AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • JUNE 2018

- History of the ASA Relative Value Guide
- Impact of the MBS Review on the public health system
- Stewardship of the MBS Relative Value Guide
- The science of rebalancing the RVG
- The MBS Review – a summary and update

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THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

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WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The September issue of *Australian Anaesthetist* will focus on the debate 'Should there be a change in name from anaesthetist to anaesthesiologist?' 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 July 2018.
- Final article is due no later than 17 July 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

Welcome to the Winter edition of the *Australian Anaesthetist*. Along with our usual reports from the CEO and the principal committees this edition will be focusing on the Medicare Benefits Schedule (MBS) Review, and the Relative Value Guide (RVG) which is the elegant system whereby the individualised care we provide our patients is characterised into a code for remuneration.

The RVG has been around for over 50 years, and in that time, it has undergone a number of revisions and updates, you will read of the history of the RVG written by our past President Dr Greg Deacon, who has been closely associated with the Guide for most of his professional life.

The MBS review, when it was introduced was welcomed by the entire medical profession as a good thing. There had been suggestions that some therapies described in the MBS were perhaps of little value, Prof Shug implied that this may number in the hundreds. Interestingly the evidence to support these vague generalisations has yet to appear. Instead what we are seeing is a critical evaluation of our practice by the speciality, not to remove procedures, but rather ensure they are applied with the critical consideration they deserve.

At the recent ANZCA ASM much attention has been focused on the decision when to operate, and when to not operate, and the involvement of the patient, and the multi-disciplinary team in this decision-making. The answer to these questions is not always simple and we are at times ethically challenged by our perceptions of the patient's needs, their wishes, and the beliefs of the surgeon as to the right course of action. The final decision should be a shared one and balanced to the needs and wishes of our patients.

The RVG is the system where many of us generate our accounts of service provided for individualised care. It has been regularly updated since its introduction 20 years ago up until the MSAC process was introduced. The ASA up until this time provided the Department of Health (DoH) with guidance and worked to provide stewardship of the guide. The obstructive and bureaucratic nature of the MSAC process has resulted in a stagnation of this process. Nevertheless the responsibility of the ASA to continue to work with the DoH to provide stewardship is vital, and I have written of this in this issue.

The RVG also supports many anaesthetists who provide care to public patients in many jurisdictions, and for many fulltime public practice anaesthetists it is the tool used to remunerate their work in the after-hours. Associate Professor Alicia Dennis writes on the importance to the RVG to public patients and their care. Professor David Story writes on the science of reviewing the RVG and how he sees the process of good stewardship of the Guide should be done.

Finally, Dr Mark Sinclair, chair of the Economics Advisory Committee, provides readers with an update of the process the ASA is engaging in with the DoH and the Health Minister Hon Greg Hunt to ensure that the final output of the MBS review into anaesthesia rebates is one that provides the best value to the public, minimises harm to vulnerable, elderly and unwell patients, and ensures sustainability.

At the ASM Professor Adrian Gelb reflected on the Lancet review and the need to provide safe surgery and anaesthesia to all the people of the globe. He went on to suggest that in many places the provision of the act of anaesthesia may well be provided by non-physician providers. The WHO and the World Federation of Societies of Anaesthesiologists (WFSA) have defined the provision of anaesthesia as a medical act and it must be physician led. Our speciality is under constant threat from non-physician providers who look at what we do in providing sedation and anaesthesia and falsely assume it's a simple thing. The safety and quality of anaesthesia has come about through decades of careful research and practice development, it is now at the point that the statement 'unfit for anaesthesia' is rarely applicable. We are able to safely anaesthetise almost anybody, it's the surgery and recovery that our patients need to survive.

How does the speciality do this? While we have made the act of anaesthesia increasingly safe through thorough assessment, careful application of invasive monitoring and modern anaesthesia

techniques, it's our role outside the operating room we must develop. The perioperative care of our patients is, and must be, a key role of the physician anaesthetist. The survival of the speciality depends on embracing and leading the pre-operative pre-habilitation of our patients, and the close post-operative care once their intervention is completed. The WFSA in its statement on these roles uses the all-encompassing term anaesthesiologist. The debate on changing our name to anaesthesiologists is not about 'Americanisation' of the speciality, the only countries in the whole world who define physician anaesthesia providers as anaesthetists are the UK, New Zealand and us. Every other country uses the term anaesthetist to describe non-physician, and non-specialist anaesthetists.

Please consider that it's far more than a name change, this debate is far more about a change in attitude and focus of the entire speciality toward becoming perioperative physicians. We are the only ones who deeply understand the crucial and life changing process of surgery and anaesthesia. No other physician has a deep knowledge of what happens when we transform a patient from prepared for surgery to a recovering patient, and it is this understanding which makes anaesthesiologists best suited to lead this role. The future of physician specialist anaesthesia providers, and the high-quality care we provide to our patients is in our hands; our name and our reputation is important to that future.

I hope you enjoy reading your latest edition of *Australian Anaesthetist*, and please share it with your colleagues.

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

2018 AWARDS, PRIZES & RESEARCH GRANTS

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Kevin McCaul Prize

NSC PRESENTATION AWARDS

ASA Best Poster Prize
Trainee Member Group Best Poster Prize
Gilbert Troup Prize

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Rupert Hornabrook Day Care Special Interest Group Prize

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REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

LOOKING BACK AS WE MOVE FORWARD

All organisations talk about the need to grow and develop and to respond to change. ASA is no different. Recently I had the opportunity to look critically at some of the changes the Society has implemented in the past five years. This simple exercise revealed an organisation that has been quite active in looking to improve, and which will assist in the development of the Society into the foreseeable future.

Strong governance, and a commitment to it, is the cornerstone of any organisation. The regular reports of companies, societies and associations that have suffered due to poor governance practises is both saddening and sobering. ASA has always had a strong focus on good governance, and it is in this area that possibly the Society has evolved most strikingly in recent times.

An active Council, who were in fact directors of the company, consisting of elected office bearers and the Chairs of the State Committees of Management served the Society well for many years. As the expectations on and responsibilities of company director have increased in recent years, it provided the ASA with an opportunity to review its system of governance.

2016 saw the Society create a new, more contemporary system of governance, with a smaller (up to eight people) Board of Directors responsible for the business of the Society established. At the same time the Council which consists of the Board members, State Chairs and various Committee Chairs, is responsible for determining the society's position on matters of professional importance to the speciality. In March, the Council undertook a Strategic Planning day to reaffirm its role and the areas it believes the Society should be addressing as we move towards 2020.

Members should feel comfortable that the system of governance in place reflects contemporary practice and is working to ensure the wellbeing of the organisation. More remains to be done in areas such as the appointment of an independent director and a focus on equity and diversity within our governance structure. Such initiatives can only serve to strengthen the governance aspect of the Society.

Risk, the recognition of it and its management is also something that weighs heavily on the minds of directors and senior management. Through sound and prudent management by successive Councils, Treasurers (in particular Dr Michael Tuch, who in 2012 was awarded Life Membership of the Society because of his service and expertise in this area) and Senior Management, the Society had established a strong financial position.

In 2015 the then Executive of Council made two significant decisions both designed to better manage the risk associated with being responsible for the Society's 'nest egg'. The first was to establish a Corpus Fund, being a sum of money from within the existing reserve that directors could not spend without the approval of the membership. The second was to seek external expertise to manage the Society's financial reserves. An important part of this process was the development of an Investment Policy which reflected the risk appetite of the Society. Ultimately the international investment house Credit Suisse was appointed, and to date the Directors have been very pleased with the result.

Financial performance aside, these two decisions reflect well on the commitment to good governance within the Society. The financial reserves and property of the ASA are its 'lifeblood' and need to be managed and protected in a manner in keeping with their importance.

The ASA is a membership-based organisation. Without members there is no Society. It is heartening to see that since 2013, the total membership has risen by just over 10%, from 3,121 to 3,464. Numbers though can be used to sustain whatever position one wishes to take and it is important to look a little more closely at them.

Importantly the percentage increase referred to above is reflected in the number of Ordinary members. In 2013, there were 1,841 ordinary members today that figure stands at 2,053.

Our trainee membership has also shown an encouraging rate of growth

from 416 in 2013 to 454 in 2018. Again, while heartening to see this increase, the question remains, does this reflect the increased numbers who are undergoing training at this time?

Interestingly the gender mix of our membership categories is 68% male and 32% female, which mirrors perfectly the current Fellowship of the College. Our Trainee membership breakdown is 50/50, which is slightly different to the ANZCA trainee mix which is 55% male and 45% female.

As we know people join Societies and Associations for a variety of reasons, all of them valid. Equally people choose not to join or stay a member for many reasons, again all equally valid. ASA through its services, advocacy and support for members would like to believe that the value proposition for joining and staying a member is compelling and our level of growth shows that. We also know that there are many others working in the speciality of anaesthesia who have yet to be convinced of this. That is a challenge for the future.

There are many other aspects of the ASA that have evolved considerably in recent times. The embracing of technology, the delivery of the Journal in application format, the redesign of the *Australian Anaesthetist*, are other examples of how the ASA has developed in a few short years.

As the Board and Council plan for the future it will no doubt draw from its successes of the past five years and use those as the basis from which to build for the next five years or so. Who knows what the ASA of 2023 will look like, because there is no doubt the ASA of 2018 is vastly different to what it was just five years ago.

In closing, may I say that I look forward to seeing you all in Adelaide for the 2018 National Scientific Congress. It promises to be a wonderful event and I can't wait for it to arrive.

CONTACT

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

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Hospital for Special Surgery, New York, USA

Clinical Assistant Professor, Weill Cornell Medical College, New York, USA

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For further information contact Anna D'Angelo: 08 7074 1293 I Anna.D'angelo2@sa.gov.au

2018 ASA ANNUAL GENERAL MEETING

Please join us to hear reports from key Committee Chairs and the presentation of Awards, Prizes and Research Grants.

Time: 1:30pm on Monday, 8 October 2018
Venue: Hall B
Adelaide Convention Centre

Visit **www.asa.org.au** for previous minutes and related documents.

ASA
Australian Society of Anaesthetists

REGULAR

LETTERS TO AUSTRALIAN ANAESTHETIST

ANAESTHESIOLOGIST OR ANAESTHETIST?

I think it would be a great mistake to change our name. Many overseas societies have felt it necessary to distinguish themselves from nurse anaesthetists. We do not have this problem. A change of name would confuse our Australian public, might antagonise our nurse colleagues unnecessarily, and indicate a lack of confidence in our own status in the medical world. We do, however, need to do a much better job of letting the public know what we do. It is costing us that they don't know – at many levels. There needs to be regular articles, letters, interviews and the like where the public are made aware of us. We are almost anonymous! For the largest Specialist Medical group this is not good enough! Our name as anaesthetists in Australia is what is important, not a change to conform with overseas groups who have a problem that is not ours.

Don Maxwell,
Past President, Life Member

BALANCED RESPONSE

Thank you for your balanced response to the polemic written in *The Australian* which purported that anaesthetists earned $1 million whilst attempting to drum up sympathy for the poor health funds. The article was poorly researched with no factual basis and yet again attempted to impugn the weakest link: the anaesthestist. Yet again another instance of doctor (in this case anaesthetist) bashing. Thank you once again for defending against those who would besmirch our profession through either laziness or malice.

Laurie Poon
Bullengarook, Victoria

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.

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INTERNATIONAL INVITED SPEAKERS

Associate Professor Thomas Bendtsen

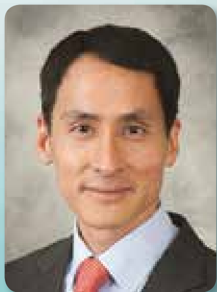
Thomas Bendtsen, Scandinavian pioneer in ultrasound guided regional anaesthesia and head of a research group of five PhD fellows in regional anaesthesia, affiliated to Aarhus University, Denmark.

His research focus is on development of new techniques in regional anaesthesia for acute, subacute and chronic pain relief after major surgery and trauma – primarily related to the hip, knee, and ankle joints.

Professor Su Ganapathy

Su Ganapathy, trained in India and England, Su also practiced in Kenya before arriving in London, Ontario in 1994 to take up a position as Professor of Anesthesia at the University of Western Ontario.

Her special interest is the management of acute post-operative pain with regional anaesthesia, and she is one of the leaders in the use of ultrasound in this field.



Associate Professor Ki Jin Chin

Ki Jinn Chin, FRCPC, is an Associate Professor in the Department of Anesthesia at the University of Toronto, and is also the Fellowship Coordinator and Regional Anesthesia Program Director at the Toronto Western Hospital, Toronto, Canada.

He graduated from the University of Newcastle-upon-Tyne, UK, completed anaesthesiology training in in Singapore, and completed neuroanaesthesia and regional anaesthesia fellowship training at the University of Western Ontario and Toronto Western Hospital respectively.

For further information please contact jmelville@asa.org.au

REGISTRATION OPENING SOON

REGULAR

WEBAIRS NEWS

WEBAIRS – A DIFFICULT AIRWAY CASE STUDY

webAIRS has analysed multiple cases of inadvertent oesophageal intubation with subsequent successful endotracheal intubation without trauma. However, a recent report describes a bougie-assisted intubation during a rapid sequence intubation where the patient suffered traumatic injury.

On a first attempt the endotracheal tube was railroaded over a bougie and was then removed before advancement of the tube. One attempt at bag ventilation was made during which a diagnosis of oesophageal placement was made. The endotracheal tube was then removed, and the patient was subsequently intubated in one attempt with a bougie. There was no immediate effects noted and the patient was stable throughout surgery. The report did not specify the type of bougies used.

On the fourth post-operative day, the patient was diagnosed with subcutaneous emphysema of the neck and a mediastinal collection. Surgical repair of a laceration of the oesophagus was required. Manipulation of the bougie was considered likely to be responsible for the oesophageal tear. The patient required ICU care for days, followed by a prolonged hospital stay of two months with ongoing dysphagia.

Internationally, difficult airway algorithms have included the use of bougies for more than a decade, to assist with difficult airway management[1,2]. Soft tissue injury is well recognised as a complication of intubation in a difficult airway[3]. Confirmation of correct placement of an endotracheal tube to exclude oesophageal placement whilst using a bougie, may be made by feeling for clicks as the bougie touches the tracheal rings, or waiting for the hold-up sign (controlled advancement of the bougie to 45 cm until resistance is felt), as endorsed by the Difficult Airway Society[1]. However, the use of the hold-up sign has been shown in a manikin study to produce a five times greater force than that needed to produce trauma[4-6]. The position held on placement of the bougie also affects the force exerted at the tip[5]. With these factors in mind, the literature shows that the bougie has been implicated in contributing to trauma, including mediastinitis, oesophageal perforation, lung laceration, pneumothorax and pharyngeal wall perforation[7-10]. Single use introducers are described as being more traumatic than reusable bougies[5, 11-13].

To contribute to anaesthesia incident reporting register with webAIRS at www.webAIRS.net

M. Culwick
ANZTADC Medical Director

P. Peach
ANZTADC Chair

H. Reynolds
ANZTADC Data Analyst

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FEATURE

HISTORY OF THE ASA RELATIVE VALUE GUIDE (RVG)

One of the defining moments in the history of the ASA was its adoption of the Relative Value Guide (RVG) in 1970 and the subsequent adoption of the RVG by the AMA into its List of Medical Services and Fees in 1989 and by the Federal Government into its Medicare Benefits Schedule in 2001.

The RVG revolutionised anaesthesia fees and rebates in Australia changing them from being based on the surgery to being based on the anaesthesia. Rather than basing anaesthesia fees and rebates on surgical item numbers and using an average anaesthesia time that was often incorrect, the RVG used anaesthesia specific items and actual anaesthesia time so as to tailor the anaesthesia account and rebate precisely to the anaesthesia provided.

Apart from the RVG being more simple, accurate and logical than previous systems it also did much for the self esteem, independence and professionalism of anaesthetists, particularly with respect to their relationship with surgeons.

How did the RVG come about? It all began in the USA.

The RVG revolutionised anaesthesia fees and rebates in Australia changing them from being based on the surgery to being based on the anaesthesia.

THE USA

Joseph H. Failing MD, an anesthesiologist with the Californian Medical Association devised and developed the RVG concept in the 1940s.

He then guided it through the Californian Medical Association and the Californian Society of Anesthesiologists who adopted it in 1952. He later introduced the concept to the American Society of Anesthesiologists who adopted it in 1962. It was the first national fee guide introduced for any specialty in the USA.

This RVG concept used a flag fall number of units depending on the degree of difficulty of the anaesthesia, units for time

based on the actual anaesthesia time and additional units for physical status, age and other special procedures. Hence a total number of units could be calculated for any anaesthetic and could be used by anaesthetists to develop a fee and by insurers to determine a rebate depending on the unit value chosen by each party.

Before the RVG was adopted in 1962 there was concern from anesthesiologists about the use of actual time rather than average time for each anaesthetic however once introduced there were very few criticisms from either anesthesiologists or third party payers.

…the use of real anaesthesia time in the calculation meant that not only was each fee and rebate tailored to the actual work done but also that as new procedures were learnt and practised by surgeons and surgical times became quicker, the RVG automatically accommodated.

The beauty of Dr Failing's concept was that the RVG was not linked to the surgical procedure but quite independent. It simply divided the body into regions and had basic unit values for work within different parts of that region eg "anaesthesia for procedures involving arteries of the upper leg". It did not matter what operation was done on those arteries or what new operation may be developed, the RVG item was unchanged and always up-to-date. There were about 400 items to cover the many thousands of surgical procedures.

Similarly the use of real anaesthesia time in the calculation meant that not only was each fee and rebate tailored to the actual work done but also that as new procedures were learnt and practised by surgeons and surgical times became quicker, the RVG automatically accommodated.

Years later with the advent of computerisation the RVG was easily adaptable to computer billing programmes.

Dr Failing's scheme proved to be elegant, simple, fair and future proof and was equally popular with anaesthetists and insurers.

AUSTRALIA

Since the 1920s Australian anaesthetists had been shackled with a fee system based on the surgical procedure. The history of this was that in those early days there were very few specialist anaesthetists and often the General Practitioner who referred the patient to the surgeon performed the anaesthesia and was paid a small percentage (often about 10%) of the surgical fee by the surgeon.

When the ASA was founded in 1934 industrial issues were not considered part of its role. This was the responsibility of the British Medical Association (BMA). From its commencement ASA members were required to be BMA members.

The Society was formally affiliated with the BMA from 1945 to 1951 so as to better direct its industrial advocacy for anaesthetists. The BMA however was disinclined to be an industrial advocate for anaesthetists. It went through the 1950's rarely ever replying to correspondence from the ASA yet it was implacably opposed to any independent approach! This status quo suited the Government very well.

The failure of the BMA to adequately represent anaesthetists led to great frustration. Even when not formally affiliated, the BMA was the only body with which jurisdictions would communicate over industrial issues.

