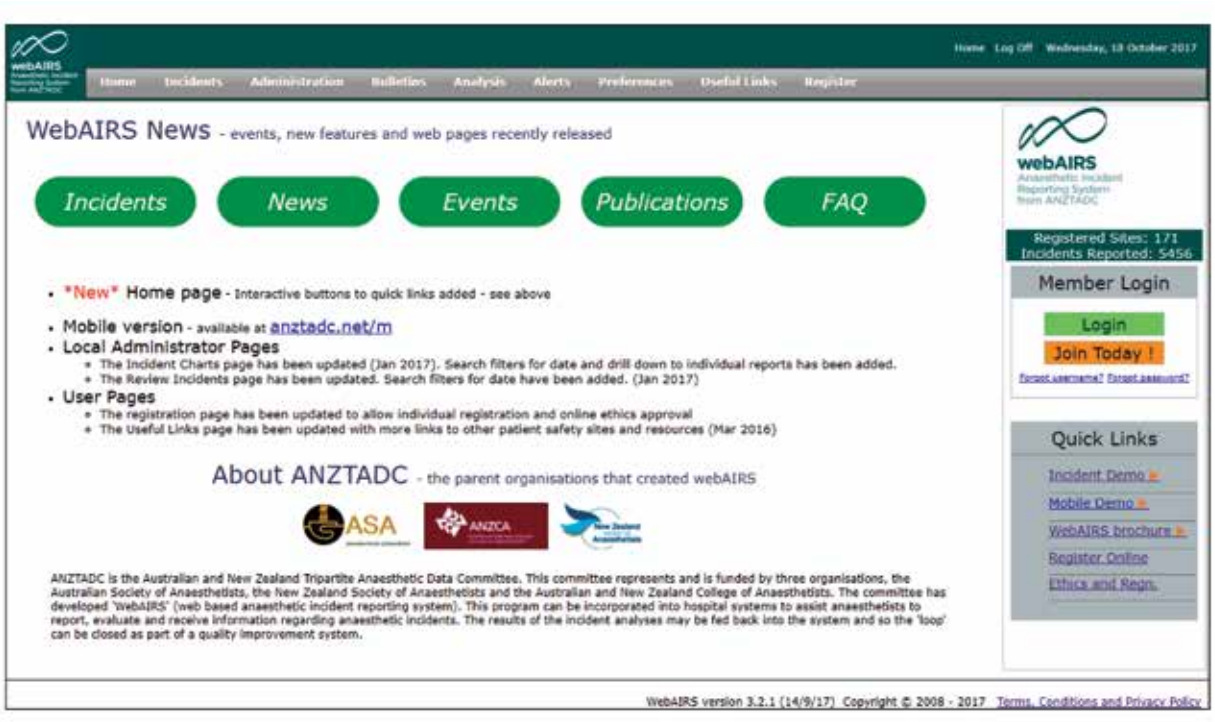

REGULAR

ANAESTHETISTS IN TRAINING
TIPS FOR JOB INTERVIEWS

Dr Vida Viliunas is a specialist anaesthetist currently working in public and private practice in Canberra. She served for 12 years as an examiner for the final fellowship exam and for two years as Chair of the Final Examination Subcommittee. Dr Viliunas is the convenor of the annual Final Exam Boot Camp in Canberra which will be held on 3-4 February, 2018. In this issue, Vida offers advice to anaesthesia trainee members preparing for Provisional Fellow or junior consultant employment interviews.

'tis the season: CV writing and preparing for job interviews are two important components of a skill set addressed by this article. Hope is not a strategy. It is always prudent to be prepared for unexpected or planned opportunities. It's always the season…

FIRST IMPRESSIONS

The cold, hard, objective facts on your CV are important, but they are not everything. There are the studies which claim that non-verbal impressions contribute a great deal to charisma, credibility and intelligence ratings. I make no comment as to the degree to which those studies survive serious scientific scrutiny, but they're out there. Whatever be the case, there is no denying that hand gestures, voice-modulation/ range and the amount that you smile (or frown), all make a difference. A first impression occurs in nanoseconds. You only have one chance to make it.

LOGISTICS AND INTERVIEW PREPARATION

Make sure that you are totally on top of:

- the details of the job advertisement
- the hospital and departmental website
- the membership of the interview panel and their individual interests
- other applicants/ vacating applicants and
- how your past experience relates to this position.

Whatever be the case, there is no denying that hand gestures, voice-modulation/ range and the amount that you smile (or frown), all make a difference. A first impression occurs in nanoseconds. You only have one chance to make it.

Be polite and nice to the gatekeeper. Never mess with the staff. You have probably already learned this as a life lesson. If you want to succeed at anything, start by choosing your enemies carefully. It's a small world. While the person who answers the phone may not be the final decision-maker, s/he may very effectively and persuasively have the ear of the person who is.

- Dress for success. It is simplest to wear a professional, classic suit. That sends a signal about the effort you are prepared to make in order to succeed.
- Aim to be punctual or early.
- Bring a well composed, well-presented, current curriculum vitae.
- Consider preparing several copies of a short resume that you can leave with the interview panel. This resume should set out how your CV dovetails with this particular role.

BEHAVIOUR-BASED SKILLS QUESTIONS

There are a number of high-quality web-based resources on medical behaviour based interviews.

There is a sandwich construct for the interview: the "putting you at your ease question", the actual questions and concluding with the close.

Just as you practised scripts for the vivas to prepare responses to questions, so you can anticipate some questions and rehearse the answers to make the job interview easier and less intimidating. This will assist to portray your qualities and skills more persuasively and accurately.

"Tell us about yourself"

This is not about your golf handicap, volunteer work or book club. Unless you are specifically asked for your star sign, this question is about the job. It calls for you to talk about the skills, experience and qualities that you bring to the fit for that position. The Anthony Stagg video (https://www.youtube.com/watch?v=OW-yxxPMtro&t=104s) uses the mnemonic EES: Education, Employment and Skills.

His short video describes what to avoid, namely a general answer such as you might give at a party. You should be specific and link how your education, previous employment and experience in training are related to the specific skills required for the particular job at hand and not your personal life. Doing so allows you, at the same time, to showcase your communication skills and ability to anticipate: a real performance winner!

So: what are the contents of a good response for an anaesthetic job?

All the candidates for a Provisional Fellow or consultant position have a FANZCA or equivalent so, how was your training distinguished? A prize or prizes? Relevant volunteer work? A particular departmental contribution? Relevant Subspecialty work? Special interests, non-technical skill development/ research/ teaching opportunities? What particular skills did you hone during training?

Concluding with the frequently asked "My biggest strengths are":

1. (Your choice of) academic/ leadership/ teaching/ niche (informatics/IT/ subspecialty etc) and how they apply to this job to improve the value of it (when you get it) to the organisation.

   If you have already achieved or mastered something outstanding in the spheres of education, employment or skills, say so! Show that you are proud of it by saying that you are proud of it. Develop this by explaining how that achievement can improve your contribution to the job/ team/ organisation.

2. Something relevant to the particular academic/community service/teaching/ departmental/global interests of the particular job description or something you intend to do in the future i.e. demonstrating the strength of your vision.

   Having anticipated the strengths question, the segue to the "weakness" question is the next obvious place to go. Yes, you have to have some weaknesses. It is too cheesy and can come across as arrogant, to reply that you are a perfectionist or similar.

What are your weaknesses?

This is not about your personality. Avoid the temptation to present a strength in disguise. This should be an issue that has occurred (often in a specific context) and which you have corrected. This question is an opportunity to show that you have powers of insight, have taken corrective initiative and have the discipline to implement a remedy.

In its disassembly, this is a Hollywood movie: Likeable hero (you) encounters an obstacle (Weakness), takes Action and emerges transformed (Result).

If you have already achieved or mastered something outstanding in the spheres of education, employment or skills, say so! Show that you are proud of it by saying that you are proud of it.

Be brutally honest with yourself about this one. Spend time reflecting on and composing a response. Again, there is useful material from Stagg at https://www.youtube.com/watch?v=u_VdMHGQnZU&t=255s using the mnemonic WAR: detailing what the Weakness is or was, Action taken to overcome it to achieve the Results that ameliorated that Weakness. This can be illustrated with an example of the weakness being difficulty in accepting criticism which produces the result that you challenge your colleagues and consultants, thereby impairing communication and losing opportunities to improve skills and knowledge at many levels. You strive to achieve the best possible outcomes for your patients but find it very challenging to be criticised by your supervisor of training. The remedial action might be to seek the advice of your senior mentors and peers, attending a "taking criticism without crying" course where you learned to deal with acute situations as well as maintenance skills that you refresh every six months online. Result? Plusses all round:

- You have improved relationships in your workplace (remember, the question is about the job).
- You have realised many more opportunities to learn from all levels of medical and non-medical staff.
- You are vigilant about not falling into old habits.
- You have taken on mentoring of your peers and juniors in this sphere.
- Recognising this fault early in your training allowed you to take full advantage of your basic and advanced training and to spread that particular joy to others.

Accepting or receiving criticism is a significant issue for many registrars. This analysis allows a job candidate to demonstrate insight and an ability to recognise and implement solutions. The results provide an opportunity for self-improvement as well as contribution to the greater good by way of patient care and improved relationships with colleagues.

The realisation that there are other areas where you can improve may well have enabled you to develop in those as well. If there is a follow-up question about another area, be ready for that one e.g. fear of public speaking.

Why do you want to work here?

Honesty and homework is required here. Know the institution, its past work, research interests, culture, reputation and people. Prepare something which addresses how the opportunities for you might be mutually beneficial or serve a higher purpose. Use specific examples which demonstrate the excellence of the match of you for the job.

Why should we hire you?

You should be answering this question from the moment you started to research the job description, the institution, panel members and outgoing job holders as well as your polite and respectful dealings with the staff. Having done all that work, tell the panel that you have made yourself aware on those fronts. The fact that you arrived early, the way you walked into the room, the way you presented yourself, your CV and your confident greeting to the interview panel, should all be persuasive.

REGULAR

Your specified and special skills which you have matched to the particular needs of the job and the added value that you would contribute, should make the panel beg you to stay.

Do you have any questions?

Prepare some questions. This signals your preparedness and motivation. Your questions should be credible and not just Dorothy Dixers or questions to which you already know the answers. Some resources:

- Mayo clinic preparing for an interview: http://www.mayoclinic.org/jobs/how-to-apply/preparing-for-interview
- aagbi.org http://www.aagbi.org/professionals/career-information
- The secret to acing Behavioural interviews: http://www.physemp.com/blog/the-secret-to-acing-behavioral-interviews-for-physician-jobs-be-a-great-storyteller/
- The SHARE model: Situation, Hindrances, Actions, Results, Evaluation
- Interview questions from FRCA.uk http://www.frca.co.uk/Page.aspx?id=44 and http://www.frca.co.uk/page.aspx?id=30

THE INTERVIEWERS

It is interesting to reflect on the interview process, its structure and to spare a thought for the interviewers, particularly at the AAGBI site http://www.aagbi.org/professionals/career-information.