The Colleges were similarly hamstrung as they had had in place since 1943, legal arrangements not to participate in medico-political discussions. This was well before the Faculty of Anaesthetists was founded.

The National Health Service Act was gazetted on 12th March 1953 and the Commonwealth National Health (Medical Benefits) service was introduced on 31st July 1953.

There were innumerable anomalies for anaesthetists in this schedule, some of which were to be perpetuated for over 50 years. Despite numerous submissions being presented to the BMA by the ASA for changes to the schedule nothing was done.

Since the 1920s Australian anaesthetists had been shackled with a fee system based on the surgical procedure.

Interestingly the Schedule of Medical Benefits of 1953 for anaesthesia was considered by the ASA Executive of the time to be inadequate as:

- Benefits were far too low.
- No benefit existed for the pre-anaesthesia consultation.
- The items were inappropriate.
- The time taken for the anaesthetic received minimal consideration.

The formation of the AMA in 1962 led to a better relationship with the ASA than that which had existed with the BMA however the next impediment to Australian anaesthetists gaining good industrial advocacy was an internal rift whereby from 1963 to 1969 there was a dispute within the profession as to whether the ASA or the Faculty of Anaesthetists should represent anaesthetists industrially.

Although today there is a clear delineation of College and ASA activity, in the 1960's it was much less clear. Thus six years passed before in 1969 it was agreed that industrial advocacy was the role of the ASA.

THE ASA

In 1964 Dr Brian Pollard, later to become ASA President, visited the USA and observed the American Society of Anesthesiologists, Relative Value Guide system for determining anaesthesia fees and rebates. He was most impressed.

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On return to Australia Brian Pollard and colleagues revised the American RVG to better suit Australia and began using it in their private practice. Brian Pollard presented the RVG to the ASA Executive in 1968, 1969 and 1970, before finally presenting it to the ASA AGM of November 1970 where it was adopted by the ASA as its recommended system for determining anaesthesia fees and rebates.

> This new system, although an improvement, still linked the anaesthesia items with the surgical items. Every surgical item in the MBS had the corresponding anaesthetic item listed along with it.

In June 1971 the ASA, represented by Dr Brian Pollard and Dr Len Shea, presented to the Federal Department of Health its first submission on the introduction of the RVG into the Medical Benefits Schedule. It would be 30 years before this was finally accepted.

This 1971 submission was considered in detail by the government however they would not accept the concept of real anaesthesia time nor the range of basic unit values of 3 to 20. Thus a modified RVG was introduced into the Medical Benefits Schedule in 1974 using a notional average anaesthesia time for each procedure and a range of basic unit values from 3 to 8 rather than from 3 to 20. In addition there was a complicated way of providing for a higher MBS rebate where the duration of anaesthesia was longer than expected, but only where it was very much prolonged beyond the allocated notional time.

This new system, although an improvement, still linked the anaesthesia items with the surgical items. Every surgical item in the MBS had the corresponding anaesthetic item listed along with it. An anaesthesia account could not be generated until the anaesthetist knew the surgical item numbers. Anaesthetists had to base their accounts on what surgeons did or said they had done and often had to wait weeks or months until the surgeon decided on the surgical item numbers before the anaesthesia account could be generated.

Apart from this system not reflecting the anaesthesia done it also perpetuated a master-servant relationship between surgeon and anaesthetist whereby all anaesthesia billing and rebates were based on the surgical billing. It even had an inferior multiple item number rule for anaesthesia services than for surgical services such that for multiple surgical items the rebates were 100%, 50% and 25% for the rest but for anaesthesia multiple items the rebates were 100%, 20% and 10% for the rest!

This system was a relic of a time when the vast majority of anaesthetists were non-specialists. With the establishment of specialty anaesthesia training through the Faculty of Anaesthetists in 1952 there was a steady and huge improvement in the safety and quality of anaesthesia. This improvement however was not reflected in the system used to determine anaesthesia fees and rebates.

THE AMA

Despite the many obvious advantages of the RVG over the MBS system, change occurred very slowly. In 1989 the ASA was successful in convincing the AMA to introduce the ASA's RVG into its List of Medical Services and Fees. This gave the RVG greater credibility and recognition.

WORKERS COMPENSATION AND THIRD PARTY INSURERS

The next step was the acceptance of the RVG by workers compensation and third party insurers into their fee schedules. Previously these anaesthesia fee schedules were mostly based on an hourly rate. Once the AMA adopted the RVG, these insurers were slowly able to be convinced of the benefits of the RVG. By the mid 1990s they had all adopted the RVG for their anaesthesia payments.

VETERANS

In 1993 the ASA met with the Federal Minister for Health on a number of occasions to improve the payment to anaesthetists for their care of veterans. Although a new much improved payment system was introduced it was unfortunately not based on the RVG, as the ASA had requested, but rather an hourly rate. The RVG was still a bridge too far. It would only be after the RVG was finally introduced into the Medicare Benefits Schedule in 2001 that the Department of Veterans' Affairs would be prepared to adopt it for their payments to anaesthetists.

> Anaesthetists had to base their accounts on what surgeons did or said they had done and often had to wait weeks or months until the surgeon decided on the surgical item numbers before the anaesthesia account could be generated.

ARMED SERVICE PERSONNEL

In contrast, the Department of Defence had always paid doctors according to the AMA List of Medical Services and Fees for their care of active service men and women, so when the AMA adopted the RVG into its List the Department of Defence immediately paid anaesthetists in accordance with the RVG at the AMA suggested rates.

MEDICARE BENEFITS SCHEDULE (MBS)

In 1996 the ASA again requested of the Federal Government the introduction of the RVG into the MBS. The case was greatly supported by the system having been used in the USA by both anaesthetists and insurers over a 44 year period and was particularly strengthened by it being adopted by the AMA, workers compensation and third party insurers and even the Department of Defence with no problems or complaints.

The Federal Minister for Health authorised the introduction of the RVG into the MBS on a strictly cost neutral basis. The introduction was also dependent on it having the full support of anaesthetists.

This was a great breakthrough. For the first time the government appreciated the benefits of the use of actual anaesthesia time. It would give them accurate data on how long operations take and because there are millions of operations each year the average time for anaesthesia was absolutely predictable for budgeting purposes.

The ASA was able to have introduced into the MBS the full ASA/AMA RVG complete with modifiers for age, physical status and emergencies plus a 50% loading for after hours emergencies because, due to the cost neutral proviso of the Federal Health Minister, the initial unit value was adjusted to accommodate these items. These modifiers gave recognition to the increased anaesthesia difficulty and complexity associated with the anaesthesia of older and sicker patients and also better rewarded the anaesthetists doing after hours emergencies, so encouraging the participation in after hours rosters.

For the first time the government appreciated the benefits of the use of actual anaesthesia time.

The government was concerned about a flow-on request from other craft groups none of whom had such loadings and modifiers but the ASA responded that they were welcome to have them on a cost neutral basis. Predictably no other craft group has requested such loadings and modifiers.

The introduction of the RVG into the MBS met internal opposition from a small group of ASA members who formed a Private Practitioner Group. They were concerned by the RVG's introduction on a cost neutral basis. They feared that the use of actual time would disadvantage those who had developed practices with fast surgeons. They contested the election for the NSW ASA Chairman in 1999 and put forward a number of motions opposing the RVG's introduction into the MBS to the ASA AGM of 1999. Their nominee for election in NSW was soundly defeated as were all their motions at the AGM. Nevertheless it was a major task to reassure the Federal Department of Health that there would not be negative political consequences if the RVG was adopted into the MBS.

The RVG… is simple to use, very compatible with computerisation, adjusts automatically to changes in surgical techniques and time and tailors the fee and rebate for each anaesthetic to the actual work done which is eminently fair and just.

Finally in November 2001 the RVG was introduced into the Medicare Benefits Schedule. The cost neutral proviso meant that for the next four years anaesthesia expenditure by the government in the MBS was scrupulously analysed and the unit value was adjusted to ensure cost neutrality.

CONSEQUENCES OF THE RVG IN THE MBS

Since the day of its introduction there has been hardly any correspondence to the ASA from anaesthetists, patients, surgeons, health insurers or Medicare officials critical of the RVG. It is simple to use, very compatible with computerisation, adjusts automatically to changes in surgical techniques and time and tailors the fee and rebate for each anaesthetic to the actual work done which is eminently fair and just. It is an elegant system which bases anaesthesia fees and rebates on the anaesthesia done not on the surgery.

Moreover it is a system which is appropriate to modern anaesthesia expertise, rather than reflecting a period when anaesthesia was an emerging entity.

In my view the introduction of the RVG is one of the greatest achievements of the ASA and has represented one of the greatest advances for the specialty in Australia.

Dr Gregory J. Deacon

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FEATURE

IMPACT OF THE MBS REVIEW ON THE PUBLIC HEALTH SYSTEM

The Medicare Benefits Schedule (MBS) Review impacts the public health system in Australia. As the ASA represents anaesthetists working in both private and public hospitals in Australia, we (the ASA) have been raising the profile of the public hospital system and the role of public hospital specialist anaesthetists at the Government level with respect to the MBS.

The aim of the MBS Review and its Taskforce was to deliver the four goals of affordable and universal access to healthcare, best-practice health services, value for individual patients, and value for the health system. The Anaesthetic Clinical Committee additionally included a further three goals of minimising ambiguity and misinterpretation of the Relative Value Guide (RVG) (the MBS items for anaesthesia), of simplifying the RVG, and of enabling the RVG to support good data collection.

The aim of the MBS Review and its Taskforce was to deliver the four goals of affordable and universal access to healthcare, best-practice health services, value for individual patients, and value for the health system.

Any significant changes to the RVG are likely to have significant effects on the public hospital system where the majority of after-hours emergency services and obstetric care in Australia is provided. Significant changes have the potential to unbalance an already fragile private/public healthcare framework in Australia. This is even more important this year with increases in private health insurance premiums and core changes to the provision of services for privately funded patients in public hospitals. These actual changes to private healthcare mean that consumers are already more likely to give up their private health insurance citing lack of affordability and value as core reasons for withdrawing. These Australians will still require healthcare, however it will be provided within the public health system placing further strain on the sector.

Any significant changes to the RVG are likely to have significant effects on the public hospital system where the majority of after-hours emergency services and obstetric care in Australia is provided.

In the area of maternity services, many young women are choosing not to take out private health insurance or alternatively to give it up after their first baby. Even more babies will then be born in public hospitals so any disincentives to the uptake of private health insurance by young women, from possible changes to the RVG, will further threaten this private/public balance. Increasing the burden of healthcare in the public sector may seriously impact upon timely access to services, increased waiting times for surgical procedures, and lead to ongoing consumer dissatisfaction. These likely outcomes prevent the achievement of the MBS Taskforce's goals. It is therefore fundamentally important that any proposed changes to the RVG must undergo robust economic modelling to ensure that access to services and value for individual patients are not compromised.

The private/public healthcare balance is fundamental to the world-class standards of healthcare we all enjoy in Australia. These high standards are underpinned by patient-centred individualised care, and excellence in care provided by anaesthetists. Anaesthesia in Australia is a speciality at the forefront of quality and safety, innovation and research, and data collection and monitoring of patient outcomes.

It is therefore fundamentally important that any proposed changes to the RVG must undergo robust economic modelling to ensure that access to services and value for individual patients are not compromised.

It is essential that all vulnerable groups such as elderly patients, sick patients, and patients with mental health issues, as well as the integrity of the speciality of anaesthesia, are protected. It is fundamental that these patients and the speciality are not targeted by changes to the RVG. We are working very hard with Government in this space to ensure that vulnerable people are protected and valued. Importantly we are also working very hard to ensure that the profile of the speciality of anaesthesia is raised at a federal level, that the lifesaving and quality of life improvement work that anaesthetists do is seriously valued, and that anaesthesia and anaesthetists are viewed as the essential and core component of safe public and private healthcare in Australia.

A/Prof Alicia Dennis
Chair, Public Practice Advisory Committee
Australian Society of Anaesthetists

FEATURE

STEWARDSHIP OF THE MBS RELATIVE VALUE GUIDE (RVG)

The RVG in the Medicare benefits Schedule (MBS) is used as a system for determining rebates for anaesthesia. The rebates are a way of providing patients with some of the public money which would have been allocated to their care if they had chosen to use the free public health system.

You can read Dr Greg Deacon's article on the history of the RVG, and how it was carefully and responsibly integrated into the MBS. It led to a paradigm shift from the anaesthetist as a servant of the surgeon (and their item number) to an independent, patient-care focused schedule which described almost everything that we do in caring for our patients.

For readers unfamiliar with the RVG, it is a system which defines each of the activities that an anaesthetist undertakes when caring for a patient by allocating a number of units to each activity:

- pre-operative assessment (from simple to complex);
- patient factors (ASA class, emergency case etc);
- the part of the body being operated on (the deeper the part the higher the base value, and extra consideration for complex things like shared airway);
- consideration of extra care provided for special circumstances (nerve blocks for pain relief, arterial lines for close physiologic monitoring and control etc); and finally,
- total anaesthesia time.

All of this ensures care individualised to the patient's needs and recognises the extra training, work and responsibility associated with providing that service.

> The RVG… is a system which defines each of the activities that an anaesthetist undertakes when caring for a patient by allocating a number of units to each activity…

As one can see from the above, because of the broad nature of the RVG, determining the anaesthesia rebate following the introduction of a new surgical procedure should be easy. As such, in many ways, the RVG is future

proof. It does however from time to time need to be examined and occasionally needs adjustment.

Unfortunately, over the past five years this close and cooperative stewardship of the RVG has substantially evaporated, with the Department now insisting that all and any changes to RVG items be required to be evaluated by the MSAC (Medical Services Advisory Committee).

Following the introduction of the RVG into the MBS in 2001, the ASA and the Department of Health jointly and cooperatively closely monitored the RVG data with the main initial objective to maintain cost-neutrality. After this initial period, the ASA continued to work closely with the Department to adjust RVG items to better reflect relativities and changing clinical practice as required. Unfortunately, over the past five years this close and cooperative stewardship of the RVG has substantially evaporated, with the Department now insisting that all and any changes to RVG items be required to be evaluated by the MSAC (Medical Services Advisory Committee).

At some point this stopped and the Medical Services Advisory Committee (MSAC) process was introduced to keep the RVG appropriate and up-to-date. Unfortunately for anaesthesia this process only viewed the introduction of new items, and even changes to existing items as an addition to the schedule – something they were apparently fundamentally opposed to. All ASA submissions to MSAC have been rejected on (weak) economic grounds and there has been little opportunity for negotiation. Recent submissions on regional nerve blocks and ultrasound were rejected despite the recognised value to patients and healthcare on shaky economic arguments.

This is where good stewardship of the RVG has a role. As the RVG is the mechanism where our patients are rebated for their medical costs we need to ensure it is as equitable and fair as possible. It is known that high-turnover cases provide a higher number of RVG units (while you are working) but this is because there is a fixed amount of work and risk associated with every anaesthetic, and the time component will be necessarily less. This adheres to the well-known principle of every new patient attracting a 'flag-fall' to acknowledge the increase in workload. Longer cases become more dependent on time but represent a very small proportion of cases (cases longer than four hours = 1.9% of all anaesthetics).

As the RVG is the mechanism where our patients are rebated for their medical costs we need to ensure it is as equitable and fair as possible.

The RVG from time to time will require some fine-tuning and addition of new item numbers for procedures which do not fit with current descriptors (eg Trans-Arterial Vascular Interventions). In many cases this will have impacts on the overall cost of the schedule, both savings and expenses. The opportunity to directly negotiate with the Department allows savings to be directed into new items and when necessary fine adjustments to the unit value to correct for overspends.

The ASA will continue to provide careful advice to the Department of Health to ensure active and reliable stewardship of the MBS for anaesthesia.

The role of the ASA in providing the Department with accurate advice in this area is key. The long history and depth of knowledge of the balance of the schedule allows for reasonable adjustment which will not disadvantage patients or lead to mis-alignments in the relativities contained in the RVG. It is not the aim of the ASA to take further money out of the MBS, rather to ensure that the share of funding allocated to the speciality is equitable and consistent with service delivery.

It is our ambition at the ASA, to ensure that the RVG remains current, relevant and balanced to provide a reliable and reasonable schedule for determining anaesthesia rebates and fees. It must be remembered that the rebates provided by the government are unilaterally determined, and do not represent any agreed fee, rather it represents the amount the public purse is prepared to reimburse taxpayers who choose to not utilise the public system for their health care. We will continue to provide careful advice to the Department of Health to ensure active and reliable stewardship of the MBS for anaesthesia.

A/Prof David M. Scott
President
Australian Society of Anaesthetists

FEATURE

THE SCIENCE OF REBALANCING THE RVG

"Many alternatives to 'patient' incorporate assumptions (e.g. a market relationship) which care recipients may also find objectionable. People who are receiving care find the label 'patient' much less objectionable than the alternatives that have been suggested."

Deber R. "Patient, consumer, client, or customer: what do people want to be called?"

Health Expectations, 2005

This Canadian survey of people receiving a range of health care from fracture, prostate cancer, breast cancer, and HIV clinics illustrates several important points about science and the MBS review of RVGs. The first is that despite their importance in the evidence hierarchy (Figure 1), meta analyses of randomised trials (Level 1 evidence) and large randomised trials (Level 2 evidence) are not the only sources of important and useful evidence to guide practice, policy and governance. For example, observational cohort studies (Level 3 evidence) play a major role in developing risk assessments by quantifying relative risks. The second point is that patients like to be called patients. When we discuss anaesthesia practice and the RVG we can confidently say we are providing care to patients not consumers or clients. In fact, I have been unable to find any study showing patients prefer any other title. Further, a leading consumer advocate supports referring to patients as patients and then using 'consumer' as shorthand for the broader community. The third point is that the Canadian survey (Level 4 evidence) had 1,000 respondents across a range of patient groups. To get representative and precise evidence about the opinions of patients usually requires sample sizes of more than 1,000 people. While qualitative studies, peer reviewed case reports (Level 5 evidence), and even anecdotes (Level 6 evidence) can be canaries-in-the-coal-mine, it can be unwise and scientifically unsound to guide policy and regulatory reviews, such as the MBS review, with very low-level evidence. The fourth point is the importance of individualised patient care.

The MBS review aims to align the MBS with contemporary clinical evidence and practice to achieve the admirable goals of: 1) Affordable and universal access; 2) Best-practice health services; 3) Value for the individual patient; and 4) Value for the health system. Importantly, the aims of the Review re-enforce that when discussing evidence based practice it is important not to discount the combined experience and

Level	Evidence
Level 1	• Meta-analysis, systematic reviews
Level 2	• Randomised controlled trials
Level 3	• Prospective cohort observational studies
Level 4	• Case control studies
Level 5	• Case report or case series narrative reviews
Level 6	• Ideas, editorials, opinions
Level 7	• Animal research
Level 8	• In-vitro (test tube) research

Figure 1: Levels of Evidence derived from the NHMRC scale and modified from www.wahtn.org. Higher levels of evidence have less risk of bias and greater ability to demonstrate cause and effect.

wisdom that guides much of contemporary practice, particularly where evidence is thin. My view is that it is highly appropriate for the MBS to both drive ("nudge") high value practice and reward expert care and associated challenges.