Interviewers are trained, not born! Be prepared for an interviewer who:

- Has not read your CV;
- Gets aggressive to see how you react under stress;
- Is constantly disturbed;
- Makes remarks about your previous bosses;
- Asks questions but doesn't listen to the answers.

The AAGBI site also warns about interviewers who might be nervous, aggressive, unprepared, disorganised or ask inappropriate questions.

It is always better to be prepared for, rather than outraged by, "forbidden" questions about family plans, religious beliefs or ethnicity. They may be simply deflected by a statement such as "My (religious beliefs/ sexual orientation) will not interfere with my ability to fulfil my job obligations." If the situation shows signs of developing into an unpleasant one, you can choose to use it as an opportunity to display a well-mannered composure.

Make a decision at a later time regarding whether you want to work in a place where inappropriate questions are asked. Remember that there is never any point in alienating anyone in this (or any) process. You never know where or when members of this interview panel might turn up on the yellow brick road of your professional life.

CV WRITING

This article in the BMJ remains relevant: http://www.bmj.com/content/313/7066/S2-7066.

NON BEHAVIOUR-BASED SKILLS QUESTIONS

You should anticipate questions relating to anaesthetic career choice, why the panel should hire you and where would you like to be in five years' time. https://www.monster.com/career-advice/article/toughest-health-care-interview-questions

Be prepared for a clinical question. Rely on your exam preparation for this: identify the issues and how your choices address those. Refer to relevant evidence for your response. Where evidence does not exist, your response should be based in sensible, defensible judgement with an emphasis on the best interests of the patient and their safety. Where the clinical question raises competing physiological interests or personal conflict, there is often no "right" answer. Acknowledge this and explain your answer appropriately.

THE ODD QUESTIONS

Sometimes panels ask uncategorisable questions. Some examples are: If you were a hamburger, would you prefer to be the hamburger or the bun?; Which superhero would you be?; What would you take to a desert island?

Don't be thrown by these, but take a deep breath and give an answer. Such questions test your flexibility and response to novelty. Use humour cautiously. However, if you are confident about the way things are going, your answer to such a question might provide a good opportunity to display something of your personality.

SOCIAL MEDIA

Clean it up.

Review your presence on:

- Linkedin
- Facebook
- Instagram
- Tumblr

Decide what face you wish to make public.

The most dangerous component in a motor car is the 'nut behind the steering wheel'. In the online world, the most dangerous vulnerability just might be the careless individual behind a keyboard.

QUESTIONS THAT YOU SHOULD ASK

This marks the closing of the interview – but not quite. Fight the urge to get out of the room having survived the experience. Take the opportunity to distinguish yourself as a candidate to the panel and to learn more about the job and demonstrate your interest for it.

Again, there are many references on the web suggesting questions that you might ask or should not ask: https://www.forbes.com/sites/jacquelynsmith/2013/07/05/30-questions-you-should-andshouldnt- ask-in-a-job-interview/2/#49e0cc2d7fb4

Questions such as the following might work:

- Of the research interests of the department, given my background in 'x' how can I best contribute?… or phrase this as stating that you have spoken to 'y' (vacating the position) who completed project 'z' and ask/state how you can build on this work.
- Pick an 'omission' in the job description and ask if you can undertake that task: rostering/mentoring/teaching.
- How do you evaluate success in this position? Is there a formal process?
- Asking when you can expect to know the decision of the panel is a nice way to close.

Having your questions written down might help you remember them as well as signal your degree of preparation for the interview to the panel.

CONTACT/ FOLLOW-UP

Have a card, leave a 'gift' (e.g. a proposal for a research project or specific suggestions for plans that you have for the particular job or create a webpage to which you refer the panel as you sign off).

Not all candidates accept the positions that they are offered. Even if you are not successful in the first round, consider sending a 'thank you' email. That might move you up the list for the second round.

RESOURCES

AMA career advice hub ama.com.au

Best wishes for a successful interview for the job you want.

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

DR ANTONIO GROSSI
PIAC CHAIR

PIAC has been considering the potential implications for patients and anaesthetists of the latest Productivity Commission report[1]. It suggests generational changes to the healthcare system, without providing adequate evidence for the assumptions made. Decoupling hospital funding from actual service demand will impact the quality and safety of anaesthesia service provision, exacerbate the workforce pressures and potentially lead to increased stress and burnout.

'Shifting the dial'[1] identifies five Australian health problem domains; a) fragmented healthcare requiring integration between hospital and primary care to better serve patients, especially those with complex and chronic disease; b) placing the patient at the centre of care; c) funding healthcare based on outcomes rather than activity; d) linking funding to quality and, e) using information and technology more effectively. Theoretically this is supposed to lead to better health outcomes and reduced hospitalisations and costs.

Unfortunately, there are drivers such as an ageing population, chronic disease and increasing patient demand for expensive services that generate fiscal health funding pressure. In order to release this pressure in the absence of new funding, there must be a redistribution of health resources. Since hospital care is considered 'expensive and distressing'[1], shifting money from this sector to primary care to manage patients in the community has been suggested[1,2,3]. Berwick[4] describes the triple aim of improving the patient experience, improving the health of populations and reducing the per capita population costs. In the USA the 'Patient-Centred-Medical-Home' (PCMH) was introduced to empower local primary carers as integrators of patient-centric services including prevention and promotion activities incorporating Starfield's four pillars of primary care; 'contact', 'continuity', comprehensiveness' and 'coordination of care'[5]. A systematic review of PCMH did not show a lower rate of hospital inpatient utilisation, emergency department attendance and total overall costs were not reduced[6]. There is some evidence that increasing vigilance in primary care can lead to more referrals for specialised hospital care[7,8]. In the UK an evaluation of the 'Integrated Care Pilots' was found not to save money[9]. Removing funding from the hospital sector prematurely will inevitably lead to increased stress and compromise the quality and safety of hospital services such as anaesthesia as healthcare workers are expected to provide existing or more services with fewer resources.

The Productivity Commission aspires to have a flexible, skilled and ethical workforce suggesting the current workforce is deficient in these domains. With any decentralisation of resources must come accountability and responsibility for delivery of services. There have been numerous unfavourable reviews of similar projects previously such as the 'Medicare Locals'[10], the 'Australian coordinated care trials' of the 1990s[7].

The Productivity Commission claims the current FFS funding model provides 'perverse incentives'. It acknowledges that the FFS 'MBS is a necessary evil' to encourage throughput and that 'activity based hospital funding' does provide increased efficiencies. The current system is criticised for rewarding activity rather than outcomes. How are these outcomes defined?

Removing funding from the hospital sector prematurely will inevitably lead to increased stress and compromise the quality and safety of hospital services such as anaesthesia as healthcare workers are expected to provide existing or more services with fewer resources.

Australians living longer is seen as a favourable outcome. Unfortunately, the last decade of life for many people involves living with the complications of chronic disease such as diabetes, mental ill-health, arthritis, cardiovascular and pulmonary disease. Optimising the determinants of disease and addressing lifestyle factors is crucial[11,12]. Removing money from the hospital sector is flawed as these patients will still require specialised care.

Reducing overall costs is seen as a favourable outcome but if this comes at the detriment of receiving clinically indicated care, this is not a favourable patient outcome. Decreasing unwarranted clinical variation and unnecessary procedures is clearly desirable. Increasing patient's health literacy is crucial in reducing the demand for these services. The same scrutiny that is applied to any other medical hypothesis should be applied to the quality and safety literature and assessment of outcomes[13]. There needs to be better prospective data collection and audit of clinical activities, including patient-centric indicators, utilising information technology to facilitate an assessment of outcomes. It is important that 'apples are compared with apples' utilising transparent criteria. Any outcome comparisons must reflect demographic population variations and be contextually relevant. Before the government 'eliminates low value health interventions', there needs to be clarity about how value is defined and which population group may be potentially disadvantaged[14]. Promulgating 'do not do' lists must not occur without scientific scrutiny and consideration for clinical variations and specific patient requirements. The private health insurance industry has recently limited funding for 'never events' and complications, considered to be hospital acquired. A similar approach has been taken to the public hospitals in the pricing framework. Ibrahim and McNeil[15] explain that there is no evidence that punishing hospitals will improve safety and quality. Introducing a 'blame culture' may decrease frank reporting and open disclosure, reducing the opportunity for analysis of potential system errors.

The private health insurance (PHI) industry has had escalating premiums, increased administrative costs and complex products with poor coverage leading to increased out of pocket expenses. This has left patients questioning the value of private health insurance. 'Shifting the dial' attributes this to 'over-regulation' characterised by risk equalisation underpinning the community rating[1]. Perhaps some of the PHI $1.8 billion in profit could be reinvested to provide a better deal for patients?

Before the government 'eliminates low value health interventions', there needs to be clarity about how value is defined and which population group may be potentially disadvantaged.

The Productivity Commission believe they know what is wrong with our universal healthcare system and provide a blueprint of how to fix it. They apostolise dismantling the MBS, reduce funding to hospitals, promote task substitution and increase taxation. They claim this will lead to better patient-centric health outcomes but fail to adequately prosecute their case.

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INSIDE YOUR SOCIETY

POLICY UPDATE

MANDATORY REPORTING: EFFECTIVE, PROTECTIVE, OR PUNITIVE?

The Australian Society of Anaesthetists recent meeting with NSW Health Minister Brad Hazzard in August, provided an interesting fact-finding mission when we asked about the progress of mandatory reporting reforms since the last Council of Australian Governments (COAG) of Health Ministers meeting – held on 4 August 2017. Minister Hazzard expressed great concern for the welfare of all doctors and their patients. National consistency was preferred but this would not be a simple task, due to certain provisions in a number of state parliaments which were amended in accordance to their own individual state needs and concerns. The Western Australian model was raised as well, but it won't be until November 2017 when the COAG re-convenes for a final decision on the matter.

Following, we will examine the legal scope of mandatory reporting, its critics and what the often-touted Western Australian model provides.

UNIFORM LAWS FOR MANDATORY REPORTING

Nationally the general rule is that any registered health professional must notify the Australian Health Practitioner Regulation Agency (AHPRA) if they form a reasonable belief in the course of their professional practice, that another registered health professional is behaving in a way that would constitute a "notifiable conduct" under the *Health Practitioner Regulation National Law Act*[1]. Such conduct would include for example:

- Intoxication (s140).
- Sexual misconduct (s141).
- Public at risk due to impairment (s141 and inclusive of students as well).
- Public at risk due to a significant departure from professional standards (s142 and inclusive of employers).

Exemptions exist for professional indemnity insurers during the course of a legal proceeding; or in association to a quality assurance committee; or if the health professional reasonably believes that the National Board like AHPRA has been informed (s142).

Current national mandatory reporting laws can have a doctor who sought treatment from a GP, psychiatrist or another health professional suddenly find themselves reported to AHPRA – "if their treating doctor believes they are impaired and could endanger the public"[2]. US psychiatrist Dr Michael Myers who wrote a book entitled *Why Physicians Die by Suicide,* is very critical of these laws stating that it is "driving people away from going for what is, in some cases, life-saving care". Melbourne psychiatrist Dr Helen Schultz adds that this type of reporting "generated a whole layer of paranoia and fear" among doctors and should be "scrapped"[3].

WESTERN AUSTRALIAN EXEMPTIONS

While the uniformity of laws can greatly streamline processes, critiques still exist in that "doctors who are unwell need to feel they can attend their treating doctor without the stumbling block of mandatory reporting"[4]. It has been reported that "over a third" of doctors who participated in a beyondblue survey[5] "were concerned that seeking health care could impact on their registration"[6]. During 2010 in Western Australia a "unique statutory exemption" existed for a health practitioner who provides treatment to another health practitioner from mandatory reporting[7]. Under this scheme a "reasonable belief" is required so as to form a discretionary decision by the health practitioner;

> *Health Practitioner Regulation National Law (WA) Act* 2010
> s4 Application of Health Practitioner Regulation National Law
> s4(7) In the Schedule after section 141(4) (c) insert: (d) the *first health practitioner forms the reasonable belief* in the course of providing health services to the second health practitioner or student

However, mandatory notifications nationally between the years 2011 to 2013 demonstrated that the presence of WA exemptions "has not inhibited reporting"[8].

NOTIFIABLE CONDUCT; PROTECTIVE NOT PUNITIVE

Any reform to mandatory reporting will have to take into consideration as to whether the current system is too rigid or punitive and what would constitute fair and proper notification to AHPRA.

Notifiable conduct usually entails conduct such as intoxication, sexual misconduct, risk of public harm in the practice of one's profession due to impairment or a "significant departure" from accepted "professional standards" under the *Health Practitioner Regulation National Act* ss140-142.

For example, a great majority of health practitioner disciplinary cases sent to the Victorian Civil and Administrative Tribunal have been of a medical nature. The power of a Tribunal is protective[9] in character and not punitive[10]. A balancing test is provided, in that a tribunal not only base its determination on the nature of the complaint but also on the degree to

which a medical practitioner has "acquired insight into his or her offending conduct"[11].

For example; in the case of *Chinese Medicine Registration Board v Woo (Occupational and Business Regulation)* [2010] it was found that Mr Woo's registration as a Chinese Medicine Practitioner be cancelled and that he lacked "good character". This led to his disqualification for a period of two years[12]. It was more than likely to protect the public. Unprofessional conduct in this context was examined in the often-cited case of *Clyne v New South Wales Bar Association* (1960) but with respect to a lawyer's actions. The principles are still the same in that the court stated, "it must be emphasised that a disbarring order is in no sense punitive in character"[13].

CONCLUSION – REVIEWING MANDATORY REPORTING LAWS

Academics have argued that it is unclear whether mandatory reporting has "increased the likelihood of incompetent practice being notified, or whether patient safety has improved as a result"[14]. Others have argued that a "major inconsistency in the regulation of health practitioners in Australia is their mandatory reporting obligations"[15]. Jurisdictions may differ. In most states, there may be a statutory mandatory obligation to report to regulatory authorities, in addition to any professional and ethical reporting duties. But in WA and Queensland notification is based on if a practitioner believes that a doctor has "placed the public at risk of substantial harm in his medical practice because he has an impairment"[16].

Resistance in New Zealand "particularly from the New Zealand Medical Association" has resulted in "discretionary, as opposed to mandatory, reporting", whereby in NSW and Queensland from 2008 to 2010 "mandatory reporting by medical practitioners of their colleagues who demonstrate poor clinical performance, are intoxicated while working or have sexual relations with patients" have been legislated[17]. The National Registration and Accreditation Scheme commenced in Australia in 2010 originating from the Productivity Commission report *Australia's Health Workforce: Productivity Commission Research Report* (December 2005).

NSW Minister for Health (Hon) Brad Hazzard, ASA Policy Officer Elaine Tieu, ASA President A/Prof. David M. Scott, ASA CEO Mark Carmichael and ASA Policy Manager Chesney O'Donnell

Chesney O'Donnell
Policy Manager

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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.

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INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

The ASA has formed a sub-committee of the Economics Advisory Committee (EAC), to deal specifically with the issues arising from the MBS Review. Its members are:

- A/Prof David M. Scott (ASA President)
- Dr Peter Seal (ASA Vice-President)
- Dr Guy Christie-Taylor (ASA Immediate Past President)
- Dr Suzi Nou (ASA Executive Councillor)
- Dr Andrew Mulcahy (AMA Anaesthesia Craft Group Representative and ASA Past President)
- A/Prof Alicia Dennis (Chair, ASA Public Practice Advisory Committee)
- Dr Antonio Grossi (Chair, ASA Professional Issues Advisory Committee)
- Dr Mark Sinclair (Chair, ASA Economics Advisory Committee)
- Mr Mark Carmichael (ASA Chief Executive Officer)

As mentioned in a recent e-new release, representatives of the ASA have been provided with a copy of the draft report of the Anaesthesia Clinical Committee (ACC), which was formed by the MBS Review Taskforce in order to undertake the review of all anaesthesia items in the Medicare Benefits Schedule (MBS). This draft was provided on the condition that it is not distributed further, and that its specific recommendations are not publicised, until the Minister for Health authorises the release of the finalised document for public consultation. Suffice it to say that the concerns of the ASA, based on the composition of the ACC, and its failure to engage in meaningful consultation not only with the ASA but also with relevant clinical experts, have been realised. The ASA has produced a detailed response to the report, and this has been made available to the Department of Health and the Minister, as well as the ACC itself. The ASA hopes to be able to share both documents with anaesthetists as soon as possible, although it is uncertain what, if any, changes will be made to the draft ACC report before it is released for public consultation.

The ASA's MBS Review Subcommittee has produced an alternative, much more reasonable set of recommendations, which will be released for public consultation once the Minister releases the ACC report. The subcommittee is very grateful to Prof David Story (Foundation Chair of Anaesthesia, University of Melbourne) for his expert assistance with the relevant clinical and scientific issues, and particularly for joining the face-to-face meetings being held with ACC and MBS Review Taskforce representatives during the second half of this year.

ACC Chair, A/Prof Jo Sutherland, and ACC consumer representative Ms Helen Maxwell-Wright, have spoken about the MBS Review at both the ANZCA Annual Scientific Meeting (Brisbane, May 2017) and the ASA National Scientific Congress (Perth, October 2017). The information provided at these two events can of course be freely discussed. There are three areas of major concern which have arisen from the information discussed at those presentations.

1. Anaesthesia attendance items

It is clear the ACC intends to recommend major changes to these items, involving the introduction of a great deal of complexity into the wording of the items' descriptors. These changes have been designed as a result of "consumer feedback" indicating concerns with the quality of consultation services by anaesthetists. However, this "feedback" has been based on discussions with a small number of individual patients, and as such, the whole proposal has no real evidence base whatsoever. Evidence demonstrating the need for a complete overhaul of MBS items for attendances by anaesthetists simply does not exist. The MBS Review Taskforce had previously advised that all significant changes made to the MBS as a result of the review are to be based on sound evidence, and are also aimed at simplifying the system. It is clear that the proposed changes to anaesthesia attendance items fail to meet these ideals, and they will therefore be strongly opposed by the ASA.

2. Therapeutic and diagnostic (T&D) services performed in association with anaesthesia

MBS items for these services, such as blood transfusions, local anaesthetic nerve blocks, and invasive pressure monitoring services, are found in subgroup 19 of the MBS version of the Relative Value Guide (RVG). The ACC has expressed concerns about the growth in claims for a number of these items in recent years. The ACC

also appears to have adopted arguments similar to those put by the Medical Services Advisory Committee (MSAC) in the past, when rejecting all applications by the ASA for better recognition for such services in the MBS. The argument is along the lines that these services will be provided by anaesthetists regardless of whether or not tthere is a Medicare rebate, and in the words of A/Prof Sutherland, need to be reviewed in terms of "whether or not they align with contemporary best practice". To the ASA this indicates that the ACC believes unnecessary services are being performed. At this stage no evidence has been produced to support this notion, and nothing has been presented to show the ACC has considered other reasons for the growth in claims for these items, such as the ageing and increasingly medically unwell population presenting for major surgery. It is well known that the population presenting for anaesthesia is increasingly older, sicker, and more overweight. Furthermore, to propose removing items on the basis (again quoting A/Prof Sutherland) that the services are "just something we normally do" overlooks a fundamental principle of the MBS. That is, that services which represent quality care to patients, and for which private patients may be charged a fee, are covered by Medicare, so that patients receive a financial contribution towards this care. Taking the ACC argument to its logical conclusion, and abolishing items which cover services that are "just something we normally do", would mean that huge sections of the MBS would simply be deleted, across all specialty groups.

3. Commonly claimed or "high volume" RVG items

Medicare data for the financial year ended 30 June 2017 again show that RVG items for anaesthesia for gastrointestinal endoscopy, cataract surgery, and dental procedures account for a significant proportion of overall Medicare expenditure on RVG base items (anaesthesia initiation items) – approximately a third of the total.

The ACC noted that the figures for "dollars per hour" spent by Medicare on these items are significantly higher than the figures for procedures of longer duration. The ACC therefore proposes to significantly cut the MBS Fees for these items. There are several clear problems with this approach.

Firstly, based on ASA survey data, anaesthesia services for lens surgery (which are almost always cataract extractions), and gastrointestinal endoscopic procedures, are overwhelmingly provided at no out-of-pocket (OOP) expense to patients. The survey data also indicate that should rebates for these services be cut, the incidence of OOP expenses will significantly increase.

Secondly, this approach is clearly at odds with the concept of a fee for service (FFS) system. A busy list with numerous cases of shorter duration involves the separate assessment and management of a series of individual patients, each with their own unique needs. If simply comparing dollars-per-hour in rebates generated, it is not unexpected that that multiple patients will always generate a higher value than a small number of patients. This is not inappropriate. Should attempts be made to "even out" funding such that all services are funded at a similar hourly rate, either OOP expenses will arise as a consequence of the significant cuts to Medicare rebates for high-volume services, as discussed, or working on lists with a larger number of patients will be de-incentivised, possibly even impacting on the availability of certain services to consumers. The FFS system has come under criticism from some quarters, on the basis that it may encourage overservicing. However, this approach overlooks the crucial fact that it is not anaesthetists who generate the demand for this caseload. Considering the four groups of services listed above, it is clear that anaesthetists can in no way generate demand for these services. There is no possibility of such a system encouraging overservicing by anaesthetists for these high-volume services. It is also noteworthy that this proposed slashing of rebates is unique to anaesthesia. There have been no proposals to cut funding for gastrointestinal endoscopy services, ophthalmological services, or dental services in the same way and for the same reasons (acknowledging that dental services do not generate Medicare rebates and are not part of the MBS Review).