Recently in an editorial in *Anesthesia and Analgesia* entitled 'A Value-Based Revolution Afoot', Kolarczyk and Zvara (2018) highlighted that value, using similar aims as the MBS review, can be expressed as the ratio of quality to cost: quality/cost. Further they advocated using the US Agency for Healthcare Research and Quality (www.ahrq.gov/) six domains of healthcare quality: safety, timeliness, effectiveness, efficiency, equity, and patient centeredness; acronym STEEEP. In my Australian academic modification, it is STEEEP-C with the domains:

Safe: Avoiding harm, supported by research looking for adverse events;

Timely and accessible: Reducing wait times and (sometimes harmful) delays for both those who receive care, and where appropriate (particularly for regional and rural patients) providing care close to home;

Effective: Care based on research (ideally randomised) demonstrating clinical effectiveness;

Efficient: Avoiding waste, including waste in equipment, supplies, ideas, time (including our time); and environmental with evidence from health services research, ideally randomised;

Equitable: Providing care that does not vary in quality because of patient personal characteristics;

Patient-centred: Providing individualised care that is responsive to patient preferences using insight into patient needs and values;

Cost effective: Quantified costs demonstrated through health economics research.

Kolarczyk and Zvara suggested the STEEEP items can be expressed as quality /costs to determine value. An example is:

$$\text{Value} = \frac{\{\text{safe x effective x patient centred}\}}{\{\text{untimely x inefficient x increased financial cost}\}} \text{ x equity coefficient}$$

Extending this idea further, all of the STEEEP-C domains can be in the numerator (increasing value) or in the denominator (decreasing value). Importantly, the challenge is evaluating the positive or negative and weighting of each item, eg: accessible vs inaccessible; effective vs ineffective, environmentally efficient vs inefficient, increased vs decreased financial costs. The ANZCA Choosing Wisely items (www.choosingwisely.org.au/recommendations/anzca), things we should stop doing or at least seriously question, are all low value using this approach: Value (at best) =

$$\frac{\{\text{safe x accessible}\}}{\{\text{untimely x ineffective x inefficient x inequitable x not patient centred x increased financial cost}\}}$$

Another good example from daily practice where we can assess value is arterial lines. Continuous monitoring using intra-arterial catheters is the gold standard for clinically measuring blood pressure (Meidert, 2018). Currently RVGs support using arterial lines. But, arterial catheters are not without risk and do hurt (personal experience). However, in contemporary practice most patients and procedures do not require an arterial line: the value proposition favours non-invasive monitoring. But, there is growing evidence from large prospective observational studies, including sub-studies of RCTs (Level 3 evidence) that even brief periods of hypotension increase risk of perioperative complications for vulnerable patients (Sessler, 2018). Further, we have increasing numbers of vulnerable patients, particularly the sick and elderly, and the clinical experience is that increasing numbers of patients have difficult arterial access, secondary to factors such as obesity and diabetes (Level 3 evidence). Recent evidence suggests the clinical effectiveness of arterial lines is likely enhanced with newer haemodynamic metrics such as pulse pressure or stroke volume variation to facilitate goal directed therapy (Saugel, 2018) as well as ease of point of care testing of blood variables such as gas exchange and acid-base.

A contrary approach is to de-emphasise direct arterial monitoring by removing

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related RVG items and therefore indirectly encourage use of newer non-invasive continuous haemodynamic monitoring devices. Based on current evidence and practice, this is hard to defend, particularly when using a STEEEP-C value approach. The comparative effectiveness of non-invasive continuous haemodynamic monitoring versus direct arterial monitoring is unclear, but early research (Level 3 evidence) is encouraging (Meidert, 2018). However, the financial costs of the new devices are substantial and it is easy to envisage a marketing onslaught to make advanced non-invasive continuous haemodynamic devices the default choice. We have already seen this kind of phenomenon with the use of desflurane. Practice change to widespread use of continuous non-invasive haemodynamic monitoring would undermine all four aims of the MBS review.

Three factors that increase risk complications and death after surgery, and require enhanced expert care to both identify and manage are: age, ASA status and frailty. Risks of increasing ASA and age were clearly demonstrated in the REASON study (Story 2010) among others (Level 3 evidence). Frailty can be defined as an increased risk of harm from stressors, including surgery and anaesthesia. Importantly age, ASA, and frailty are three different things that interact. There are fit older patients, there are unwell young patients, there are frail young patients, and frail patients who are old but without major co-morbidity. These interactions can be demonstrated through modelling with the American College of Surgeons (ACS) Risk Calculator (www.riskcalculator.facs.org/RiskCalculator/) derived from a massive ongoing observational study (Level 3 evidence) of millions of patients: the ACS National Surgical Quality Improvement Program (NSQIP). Currently there is no agreed simple measure of frailty, but leading approaches such as the Clinical Frailty Scale use increasing dependence on others for activities of daily life as a frailty measure. The ACS risk Calculator uses partial or complete dependence for activities of daily living which is an increasingly used indicator of frailty. Using the ACS risk calculator, I modelled risks for a woman having an elective hip replacement (Figure 2). I estimated the number of women per 1,000 patients predicted to have major complications after elective hip replacement using the following variables: age <65 vs age 75+, ASA II vs ASA III, and Independent vs partly dependent.

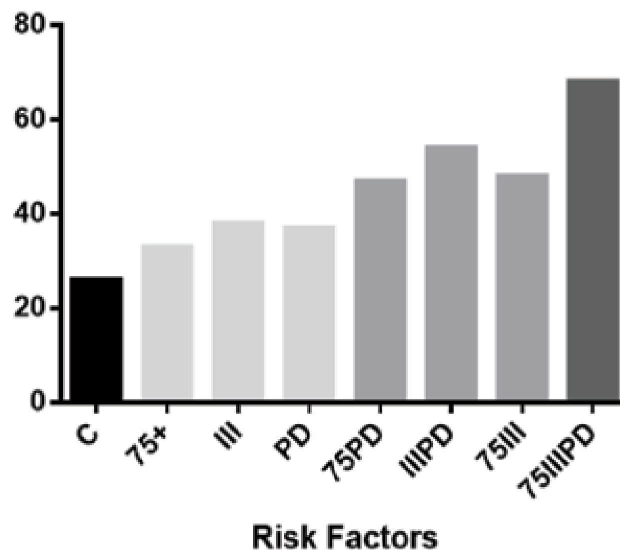

Figure 2: ACS calculator risk estimates for major complications showing individual risks and interactions between age >75year (75), ASA III (III) status, and partial dependence (PD) for a woman undergoing elective hip replacement.

Three factors that increase risk complications and death after surgery, and require enhanced expert care to both identify and manage are: age, ASA status and frailty.

Compared to an independent 64-year-old woman, a woman who is 77, ASA III and needs help around the house has three times the risk of a major complications (7% vs 2.5%), further combinations of age, ASA, and dependence (frailty) have increasing additive risk. Currently, and appropriately. the RVG system encourages individualised care of older and/or sicker patients. Frailty, or at least dependence, could be a future RVG inclusion.

Related to assessing and managing risk, another area where non-randomised evidence provides some guidance is in the value of the escalating preoperative assessment RVG items. Successive Australian anaesthesia mortality and morbidity reports, across the life of the current RVG items, indicate that lack of adequate preoperative assessment is increasingly less frequent as a cause of major morbidity and mortality. This in turn suggests that the current items may be associated with improved outcomes, or at least fewer bad outcomes. In the 2000-2002 ANZCA Safety of Anaesthesia in Australia report (Level 5 evidence) there were 137 patients with possible anaesthesia related deaths and 41 (30%) had contributing preoperative assessment elements. However, by the 2012-2014 report, of 200 patients with possible anaesthesia related deaths only 26 (13%)

had contributing preoperative assessment elements. That is a 57% relative decrease and 17% absolute decrease. Further, quantifying risk and using risk, such as a 5% risk of 30-day mortality (Swart 2017), to guide practice including the nature of intraoperative and post-operative care may become part of expected assessment in future reviews of RVG items.

Quantifying and managing risk are central elements of the evolving contemporary practice of perioperative medicine, the RVGs are yet to reflect these practice changes. One example is the growing use of perioperative cardiopulmonary exercise testing (CPET), with heavy influence from UK practice, where about two-thirds of preoperative tests were conducted, and reported by anaesthetists (Reeves 2018). Ironically, the first evidence for perioperative clinical value of CPET came from Anaesthesia and ICU at Western hospital in Melbourne 20 years ago. A recent systematic review of non-randomised studies (Moran 2016) concluded that CPET is a useful preoperative risk-stratification tool that can predict postoperative outcome (Level 3 evidence). It is reasonable that RVGs now support anaesthetists, among others, conducting preoperative CPET. RVGs could also reflect anaesthesia leadership of perioperative medical teams and components such as prehabilitation, diagnostic transthoracic ultrasound (before, during, and after surgery), and postoperative perioperative medicine rounds (www.rcoa.ac.uk/perioperativemedicine; www.asahq.org/psh), again where there is evolving evidence of value.

Quantifying and managing risk are central elements of the evolving contemporary practice of perioperative medicine, The RVGs are yet to reflect these practice changes.

So what role do the large randomised trials (Level 1 and 2 evidence) play in the RVG review? Some complain that our large trials are "usually just negative". It is more nuanced and important than that. We should go back to the first triumph of the ANZCA Clinical Trials Network, the MASTER trial (Rigg, 2002) that compared perioperative epidural use with systemic analgesia. In that 'negative study' the researchers were unable to demonstrate any significant effect of epidural management on the overall frequency of complications after major abdominal surgery except a beneficial effect of epidurals on respiratory complications.

RVGs could also reflect anaesthesia leadership of perioperative medical teams and components such as prehabilitation, diagnostic transthoracic ultrasound (before, during, and after surgery), and postoperative perioperative medicine rounds…

Further, they found significantly better pain scores in the epidural group. Therefore, based on Level 2 evidence, it is reasonable for an expert FANZCA to individualise care to epidural or systemic analgesia based on a range of patient, procedure, place and practitioner factors. RVGs appropriately acknowledge these decisions. Our RCTs (Level 2 evidence) show nuanced complexity in high quality care and we can use that evidence to justify why anaesthesia care should be provided by experts, that is FANZCA specialist anaesthetists (I prefer anaesthesiologists) and where appropriate ANZCA credentialed GP anaesthetists.

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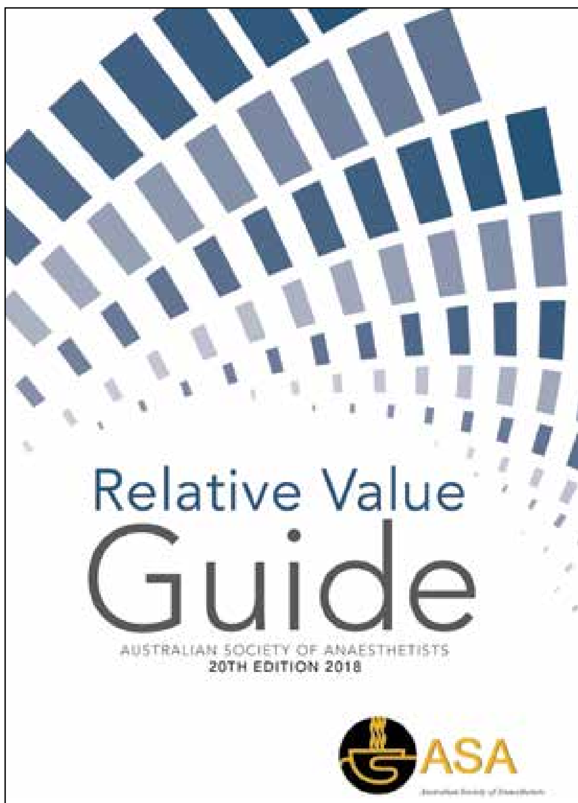

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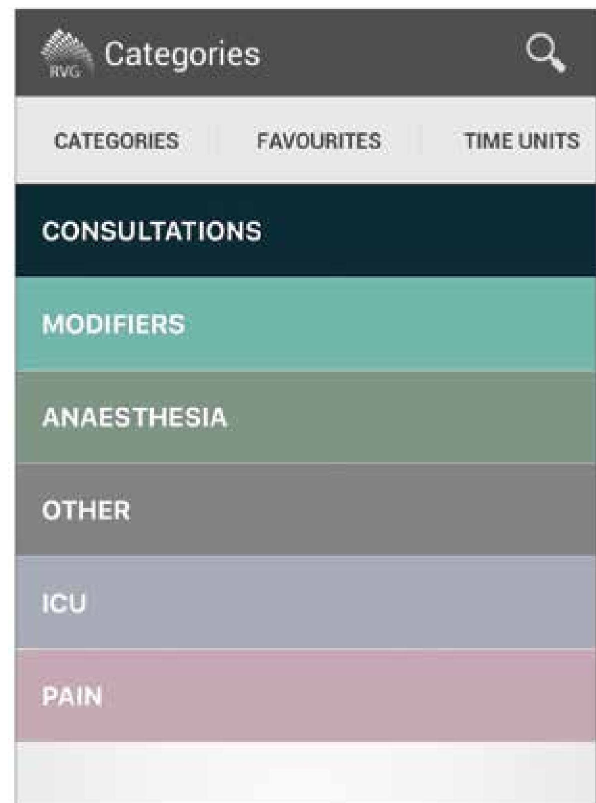

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FEATURE

THE MBS REVIEW – A SUMMARY AND UPDATE

In April 2015, the Federal Minister for Health, Hon. Sussan Ley MP, announced the 'Healthier Medicare' initiative.

The three priority areas for consideration were:

- A Medicare Benefits Schedule (MBS) review, involving a review of all 5,700 MBS items, to be led by a Taskforce chaired by Prof. Bruce Robinson, Dean of the University of Sydney Medical School. This would involve each individual medical specialty having its own review committee, tasked with reviewing the relevant MBS items, and formally reporting back to the Taskforce.
- A Primary Health Care Advisory Group (PHCAG), led by former Australian Medical Association (AMA) President Dr Steve Hambleton.
- The development of clearer Medicare compliance rules and benchmarks. The Minister publicly noted that while the vast majority of medical practitioners do the right thing by Medicare, there nevertheless remains a small number who do not.

The ASA had already been closely involved with, and supportive of, initiatives such as the successive Medicare Compliance Programmes of 2012 through to 2015, and we assisted both the government and the anaesthesia specialty during this time. Compliance remains an important part of the work of the Department of Human Services (DHS), but it is fair to say that this aspect of the Healthier Medicare initiative has not been at the forefront. And while the role of the PHCAG is clearly essential, the ASA did not see itself as having a specific role in this area. Therefore, the ASA has confined its involvement largely to the MBS Review itself.

Firstly, it must be noted that the idea of reviewing MBS items is nothing new. There had already been numerous initiatives introduced, given the growth in Medicare expenditure each year.

Refreshingly, feedback and submissions from stakeholders were strongly encouraged by the Taskforce from the very beginning of the process. The AMA took the lead role in representing the medical profession overall and has continued to involve and consult with all of the numerous individual medical specialties in fulfilling this role.

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Table 1: Annual Medicare expenditure 2011-2017

Financial year	Medicare expenditure ($ billion)	Annual growth
2011-12	$17.7	8.1%
2012-13	$18.6	5.2%
2013-14	$19.3	3.5%
2014-15	$20.5	6.3%
2015-16	$21.4	4.4%
2016-17	$22.3	4.2%

had already been numerous initiatives introduced, given the growth in Medicare expenditure each year. Table 1 shows the annual growth in overall Medicare expenditure in recent years.[1] While growth has remained above inflation each year, it has been variable, but is at a lower level now than in most other recent years. Nevertheless, regular reviews of the Medicare system are reasonable. The processes for reviewing the evidence base in the past were no less rigorous than those proposed for the 2015 MBS Review. Examples were:

- The Medicare Benefits Consultative Committee (MBCC), which was convened by the AMA (with the agreement of successive Health Ministers), and was in existence from 1990 through to 2009. The MBCC undertook evidence-based reviews of services listed in the MBS, to ensure the MBS reflected and encouraged appropriate clinical practice. It included representatives from the relevant government departments, the Health Insurance Commission, and relevant craft groups from the medical profession.
- The Relative Value Study (RVS), which was jointly designed by the AMA and the Department of Health and Ageing (DoH). This study commenced in 1994, and reported in 2000. Unfortunately, the report was never acted upon most likely due to the considerable cost implications.
- The MBS Quality Framework (2009-10), which aimed to introduce a new evidence-based framework for reviewing existing MBS items.
- The MBS Enhanced Management Framework (2011-12). This expanded the role of the DoH Medical Services Advisory Committee (MSAC) from examining the evidence base for proposed new MBS items, to conducting 'rolling reviews' of existing items.
- The MBS Comprehensive Management Framework (2013-14) to review the quality, safety and cost-effectiveness of services covered by MBS items.

While growth has remained above inflation each year, it has been variable, but is at a lower level now than in most other recent years.

The AMA nevertheless supported the idea of the MBS Review, as did the ASA, as long as the process remained evidence-based, was transparent and was not simply a cost-cutting exercise. The ASA has however had to repeatedly highlight the fact that the Relative Value Guide (RVG) in the MBS is relatively new, having been introduced at the end of 2001 rather than in 1985. Nevertheless, it was agreed that it was important to formally review the entire MBS, including the RVG, as a single process.

There was (and still is) no doubt that changes are necessary. However, to enjoy the support of the medical profession, it was noted that the process should not just concentrate on financial matters. The following were stated to be essential[2]:

- a clear and overarching vision and specific direction for the Australian healthcare system to guide the final outcomes of the reviews;
- specific and quantifiable aims;
- the direct involvement of specialist colleges, associations and societies (CAS);
- full transparency of the individual reviews as they progress and the decisions that will come from them;
- the ability for new items to be added to the MBS.

STAKEHOLDER CONSULTATION

Led by Prof. Robinson, the MBS Review Taskforce, to its credit, very quickly organised a number of stakeholder forums all around Australia, and ensured that all relevant bodies had the opportunity for input. Prof. Robinson and other members of the taskforce also attended and addressed meetings convened by the AMA. The discussions at these meetings informed the early output of the Taskforce, and were held before any of the individual specialties' review committees were formed.

However, from the outset, concerns became apparent.