Abolition or significant curtailing of FFS medicine may well be on the agendas of some, but it is not one of the terms of reference of this particular review. Also, the MBS Reviews Taskforce has repeatedly emphasised that the review process is not aimed at saving money. The review has been stated to be aimed at ensuring MBS items are evidence-based, fit for purpose, and are an accurate representation of contemporary medical practice. At no stage has it been suggested that the review must be aimed at evening out MBS expenditure so that all services are rebated at a similar hourly rate. In fact, this approach completely conflicts with the core principle of the RVG – that each

Anaesthesia for:	MBS Item	Claims 2016-17 (x 1000)	Expenditure ($m)	% of total
Gastroscopy	20740	387	$46.9	12.0%
Colonoscopy	20810	351	$36.4	9.4%
Lens surgery	20142	168	$25.8	6.6%
Dental surgery	22900/5	112	$19.4	5.0%
TOTAL				**33%**

INSIDE YOUR SOCIETY

patient's rebate is based on exactly what their anaesthesia service entails, not on an estimation of the average nature of anaesthesia services across all similar procedures, nor on an agenda to reduce private-practice anaesthetists to nothing more than salaried servants of the system.

By the time this edition of *Australian Anaesthetist* is published, the ASA MBS Review Subcommittee will have again met with representatives of the ACC and the Taskforce. ASA members are strongly encouraged to visit the ASA website regularly. The banner on the home page has a link to a number of useful documents regarding the review, and these will be regularly updated as further information comes to hand.

PRACTICE MANAGERS' CONFERENCE

The ASA again held a highly successful PMC in Brisbane in October. We would like to thank the sponsors of the meeting (Avant Mutual Group, Miller Biller, Medical Business Systems, Direct Control Medical, and Meditrust). And of course, the meeting would not be possible without the expertise of our guest speakers – Ms Annabel Herron (Avant Mutual), Ms Lilian Kukuvi (Medibank Private), and Ms Emma Norman (Medical Business Systems). The afternoon Q&A session, which has received excellent feedback, was led by anaesthesia practice managers Ms Lexie Harris (Wesley Anaesthesia and Pain Management) and Ms Cheryl Wood (Associated Anaesthetists Group Ltd), and also featured Mr George Sotiris from the AMA (Queensland) Human Resources Department.

Thanks also go to Ms Jade Melville (ASA Events Coordinator) for doing an excellent job in organising the meeting, with the assistance of the ASA Policy team, Mr Chesney O'Donnell and Dr Elaine Tieu (both of whom also spoke during the morning session).

Members are reminded that their practice managers are entitled to access certain sections of the ASA website. A number of useful resources are available here. All that is required to obtain a password is the name and membership number of an ASA member for whom they work. Registered ASA practice managers are also entitled to free registration at the PMC.

THE ECONOMICS ADVISORY COMMITTEE

2017 has been a very busy year for all of the key committees, but especially for the EAC with the ongoing MBS Review. The Professional Affairs Advisory Committee (PIAC) and the Public Practice Advisory Committee PPAC) led by Dr Antonio Grossi and A/Prof Alicia Dennis respectively, have provided excellent input here and in other areas, and have our thanks. We also thank the ASA team at North Sydney, led by Mr Mark Carmichael. Past EAC Chair, Past ASA President and Life Member Dr Greg Deacon also continues to provide highly valued support. The EAC members for 2017, (including ex-officio members) were:

Chair	Dr Mark Sinclair (SA)
ASA President	A/Prof David M. Scott (NSW)
ASA Vice President	Dr Peter Seal (Vic)
ASA CEO	Mr Mark Carmichael (NSW)
ASA Policy Manager	Mr Chesney O'Donnell (NSW)
ASA Policy Officer	Dr Elaine Tieu (NSW)
Immediate Past Chair	
AMA Federal Craft Group Rep	Dr Andrew Mulcahy (Tas)
ASA Past President & Life Member	
PIAC Chair	Dr Antonio Grossi (Vic)
PPAC Chair	A/Prof Alicia Dennis (Vic)
ASA Specialty Affairs Advisor	
ASA Past President & Life Member	Dr Jim Bradley (Qld)
NSW & ACT EAC Officer	Dr Callum Gilchrist
Vic EAC Officer	Dr Renald Portelli
Qld EAC Officer	Dr Timujin Wong
WA EAC Officer	Dr Rob Storer
SA & NT EAC Officer	Dr Tim Porter
Tas EAC Officer	Dr Michael Lumsden-Steel
Trainee Group Representative	Dr Maryann Turner (Qld)
Committee Member	Dr Mark Colson (Vic)
Committee Member	Dr Graham Mapp (Qld)
Committee Member	Dr Anne Rasmussen (NSW)
Committee Member	Dr Michael Soares (WA)
Committee Member	Dr Ian Woodforth (NSW)

ASA MEMBER'S GROUPS UPDATE

TRAINEE UPDATE – PERTH NSC

Scott Popham, Immediate Past Chair

As always it was great to catch up face-to-face with the state representatives at the Perth NSC. The state reps are highly motivated registrars who willingly invest time and energy into ensuring that trainees voices are heard within the Society at a state and national level. It was a great opportunity to welcome Richard Seglenieks as the new TMG Chair.

The main topics of discussion surrounded trainee welfare, the various projects occurring in this realm (see the feature article), the role of the society in training as well as the logistics of various educational and networking events organised by the ASA Trainee Members Group (trainee stream at the Perth NSC, next years stream in Adelaide, Part Three Courses assisting with the transition to consultancy and state specific lecture evenings).

The NSC itself opened with the Kester Brown lecture from Professor Bruce Robinson who delivered a thought-provoking session about fatherhood and medicine. The importance of work life balance was addressed as well as strategies for achieving this. My impression was that this topic was rather unorthodox for an opening lecture but it paid off, seeming to touch a nerve with all who attended.

Another notable talk was a Meet the Presidents session where Dr Jeff Plagenhoef gave a rousing talk on professional citizenship. He spoke of threats to anaesthesia as a speciality (both within and outside the operating theatre) and the danger of complacency when advocates are needed. In the USA there are the usual threats of government policy, health fund agendas plus the added pressure of nurse anaesthetists fighting for more independence and remuneration (at the moment this is not a reality in Australia, but the possibility has come up in various forums and the Society has a stance). His message was to take ownership of the speciality, 'give' more than you 'take' and ended with the following quote:

"Patient safety and anaesthesiology will not be destroyed by those unaware of

Chair, Scott Popham at left with trainee members at NSC 2017, incoming chair Richard Seglenieks on the right

INSIDE YOUR SOCIETY

what is required for optimal patient safety and quality of care but by those totally aware – through training and experience – who watch them and elect to say or do nothing to lead in the right direction."

The MBS review session illustrated a case in point where anaesthesia is being targeted. Dr Jo Sutherland (Chair of the Anaesthesia Clinical Committee for the MBS review Taskforce) and Ms Helen Maxwell-Wright (patient advocate) delivered a presentation on their role and received impassioned feedback from many in attendance. The main points of contention were that the ASA was poorly represented from an economic perspective and that there seemed to be a lack of transparency in the recruitment process for the committee as well as information relating to decision-making processes. Ultimately it is up to the Minister for Health to make a decision after the recommendations from the committee have been presented, and as such the ASA is focussing on the liaising with the Minister where possible.

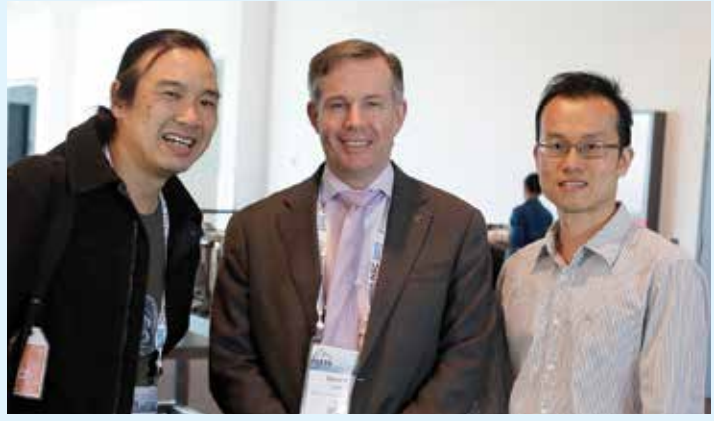
The Welfare SIG session on Suicide Prevention at Work and in the Community invited speakers from BeyondBlue and LivingWorks to discuss the conversations that we can have in the workplace if we suspect (or if someone indicates to us) that they are considering suicide. It is of the utmost importance to never be the only person who knows that someone is thinking about suicide and there are resources and training courses available to assist people with having these conversations.

The whiskey workshop on the Monday was a fantastic idea and showcased several, very distinct malts from a local distillery. Being Scottish by birth it was a great opportunity to learn a thing or two about my palate and be a bit more informed when engaging in conversations about the beverage!

It's impossible to attend all the stimulating sessions that are organised* but I would recommend you give it a good try, and register for Adelaide NSC 2018.

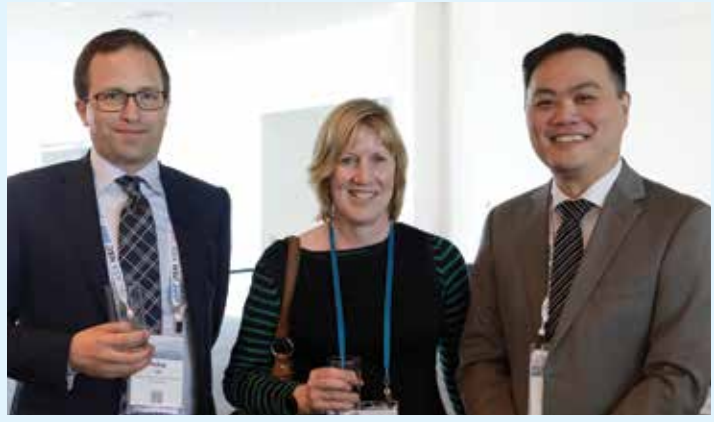
* I also attended exceptional talks relating to statistics, research methodology, an *Anaesthesia and Intensive Care* editors session, a Part 2 prep course, the annual general meeting and a discussion from Prof David Story about positive leadership. Not to mention the untold social and networking events.

ASA Trainee Members' lunch, NSC 2017



Trainee members with David M. Scott at Trainee Members' lunch

ASA Trainee Members' lunch, NSC 2017



Philipp Lirk, Jodi Gordon and David Law at Trainee Members' lunch

ON SACRIFICES

It was approaching midnight and I was working overtime with my consultant as we were anaesthesing a premature infant in our neonatal ICU. Cachectic and small, too young to understand how delicately her life hung by just a thread, we worked with the surgical team to give her a fighting chance. Afterwards, with her finger stroking the bare skin that was not burdened by infusion lines or dressings, her young mother wept and said, "I appreciate you being away from your family to save mine."

I am blessed to be a physician. There is no other job that satisfies my thirst for intellectual curiosity, that constantly throws daily challenges at me and yet is able to distill a sense of regard for humanity. Our reward is a humbling connection, a glimpse into our patient's private lives who if not for circumstance, would just be nameless faces we pass by on a street.

And it comes with a price. The practice of medicine is life-long and time consuming, The years we invest in late-night studying, as life quietly shuffles past like a thief in the night robs us of a choice to pursue other enriching pursuits. We move away from home and across geographical boundaries for training, we have sleepless nights perusing over our failures and we stay just a little while more for the critically ill as our family waits. For when we falter, the consequences are too punishing. This is a profession that provides a privilege but not without the occasional paralysis.

There may be times when regret and despair sink in. The manipulative drug seeker that harasses the ward staff and hurls abuse at you. Holding a letter that spells out an unsuccessful exam attempt as you count the many months prior that were spent in vain. Having a patient die on the table as you place the adrenaline syringe down in weighted defeat.

But somehow, somewhere along the way, there will be someone who will hold your hand as you wheel her into the operating theatre, saying thank you. There will be many more who will have their appreciation sketched on their faces, or animated in their gestures. You may feel an elated rush as you peek through the ICU curtains to see a patient survive because you didn't let them die days ago. Those hours spent away from living life will lead to a breadth of experience that will help so many in the future.

A consultant once told me that boredom is the result of not pushing ourselves further. This early stage in my career demands this sacrifice, for I need to be better if I want to provide safe quality care. This is my responsibility as a physician and so, I must face any adversity with my head held high. If I had a chance to live my life again, I would choose to face this challenge once more. But only with a more hardened heart and a humbled mind gifted to those who have lived through it all.

Dr D. Ishak
Advanced Trainee, Tasmania

INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

National Scientific Congress 2017 – Perth

The Congress was a great success and included a well-attended RAG luncheon with 35 guests. It was great to see our former colleagues and particularly good to see so many of our WA members including Wally Thompson the WA RAG Chairman.

Associate Professor David M. Scott, ASA President, welcomed our RAG members and a good time was had by all.

NSW GROUP

Dr Donald Maxwell

RAG NSW had its second luncheon of the year in August 2017, attended by 29 guests, at The Cruising Yacht Club of Australia in very pleasant surroundings. At all our recent lunches we have had one of our members speak on a topic of special interest. This has enlivened the lunch and has been quite popular. RAG members have all sorts of interests outside medicine!

At this lunch Dr Newton Potter spoke on 'Woodworking – from furniture to boxes' and showed some of his work. Newton is a former NSW State Chairman of the ASA. He was also formerly Director of Anaesthesia at Crown St Women's Hospital Sydney and later in private practice at Royal Newcastle Hospital in the Hunter Valley. He developed an interest in woodworking in Newcastle, England as an 11-year-old boy. In retirement this became a passion.

SOUTH AUSTRALIA

Dr John Crowhurst

Dr John Hancock, the most senior member of the SA RAG, died two weeks ago after a short illness. John was one of the first specialist anaesthetists in SA.

Prof. David Cherry was guest speaker at our September lunch meeting, when he presented a fascinating account of his researches into 'World War I Censorship', the unappreciated and largely unknown directives of British army generals and other senior military officers given to their underlings at 'The Front'. The massive death tolls, which will never be forgotten, could have been avoided.

Our November meeting will be held at the Kensington Hotel on Monday 13th November, and will be the last for 2017.

AUSTRALIAN CAPITAL TERRITORY

George Jerogin and Hugh Lawrence

ACT retired anaesthetists are few in number. Some 12 on the books, so that our sporadic group meeting is small but lively. More organised are quarterly get togethers with other specialists and GPs.

We keep in touch with anaesthetic events such as the 'Thomas Lo' ASA Prize presentation to be held in November with registrars presenting papers on current topics.

In May some of us met socially with our ever-increasing number of working anaesthetists (anaesthesiologists) and registrars at the invitation of Mark Skacel, Chair, ACT Committee.

We expect our numbers in retirement to increase and report with greater frequency.

VICTORIA

Dr Rod Westhorpe

In September, 30 members and guests enjoyed a visit to the 'Australian Garden' of the Royal Botanic Gardens, Victoria. This garden was established in 1970, some 50km south east of the city of Melbourne, to promote the cultivation and research of Australian plants. The area now occupies 363 hectares and is under continuing development and expansion, with areas to demonstrate all aspects of the Australian landscape.

We enjoyed a fascinating lecture by Dr Neville Walsh, the Senior Conservation Botanist at the Royal Botanic Gardens, co-author of the four volume *Flora of Victoria* and author of numerous other scientific publications. Following a delightful lunch, we were taken on a guided tour of sections of the gardens.

Our next meeting on 15th November will be addressed by Tony Bajurnow on 'The Dead Sea Scrolls'.

We are sad to report the death of long-time member, Bob Cowie, who had been ill for some time.

RETIRED ANAESTHETISTS GROUP LUNCH, NSC 2017

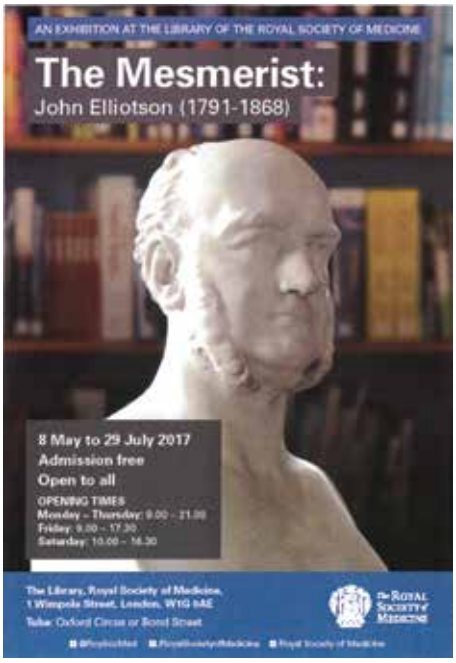
MESMERISM MARCHES ON

A recent display in the Richard Bailey Library highlights recently published novels, biographies and an exhibition relating to mesmerism.

MESMERISM IN PRINT

The Booker Prize winner, Tasmanian Richard Flanagan, made references to mesmerism in his *Gould's Book of Fish* (Picador, 2001). Catherine Jinks from the Blue Mountains, NSW, wrote this year about the stage mesmerist Thomas Gutherie Carr in *Charlatan* (Vintage Books, 2017). Other recent books include Cayle Lynds' *Mesmerized* (Harper Collins, 2001) Barbara Ewing's *Mesmerist* (Sphere, 2007) and Wendy Moore's *The Mesmerist* (Weidenfeld and Nicholson, 2017). The latter book describes the feud between John Elliotson and Thomas Wakley about Elliotson's over-confident claims for mesmerism.

An exhibition at the Royal Society of Medicine in London this year also discussed the mesmerist John Elliotson.



Brian O'Doherty's *The Strange Case of Mademoiselle P* (Midgal Press, 2000) goes back to the practice of Dr Franz Anton Mesmer. Mesmer partially restored the sight of a girl who was blind since age three only to have her sight fail again when her parents intervened.

That writing about mesmerism is not a new phenomenon is shown by *Victorian Literary Mesmerism* edited by Martin Willis and Catherine Wynne (Rodopi, 2006) who discuss and instance references to well-known European authors such as Thackeray, Dickens, Balzac, Dumas, Collins, du Maurier, Browning, Coleridge and Shelley. Who did not learn part of *The Rime of the Ancient Mariner* by Samuel Taylor or read at least some of *Dracula* (Bram Stoker, 1897) or *Frankenstein* (Mary Shelley, 1818)?

In a paper in *Anaesthesia and Intensive Care* (Vol 40, 2012 (Suppl 1): 10-17) I published a table showing the number of publications about mesmerism from the 1760s to the 1920s. The peak years for publications were the 1780s, 1850s, 1889s and 1920s. Perhaps the early 2000s will show another peak?

MESMERISM IN AUSTRALIA

Mesmerism does not seem to have raised much attention in Australia's earliest years. More pressing matters were on the mind of most people: food, wealth and a place to live were paramount concerns. If mesmerism is a form of hypnotism practised by an authoritative imposing person on a willing and believing subject, the conditions in the early white settlement of the land were hardly conducive to the practice.

In the *Sydney Morning Herald*, Wednesday 16th July 1845, WB Clarke wrote:

> *We had never known or heard of mesmerism in Australia until Mr. CUNNINGHAM's recent experiments, one before a select party of the philosophically curious, at the Sydney Hospital, and another in a private house. The subject of the first was a man. The man was placed by the operator in a reclining position, who forthwith began staring at his patient and pawing the air before his face in the orthodox fashion, until in about half an hour the latter fell into a sound sleep. With the object of showing that this sleep was not simulated, pins were thrust into the man, with philosophical indifference, by the spectators, the patient showing no more disturbance at the insertion than if he had been an ordinary pincushion.*

Dr Richard Bailey has drawn my attention to an article in the *Sydney Morning Herald* on Saturday 5th December 1846 about James Esdaile's successful mesmeric practice in India. The same publication later lampooned mesmerism:

> *The time may arise when vain and foolish old ladies will walk off to their dentist, and, during a mesmeric nap, change their teeth, as coolly as they may drop in at Robinson's to have their hair cut.*

Mesmerism was certainly practised in Australia by 1854 when Caroline Harper Dexter from Nottingham arrived a year after her husband had come to seek a better life. He went to the goldfields. She had been educated in France at a time when enthusiasm for mesmeric phenomena was high. Parting from her husband soon after her arrival, she set up in Collins Street Melbourne as Madame Carole in 1858. She practised as an herbalist, mesmerist and clairvoyant (she preferred 'clairvoyante') but eschewed spiritualism. Most of her patients were women who did not like discussing

INSIDE YOUR SOCIETY

their concerns about health with male doctors and needed more than anything a sympathetic ear. Dexter attempted to attract a supply of new patients by her publications: *Ladies Almanack: The Southern Cross* or *Australian Album and New Year's Gift* (1858) and *The Interpreter: An Australian Monthly Magazine of Literature, Science, Art* (1861).