The Taskforce stated that, while the various medical Colleges, Societies and Associations (CAS) could nominate members to their individual specialties' review committees, they would not be allowed direct representation. To the ASA, this represented a fundamental flaw. For the process to be recognised as robust, open, and transparent, and representative of the entire membership of each specialty, the members of each review committee should be recognised leaders of their specialty. Furthermore, as a stated aim of the review process was for the Review Committees to work on ongoing modifications of the MBS into the future, the ASA believes it is essential that

the CAS have direct input. As it turned out, CAS leaders were, as recognised experts in their fields, appointed to many of the committees. However, they were appointed as individuals rather than representatives of their professional bodies. This issue will be discussed again later, specifically in reference to the MBS Review Anaesthesia Clinical Committee.

At stakeholder forums, despite the clearly stated (and often repeated) objective being to align the MBS with current, contemporary 'best practice' there was a heavy emphasis on Medicare financial data. The ASA and AMA initially accepted statements from the taskforce along the lines that there were no instructions from Government to achieve cost savings, and that no specific cost savings targets had been identified. However, it became apparent that, regardless of these reassurances, costs would be a major focus of the process, and that regardless of the lack of any targets, cost savings were most definitely expected to materialise. Minister Ley herself confirmed this when discussing what would happen to the money saved. Not only did this confirm the Taskforce's and Government's expectation of savings, but more worryingly, it became apparent that a significant proportion of the savings could well end up in general government revenue, rather than being re-invested into health. That is, the ultimate outcome would be a decrease in the funding of health care.

Furthermore, certain statements by the Taskforce and Government indicated that pre-conceived positions may have been an issue. For example, the Taskforce's introductory document stated that only a 'small proportion' of MBS items have an evidence base[3], and the Minister publicly stated that "97 per cent of (MBS) items have never undergone consideration to determine whether or not they are actually clinically-effective, cost-efficient or safe"[4]. Putting aside the fact that there had already been a series of processes initiated to assess numerous MBS items (as above), many MBS items do not actually need formal assessment of any evidence base. For example, no sensible person would argue against lifesaving emergency medical services being provided to patients, and funded by Medicare, despite there possibly being no level 1 evidence in their favour. The oft-quoted example of the lack of a randomised double blind study of the benefits of parachutes to skydivers, comes to mind!

Putting aside the fact that there had already been a series of processes initiated to assess numerous MBS items, many MBS items do not actually need formal assessment of any evidence base.

Prof. Robinson stated, "It has been estimated that 30 per cent or more of health expenditure is wasted on services, tests and procedures that provide no or negligible clinical benefit and, in some cases, might be unsafe and could actually cause harm to patients[5]." This statement appears to have been based on USA data. As the AMA highlighted, "…there is no evidence base to characterising 30 per cent of health care in Australia as unnecessary and harmful. There are very big differences between Australian and American health care practices and the estimated 30 per cent of waste in the US relates not only to inappropriate medical care, but also to individual behaviours that lead to health problems and to regulatory and administrative costs. The estimate therefore cannot be applied to the Australian health system[2]."

An article by health economist Prof. Adam Elshaug[6] (a member of the Taskforce) was frequently quoted. This article addressed 150 potentially low-value services which are funded by the MBS. It is however essential to note that this study did not state outright that such services were not worthy of funding (and nor, in fact, has any other publication presented evidence for this). The article simply pointed out the need for formal assessment of such services.

Therefore, while the ASA supported the overall concept of the MBS Review, it was clear that caution would be needed. As per the AMA – "The Government does not need to justify the Review on such spurious grounds. A review of the MBS has the support of the medical profession because the MBS is in desperate need of updating. Let's do the review and see what the evidence does and doesn't support, without any preconceptions about the number of items that should be included on (or removed from) the MBS or the quantum of potential savings[2]."

Committees for each individual specialty represented in the MBS were formed from September 2015 onwards. The Anaesthesia Clinical Committee (ACC), tasked with the review of anaesthesia MBS items, was one of the third tranche of committees to be formed, in September 2016.

Nominations for appointments to these committees were called for well in advance. The ASA nominated a number of people, including senior office bearers, past and present EAC members and Chairs, and other committee chairs and Councillors.

None of these nominations were accepted.

The ACC appointees were, as listed and described on the MBS Review website[7]:

- Assoc. Prof. Jo Sutherland (Chair) – Anaesthetist, Coffs Harbour Health Campus, private practice member, Mid North Coast Local Health District Government Board.
- Dr James Bradley – Anaesthetist, Wesley Anaesthesia and Pain Management.
- Dr Genevieve Goulding – Anaesthetist & Deputy Director, Quality and Safety, Department of Anaesthesia, Royal Brisbane and Women's Hospital.

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- Dr Margaret Schnitzler – Colorectal Surgeon, private practice.
- Associate Professor John Stokes – Anaesthetist & Intensivist, Associate Professor, College of Medicine and Dentistry, James Cook University Director of Intensive Care, Mater Hospital, Townsville.
- Ms Helen Maxwell-Wright – Director, Maxwell-Wright Associates Panel of Chairs, Monitoring Committee, Consumer Representative, Medicines Australia, Quality & Safety Committee, Australian and New Zealand College of Anaesthetists, Former Managing Director, International Diabetes Institute Chair Community Advisory Group, College of Intensive Care Medicine.
- Dr Timothy Weston – Anaesthetist, private practice.
- Ms Ruth Bollard – General & Breast Surgeon, Specialists on Drummond, private practice.
- Dr Penny Burns – GP, private practice, Senior Lecturer, Department of General Practice, University of Western Sydney.
- Dr Mark Reeves – Anaesthetist, North West Regional Hospital.
- Dr Jodi Graham – Anaesthetist, Medical Co-director Surgical Division, Charles Gardiner Hospital.
- Prof. Michael Grigg (Surgeon) – MBS Review Taskforce (Ex-Officio).

Some members of the ACC could be expected to have an above-average grasp of the Relative Value Guide (RVG) in the MBS, for example, ASA Past President (2002-04) Dr Jim Bradley, and Immediate Past President of ANZCA (and past ASA Councillor) Dr Genevieve Goulding. However, it was of significant concern to the ASA that people with specific expertise and experience in matters related to the MBS, including those who authored the entire RVG and its accompanying MBS explanatory notes, and who have many years of combined experience in dealing with the relevant government departments and Ministers, were completely excluded from the process.

The decision-making process regarding appointments to the ACC has never been disclosed. However, verbal discussions have indicated that there is prevailing opinion that the role of the ASA in such matters is as a 'negotiator'. This perhaps indicates a belief that ASA office bearers would simply act in a self-serving capacity if appointed. To the contrary however, the ASA has a long and distinguished history of honest and transparent involvement of its office bearers in government processes.

The fact that no currently serving President or Vice President of our professional bodies was appointed was also of concern. This is in stark contrast to most of the other specialties' committees, where such representation is the norm. Indeed, commonly, senior CAS office bearers actually chair their specialty's review committee. A/Prof. Alicia Dennis, Chair of the ASA Public Practice Advisory Committee (PPAC), has formally documented the membership of all review committees (those formed as of mid-2017) and highlighted where senior office bearers of the CAS have been appointed. This document is available to ASA members on the ASA website: www.asa.org.au/mbsreview – a series of useful and informative documents will be found at the bottom of this webpage.

The ACC was comprised of seven anaesthetists, one GP, one consumer representative, and three surgeons. The ASA had no particular issue with the Taskforce's approach, as stated from the outset, that representation of allied specialties was planned for each individual committee. However, with three surgeons on board, only 58% of the ACC members are anaesthetists. By way of contrast, the Intensive Care and Emergency Medicine Clinical Committee has 80% representation by relevant specialist doctors[8]. Furthermore, while 25% of the members of the ACC are surgeons, only one anaesthetist has been appointed to any of the multiple surgical committees formed to date. Again, no explanations for these inconsistencies have been received.

Nevertheless, the ASA maintained its general support for the Review. It was noted that a key component of the work of the review committees was to engage and consult with suitably qualified practitioners outside of the committees, and it was anticipated that the ASA might be able to assist in this manner.

This certainly did not eventuate.

ACC member Dr Jim Bradley brought several questions to ASA representatives, early in the process, but was obliged to adhere to the requirement for confidentiality regarding ACC deliberations. Dr Bradley, as ASA Specialty Affairs Advisor, has an 'ex officio' listing on the EAC (see later), but was not in fact an ASA nominee to the ACC. However, given his background and expertise, he was certainly nominated by the ASA to other MBS Review committees. Consultation with the ASA (and ANZCA) was otherwise notably absent.

There were also two meetings between the Taskforce chair, the ACC Chair and the Presidents of the ASA and ANZCA. These meetings were represented as being for the information of the Presidents, with no pre-reading, and no request for formal feedback after consideration of the data provided – effectively they were window-dressing.

REPORT OF THE ANAESTHESIA CLINICAL COMMITTEE

The ACC produced its draft report in April 2017. The next stage of the process, as with all committee reports, was to be the release of the draft report for public comment. Given the concerns regarding the process to date, however, the ASA lobbied the Health Minister and asked to

Table 2: RVG Subgroup 19 items – 5-year growth

Service	MBS Item	Claims 2011-12 (x 1000)	MBS cost 2011-12 ($m)	Claims 2016-17 (x 1000)	MBS Cost 2016-17 ($m)	5 year growth
Pressure monitoring	22012	116	$5.2	154	$7.1	36%
Pulmonary Art. catheter	22015	5	$4.4	5.3	$4.9	12%
Central v. catheter	22020	22	$1.3	23	$1.4	9%
Arterial line	22025	83	$5.9	117	$7.2	45%
Neuraxial analgesia	22031/6	81	$6.1	94	$7.1	18%
Blood transfusion	22002	24	$1.4	20	$1.2	-12%
All 'anaesthesia initiation' items			$321m		$389m	21%

review the report prior to its release. We are grateful to the Minister for allowing this. It should be noted that the report was shown to us on the perfectly reasonable condition that we not publicise its contents, until authorised.

Given the flaws in the process to that time, it was of no great surprise that the ASA had a range of significant concerns with the ACC report. Some aspects of the report are now public knowledge, after presentations by A/Prof Sutherland and Ms Maxwell-Wright (consumer representative) at the national conferences of the ASA and ANZCA in 2017, and can therefore be discussed.

The ACC has suggested major changes to anaesthesia consultation items, based merely on feedback from the consumer representative, with no systematic review or evidence base. The proposals would introduce a major degree of complexity, and place administrative demands upon anaesthetists which are unprecedented in the MBS. There is no evidence that these changes are needed, and the proposals therefore completely conflict with the terms of reference of the Review.

The ACC proposes major changes to the funding of diagnostic and therapeutic services performed in association with anaesthesia (MBS RVG Subgroup 19), such as invasive cardiovascular pressure monitoring. No evidence was presented other than the growth in claims for these items in recent years. The ACC also takes a similar line to bodies such as MSAC; that anaesthetists will provide these services where necessary, regardless of whether or not they are funded (in the words of A/Prof Sutherland, these services are just "something we normally do"), and therefore their funding should be removed. Such arguments fail to take into account that this approach would lead to most of the MBS being abolished, as there are literally hundreds of items covering services which doctors 'normally do'. The MBS is currently a fee-for-service (FFS) system, and this Review and its participants have not been given the authority to change this. A service of proven quality is eligible for Medicare funding, regardless of whether or not a doctor will 'normally do' it in order to provide best possible patient care.

An examination of the actual Subgroup 19 data is also enlightening (Table 2). While the growth in invasive arterial pressure monitoring is clear, there may well be a number of reasons for this. We are certainly dealing with an ageing and increasingly medically unwell population, and there is also evidence that the use of invasive pressure monitoring is growing in the public sector. Arguments about the growth in such 'discretional' services predate the MBS Review. However, those arguing for curtailing of such expenditure on the basis of inappropriate growth in claims do not seem to be interested in the detailed data. As can be seen from Table 2, the growth for some Subgroup 19 items has been similar to or less than the growth in overall anaesthesia expenditure, keeping in mind that the latter is in no way under the control of anaesthetists – we do not generate the demand for these services. In the case of blood transfusion in association with anaesthesia, there has actually been a significant drop in claims over the last five years.

The ACC also proposes to slash funding for services of lesser duration, on the basis that more such procedures can be performed in any given amount of time, and that the income to the anaesthetist is therefore 'disproportionately' high, resulting in such services being 'incentivised'. No attempt was made to define what is 'disproportionate', or indeed what constitutes 'correct' proportionality. No consideration has been given to the fact that in any FFS system, the provision of more services results in a higher income to the practitioner. Each new patient attracts a 'flag fall' of funding, and this is entirely appropriate, given each patient has their own unique individual circumstances which need to be taken into account when deciding upon the correct approach to anaesthesia care, and in initiating anaesthesia management. The same is true for the proceduralists performing the services in question (upper GI endoscopy, colonoscopy, cataract extraction), and for all other services provided on a FFS basis, including non-medical services. No consideration was given to this fact. However, it would appear this attack on the FFS system is to be limited to anaesthesia. No other clinical committee has adopted this approach. The ACC agenda also overlooks the fact that anaesthetists do not generate demand for these services, but rather, are there because the proceduralist

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has requested it. There is therefore no question of anaesthetists having an 'incentive', or even the ability, to generate this workload.

The ASA naturally recognises that procedures of longer duration are not as well rewarded on a dollars-per-hour basis, across all specialties. The ASA has proposed on numerous occasions that longer-duration anaesthesia services should have improved funding for their anaesthesia time items. This resulted in the adoption into the MBS of 10 minute MBS items after two hours of anaesthesia time, and the ASA's own system goes further, allocating five minute time items after four hours. These ideas were in place well before the MBS Review was even proposed.

The proposed changes would lead to a complete re-writing of the RVG, with a significant loss of the ability of the RVG to tailor rebates to the nature of the individualised care provided to patients.

These are only a few examples of major problems the ASA sees in the ACC report. There are numerous other inconsistencies (for example, a completely opposite approach taken to services which are also provided by specialists other than anaesthetists), many factual errors, and proposals with no evidence base, but these cannot yet be detailed due to confidentiality requirements.

The implications for the provision of anaesthetic services to the public if the ACC proposals are implemented are extremely serious, with significant sections of the community being targeted for funding cuts, with a likely negative impact on either service provision or out-of-pocket costs. The proposed changes would lead to a complete re-writing of the RVG, with a significant loss of the ability of the RVG to tailor rebates to the nature of the individualised care provided to patients. It would appear one of the major drivers for change behind the proposals was the belief of the ACC that many services provided by anaesthetists were provided purely for financial gain.

This edition of *Australian Anaesthesist* also contains an excellent article on the history of the RVG, written by Dr Greg Deacon (Past ASA President, and Past EAC Chair). ASA members will no doubt recall the enormous amount of work done by Dr Deacon, and the other members of the EAC at that time, in having the RVG adopted into the MBS. His article shows just how dangerous it is to allow fundamental changes to be made to the RVG, without fully considering the knowledge and expertise of people who have devoted much of their professional lives to this work.

THE ASA'S WAY FORWARD

The ASA formed a working group to specifically examine the draft ACC report, and suggest an alternative approach. ASA members and staff who have worked with the group are (in alphabetical order):

- Dr David Borshoff, Chair, ASA WA Committee of Management, Council-Elected Member of ASA Board of Directors.
- Mr Mark Carmichael, ASA CEO.
- A/Prof. Alicia Dennis, Chair, ASA Public Practice Advisory Committee.
- Dr Antonio Grossi, Chair, ASA Professional Issues Advisory Committee.
- Dr Andrew Mulcahy, ASA Past President and Immediate Past Chair EAC, Federal AMA Craft Group Representative for Anaesthesia.
- Dr Suzi Nou, ASA Executive Councillor.
- Mr Chesney O'Donnell, Past ASA Policy Manager.
- A/Prof. David M Scott, ASA President.
- Dr Peter Seal, ASA Vice-President.
- Dr Mark Sinclair, Chair, ASA Economics Advisory Committee, Council-elected Member of ASA Board of Directors.
- Dr Elaine Tieu, ASA Policy Officer.

The working group is also most grateful for the input of Prof. David A. Scott (ANZCA President) and Prof. David Story (Foundation Chair of Anaesthesia, University of Melbourne) for their input and advice on quality of care, patient safety, standards of practice, and other clinical and scientific aspects of the ASA's approach to the future of the RVG.

The working group, via ASA President David M. Scott, has liaised closely with the DoH and the Minister, and we are grateful that our input is being seriously considered.

The first result was a detailed 77-page response document, responding to each ACC proposal point by point. It is important to note that the ASA does support some of the ACC proposals, and this has been highlighted wherever it is the case.

Secondly, the group has produced a 50-page 'ASA Alternative Recommendations' document, which has also been received by the Department and the Minister (the Minister for Health now being Hon. Greg Hunt MP). We believe this set of recommendations will be far more acceptable to the anaesthesia specialty and our patients. We firmly believe we can get the specialty on board, despite the fact that the Alternative Recommendations will result in reductions in funding for some services. We are confident the specialty will recognise that these reductions are based on an in-depth and clearly superior knowledge of the RVG, and that they reflect modern anaesthesia practice, rather than pre-conceived, non-evidence-based agendas. Importantly, our recommendations will not have the negative impacts on patients which we believe will result if the ACC proposals are adopted.

Given our many years of stewardship of the RVG, the ASA would have preferred to be involved from the very start, when the process had a 'clean slate', rather than our

input having to be a response to a process imposed upon us. But that was not to be, as detailed earlier. We have carefully explained all of this to the Department and the Minister.

It is essential to note that the Department and the Minister are firmly motivated to ensure that the MBS Review has positive outcomes for health funding and patient care, and this is clearly the reason why they have been careful to listen to our input. The AMA (particularly AMA President Dr Michael Gannon), has also been most supportive and helpful. The ongoing dialogue between Mr Hunt, his office, and the Department, with the AMA and ASA, has been a most welcome development.

The ASA will firmly lobby, as a priority, for the ASA's recommendations for the RVG to be adopted.

At the time of writing, a Stakeholder group consisting of several members of the ASA working group, along with Professors David A. Scott and David Story, and Dr Phillipa Hore (Chair, ANZCA Safety and Quality Committee) has recently met with Departmental representatives via teleconference, and a face-to-face meeting is being planned, probably for June 2018.

The timeline is uncertain, and of course the overall process is not under our control. This is the first time a draft report of an MBS review committee has been withheld, due to a key stakeholder group expressing significant opposition. Our strong views, put directly to the Minister in face-to-face meetings as well as in writing, have convinced the Department and Minister to make a significant change to the previously announced process for the MBS Review, and as such, there is no precedent.

The ASA will firmly lobby, as a priority, for the ASA's recommendations for the RVG to be adopted. Our Stakeholder group has again emphasised the ASA's points on the ACC report in detail, and these have been received, but largely ignored or dismissed by the ACC. The ACC report remains essentially unchanged, and it would now appear that the ACC's work on the document is likely finalised.

It is probable that at some stage, the ACC document will be made available for public consideration. In this case the ASA will release its full response to every aspect of the ACC report, as well as our alternative recommendations, for consideration by the specialty. The Minister has informed the ASA that further discussions will be held with us, before any material is released for public consultation.

I would also like to thank all of the members of the ASA Economics Advisory Committee for their ongoing support and expert assistance. The 2018 EAC team, including 'ex officio' members, is:

Dr Mark Sinclair (SA), Chair
Dr Andrew Mulcahy (Tas), EAC Immediate Past Chair, AMA Craft Group Representative, ASA Past President and Life Member
Dr Antonio Grossi (Vic), PIAC Chair
A/Prof Alicia Dennis (Vic), PPAC Chair
Dr James Bradley (Qld), Specialty Affairs Adviser, ASA Past President and Life Member
Dr Maryann Turner (Qld), TMG Representative
Dr Anne Rasmussen, NSW/ACT EAC Officer
Dr Timujin Wong, Qld EAC Officer
Dr Michael Lumsden-Steel, Tas EAC Officer
Dr Renald Portelli, Vic EAC Officer
Dr Tim Porter, SA/NT EAC Officer
Dr Robert Storer, WA EAC Officer
Dr Mark Colson (Vic), Committee Member
Dr Graham Mapp (Qld), Committee Member
Dr Michael Soares (WA), Committee Member
Dr Ian Woodforth (NSW), Committee Member
A/Prof David M. Scott (NSW), President
Dr Peter Seal (Vic), Vice President
ASA Chief Executive Officer, Mark Carmichael
Jacintha Victor John, ASA Policy Manager
Elaine Tieu, ASA Policy Officer

Dr Mark Sinclair
Chair, Economics Advisory Committee
Australian Society of Anaesthetists

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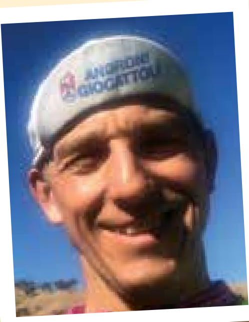
FEATURE

THE 2018 NATIONAL SCIENTIFIC CONGRESS

The year was 2002, I was still in high school, Warnie was bowling leg breaks for the Australian Cricket team, Pluto was still a planet, and Trump was running beauty pageants.

This was also the last time Adelaide hosted the ASA NSC. Like the rest of the world, Adelaide has seen some significant changes, mostly for the better! We now boast the most expensive building in the southern hemisphere, a world class sporting stadium, a thriving small bar and restaurant scene, a flagship independent health and medical research institute (SAMHRI) and an airport worthy of a capital city. On behalf of the organising committee we are really excited to host the ASA NSC this year and can't wait to share with you what we know will be an amazing few days in RAdelaide!

Before I tell you more about what we have planned for the NSC this year I thought I would sit down and find out a little more about two very important people involved in the organisation of the ASA NSC this year. Dr Simon Macklin the 2018 NSC Convener, and Dr Kate Drummond the 2018 NSC Scientific Convener.



Hi Simon, thanks for sitting down to have a chat with me. Can you start by telling us a little bit about yourself?

Not a problem Kris. Born in the UK, I first came to Adelaide in 1991 as a post-fellowship registrar. We ended up spending a really enjoyable 14 months in Adelaide, making great friends and connections. It wasn't until July 1995 however that we permanently moved to Adelaide and we haven't looked back once. Fast forward 23 years and I'm sitting in a brand-new state-of-the-art hospital. I currently spend most of my time in public practice but do a small amount of private practice. My subspecialty interests include anaesthesia for Upper GI surgery and teaching airway and FOI skills.

How did you end up as the Convener of the Adelaide ASA NSC?

Kris, I really enjoyed my time as South Australian State Chair of the ASA from 2014-2016. It was an eye-opening experience. I had the opportunity to be involved with senior members of the anaesthetic community across Australia and witness first-hand the camaraderie that exists between members of the ASA and their commitment to furthering the specialty. As my time as the State Chair was coming to an end the opportunity to convene the Adelaide ASA NSC presented itself. I enjoy challenges and I saw this as an opportunity to broaden my skills. Adelaide has the potential to deliver an outstanding meeting. Central to this is having the right people in the organising committee. I'm really excited about what we have in store for the meeting this year.

Is there anything you are particularly excited about?

Can I say the whole thing? Kate Drummond and her team have put together an amazing scientific program. It ticks all the boxes. We have some truly excellent speakers. The workshop program takes advantage of the world-class, brand new, purpose-built simulation centre at the new medical school. The small group discussions are full of renown speakers presenting on a variety of topics that I know will be of interest to the everyday anaesthetist. I'm also really pleased that we have so many of the SIGs involved in the NSC this year.

Moving away from the NSC, I understand you have a passion for line dancing? Where did this come from? Will there be any line dancing at the ASA NSC?

Thanks Kris! My interest in this type of dance comes from my enjoyment of Scottish country dancing. It doesn't require a deafening volume of music and it can be performed if you are young or old, agile or frail. I also love the fact it gives you the opportunity to interact with a large number of people. As you are well aware Kris, I was very keen to have some line dancing at the ASA Gala Dinner – unfortunately this decision falls outside of my control.

What is the one thing you couldn't live without?

I'm not sure I could come up with just one thing. My passion at the moment is riding, mountain bikes or road bikes, I'm not fussy. I'm actually about to complete a charity ride for Pain Revolution which will see me ride from Sydney to Albury-Wodonga over seven days. Like most of us I couldn't live without friends or coffee!

Thank you for your time Simon.

Hi Kate, thanks for taking the time to sit down with me. We might start by finding out a little bit about yourself.

Well, just like Simon I'm also not originally from Adelaide. I was born and grew up in Canberra. I ended up moving to Adelaide for university and I liked it so much that I stayed. After obtaining my FANZCA in 2010, I completed a Cardiothoracic Anaesthesia Fellowship at Papworth and now enjoy a public post at the Royal Adelaide Hospital with a small amount of private practice. My clinical interests outside of cardiac anaesthesia and TOE include perioperative medicine and blood management. In fact, I completed my Masters in Perioperative Medicine in 2016.

How did you find the time to be the NSC Scientific Convener?

It is actually a funny story. I had registered some interest in being the Scientific Convener but decided that if I didn't have the time to do it properly and do a good job I wouldn't take it on. On the final day of my Masters in Perioperative Medicine, Simon and Piers approached me as a united front! To be honest they caught me a little off guard and I said "yes". My only conditions were that I wanted to select my own team and that I had full control of the program.

What was the grand plan for the Scientific Program?

I approached the Scientific program by starting with what I didn't want. I didn't want a program that was too narrow and wouldn't appeal to everyone in the ASA. I really wanted to achieve a balance between new, exciting, practice-changing topics and everyday interesting stuff. Topics that would create some discussion. I also had two other goals. The first was to engage high quality speakers. I think we have achieved this. The invited speakers are excellent. I'm really with happy with the mix of practice and experience from across Australia and New Zealand and I'm really excited about some of the non-anaesthetic speakers. My other goal was gender balance and I think we have achieved that as well.

When you are not being a Cardiac Anaesthetist or organising an ASA NSC Scientific program what do you get up to?

To be honest, I haven't had a vast amount of spare time over the last 18 months but when I do, I like spending time with friends, going out for dinner and spending time at the beach. I also love reading books. I will read anything. At the moment I am reading *Sapiens: A Brief History of Humankind* by Yuval Noah Harari.

Simon likes line dancing; do you have any strange interests or weird hobbies?

Maybe not as exciting as line dancing but I do love archaeology. I'm actually currently doing a short course in archaeology through Oxford University.

Thanks very much Kate, I am really looking forward to this year's Scientific Program!

KIDS TAUGHT LIFE SUPPORT

ABOUT THE KIDS TAUGHT LIFE SUPPORT PROGRAM

This is an innovative and interactive program for children in Year 2 and above to learn how to respond to an emergency situation. The foundation will teach within schools and sporting clubs how to perform CPR at the national standard. Other elements such as defibrillation, choking, concussion, anaphylaxis and epilepsy are also covered. This is a hands-on visual learning experience for students using manikins to practice the fundamental techniques in a variety of emergency scenarios. The inspiration for creating this education program came about when Romy Ottens' seven-year-old daughter asked if she could demonstrate CPR for her class show-and-tell with her mother's support.

NEW TO THIS YEAR'S NSC 2018
PARENTS & CHILDREN WELCOME

"Thank you so much Romy. Lila had an amazing learning experience and has been practising and teaching the whole family!" Lynlee – parent

ABOUT THE FACILITATOR

Romy Ottens - Director

Romy Ottens graduated from the University of South Australia with a Bachelor of Nursing degree in 1996. Having worked as a Registered Nurse for 20 years at the Royal Adelaide Hospital (RAH) in the Surgical Plastic/Craniofacial unit, then Oncology. She has also worked as an educational facilitator for the University of South Australia within the nursing faculty and a Clinical Facilitator for the Staff Development unit for graduates in their first year out within the RAH. Romy currently works in the Operating Room Services unit with her specialty being perioperative/day surgery/recovery with airway management as a major focus of her clinical care. Romy has a certificate in Advance Life Support and is an accredited Basic Life Support instructor at the Royal Adelaide Hospital.

www.kidstaughtlifesupport.com.au

FREE TO CONGRESS THIS YEAR!

FEATURE

So, what else can you expect in Adelaide this year at the NSC?

The exciting variety of workshops will kick off on the Friday with three one-day workshops. RAW, a hands-on Regional Anaesthesia Cadaver course and Communication in Anaesthesia. Just off site at the brand-new world-class Adelaide University simulation centre we will be running the ALS and CICO ANZCA Emergency Response workshops over the Saturday and Sunday and at the convention centre you will find a great diversity of workshops over the four days. There should be something for everyone including 3D printing for clinicians and a team building adventure course at the beach! The iHeartScan Course we will also be running prior to the conference.

Our small group learning and masterclass facilitators hail from a variety of backgrounds and bring a huge amount of enthusiasm, knowledge and experience to the discussion table. On offer are more than 30 sessions with small participant numbers, providing ample opportunity for discussion, debate and hopefully finding answers to those burning questions. There are sure to be some animated discussions at sessions based around cases involving the patient with a myriad of allergies, or the provision of bariatric anaesthesia in non-tertiary settings.

Looking beyond the academic program our social program will open with a welcome reception on Friday evening. This is a great opportunity to meet colleagues, old and new and share in some of South Australia's finest food and wine including some award-winning gin from the Adelaide Hills. For the first time at an ASA NSC, this year's Gala Dinner will be held on the Saturday night and will be a black-and-white themed masquerade ball. The dinner will be held at the Adelaide Oval and will be a night not to miss! Sunday night allows you to mingle with the exhibitors and also meet some local boutique wine makers before the social program closes with a casual night at the Adelaide Zoo on the Monday. Meet the pandas, feed the hippos and enjoy an evening with family and friends.

For those of you planning to come with family there are endless options for entertainment. Kick off the conference with some indoor rock climbing or take the kids to a cooking class. For more options please refer to the website or registration brochure. Here you will find a variety of activities and suggestions for you and your family including the comprehensive and exciting partners program. Following the success of the Parent's Room and crèche in Perth last year this will also be available in Adelaide to facilitate the attendance of members with young families.

Adelaide really is a great place to visit and explore. Australia's best wine regions are only a short drive from the city and the small bar and restaurant industry is thriving, making for some great places to relax and unwind while you are here. On the website you will find our personal recommendations for your time here in Adelaide.

We look forward to hosting you all in Adelaide at the 77th ASA National Scientific Conference.

Kris Usher
Social Co-Cordinator

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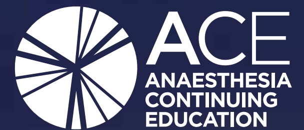

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Cardiac Thoracic Vascular and Perfusion (CTVP) SIG – ECHO Meeting

Satellite to the 77th Australian Society of Anaesthetists' NSC

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#CTVP18

NSC 2018 SPEAKER ABSTRACTS

PROFESSOR JOYCE A. WAHR | MD FAHA

Vice Chair, Safety and Quality, Department of Anesthesiology, University of Minnesota, USA

WHY IS PATIENT SAFETY SO HARD?

Introduction

An editorial in the *British Medical Journal* noted that, if medical error was a disease, it would be the third leading cause of death in the US.[1] Despite intense efforts, and nearly 14,000 publications on this subject since 1999, it is hard to demonstrate significant improvements. The annual incidence of sentinel events has remained unchanged over the past decade. The truth of the matter is that medicine is a highly complex field, and one that is tightly coupled such that an error in any step of a patient's care can quickly lead to severe harm.

The sheer number of 'opportunities for error' that exist for each patient may seem daunting, but there are other highly complex and tightly coupled industries that have an incredible degree of reliability. Wieck and Sutcliffe studied these industries and identified five common traits: 1) preoccupation with failure (where/how is the next accident likely to occur); 2) sensitivity to operations (must truly understand how the work is actually done on the front lines); 3) reluctance to simplify explanations (work hard to understand deeply how an accident of near miss occurred); 4) resilience (when things do go wrong, how to get back on track); and 5) deference to expertise (involve frontline workers in any solutions, as they understand the work).

Leadership

The leaders of an organization must provide transformational leadership, a clear and unwavering vision for patient safety, including a commitment to a culture of safety.[2] These leaders welcome and depend on input from the frontline staff about where errors are likely to occur (or where and why they have occurred) and they defer to the expertise of those who do the job every day when designing systems improvement. There are three initiatives that leaders should take to improve safety culture: development and implementation of a just culture, broad application of training in teamwork skills and communication, and tools like WalkRounds™, adopt-a-unit, or patient safety rounding.[3,4] These initiatives lead to alignment of frontline workers with the safety vision of leadership.

Culture

While all agree that we need a 'culture of safety', it is less well recognized that one cannot simply order or transform an existing culture. But changing form a blame and shame culture to a just culture is not achieved by decreeing a change in culture. Rather, leadership must change behavior, both their own behavior (responding to harm events with a view to a just response), and in their care teams, teaching teamwork behaviors of coaching, collaborating, communication patterns, and so on.[5]

Critical Incident Reporting

Even as all politics are local, all safety is local. That is to say, each clinic or unit or operating room has their own ways of doing things. Each unit therefore needs their own incident reporting and a method to analyze and define a correction plan. Although the entire institution may use a single incident reporting tool, deference to expertise and sensitivity to operations dictates that the solution to the vulnerability should come at the unit level.[6] Edmondson has described that when nurses feel valued and respected and respect their manager, they feel safe when reporting errors, so report often. Conversely, when nurses fear repercussions, they hide errors as much as possible.[7-9] Unless executive leadership spends time on these units, doing what are termed 'gemba walks', they "may not know which group has which culture."[7]

Even when leadership acts in a non-punitive fashion, cultural norms influence reporting rates, in that nurses and pharmacists are far more likely than physicians to report errors.[10] Shame is certainly pervasive in physician training,[11] and likely contributes to physicians' reluctance to report even incidents that do not reach patients.

Disrespect: Power Distance, Hierarchy, and Disruptive Behavior

Geert Hofstede has described the power distance, which is defined as "the extent

NSC 2018 SPEAKER ABSTRACTS

to which the less powerful members of organizations and institutions (like the family) accept and expect that power is distributed unequally."[12] Power distance is largely set by cultural norms, but even in countries where the power distance is relatively low (Australia and US), it tends to remain high in healthcare, such that nurses do not question physicians, and that junior doctors do not challenge senior physicians. Where there is a strong hierarchical structure, there is also a lower safety climate.[2,13] Over the past 30 years, the airline industry has successfully moved to a culture where anyone who has a concern can, and must, voice it, and can even stop a plane from taking off.[14] In medicine, we are far from this ideal. There are countless medication errors where a nurse, pharmacist, or resident recognized the error, but did not speak up because of previous encounters with disrespectful physicians.

Disruptive behavior has been pervasive throughout healthcare for a very long time: in a 2008 survey, 77% of respondents had witnessed disruptive behavior in physicians, and 65% had witnessed disruptive behavior in nurses. Two-thirds agreed that these behaviors were linked to adverse events, even mortality.[15] Once again, executive leadership must set the tone, must move quickly to correct any disruptive behavior by any team member, and must continually insure accountability.

Lies, Damn Lies, and Statistics

The heading here is meant to point to the reality that it is very difficult to perform randomized, controlled studies of safety interventions, although they do exist. Scientific studies of computerized physician order entry have found that they decrease medication errors.[16,17]

The paucity of rigorous data for many interventions (prefilled, premixed syringes in the OR) has led some to discount any guidance, such as that from expert groups. However, Sackett states that "evidence based practice does not always require RCTs, but can certainly include 'tracking down the best external evidence with which to answer our clinical questions'.[18]"

Costs

Improvements in patient safety, as noted, require comprehensive patient safety programs, which cannot be manage with existing staff. These programs require dedicated, trained staff to manage critical event reporting systems, perform root cause analyses, perform audits of compliance with safety interventions (wash your hands), and continually analyze rates of preventable adverse events. An urban, free-standing children's hospital implemented a comprehensive patient safety program, increasing the QI department from 8 to 33, and the budget from US$690,000-$3.3 million.[19] Every employee was trained on safety behaviors, and safety efforts were concentrated on specific areas of patient harm: pressure ulcers, adverse drug events, and hospital acquired infections. These efforts saw a significant decrease in the rate of serious safety events, from 1.2 per 10,000 adjusted patient days to 0.2 ($P<0.001$). The estimated direct cost of preventable harm decreased by US$1.8 million.[19]

There are weak interventions to improve safety, and there are strong ones.[20] The weak ones tend to be cheap (re-education, write more policies and procedures); the strong ones are expensive (forcing functions, computerized oversight, electronic health records, bar code administration, automated dispensing cabinets networked to the central pharmacy). It can be difficult for leadership to weigh the return on investment for any of the effective, but expensive, technologies. With healthcare costs already a significant proportion of any country's GDP, it is uncertain how to support these proven safety interventions.

No, I Won't and You Can't Make Me, and other aspects of human nature

Change is hard. Since most of patient safety involves change, we must accept that we cannot simply write a new policy or procedure and expect all to fall in line. Reams of books have been written about change management; they provide a deeper understanding of why patient safety is so hard, and a recognition that when we fail to effect the change we desire, the underlying reason is rarely that we are inept, or that our colleagues are acting badly or are just stubborn.

Violations

As with errors, violations arise out of complex frameworks and interactions – often contradictions – between human operators, and those who write regulations, policies and procedures, all of whom are most-often entirely well meaning. Violations are hardly unique to healthcare, but occur across all of life (driving faster than the speed limit) and in all industries.

Healthcare is full of policies and procedures, rules and regulations. Unfortunately, policies and procedure can be poorly written, complex, outdated, top down rather than bottom up, be poorly aligned with how work is done, and be poorly supported by technology. Indeed, some will be frankly wrong. Healthcare workers often feel as though the work can only be done through a violation, or violations are required to provide better care.