In contrast, in the northern hemisphere, as early as 1789 a play, *Animal Magnetism*, a farce of three acts, written by Mrs Elizabeth Inchbald, was performed in the Theatre Royal, Covent Garden, London. The text is available on the internet at http://quod.lib.umich.edu/e/ecco/004834158.0001.000/1:3?rgn=div1;view=fulltext.

FILMS ABOUT MESMERISM

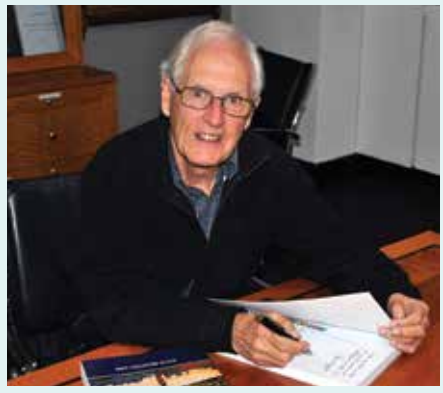
I am indebted to Dr Rajesh Haridas who has given me a list of some early films alluding to mesmerism, two of which can be viewed on YouTube. The list includes:

- Edison, USA: The Mesmerist and the Country Couple, 1899 (Available on YouTube)
- Méliès, France: Mesmerism
- Méliès, France: A Mesmerian Experiment, 1905 (Available on YouTube)
- Pathé Frères, France: The Mesmeriser
- Pathé Frères, France: Astounding magnetism
- Pathé Frères, France: Chinese Juggler and Mesmerizer
- American Vitagraph Co., New York: The Mesmerist

The two that can be seen on YouTube are early cinematic comedy rather than depicting science or medicine.

In view of the many recent publications in print about mesmerism, perhaps the time is right for a serious full length feature film?

Dr Peter Stanbury
Librarian, Richard Bailey Library



Dr David Gibb recently presented the Richard Bailey Library with two comprehensively illustrated biographies entitled *From Birth to Berth – My First 27 Years* and *A Tale of Three Cities*. The books were personally signed by David in the Library after a recent HALMA meeting. Such items are of important historical interest to the Society.

YOUR TRASH IS OUR TREASURE

The role of the museum is twofold, collecting and storytelling. Curators, the bowerbirds of the history world collect objects for their significance and the stories associated with them.

The accompanying image is an artwork created by nurse and author Tilda Shalof with artist Vanessa Herman-Landau. There are over 10,000 little plastic pieces in the artwork. The coloured pieces are some of the disposable lids, tabs, levers, pins, screws and connectors collected from the equipment used, or medications given to patients by Shalof during the course of her 28 years working in Toronto General's ICU. Each piece in the artwork has a story, each is a talisman of the patient treated; for many a symbol of the condition cured, and for others a key to the afterlife.

Shalof writes:

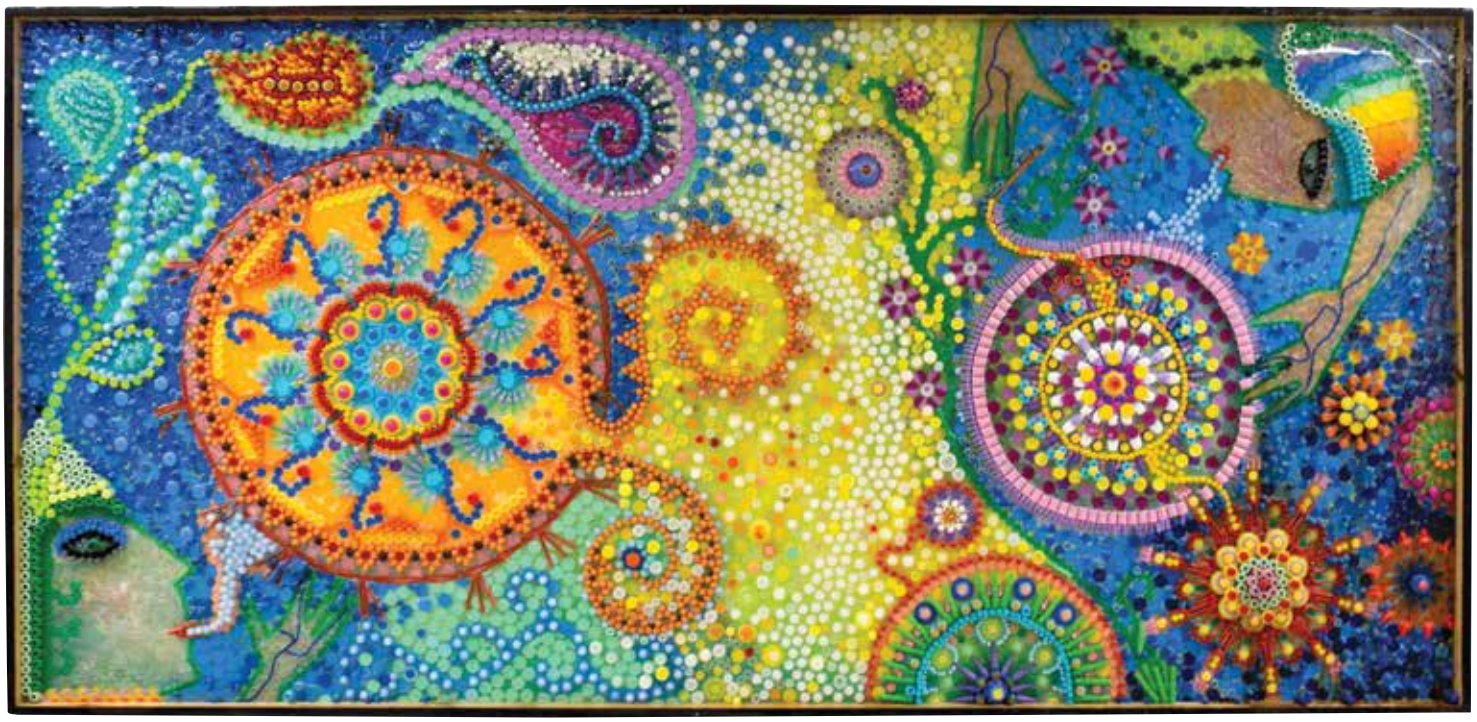
Mindfulness is the key message in the mural. You may not see value in these small pieces alone, however when you put many of them together with a helpful imagination you can turn these little fragments into something of value.

All these little things we do are huge for the patient. We do it hundreds of times a day and night for all these years but each thing that we did with each little piece of plastic meant so much to the patient.

The Harry Daly Museum is in the business of storytelling. Like Shalof we collect what are sometimes perceived as meaningless objects. But it is the stories behind and associated with these objects that give them their meaning. The stories told are the stories of anaesthetists, and the history of those that came before to develop the profession into what it is today.

We collect both large and small things, complete and incomplete. The interpretation potential of an empty vial is just as strong as a full one if not more so for… who was the agent administered to, what is that patients story, and what is the story of the practitioner who administered it? As such we like empty packets, packaging, marketing material and those scraps of paper you've written notes on.

As the gatekeeper to 'our repository of small things' over the last five years or so, on occasion, and quite innocently I have found myself on the wrong side of the law… I speak of those occasions where restricted drugs (Schedule 8) have appeared on my desk or been discovered in the bottom of a box or exhibition cabinet. Tablets of cocaine and



A Mural Moment. 2016. Tilda Shalof and Vanessa Herman-Landau 1.2m x 2.7m. Toronto General Hospital, USA. Photo: Ellie Landesberg.

morphine, ampoules of pethidine and hydromorphone (Dilaudid) and a drawer full of ketamine are some of the restricted items I have handled.

My request henceforth is this; please bring the packaging, I want it, I want to know all about the contents and the story of the patient, you the anaesthetist who did the administering, the weather that day and the mood of the theatre or consulting room, even the colour of the walls and what you ate for breakfast that morning, just not the drug.

Thus prior to making donations of any agents listed please dispose of the contents prior to donation and according to the regulations. It's much more romantic for the agent to be administered by you than to be poured by me into a plastic bag full of clay kitty litter under the supervision of a representative from the NSW Department of Health.

To learn more about Shalof's work or mural visit www.nursetilda.com, Email: tilda@nursetilda.com.

See interview https://www.youtube.com/watch?v=ex54lkG5afw.
Herman-Landau can be contacted at vanessahermanlandau@gmail.com

Please note we currently have a 12 month hold on donations to the Harry Daly Museum to clear the backlog of items procured during my maternity leave. So keep them in that shoebox in your bottom drawer until December 2018 and then we'll come knocking!

Anna Gebels
Curator, Harry Daly Museum

SCHEDULE 8 DRUGS – DRUGS OF ADDICTION

Alfentanil, alprazolam, amobarbital (amylobarbitone), amfetamine (amphetamine), buprenorphine, butorphanol, cannabis, cocaine, codeine, dexamfetamine (dexamphetamine), dextropropoxyphene, dihydrocodeine, diphenoxylate, dronabinol, fentanyl, flunitrazepam, hydromorphone, ketamine, lisdexamfetamine, methadone, methylamfetamine (methylamphetamine), methylphenidate, morphine, nabilone, nabiximols, opium, oxycodone, pentobarbital (pentobarbitone), pethidine, pholcodine, quinalbarbitone (secobarbital), remifentanil, secobarbital (secobarbitone, quinalbarbitone), sodium oxybate, tapentadol, and tetrahydrocannabinols.

CONTACT US

Contact us to arrange a visit to browse or for research. We are open by appointment Thursday and Friday, 9am to 5pm. Please phone ASA head office (1800 806 654).

INSIDE YOUR SOCIETY

OCTOBER 16, NATIONAL ANAESTHESIA DAY

On 16 October 1846, William T. G. Morton performed the first public demonstration of surgical etherisation at Massachusetts General Hospital, Boston, MA, USA.

Morton administered sulphuric ether to Edward Gilbert Abbott for an operation performed by Boston's leading surgeon John Collins Warren. Reports of surgical and dental operations performed when patients were rendered insensible by the inhalation of ether appeared in newspapers, medical journals and in personal correspondence from Boston's physicians. Ships carried news of etherisation to Europe and the rest of the world.

Travel between Europe and Australia by sailing ships was accomplished in approximately four months. In Australia, the earliest known report of surgical etherisation appeared in the 4 May 1847 issue of the *South Australian*, published in Adelaide, SA. This newspaper report described an operation performed in Edinburgh in January 1847. The earliest reported operations under etherisation in the Australian colonies were performed on 7 June 1847.

October 16 is known around the world as Ether Day, National Anaesthesia Day and World Anaesthesia Day. The names are analogous to the three ways in which the day is observed: as a celebration of a historic moment in medicine, as a day to educate the public about anaesthesia and as a day to contemplate the world-wide challenges facing anaesthetists.