While some violations are done with the patient's best interest in mind, many grow out of errant and self-serving preferences. Healthcare works are somewhat unique in that violations rarely result in harm to the violator, but only to someone else, resulting in 'risk displacement'.[21] Perhaps one of the most difficult perception, or

human trait to understand and manage is the 'powerfulness' construct. It is a joy to accomplish a task with skill and efficiency; for some, seeking this 'joy' becomes thrill seeking, where more and more risks are taken in the belief that "it won't happen to me."[21,22] Finally, there is the concept of 'risk tolerance', that there is a certain level of risk that humans are comfortable with, and, that, as safety increases due to better technology, we are willing to take more extreme risks, and likely are willing to violate, thinking the rules are unnecessary with the technology in place. A easily recognized example is drivers who would have crept cautiously along snowy and iced roadways now drive at normal speeds, given that their car is equipped with all wheel drive and anti-lock braking technologies.

Conclusions

The foregoing is barely the tip of the iceberg of 'why patient safety is so hard'. Hopefully it provides a glimpse into the enormous complexity of providing truly safe medical care so that we all understand what an effort it will take by the entire community to accomplish this goal. We should also take heart in the fact that we have roadmaps and manuals provided by the airline and the nuclear power industries that have shown us that achieving high reliability is possible. It must be recognized that healthcare is unique – a pilot flies the exact same aircraft every single day; a nurse cares for vastly different patients from day to day, so the complexity is far greater. Nonetheless, hospitals such as National Children's have shown us that we can dramatically reduce serious safety events.

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SESSION TIMES

Why is safety so hard?
Saturday 6 October
Hall C and A

Hazards in the operating room
Sunday 8 October
Hall C

Using incident reporting to implement change and improve safety
Tuesday 9 October
Hall A

NSC 2018 SPEAKER ABSTRACTS

PROFESSOR LARS I ERIKSSON | MD PHD FRCA

Professor of Anesthesiology and Intensive Care and Academic Chair, Karolinska Institute; Head of Research and Education in Perioperative Medicine and Intensive Care, Karolinska University Hospital, Stockholm, Sweden

LONG TERM BRAIN DYSFUNCTION AFTER ANESTHESIA AND SURGERY – WHAT WE KNOW AND WHAT WE WANT TO KNOW

Impairment of higher cognitive functions by surgical trauma, recently included in the term perioperative neurocognitive disorders (PND) by an International Consensus Working Group, is one of the most common serious long-term complications after otherwise uneventful surgical procedures and involves impaired memory, learning and attention processes. While 20-40 % of patients typically show cognitive decline at one week after major surgery, 10% of patients over 60 years may still suffer from a significant postoperative neurocognitive disorder at three months. Patient factors such as age, pre-existing cognitive decline, educational level and type of surgery (e.g. cardiac vs outpatient) are closely related to the risk for this impairment. In the search for blood- or CSF-born biomarkers of at-risk patients, recent findings suggest that patients with preoperative subclinical CSF biomarkers for neurodegenerative disorder (i.e Alzheimers disease) have a significantly higher risk for postoperative cognitive impairment than patients lacking such biomarkers. Moreover, it is now established that any pre-existing cognitive impairment is a powerful risk factor for more profound postoperative cognitive decline, which underscores that we in the future need to examine and evaluate brain function in the same way as we routinely assess and score other vital organ systems prior to surgery in order to identify patients at-risk for perioperative adverse events.

While the underlying mechanism behind longterm cognitive decline after surgery is not fully understood, there are growing body of evidence from series of animal models and recent translational clinical studies to suggest that surgery cause prolonged and profound changes in brain immune system that closely associates with long-term cognitive decline. In detail, surgery triggers the innate immune system via damage-associated molecular patterns (DAMPs) and alarmins targeting pattern recognition receptors on local immune cells such as macrophages. Orchestrated by systemic inflammatory molecules and activated immune cells, this local response spread systemically to remote organs and rapidly (hours) augment blood-brain-barrier (BBB) permeability allowing peripheral immunocompetent cells to migrate and invade the CNS. This inflammatory signal subsequently accounts for an immune activation involving resident brain immune cells (microglia, astrocytes) that associate with later impaired cognitive processing. This periphery-to-brain signalling after surgery ultimately leads to changes in synaptic processing (days) within neuronal circuits of relevance for cognitive processing that ultimately leads to behavior changes (days/week). In parallel to observations within the innate immune system by surgery, there is a general concern that anesthetic agents per se may induce long-term reduction or permanent cognitive decline (dementia). While there is substantial information from cell and animal models to suggest distinct degenerative or apoptotic cellular changes within the CNS by general anesthetics, recent studies suggest more of a modulatory effect by anesthetic agents on the risk for longterm cognitive decline. In this context, there are conflicting data on potential between classes of anesthetics, rather present information suggest close intraoperative monitoring of circulation and age-adjusted end-tidal MAC levels.

Because patient factors are closely linked to this complication, we need to introduce routine preoperative assessment of brain function and develop suitable perioperative screening tools, in order to preoperatively identify patients at risk for long-term cognitive decline postsurgery and morover find those patients that develop cognitive changes in the postoperative period. At risk patients benefit from improved perioperative management to minimize the risk for cognitive impairment where targeted interventions potentially could reduce the risk for PND. In parallel, we need to better understand the role of immune-activation and -resolution to define novel treatment strategies to prevent negative impact on cognitive processes. Finally we need to further explore the potential link between surgery, perioperative cognitive disorders and dementia.

This lecture will provide insights into basic physiology and pathophysiology behind longterm impact of surgery on the human brain and our future challenges.

NEUROMUSCULAR PHARMACOLOGY AND MONITORING – FROM BASIC MECHANISMS TO CLINICAL PRACTICE

Neuromuscular blocking agents (NMBAs) are widely used in anesthetic practice and occasionally in patients within intensive care. The molecular target for this class of agents are the nicotinic acetylcholine receptor (nAChR), widely spread with the central and peripheral nervous systems. This family of nicotinic cholinergic receptors consists of several subtype receptors, each having a typical structural conformation and subsequent function within neuromuscular transmission (muscle type nAChR) or neuronal control (neuronal subtype nAChRs). The nAChR is a membrane-bound and ligand-gated ion channel that operates over a wide range of synapses involved in critical control of vital functions. Non-depolarizing NMBAs interact with all subtype nAChRs, hereby producing a classical neuromuscular block with subsequent muscle paralysis and in addition, an array of interactions with regulatory control of vital functions with significant clinical relevance. The interaction with muscle type nAChRs and neuronal subtypes nAChRs by non-depolarizing NMBAs (but not depolarizing NMBA) gives rise to impaired neuromuscular transmission and typical changes in neurochemical transmission of action potentials over the synaptic cleft. This lead to typical electrical (EMG) and mechanical response patterns underlying the routine neuromuscular monitoring devices clinicians apply in daily clinical practice. The relationship between NMBA dose and neuromuscular blocking effect (sensitivity) varies considerably between different muscle groups, with muscles involved in pharyngeal control and airway integrity being the most sensitive among the vital muscle groups. In addition, the affinity of NMBAs to neuronal nAChRs lead to distinct changes in neurotransmission within the wakefulness and regulation of breathing, and in particular oxygen sensing and signaling systems involved in regulation of breathing during hypoxia. Residual effects of NMBAs therefore target vital control of ventilation in such as way that patient with residual neuromuscular block after extubation may encounter airway obstruction, aspiration and impaired ventilatory response to acute hypoxia. This lecture will provide basic molecular and cellular understanding of the pharmacology behind neuromuscular transmission and neuromuscular blocking agents in particular of relevance for neuromuscular monitoring in clinical practice.

SESSION TIMES

Postoperative cognitive impairment: clinical features, definitions and preoperative management
Saturday 6 October
Hall B

Longterm brain dysfunction after anesthesia and surgery – what we know and what we want to know
Sunday 7 October
Hall C & A

This is what you should consider when planning to do clinical research
Sunday 7 October
Hall C & A

Neuromuscular pharmacology and monitoring – from basic mechanisms to clinical practice
Monday 8 October
Riverbank 3

Academic performance after early childhood anaesthesia
Tuesday 9 October
Hall A

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Directors of Departments of Anaesthesia, Adelaide Public Hospitals

Saturday 6 – Tuesday 9 October 2018

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Sunday 7 October 2018

Workshop 2: Hypnosis for trainees

Dr Allan Cyna

Chair of the Communication in Anaesthesia SIG

Director of Studies for South Australian Society of Hypnosis

Sessions:

Public versus private practice *Dr Ammar Ali Beck*

Financial planning *Mr Jon Silcock*

Transitioning to consultancy *Dr Scott Ma*

What health care will look like in the future *Professor Guy Ludbrook*

Optimising exam performance *Dr Anthony Coorey*

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NSC 2018 SPEAKER ABSTRACTS

A/PROFESSOR DUMINDA N. WIJEYSUNDERA | MD PHD FRCPC

Associate Professor, Department of Anesthesia, Institute of Health Policy Management and Evaluation, University of Toronto; Staff Anesthesiologist, Department of Anesthesia and Pain Managment, Toronto General Hospital; Scientist, Li Ka Shin Knowledge Institute, St Michael's Hospital, Toronto; Adjunct Scientist, Institute for Clinical Evaluative Sciences, Ontario, Canada

PERIOPERATIVE ASSESSMENT – PAST, PRESENT AND FUTURE

Preoperative evaluation is an integral component of anesthesiology practice. It has evolved substantially over the past few decades. This lecture will provide an overview of this evolution, identify important lessons learnt, and define key future challenges. Multiple factors have driven this evolution in preoperative assessment, including changing financial incentives in the healthcare system, recognition of increasing medical complexity in surgical patients, and anesthesiologists' transition into perioperative medicine. These changes have imposed important new challenges for the profession. For example, financial incentives for hospitals to reduce inpatient length-of-stay now means that surgical procedures are often performed on an outpatient or same-day admission basis in many countries. This structural change required anesthesiologists to face the organizational challenge of developing efficient and thorough outpatient preoperative evaluation clinics. Subsequent recognition of increased comorbidity burden in surgical patients led anesthesiologists to become increasingly involved in preoperative risk assessment and optimization. While much progress has occurred in structured risk assessment, most early and apparently straightforward preoperative interventions to prevent complications (e.g., beta-blockers, aspirin) did not prove to be efficacious. In the current stage of this evolution, anesthesiologists will have to better integrate perioperative assessment into the longitudinal process of surgical care. This work will push the profession forward along many avenues, including specialized preoperative physiological testing (e.g., cardiopulmonary exercise testing), more intensive preoperative optimization (e.g., prehabilitation), integration with postoperative perioperative medicine teams, development of patient-centered metrics for postoperative recovery, and participation in shared-decision making for surgery.

SESSION TIMES

Alternatives to CPET for assessing preoperative functional capacity

Saturday 6 October

Hall B

Preoperative assessment – past, present and future

Sunday 7 October

Hall C & A

Perioperative troponins and biomarkers

Monday 8 October

Hall C

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NEWS

CHARITABLE IDEA IMPROVES PATIENT SAFETY

A simple idea for pre-cut endotracheal tube ties is raising money for breast cancer research and improving safety in the operating room.

It began with a casual conversation in theatre. A disjointed conversation, in which a nurse was complaining about the tedious work of cutting endotracheal tube ties from rolls of cotton tape, and the anaesthetist, Dr Steven Gubanyi, was wondering how he could contribute to the cause of breast cancer charities.

Dr Gubanyi's wife, Kate, had been diagnosed with breast cancer five years earlier. She now contributes some of the profits from her bridal boutique business to cancer charities, and Dr Gubanyi wanted to do the same. The nurse's complaint led to his Eureka moment: a project he now calls "ettties".

The very next patient in theatre required intubation, but he had a large head and the tie the nurse had cut was not long enough. Precious seconds were wasted while the nurse rustled up another.

Dr Gubanyi knew the endotracheal tube ties are used "everywhere" – theatres, crash trolleys, the intensive care unit, the emergency department – to hold in place the tubes that connect patients to machines that help them breathe. He thought it was a waste of nursing time – and hospital money – for university-trained nurses to have to cut and tie them. And he thought it was unsafe for patients that ties were sometimes too short, causing a delay in securing the airway.

So now: "I import the ETT ties already cut and knotted, dyed pink to represent breast cancer awareness, and sell them to hospitals," Dr Gubanyi says. "One hundred per cent of the profit goes to the McGrath Foundation, which funds breast cancer nurses, or to the National Breast Cancer Foundation, to fund their research. The accounting is open source to anyone who wants to look."

Nominally, his individual ties cost more than big rolls, which are hand-cut. But he argues that this is true only if one fails to take into account the real cost of nurses' labour: "A roll of 500 metres is supposed to cost around 10 cents apiece, but by the time you add in the time it takes nurses to cut the roll up and knot the ties, the real cost is closer to 40 or 50 cents."

Another advantage of his ties is that they are always long enough, which means precious seconds are not wasted in an emergency. And they are never too long, which means there is no wastage.

Dr Gubanyi, who is based on the Gold Coast, is selling to public and private hospitals in several states. If he can get up to 250 hospitals using ettties, he hopes be able to donate $A50,000 a year.

The cause is very close to his heart. His wife, Kate, owes her life to modern breast cancer treatment. Then, after chemotherapy drastically reduced her fertility, the couple's son, Jackson, was an unexpected blessing.

So, the one-man band is committed to continuing to order, import, spruik, pack and mail his ettties. He sees it as a win-win initiative.

"It's an easy way for hospitals to become more charitable while saving money and improving patient safety," he said.

For further information, contact ettties@gmail.com or http://ettties.wixsite.com/website.

Karen Kissane

This article appeared in the December 2016 edition of the *ANZCA Bulletin*.

Far left: Dr Steven Gubanyi, Kate and baby Jackson.
Left: samples of Gubanyi's 'etties'.

INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

DR ANTONIO GROSSI
PIAC CHAIR

INFORMED FINANCIAL AGREEMENT. WHAT'S IN A WORD?

The discussion about changing the name of the specialty of anaesthesia is well underway and some will be wondering 'what's in a word?' The recent Senate report, 'Value and affordability of private health insurance and out-of-pocket medical costs'[1], the new term 'informed financial agreement' (IFA) is replacing what has previously been known as informed financial consent (IFC). It is worth considering what this means.

Recent media reports[2] have highlighted the out of pocket costs facing patients seeking medical care. Doctors are often blamed for these costs. The reasons for these out of pocket costs are multifactorial including the inadequate indexation of the MBS over several decades, increasing practice costs, increasing costs of technology and treatments, demographic changes, evolving patterns of disease, and probably most importantly, the increased demand for healthcare services.

There needs to be increased transparency and insight regarding medical billing. The community deserves and demands the opportunity to make an informed choice about their healthcare provider[3]. Those who charge significant out of pocket expenses without appropriate communication may not even be aware of the implications of these practices. The relative value guide (RVG), provides anaesthetists with a meaningful way of generating an account based on the type, complexity and duration of the procedure and anaesthesia required, which may be modified by patient and other relevant factors. Determining one's unit value is a personal choice that may take many factors into account including years of experience and training, complexity of practice and overheads. This has been summarised recently and eloquently by Greg Deacon, "Anaesthetists may charge what they are worth however they should also be worth what they charge and always take their patients' circumstances into account".

The process needs to be fair

With regards to anaesthesia, what choice do patients have really? If patients are notified on the day of surgery or shortly before admission of their proposed out of pocket costs, are they genuinely empowered to seek an alternative anaesthesia provider? Arrangements have been made, time taken off work, the surgeon has referred the patient to this particular anaesthetist and the choice of an alternative may be limited or practically not available. There must be a robust process for informing patients about costs around the time of booking the procedure. There must be an opportunity for patients to ask questions and provide some feedback acknowledging their understanding and agreement, which constitutes IFA. There needs to be consideration for obstetric and emergency situations. The ASA position statement on IFC was developed to assist members in this regard[4]. Furthermore, the ASA is working collaboratively with AVANT to further develop more educational and resource tools to help members improve their IFA process. How anaesthetists tell their story to patients is incredibly relevant.

Beyond IFA

It makes sense to provide good IFA. The medical indemnity industry is well aware of the correlation between poor communication and litigation and complaints. The process and discussion should be broadened to provide better clinical consent. The essential elements of consent include voluntariness, competence, adequate information including relevant and material risk, opportunity to ask questions, demonstrate understanding and appropriate documentation[5].

From a public relations perspective it is far better for patients to be engaged with their anaesthetist about their care primarily. The billing information should not be the first contact the patient has with their doctor if the objective is to optimise the patient experience.

The patient [customer] experience

In a consumer driven free market where patients are paying for their private health insurance and at least in part for their healthcare, the patient is also a customer. Traditionally doctors may have found this difficult to accept for various reasons. It is no longer good enough to satisfy customers, we have

to delight customers. It is about having an authentic purpose, building trust and treating people with respect by delivering the quality and service promised. How does the anaesthetist contribute to the value proposition for patients? This may be through timely care, a thorough preoperative assessment, relevant, quality anaesthesia care, post and perioperative care including being available after the surgery if required. An understanding and participation in the pain and perioperative medical issues helps to differentiate an anaesthetist as a specialist medical doctor and not merely a technician.

Navaro discusses the four 'Cs' in improving the customer experience[6] and this is relevant for anaesthetists:

i) Customers. Do anaesthetists offer their patients a unique experience that keeps them engaged, makes them feel safe and genuinely cared for? It is important when considering IFA, that anaesthetists move beyond the transactional and consider the emotional implications of their actions.
ii) Content. In providing information to patients, anaesthetists may consider framing their story in the relevant context.
iii) Channels. Modern, meaningful IFA requires exploiting the current technology to reach the right people, in the right way at the right time. This will need to be contextually and practice specific.
iv) Consistency. In order to build trust, the genuine care anaesthetists have for their patients as their primary motivation, needs to be conveyed appropriately.

Providing a great patient experience is a way of differentiating the anaesthesia service. If there is no point of difference between the service provided, anaesthesia becomes a commodity that may only be differentiated on price. This becomes a race to the bottom and promotes mediocrity.

Better value care

Anaesthetists are in a unique position to contribute to providing better value care. This may be through useful perioperative care, participating in 'choosing wisely' decisions about futile care, managing staff, equipment and drugs in a cost effective manner. As health practitioners, anaesthetists have a responsibility to minimise the community's cost burden of disease. This will include becoming involved in public health and disease prevention, research, quality assurance, adopting evidence-based safe health practices that minimise unsubstantiated clinical variation in care, and health management that improves efficiency and cost effectiveness.

Conclusion

Thinking about going from IFC to IFA raises many other issues. If the anaesthetist's genuine concern is for the patient, adopting the appropriate process with effective communication, will ensure the delivery of long-term, sustainable health care.

References

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Go to: www.asa.org.au/positionstatements to read the ASA position statement on IFC.

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

The Medicare Benefits Schedule (MBS) Review is discussed in a separate article in this edition of Australian Anaesthetist. This is clearly a core focus of the ASA at present, but it's by no means the only issue with which your Economics Advisory Committee (EAC) is dealing.

PRIVATE HEALTH INSURANCE

Virtually every doctor in Australia would now be familiar with the new policies of the health insurer Bupa, to be implemented on 1 August 2018.

The 'preferred provider' arrangements for allied health, and 'members first' hospital initiatives, providing extra patient services such as a private room, are nothing new. However, Bupa is now taking things a step further.

From August 1, Bupa will no longer pay above-MBS rebates for patients treated in hospitals with which it does not have an agreement. Bupa refers to these as 'Members First', 'Network', or 'Fixed Fee' facilities. If a patient is treated in a different facility, the total rebate for doctors' fees will be MBS ($19.80 per RVG unit, as opposed to approximately $33-$36, varying on a state-by-state basis). The potential implications for out-of-pocket expenses to patients are obvious.

The immediate perception is that Bupa is attempting to implement a USA-style 'managed care' system. Bupa has strenuously denied this. However, these denials appear to be based only on a strict interpretation of the definition of 'USA managed care'. The concern is of course that Bupa is seeking to gain control over where its customers can be treated, by financially penalising patients whose doctors admit them elsewhere. No satisfactory answer to this concern, or the concern that this is only one step in the direction of increasing insurer control over patient care, has been received.

ASA representatives met with Bupa executives at North Sydney on 12 March. These concerns were discussed in detail, but little progress was made. The only concession given by Bupa was that they would reconsider their policy for patients from rural and remote areas, where there may be little or no choice of hospital.

Bupa has also foreshadowed other changes, particularly to its lower-level health cover policies. Full details can be found here: www.asa.org.au/bupa.

The AMA has been fully engaged in leading the debate on behalf of the whole medical profession and our patients, and no doubt will continue to do so.

Meanwhile, the work of the Private Health Ministerial Advisory Committee (PHMAC) continues. This committee, which includes AMA representation, is to provide advice to the Federal Minister for Health (Hon. Greg Hunt MP) on simplifying the vast and complex range of private health insurance policies available, in order to better inform consumer choice. The AMA has formed a committee of doctors from a range of specialties, to enable the AMA's PHMAC representative (AMA Secretary-General, Ms Anne Trimmer) to present strong medical practitioner feedback to PHMAC and the Minister. I am a member of this AMA committee. Members should watch for their regular ASA President's e-news releases to keep up to date with developments in this and other areas, as further information comes to light.

MINISTERIAL 'OUT-OF-POCKET EXPENSES' COMMITTEE

Members will no doubt be aware of the formation of this group, which has been given the task of providing Minister Hunt with proposals as to how patients can be better informed as to their likely out-of-pocket (OOP) expenses, specifically for doctors' fees, for private hospital care. The committee is not examining fees for the services of general practitioners. A range of medical specialties, as well as private health insurers and consumer advocates, are represented. The anaesthesia specialty is represented by myself and ANZCA President (at the time of writing) Prof. David A. Scott.

The detailed deliberations of this committee cannot be revealed at present due to confidentiality requirements, but fortunately, the committee Chair (Prof. Brendan Murphy, Commonwealth Chief Medical Officer) has released a series

of notifications to the public about the general direction of the committee's work.

The committee is of course aware of the publicly-available statistics on the incidence of OOP expenses in the private medical sector. These data indicate that only a minority of services (around 11%) involve such expenses. Nevertheless, all parties agree that the absolute number of patients facing such expenses is significant, and that it is essential that all possible efforts are made to inform patients of such expenses, as early as possible in their episode of care.

The proposals for how such information might be provided are still under discussion, but the Department of Health recently provided a press release, which stated in part:

"The Committee agreed that a collaborative approach involving consumers, medical specialists, insurers and the private hospital sector is critical to ensure the development of a practical and robust model. The Committee also acknowledged a potential role for General Practitioners in the solution to transparency. In addition to a best practice transparency model, consumer education is essential".

ASA members should rest assured that Prof. Scott and I will strive to represent the interests of anaesthetists and our patients in this ongoing initiative. Informed financial agreement (IFA) by patients is now the preferred term (previously informed financial consent), as 'agreement' is thought to better describe what should be a two-way process between doctor and patient. The ASA and ANZCA are committed to ensuring best possible IFA practices, as an essential aspect of patient care.

Finally, I regret to inform members that Dr Callum Gilchrist (NSW EAC Representative) has decided to leave the EAC after four years of enthusiastic and informed contributions. Callum has a young family and a very busy practice, and understandably feels that these must be his focus at present. We sincerely hope the ASA committees have not seen the last of him!

ECONOMICS ADVISORY COMMITTEE

Back row, left to right: Greg Deacon, Andrew Mulcahy, Michael Lumsden-Steel, Anne Rasmussen, Tim Porter, Graham Mapp and Ian Woodforth
Front row, left to right: Maryann Turner, Tim Wong, Mark Sinclair (Chair), David M. Scott and Renald Portelli

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POLICY UPDATE

CHANGES TO MBS URGENT AFTER-HOURS ATTENDANCE ITEMS

Members will be aware of the recent changes to the Medicare Benefits Schedule urgent after-hours attendance items. Since its introduction on 1 March, the ASA policy team have received several member queries seeking clarification about these changes.

The Australian Government announced the introduction of four new urgent after-hours attendance items and removal of two existing urgent after-hours items. These changes were recommended by the Medicare Benefits Schedule (MBS) Review Taskforce and its After-hours Working Group in response to clamping down on excessive after-hours claims by organisations such as medical deputising services. These changes aim to reimburse those doctors who provide genuinely urgent after-hours care in addition to their main workload during normal business hours.

In relation to after-hours care provided by medical specialists, MBS item 598 has been deleted and replaced by new items 588 and 591. In addition, new item 594 has been introduced to address subsequent attendances during the same unbroken after-hours period.

Urgent after-hours attendance during unsociable hours (between 11pm-7am), item 600, is retained with the current MBS fee, with minor modification to its descriptor.

Whilst new items 588 and 591 share a number of common descriptor points,

Table 1. The new MBS urgent after-hours attendance items as of 1 March 2018. These descriptors should be read in conjunction with Explanatory notes AN.0.19.

MBS Item	Fee	Descriptor
588 (New)	$129.80	Professional attendance by a medical practitioner (other than a GP) on one patient on one occasion – each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) the attendance is in an after-hours rural area; and (d) if the attendance is at consulting rooms – it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance
591 (New)	$100.00	Professional attendance by a medical practitioner (other than a GP) on one patient on one occasion – each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) the attendance is not in an after-hours rural area; and (d) if the attendance is at consulting rooms – it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance
594 (New)	$41.95	Professional attendance by a medical practitioner – each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient
600 (Amended)	$124.25	Professional attendance by a medical practitioner (other than a GP) on not more than one patient on one occasion – each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms – it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance

INSIDE YOUR SOCIETY

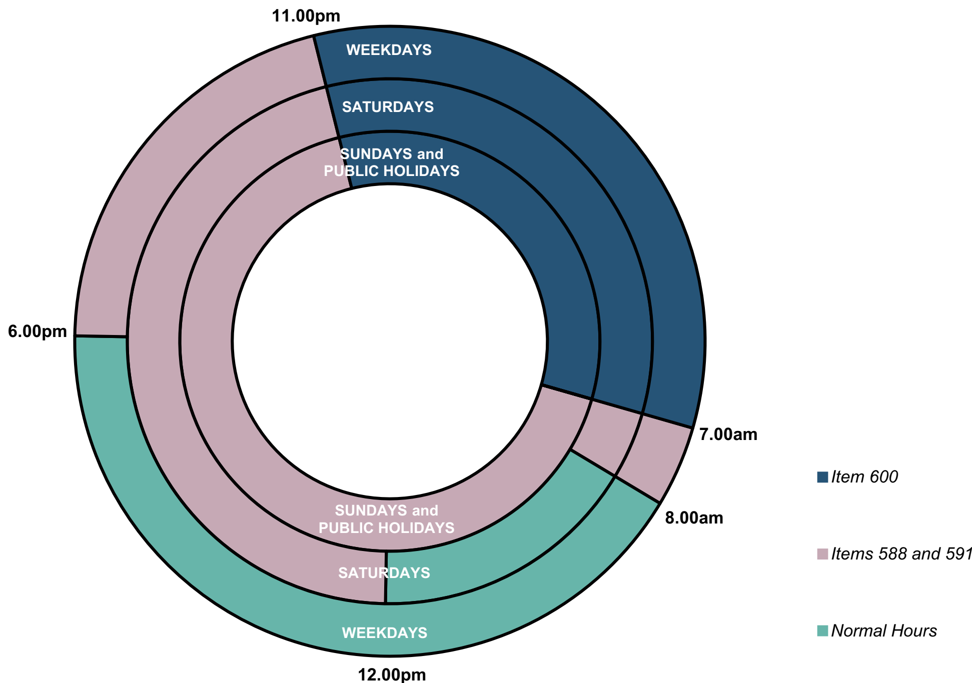

Figure 1: Revised MBS Urgent After-Hours Consultation Clock

the main point of difference is that 588 addresses services provided in the rural and remote areas. To be eligible for 588, medical specialists must be working in areas categorised as Modified Monash Model Classification 3 to 7. The classification of your medical practice can be determined on the DoctorConnect website: http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/MMM_locator

Item 588 is set at a slightly higher MBS Fee of $129.80. It aims to recognise the difficulty Australians in the remote areas can face in accessing after-hours care. A reduced MBS Fee of $100.00 (a decrease of $4.75) for item 591 is payable for those providing after-hours care in capital cities and metropolitan areas. These areas are categorised as Modified Monash Model Classification 1 and 2.

Table 1 provides details about the new fees and descriptors for each of the after-hours items. The ASA MBS after-hours consultation clock has been revised to include these new items (Figure 1).

Previously, doctors were permitted to organise urgent after-hours service two hours prior to the commencement of the after-hours period. This option to pre-book has been removed from the new MBS items and existing unsociable after-hours item 600. The service must be both requested and provided within the after-hours period.

It was recognised that doctors may see multiple patients in the one location during the same after-hours period. New item 594 has been introduced for subsequent consultations during the same emergency call-back visit. However, specialist anaesthetists should be able to use pre-anaesthesia consultation items from the item range 17610-17625, or referred consultation items 17640-17655.

Whilst we are still seeking official confirmation from the Federal Department of Health, it is likely that an item from 17610-17625 would be fine to use for the subsequent consultation on the next patient, for a pre-anaesthesia assessment. For a reason other than a pre-anaesthesia assessment, either item 594 or an item from the range 17640-17655 should be applicable. There is not much difference in the MBS fee between items 594 and 17610 / 17640, but there appears to be a considerable difference in rebates payable under the private health insurers' schedules. Table 2 compares the rebates payable by a number of private health insurers.

At the time of writing, in addition to the above, the ASA policy team is waiting for clarification from the Federal Department of Health regarding circumstances when specialists are called into a hospital for

Table 2. Fees payable for MBS items 594 and 17610/17640 by MBS compared to private health insurers.

	594	17610/17640
MBS	$41.95	$43.00
Medibank Private	$41.95	$71.05
St Luke's	$75.15	$71.60
HCF no gap schedule	$52.02	$90.30
HCF known gap schedule	$51.60	$73.00
HBF no gap schedule (WA)	$54.00	$83.20
NIB	$41.95	$66.30
Bupa*	$47.30-$50.25	$73.90-$78.30
AHSA*	$45.20-$50.90	$65.00-$70.10

Bupa and AHSA have different schedules for each state.

urgent after-hours attendances, as the information provided to date makes reference to GPs and non-vocationally registered doctors in after-hours clinics or as part of deputising arrangements. Furthermore, we are seeking confirmation that specialist anaesthetists can use 591 in the same way the old item 598 was.

Should members require more information about these changes, please do not hesitate to contact the ASA policy team via email: policy@asa.org.au or by calling 1800 806 654.

Further information can be read on the following:

1. Questions and Answers – New MBS urgent after-hours Items starting on 1 March 2018 http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/news-2018-03-01-new-urgent-afterhours-items
2. MBS Explanatory notes AN.0.19 in relation to items 588, 591, 594 and 600. http://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=AN.0.19&qt=noteID&criteria=AN%2E0%2E19

Elaine Tieu
ASA Policy Officer

CONTACT US

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

Email: policy@asa.org.au

Phone: 1800 806 654.

RENEW YOUR
ASA MEMBERSHIP

We work with and for our members to ensure the high standards of the profession.

We primarily focus on the economic, workforce and professional interests of our members.

Support. Represent. Educate.

ASA
Australian Society of Anaesthetists

INSIDE YOUR SOCIETY

ASA MEMBER'S GROUPS UPDATE

NATIONAL SCIENTIFIC CONGRESS 2018

Registration is open for the 2018 NSC, to be held in Adelaide from 6-9 October. The congress will feature a number of excellent dedicated trainee events, including:

- Trainee luncheon – complimentary sit-down meal, with an international speaker, in the Panorama Ballroom overlooking the River Torrens.
- A whole day of trainee sessions – Part 2 Boot Camp, Financial Planning, Transitioning to Consultancy and more!
- Two trainee workshops – How to Get the Job You Want and Hypnosis for Trainees.

The NSC organising committee and convenor Dr Simon Macklin are organising an outstanding meeting, with local South Australian ASA trainee representatives Dr Cheryl Chooi, Dr Nik Fraser and outgoing representative Dr Nicole Diakomichalis helping with the trainee events. There's sure to be plenty to interest anyone so if you can get away for a few days – or even just the weekend – then I strongly encourage you to consider attending. Early bird registration closes 11 July and standard registration closes 28 September.

ASA members are entitled to claim one complimentary NSC registration during their Advanced/Provisional Fellow Training or in their first year as an Ordinary Member, provided they have been a financial Advanced/Provisional Fellow Trainee member for two years. This is claimable once and excludes travel, accommodation, sundry expenses, supplementary activities and workshops. Get the most out of your membership and register!

TRAINEE MEMBER INTERNATIONAL SCHOLARSHIPS

Each year the ASA awards three scholarships of $4,000 each to allow trainees to attend international conferences. The meetings this year are:

- Canadian Anesthesiologists' Society (CAS) Annual Meeting
  15-18 June 2018 in Montreal, Quebec

COMPLIMENTARY NSC OR CSC REGISTRATION

ASA members are entitled to claim one complimentary National Scientific Congress (NSC) or Combined Scientific Congress (CSC) registration during their Advanced Provisional Fellow Training or in their first year as an Ordinary Member, provided they have been a financial APFT member for two years. This is claimable once and excludes travel, accommodation, sundry expenses, supplementary activities and workshops.

Email: membership@asa.org.au or call 02 8556 9700 for more information

- Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training (GAT) Annual Scientific Meeting
  4-6 July 2018 in Glasgow, Scotland
- American Society of Anesthesiologists (ASA) Annual Meeting
  13-17 October 2018 in San Francisco, California

Applications for 2018 closed on Friday 20 April and successful applicants will have been notified by the time this article goes to print. For those who missed out – there's a new round every year and we're happy to give feedback on how to improve your application for next time. We look forward to several interesting and insightful reports over the coming months, which may be published in future editions of *Australian Anaesthetist*.

ELECTRONIC EXAMINATIONS

In light of events surrounding the recent RACP examination for basic physician trainees, wherein a 'technical fault' resulted in the examination being terminated and rescheduled for all candidates, the TMG wrote to ANZCA president Prof. David A. Scott to express concerns about the potential for a similar incident to impact on anaesthetic trainees as examinations become increasingly digitised. In particular, we highlighted the poor track record of the examination provider contracted by the RACP (Pearson Vue), the importance of rigorously testing systems prior to their use in a high stakes situation and the need for reliable contingency plans, such as a paper-based examination. Prof. Scott's reply acknowledged our concerns, highlighted ANZCA's efforts to undertake fair and well-supported examinations for all trainees, and assured us that should electronic examinations be employed then it will be a robust and well-tested process with all changes clearly communicated to trainees well in advance. Updating and modernising systems of assessment is an important process and we want to ensure this proceeds with trainees' interests at the fore.

REPRESENTATION

One of the core purposes of the ASA is to represent our members, with the TMG specifically focussing on issues facing trainees now and into the future. It can be cathartic to simply complain about the challenges we face from time to time but it's vital to also work towards real change where we can. As trainees it's common to feel disempowered and frustrated at times by our place in the medical hierarchy, however, meaningful progress can and does occur. Issues that appear insurmountable as an individual are often more easily and effectively addressed by a representative body – we have time, resources and skills that no individual can deploy on their own.

The ASA understands that trainees are the future of the profession and is increasingly interested in the problems we deal with and how our professional lives can be improved. If there are any issues about which you are concerned and feel that we should be advocating on, or that you are unsure about and would like further information or advice, please contact us at trainees@asa.org.au

Richard Seglenieks
Chair, Trainee Members Committee

RETIRED ANAESTHETISTS GROUP

Victoria

This year started well for the Victorian Retired Anaesthetists Group (RAG). David Crankshaw (Honorary Secretary) organised our first lunch at Kooyong Lawn Tennis Club; Dr Robin Marks who was formally Professor of Dermatology at the University of Melbourne spoke at the lunch. The presentation highlighted the three voyages of James Cook to the Pacific Ocean. The role of Joseph Banks was also emphasised even though his background was substantially different from that of Cook. The presentation was very interesting and stimulated a lot of discussion amongst the 40 members who attended. The committee is planning another three lunches for 2018.

Dr Westhorpe retired as President after organising two years of very interesting RAG lunches, I was elected to this position for 2018. Thanks to Rod for all his hard work. We welcome Dr Terry Little as a new member of the Committee.

Dr Michael Davies

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

AUSTRALIAN CAPITAL TERRITORY

Mark Skacel, Chair

The year started on the evening of 29 January with a very well-attended Thomas Lo ASA Registrars Presentation Night. Three registrars presented, namely:

- Dr Dinushka Kariyawasam
  Post-operative outcome among patients undergoing elective joint placements – Impact of pre-operative anaemia.
- Dr Holly Manley
  Length of stay for general surgery prior to implementation of an ERAS protocol.
- Dr Anneliese McBride
  Sedation for awake fibreoptic intubation.

The winner of the Thomas Lo award for 2017 and ASA prize of $500 was Holly Manley.

Congratulations to Holly on her outstanding presentation. On the night, all three presentations were of a high standard. Hopefully the Thomas Lo night will be moved back to its normal date of late October and all ACT registrars will be given early notice of this event in late May and again in mid-August by email.

On the evening of 31 January I represented the ASA at the Part 0 registrar course organised by ANZCA. Seven 1st year registrars attended and I wish them all well for their future careers in anaesthesia.

The 2nd Part ACT weekend Bootcamp was organised by Dr Viliunas and held in early February. Yet again, it was a great success with around 75 registrars from all over Australia attending. I must congratulate Vida and all the other consultant anaesthetists who helped make this such a successful event.