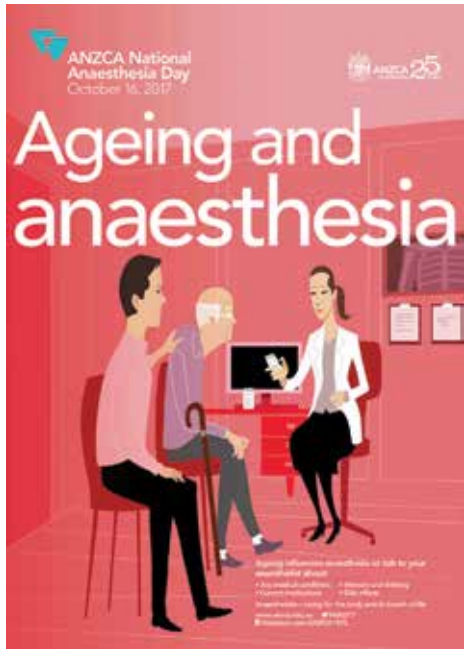
ETHER DAY

In the early twentieth century, October 16 came to be known as Ether Day. Annual celebrations and Ether Day addresses are held at Massachusetts General Hospital, Boston.

On 16 October 2016, a seminar on the history of anaesthesia was held at the offices of the Australian Society of Anaesthetists, Sydney. From 2018, annual history of anaesthesia seminars will be held in June, close to the anniversary of the first ether anaesthetics in Australia.

NATIONAL ANAESTHESIA DAY

In Australia and New Zealand, October 16 is known as National Anaesthesia Day. Promoted by the Australian and New Zealand College of Anaesthetists, the day is an opportunity to raise public awareness of the clinical responsibilities of anaesthetists and promote educational campaigns. This year the theme of National Anaesthesia Day was 'Ageing and Anaesthesia: the influence of ageing and coexisting medical conditions on anaesthesia'.



WORLD ANAESTHESIA DAY

October 16 is also known as World Anaesthesia Day. On this day anaesthetists may reflect on the achievements of the profession and the global challenges in the provision of adequate and safe anaesthesia services. We can support colleagues around the world and promote campaigns to improve medical care.

On October 16, 2017, the World Federation of Societies of Anaesthesiologists (WFSA) launched the "Count Me In!" campaign to raise awareness of the shortage of anaesthesia providers.

The WFSA Fund a Fellow program is an educational program for anaesthetists from lower income countries. Fifty-one fellowships are awarded each year for six month training programs in subspecialties such as paediatric and obstetric anaesthesia. Donations support a Fellow's travel and living expenses. [WFSA Fund a Fellow: https://www.wfsahq.org/get-involved/as-an-individual/fund-a-fellow]

The Lifebox Foundation, co-founded by the WFSA in 2011, distributes pulse oximeters for use in under-resourced hospitals to make anaesthesia and surgery safer. The foundation also promotes programs such as the Surgical Safety Checklist (a perioperative checklist) and Clean Cut (a program to reduce surgical site infections). [Lifebox. At www.lifebox.org/about-us/]

On every October 16, get involved: celebrate, educate, contemplate and advocate – and contribute to global campaigns to make anaesthesia safer.

Rajesh Haridas
Honorary curator, Harry Daly Museum and Honorary librarian, Richard Bailey Library

* This article contains material published in an editorial titled 'October 16: Ether Day, National Anaesthesia Day and World Anaesthesia Day' in the *Journal of Anesthesia History.*

AROUND AUSTRALIA

SOUTH AUSTRALIA

Josh Hayes, Chair

Congratulations to the convenors of the 2017 ASM on a well-received and attended meeting!

Preparations for the 2018 Adelaide ASM are coming together – the educational and social program should be excellent. I hope it is already in your diary. The program for the 2018 CME evening meetings is also being finalised by the SA/NT CME Committee.

Our Post exam/Networking event was held at Stone's Throw in Norwood on the 27th of October. Those that attended seemed to enjoy themselves. The ASA and ANZCA also supported the annual trainees dinner held on the 4th November.

Please note that we hope to hold at least one meeting updating on the MBS Review in the coming weeks. If notification hasn't arrived in your inbox already, keep an eye out for it.

Finally, a group of retired Adelaide anaesthetists are gathering information for a book that they intend to publish – '1847-1997, The first 150 years of Anaesthesia in South Australia'. They are sourcing archival information on individuals who contributed to the specialty in that period but unfortunately the minutes of the ASA meetings from 1934 to 1981 appear to have been misplaced. They were handwritten in a large (approximately foolscap) leather bound book (pity the secretary of the time!).

On behalf of Dr John Richards and this group could I ask that anyone with information on its whereabouts, or other relevant anaesthetic memorabilia contact Dr Richards at Hercules@micronet.net.au or via myself.

WESTERN AUSTRALIA

David Borshoff, Chair

The biggest news from WA in the last few months is the outstanding success of the ASA NSC.

It proved to be a very enjoyable four days, and despite the ambivalent weather, many of the European visitors seemed undeterred! The scientific program was well received and all key note speakers delivered many interesting and thought-provoking presentations.

The Gala Dinner with its theme of 'A Song of Ice and Fire' was a spectacular event. Dr David Law and his Sir Charles Gairdner's Hospital Anaesthetic Department organising committee deserve all their accolades. It was a wonderful evening.

WA Health appears to have extended its simulation contract with ECU to continue EMAC courses through 2017/18 until the Perth Childrens Hospital is ready. There are four courses between November 2017 and June 2018 currently advertised.

ANZCA have made inroads into drafting a proposal for ASA reinstatement on the Morbidity Mortality committee. We have received a response from the DoH after enquiries made by Jay Bruce from ANZCA, requesting an outline of the additional expertise the ASA would bring to the committee. It is undoubtedly going to be a long and uncertain process but we are grateful to ANZCA and Dr Jay Bruce for their collaboration and determination in trying to resolve this issue.

Difficult private health economic conditions continue and despite some initial proclaimed differences between institutions, word is that most are implementing changes to see out this current climate.

There is very little to add to our Children's Hospital saga. Its opening time is still uncertain and my understanding is that water lead levels have still not returned completely to acceptable levels.

Although there initially had been little talk of the MBS review in this state, since the NSC and the MBS review session, the distinct lack of scientific evidence for proposed changes to the RVG has stimulated much discussion and considerable passion. It will be interesting to examine the details if the report is eventually released.

TASMANIA

Dr Michael Challis, Chair

Things have been relatively quiet for the Tasmanian committee over winter, although our one-day Winter CME meeting was held at the iconic 'Barnbougle Dunes' and was very successful. Attendance was very pleasing, and the feedback was very good,

INSIDE YOUR SOCIETY

particularly regarding the CICO workshop run by Dr Dane Blackford. I would like to thank the organising committee for their hard work, and plans are already underway to hold next year's event at the same location.

Our 2018 annual scientific meeting is shaping up nicely, but will be reduced to a one-day event in 2018 (Saturday 3rd March). It will still be a high quality meeting with interesting speakers and opportunities to obtain valuable emergency response CPD points, so please consider making the trek to Hobart and enjoying some of the best weather of the year here.

Like the rest of the country there has been lots of discussion among Tasmanian anaesthetists about the potential outcome of the MBS review in relation to anaesthesia. Many Tasmanian anaesthetists have serious concerns about rumoured changes to the RVG section. As with any modern review we expect any proposed changes to be based on the best available evidence. Proposed changes that are based on anything less than the best available evidence will no doubt be met with hostility, and challenged appropriately. Like all interested anaesthetists we wait anxiously for the official recommendations of the Anaesthesia Clinical Committee to be released and appropriate responses to be made.

ARUMUGAM (TONY) GANENDRAN 1927 – 2017

Arumugam (Tony) Ganendran was born on 1st April 1927 and passed into eternal life on Monday 18th September 2017.

Tony was born in Kuala Lumpur on 1st April 1927 and received his early education at the Pasar Road School and the Victoria Institution. He successfully applied to the University of Bristol to study medicine and qualified in 1956. In 1957 Tony moved to Singapore and took up a position as an anaesthetic trainee. In 1960 he received a two-year scholarship for Advanced Anaesthetic Studies and Training at the Liverpool Post-Graduate School of Medicine. In Liverpool he was mentored by several founders of the specialty of anaesthesia in the UK including Professor T. Cecil Gray, Dr Gordon Jackson Rees, Dr Alan Stead and Professor John Utting. During this time Tony sat for the Primary fellowship examination and was awarded the Nuffield prize. The following year, Tony passed the final fellowship exam and became a Fellow of the Faculty of Anaesthetists of the Royal College of Surgeons in 1961. Also in 1961, Tony sat and passed the exam to become a Member of the Royal College of Physicians. This was an astonishing and exemplary series of academic achievements in a very short space of time.

Tony returned to Singapore as a Senior Registrar in 1962 and in 1963 was appointed as anaesthetist in charge of neurosurgery at the Thomson Road Hospital Singapore. In 1965 Tony was invited to set up the anaesthetic department at the University of Malaya. Having established the first independent anaesthetic department in Malaysia and Singapore, he conducted research, including pioneering work on the treatment of tetanus in intensive care with the careful use of Gamma Hydroxybutyrate for deep sedation, for which the Academy of Medicine, Singapore awarded him the Galloway Memorial Prize in 1963. Among his other milestones and achievements were the establishment of the first Intensive Care Unit in Malaysia in January 1969 followed by involvement in the first successful open-heart surgery in Malaysia (including Singapore). In 1973, he was elected to the award of FFARACS and as a Fellow of the Royal College of Physicians.

His greatest achievement at that time was obtaining full recognition from the Faculty of Anaesthetists of the Royal Australasian College of Surgeons for the establishment of a training centre for anaesthetists at the University of Malaya Medical Centre. Six training positions were established, with the first batch of fully trained anaesthetists graduating, with the Australasian FFARACS in 1974.

Subsequently he conducted research into the treatment of organophosphate insecticide poisoning which was not uncommon in the region at that time and ultimately led to his award of the degree of Doctor of Medicine by dissertation in 1975 from the University of Bristol. In 1976 the position of Chair of Anaesthesia was created at the University of Malaysia and Tony was appointed as the first Professor of Anaesthesiology in Malaysia and Singapore after a rigorous selection process, in the face of international competition. In recognition of his contribution to the profession of anaesthesia, he was awarded the DPMT, a knighthood carrying the title of Dato by the Sultan of Terengganu in 1977.

Tony was a close friend of Professor Tess and Doctor Humphrey Cramond. When Tony was considering a move and also furthering his career in 1978, he had two countries in mind which were the USA or Australia. He had been offered positions in both countries. He discussed the options with Tess and she strongly encouraged Tony to choose the position as Director of Anaesthesia at Greenslopes Repatriation Hospital in Brisbane. After taking up the position, Tony reorganised the anaesthetic department using his previous experience and was responsible for the training of anaesthetic registrars and also medical students. In 1995 the hospital was sold to Ramsay Health Care and in 1996 was renamed Greenslopes Private Hospital. Tony was appointed Director of Anaesthesia in the hospital under the new administration.

INSIDE YOUR SOCIETY

Tony also visited the Dental Hospital in Brisbane where he instructed dental students and, in recognition of his work in anaesthesia and dentistry, he was appointed as a Clinical Professor of Anaesthesia of the University of Queensland in 1993. He retired from his directorship at Greenslopes in 2002 but continued providing anaesthesia at Belmont Private Hospital until he retired from clinical practice in 2007. However he continued his academic activities after retirement and completed an MA in Theology in 2005 at the Australian Catholic University.

As well as high achievements in anaesthesia, Tony also excelled in other complex activities such as becoming a registered owner builder and supervising the building of his own house in Carindale in 1984.

Tony was married for over 58 years to his dear wife Cecilia. His four children Jaci, Billie, Frank and Tony all became professionals in their own right, following in their father's ethic of hard work and determination, and in Tony Junior's case, also following the specialty of Anaesthesia. His 90th birthday party was a wonderful event, celebrated by family and many friends earlier this year, and Tony impressed us yet again with his good health and sharp wit.

Tony was a devout Catholic and a Knight of Malta. He received Holy Communion and the Last Rites in his last few hours of life. He passed away peacefully in the early hours of Monday 18th September, surrounded by family. He is survived by his dearly loved wife Cecilia, his four children and six grandchildren. He is sadly missed by his family, friends and colleagues. Tony brought joy and fulfilment to many, and his legacy will live on forever.

Dr Martin D. Culwick
Friend and colleague with assistance from the Ganendran family.

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from August to November 2017.

TRAINEE MEMBERS

Dr Luke Neville Arthur	SA
Dr Thomas Joel Chalk	NSW
Dr Thomas David Darling	NSW
Dr Tabara Dione	VIC
Dr Ronald Kam Fai Fung	NSW
Dr Brendan Goodwin	QLD
Dr Tiffany Ellen Holmes	QLD
Dr Klara Krivanek	VIC
Dr Daniel Ka Yue Lau	VIC
Dr Vivian Liang	VIC
Dr Mahsa Mirkazemi	NSW
Dr Daniel Gerard O'Callaghan	WA
Dr Justine Majella O'Shea	NSW
Dr Rosalind Elizabeth Oakes	WA
Dr Sanchia Sapphira Smith	NSW
Dr Shervin Tosif	VIC
Dr Ya-Chu May Tsai	VIC

ORDINARY MEMBERS

Dr Thiago Anderson Cabral Moreira	WA
Dr Nicholas Charles Chrimes	VIC
Dr Vyhunthan Ganeshanathan	WA
Dr Arya Gupta	WA
Dr Michael Hicks	NSW
Dr Martin (Saejin) Kim	VIC
Dr Jonathan Lau	QLD
Dr Martyn Ian Lethbridge	WA
Dr Patrick Liston	NSW
Dr Praveen Babu Mamillapalli	SA
Dr Jeremy Ian Milne	WA
Dr Michael Mould	NSW
Dr Neil Lawrence Pillinger	NSW
Dr Robert Savage	NSW
Dr Fiona Taverner	SA
Dr Tracey Maree Tay	NSW
Dr Grant James Turner	QLD
Dr William Edmond Wilson	SA
Dr Camille Yip	NSW
Dr Josko Zaja	QLD

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Robert William Cowie, VIC, Dr Rudolf Duncan Anderson, WA and Dr Richard Hugh Connock, VIC.

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

REMEMBERING A 'GIANT' OF ANAESTHESIA: EDMOND I. EGER II

Edmond I. Eger II died peacefully on August 26, 2017, in the company of his family after a short illness with pancreatic cancer. He was but a week short of his 87th birthday.

Known to all as 'Ted', his contribution to the science and practice of anaesthesia ranks with an elite group of teachers and researchers who have had a profound and continuing global influence on the growth and development of the specialty. He is best known for his role in the introduction of 'MAC' (minimum alveolar concentration) as a standard dosing unit for all inhaled anaesthetics, a tool that became a standard for their administration and study. He also identified the processes governing the onset, uptake and distribution of inhaled anaesthetics into the lungs and body tissues. These principles have governed the administration of these agents to this day. He was thus intimately involved in the pre-clinical and clinical research that preceded the introduction of nearly all the inhalation anaesthetics used in the last sixty years.

Born in Chicago, the son of an advertising executive, Ted graduated from Hyde Park High School at the age of 15. He graduated at the lower end of his class but had excelled at checkers (draughts) and led his school checker team to two championships. He started work selling women's shoes, only to quit after one day, resolving to study hard. He enrolled in Roosevelt College in 1946, transferring to the University of Illinois a year later, from which he graduated with a major in chemistry and a minor in mathematics. He then enrolled in Northwestern Medical School.

As a new medical student, he had visions of becoming "a second Robert Koch who would make great discoveries as a general practitioner", however Ted's career in anaesthesia began at the end of his first year, in 1952, as he set about earning some money as an 'extern'.

Ted's earliest recollections of anaesthesia were two ether anaesthetics as a child. He recalled a "choking swirling down into vortex of descending blackness", and the need for "four strong men to hold me down".

After a two-month summer apprenticeship in anesthesia, I would take call for my mentor, who could rest secure at home knowing that the care of emergency patients was in my capable hands! On that first day, he showed me how to start an intravenous infusion of 0.2% thiopental, dial a 70% concentration of nitrous oxide, properly hold a rubber mask to the patient's face, and watch the rebreathing bag. Then he left the room. And I was in trouble. The rebreathing bag moved less and less and finally stopped. I knew little of anaesthesia… but I knew that breathing was good and not breathing was bad. In a squeaky voice, I told the surgeon… Instead of berating me… he asked if I wanted him to give artificial respiration. 'Yes, please', I responded, voice still high pitched. The surgeon squeezed the chest, the rebreathing bag now moved, and the nurse fetched my mentor… I finished the day exhausted and smelling of terror. The epiphany came as I was thinking of the day's events. 'You nearly killed a patient today, and if you chose anesthesia as a career, you could do that every day. Every day you could take a patient's life in your hands. Every day. To a control freak that image was as seductive as seduction comes'.

Ted graduated in 1955, and after an internship at St Luke's Hospital in Chicago, he began residency training at the University of Iowa, with a wife and new baby in tow. Under the leadership of

INSIDE YOUR SOCIETY

Dr Stuart Cullen, his enthusiasm for research was fostered, aided by the beginning of a life-long association with a second year resident in the same department, John Severinghaus.

Severinghaus lectured on the uptake of inhaled anaesthetics, using Kety's ideas and the results from Severinghaus' own studies of nitrous oxide. He said that uptake of greater amounts of anaesthetic (as with the highly soluble ether), would slow the induction of anaesthesia. To Ted (and most anaesthesia residents since), it seemed obviously incorrect. They argued for an hour after the lecture, but Severinghaus wouldn't budge. Higher solubility, greater uptake, slower onset of action. "It just didn't seem correct… but it was. Severinghaus was always correct." Ted was hooked.

During the next two years from 1958 to 1960, spent as a Captain in the Medical Corps at Fort Leavenworth, he used algebra and iterations to develop his descriptions of inhaled anaesthetic pharmacokinetics. Then he followed Severinghaus to UCSF, and together with Giles Merkel and Lawrence Saidman, the concept of MAC was born.

Ted remained on the Faculty at UCSF for the next 46 years, and retained a close association until his death. He continued to try and understand the mystery of how inhaled anaesthetics work. He was the author of more than 500 scientific papers, including nine of the most highly cited anaesthesia-related publications. He was an author or editor of seven books. The first, *Anesthetic Uptake and Action*, published in 1975, remains as the definitive description of the principles of anaesthetic pharmacology. His research trainees include editors-in chief of the journals, *Anesthesiology* and *Anesthesia and Analgesia*, and 24 chairs of departments of Anesthesiology. Eger himself was the recipient of numerous awards including the Distinguished Service Award, and the Excellence in Research Award by the American Society of Anesthesiologists.

Ted Eger at the 'Ether Dome', Boston

Ted loved nature, and was a keen hiker. Together with his second wife, Lynn, he had walked the John Muir Trail in the Sierra Nevada three times (the trail is 340km long and reaches a height of 4,400 metres!). A favourite climb was Yosemite's Half Dome, which he last climbed with his family on his 75th birthday. In recent times, he frequented the three-hour hike to Mount Livermore on Angel Island, near his home on Tiburon, overlooking the San Francisco Bay. My wife and I were privileged to join his family and close friends recently, at his home, to celebrate his life and to join Lynn on his Angel Island hike.

He loved theatre and music, and was fond of poetry, reading every night at bedtime. He wrote some exquisite poems himself.

Ted is survived by Dr Lynn Spitler, his wife of 21 years, his half brother, Larry, four children, two step-children, seven grandchildren, and six step-grandchildren.

One of Ted's last legacies was a comprehensive work on the history of anaesthesia, involving both myself and Larry Saidman as co-editors and authors, along with another 100 contributing authors. The task took six years, and is a tribute to Ted's determination to see it completed. I was in awe of his work ethic and his intellect, yet he was a warm and embracing companion, who loved a laugh and a good story.

The practice of anaesthesia, world wide, is in his debt.

Rod Westhorpe OAM

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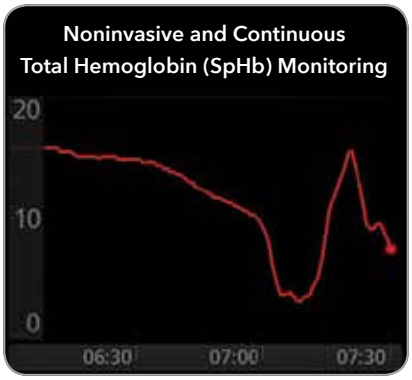
> 47% reduction in average units transfused (1.9 to 1.0)[2*]



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[1] Ehrenfeld et al. *J Blood Disorders Transf*. 2014. 5:9. [2] Awada WN et al. *J Clin Monit Comput*. DOI 10.1007/s10877-015-9660-4.

[*] Study Protocol: In each group, if researchers noted SpHb trended downward below 10 g/dL, a red blood cell transfusion was started and continued until SpHb trended upward above 10 g/dL. The transfusion threshold of 10 g/dL was predetermined by the study protocol and may not be appropriate for all patients. Blood sampling was the same for the control and test group. Arterial blood was drawn from a 20 gauge radial artery cannula into 2 mL EDTA collection tubes, mixed and sent for analysis by a Coulter GEN-S Hematology Analyzer.

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Clinical decisions regarding red blood cell transfusions should be based on the clinician's judgment considering among other factors: patient condition, continuous SpHb monitoring, and laboratory diagnostic tests using blood samples. SpHb monitoring is not intended to replace laboratory blood testing. Blood samples should be analyzed by laboratory instruments prior to clinical decision making.

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PLIT-10450B