The Scan and Ski Thredbo Workshop meeting will be held on July 13 and 14. Dr Ross Peake will again convene the workshop, together with world-renowned ultrasound specialists Dr Alwin Chuan, Dr Peter Hebbard, Dr Andrew Lansdown, and Dr Brad Lawther. The workshop will run over two days, using the morning and evening sessions for hands-on ultrasound scanning and instruction. I understand that at this stage the workshop is full but the organisers are taking names for a wait list in case of cancellations.

The 2018 Art of Anaesthesia meeting will be held on Saturday 15 and Sunday 16 September at the National Museum of Australia. The meeting will explore and expand the risks in anaesthesia. Online registration for the meeting will open in May. The convenors Drs Palnitkar and McInerney have confirmed our international keynote speaker is Professor Franco Carli from McGill University. Prof Carli is a world expert in prehabilitation and ERAS and will be giving two talks on Saturday and a workshop on Sunday. Other speakers during the Saturday program include Assoc Prof David M. Scott, Dr Jai Darvall, Dr Lachlan Miles, Assoc Prof Stephen Bolsin, Dr Martin Culwick and Ms Kate Cole-Adams, together with our local speakers Dr Julia Hoy and Dr Jill van Acker. On Sunday morning the convenors will be running three workshops, including two emergency response workshops (CICO and anaphylaxis).

A meeting of the Calvary John James Private Hospital Department of Anaesthesia was held on 7 March with the hospital CEO to discuss the maternity unit. Apparently, the number of confinements has dropped from an average of 1,200 to 700 per year and this makes the financial viability of the unit questionable. On call payments to anaesthetists, which currently stands at around $50 per hour and out-of-pocket expenses for patients were discussed in a very general manner. A healthy debate occurred amongst the quorum with no real resolution apart from forming a group of anaesthetists and obstetricians to further look into the cause of the decline in patient numbers.

The second area the CEO discussed was public in private and it was highlighted by the CEO that John James makes much more money from public patients than private patients. The hospital would like to begin Saturday operating for public patients. It was pointed out by attendees that anaesthetists would not be supportive of this for a number of reasons. The bottom line from the CEO was that there is an oversupply of anaesthetists and the hospital might consider employing their own. We live in interesting and changing times.

Dr Arne Schimmelfeder is resigning as head of the John James department

after many years of service and I would like to thank him on behalf of all ACT anaesthetists for the many hours of work he has put into the hospital. As I write this, I understand the position of director still stands vacant.

The new Calvary Bruce Private Hospital which opened in September of last year still has major problems. Last week all anaesthetic nurses were locums from interstate which obviously is not in the best interests of patients from a safety point of view.

After an unfortunate incident at one of the private hospitals I would like to take the opportunity to remind all members to dispose of unused S4 and S8 drugs in a timely, safe and professional manner.

Let's hope for a great ski season and ski safely this winter.

NEW SOUTH WALES

Ammar Ali Beck, Chair

BUPA changes to its Medical Gap Scheme and its implications on our practice will be significant to our practice. The AMA-NSW is holding briefing sessions which I encourage everyone to participate in.

The NSW Annual General Meeting will be held on 10 November, at Byron Bay Community Centre. The agenda, nomination forms and minutes from AGM 2017 are on the website for reviewing.

The planning for Part 3 course has started under the supervision of Drs Adam Hill and Michael Levitt. I am confident it will be a great starting point for our young anaesthetists. The course will held on the 10th of November, more details will be on the website as the programme is being finalised.

Dr Murray Selig has been representing us on the NSW Parliament inquiry into cosmetic health service complaints in NSW and Dr Barb Robertson will be participating in the Consultation Workshops for the National Strategic Approach to Maternity Services

Finally, Dr Andrew Emanuel (Junior Trainee Rep), Dr Callum Gilchrist (EAC rep) and Dr Surbi Malhorta (PPAC rep) have stepped down from the committee. We are very grateful to their contributions and wish them all the best.

WESTERN AUSTRALIA

Philip Soet, Chair

Following on from the very successful National Scientific Congress at the Perth Convention Centre in 2017, the ASA in association with ANZCA, presented another engaging and informative Autumn Scientific Meeting at the Joondalup Country Club on 7 April 2018.

In the magnificent surrounds of this world-class golf course, delegates received thought-provoking perspectives on volunteering and the practice of anaesthesia in challenging environments. We considered our own responsibilities regarding sustainable practice in health care before enjoying local legend Dr David Perlman's perspective on life, practice and retirement. Congratulations to all those involved in this meeting. It reminded me that a lot can be achieved by a small group of dedicated individuals motivated to help others.

Sounds like the ASA!

In other news, Dr Neville Gibbs recently stepped down from the ANZTADC after many years of service. We are very fortunate to have an anaesthetist of the calibre of Dr Gibbs representing our profession in this state and we look forward to his ongoing contribution in other roles in the future.

On a sadder note I would like to mention the passing of Dr Bruce Marks on 4 March 2018. His passing was acknowledged in a warm tribute by Dr Stephanie Davies that was circulated to ASA members. Larger than life, he will be greatly missed.

Other developments of note in Western Australia include the release of the Special Inquiry into Government Programs and Projects in Feb 2018. The inquiry was commissioned by the newly elected state Labor government and was overseen by prominent West Australian John Langoulant. Political motivations aside, it provides a useful summary of what happened in WA in the last decade, at least as far as infrastructure projects are concerned. Fiona Stanley Hospital and the Perth Children's Hospital feature prominently in this inquiry.

Speaking of the Perth Children's Hospital, a date has been announced for the official opening, mid-May and mid-June.

The SJGHC and ASA combined M and M Meeting was held on 1 May and was attended by more than 100 anaesthetists. The next M and M Meeting will be held in August on a date to be finalised.

Future events include the Part 3 course in November at a date to be finalised and we have the ANZCA/ASA Country Meeting on 26-28 October at the Pullman Resort in Bunker Bay which is always heavily subscribed.

Anaesthesia in Japan

12 – 23 September 2018

Tokyo • Hiroshima • Matsuyama • Kobe

Medical and Military History in Vietnam and Cambodia

17 January – 2 February 2019

Hanoi • Hue • Saigon • Mekong River Cruise • Siem Reap

Torii Shrine near Hiroshima

The Bayon, Siem Reap

- Explore ancient and modern Japan on a tour that reveals many facets of this land of contrasts.
- Visit a range of prestigious hospitals in Tokyo, Hiroshima and Matsuyama, meet Japanese anaesthetists and visit the excellent Kobe Japanese Museum of Anaesthesiology.
- Visit the neon extravagances of Tokyo, take the bullet train to Hiroshima and visit the Peace Park, explore Naoshima 'Art Island', cruise the Inland Sea, see traditional Japan in Kobe and Kyoto and enjoy exquisite cuisine throughout.
- Travel with experienced tour leader, internationally renowned anaesthetist and founding member of the History of Anaesthesia Society, David Wilkinson.

www.jonbainestours.com/anaesthesia

- Explore the long medical and military histories of the beautiful lands of the Mekong; Vietnam and Cambodia.
- Journey through Vietnam with a seven-night cruise along the Mekong into Cambodia and a final two nights to explore the temples of Angkor Wat in Cambodia, with a full cultural itinerary throughout.
- There are a number of specialist visits and talks on this journey, providing real insight into the medical and military histories of Vietnam and Cambodia.
- Travel with experienced tour leader, anaesthetist, paramedic and Captain in the Royal Australian Naval Reserve, Paul Luckin, who will provide the benefit of his long experience and insight throughout the tour.

www.jonbainestours.com/vietmed

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Tel: 03 9343 6367
www.jonbainestours.com

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

NEW ACQUISITIONS OF THE HARRY DALY MUSEUM

Over the past 12-16 months the Harry Daly Museum has received a great many donations. These are being integrated into a newly revitalised museum display, and entered into our collection management system, eHive. Please see below a few of the new collection items donated by Chair of our HALMA Committee Dr Reginald Cammack.

XYLOCAINE OINTMENT

Manufacturer: Astra Chemicals Pty Ltd., c.1980

Donated by Dr Reg Cammack; Object number: 2017.001

Lidocaine is a local anaesthetic developed in the 1930s and was released into the market by Astra pharmaceuticals in early 1948. The story of its development, and that of the two primary chemists behind it, Nils Löfgren and Bengst Lundquist, is particularly sad. More can be read in C. Ball, R.N. Westhorpe, 'Local Anaesthesia – The introduction of xylocaine into clinical practice', *Anaesth Intensive Care*. 2004:32, 733.

CO-PHENYLCAINE FORTE SPRAY

Manufacturer: Paedpharm Pty. Ltd., c.1995

Donated by Dr Reg Cammack; Object number: 2017.004

A compound containing both lidocaine (xylocaine), and phenylephrine used in procedures requiring both local anaesthetic and vasoconstriction of the nasal mucosa. Co-phenylcaine Forte was introduced in the mid 1990s by Paedpharm Pty. Ltd. A study conducted by P. Lennox et al., published in *The Journal of Laryngology and Otology*, June 1996 found that Co-Phenylcaine was a viable alternative to cocaine as it is not a controlled substance and significantly cheaper[1].

SCHIMMELBUSCH MASK – WWI

Manufacturer: unknown, c.1917

Donated by Dr Reg Cammack; Object number: 2017.002

A Schimmelbusch mask created from 'found' materials (wire) c. WWI. The mask is incomplete but is significant because it is an example of the ingenuity of medical personnel in times of conflict and shortage of materials. It joins one of many items within the Harry Daly Museum from this significant era of sacrifice.

HEPARIN RETARD INJECTION

Manufacturer: Boots Pure Drug Co., c.1950

Donated by Dr Reg Cammack; Object number: 2017.003

Five 2ml ampoules of Heparin in modified Pitkins Menstrum. Heparin was discovered in 1916 by J. McLean, then a medical student looking for a coagulant in the liver[2]. Introduced in the late 1930s[3] for the treatment of deep vein thrombosis[2] it has since been used to treat a variety of conditions from unstable angina, venous thromboembolism and pulmonary embolism, to foetal growth retardation in pregnant women[2].

This example dates from about a decade later as the Heparin is suspended within Pitkin's menstruum. Pitkin's menstruum, created in the 1940s by Dr George P. Pitkin, acts as a suspension for a water soluble drug. The aim of the menstruum is to retard the absorption of the active drug and therefore prolonging the duration of its action[4].

References

1. Lennox P, Hern J, Birchall M, Lund V. (1996). Local anaesthesia in flexible nasendoscopy. A comparison between cocaine and co-phenylcaine. *The Journal of Laryngology & Otology*, 110(6), 540-542.
2. Oates JA, MD, Wood AJJ, MD, Hirsh J, MD (1991). Heparin. *The New England Journal of Medicine*, 324(22), 1565-1574.
3. Ball CM, Westhorpe R. (2000). Intravenous cannulae. *Anaesthesia and Intensive Care*, Vol. 28, No. 5, October. 467.
4. Aronson J. (2000). Monthly injections. *British Medical Journal*, 320(7241), 1071.

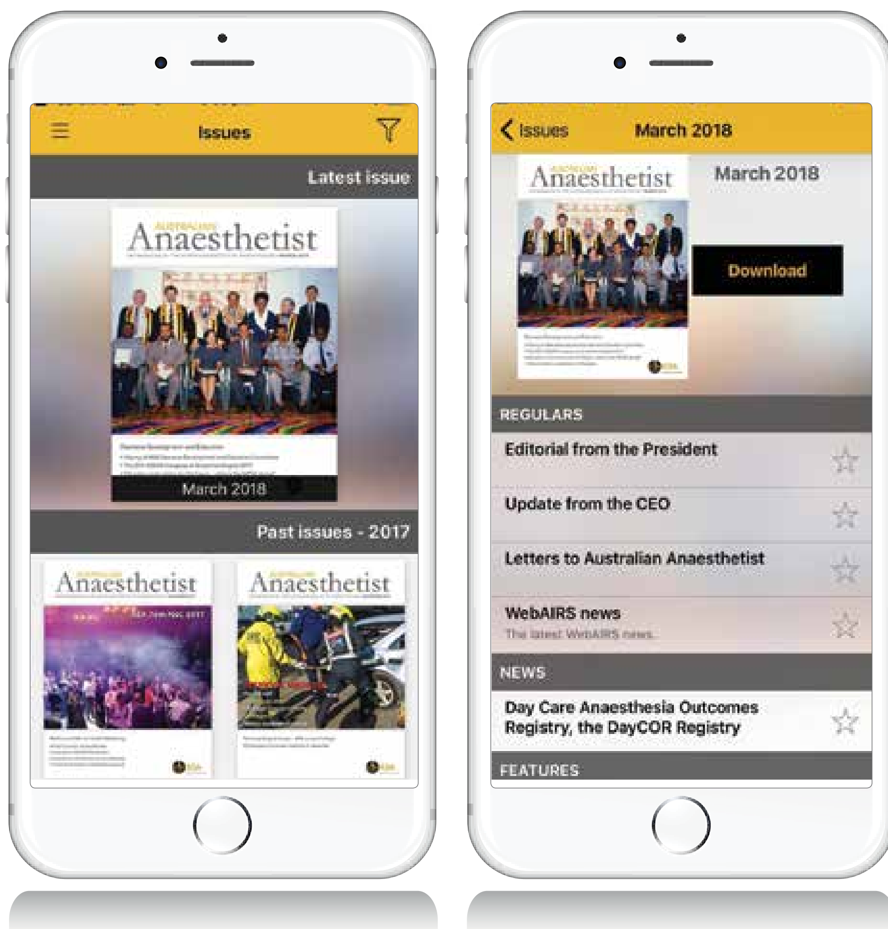
AUSTRALIAN Anaesthetist

THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

Available as an App

The App can be accessed using your standard ASA member login details.

FOR ASA MEMBERS!

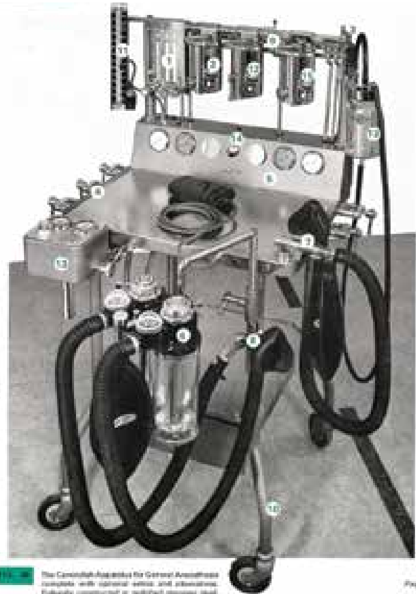


To download the App search for 'Australian Anaesthetist' in your App store and look for the following icon:

Please contact: membership@asa.org.au if you have misplaced your login details.

INSIDE YOUR SOCIETY

The AIRSIM was developed by TruCorp in March 2005 as a highly realistic and functional airway training system.



The Cavendish Anaesthetic Machine first appeared around 1978 using basic principles devised a century before. Later models incorporate important safety features and are more efficient.

London has over 25 medical museums – how many can you name?

SPECIALIST ANAESTHETIC BROCHURES

On display in the Richard Bailey Library are some advertising brochures for equipment (or devices) used for airway management. They were collected over a number of years by Dr Rajesh Haridas, Honorary Curator, Harry Daly Museum and Honorary Librarian, Richard Bailey Library. They are useful to the Harry Daly Museum for identification and captioning purposes and to the Richard Bailey Library as reference and research material.

The pamphlets often provide a series of line drawings about how the product is used and what to do if problems arise. Such information is not easily available in textbooks or histories of anaesthesia.

The material also provides information about the history of manufacturers, evolution of new suppliers, introduction of sequentially improved models and, in some case, the name of the inventor.

Each year HALMA organises at least one seminar at the Society's headquarters in North Sydney about the History of Anaesthesia. The next one is on 3 June when six speakers and the audience will discuss among other topics, Anaesthetic Events at Pearl Harbour, Deaths under Anaesthesia and The Origin of the Word Anesthesiology.

As well as the anaesthetic brochures mentioned above, other collections of ephemera are useful, such as collections of anaesthetic and medical museum leaflets, newsletters and abstracts from specialist anaesthetic sectors and catalogue/price lists of medical equipment, especially those with copious illustrations. If you have collected a set of ephemeral material that defined your special interest some years ago and it is now rarely unused and just taking up space, the ASA would be pleased to have it for our collections and researchers. Please remember us in your next office clean out.

Peter Stanbury
Richard Bailey Librarian
pstanbury@asa.org.au

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).

ASA Art Exhibition

Call for professional & amateur artwork!

WE WELCOME SUBMISSIONS FROM ALL DELEGATES IN ANY MEDIUM THEY CHOOSE.

DEADLINE FOR SUBMISSIONS 11 AUGUST 2018

For more information contact: drobertson@asa.org.au

NOVEMBER 1-5, 2018

BEIJING, CHINA

China National Convention Centre

The 15th Asian and Australasian Congress of Anaesthesiologists (AACA) & the 26th Annual Meeting of Chinese Society of Anesthesiology (CSA)

AACA will be held in the China National Convention Center, Beijing, China, 1-5 Nov 2018

The theme of this congress is:

'From Anesthesiology to Perioperative Medicine'

For more details or to register please visit:

www.cmacsa.org

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from March to June 2018.

TRAINEE MEMBERS

Dr Keith Addy	QLD
Dr Guy Amey	QLD
Dr James (Jim) Bainbridge	VIC
Dr Margaret Blanco	QLD
Dr Andrew Bond	QLD
Dr Ryan Breslin	SA
Dr Andrew Burch	SA
Dr Tegan Nicole Burgess	QLD
Dr Lillian Coventry	TAS
Dr Ashwin Dhanapathy	QLD
Dr Priyanka Dhillon	QLD
Dr Timothy Duong	NSW
Dr Richard Branden Emmerson	SA
Dr Elliot Field	QLD
Dr Emily Fokkes	NSW
Dr Charles Greet	QLD
Dr Richard Christopher Hall	NSW
Dr Rohan Hardikar	VIC
Dr Maxim Hatton	QLD
Dr Kathryn Hersbach	VIC
Dr Matthew Higgins	SA
Dr Andrew Huang	TAS
Dr Rachel Jesudason	SA
Dr Kelly Anne Jones	QLD
Dr Tarrant Kenman	QLD
Dr Rebecca King	QLD
Dr Kathleen Lanigan	QLD
Dr Sara Letafat	NSW
Dr Michael Li	NSW
Dr Frank Marroquin-Harris	NSW
Dr Linda Mattheyse	VIC
Dr Emma Jane Panigas	SA
Dr Rachel Preisenberger	QLD
Dr Kartik Ramesh	NSW
Dr James Edward Roth	VIC
Dr Aimee Som	SA
Dr Chris Stanton	SA
Dr Patrick Stapleton	NSW
Dr Justin Nicholas Swierczek	QLD
Dr Joanne Tan	SA
Dr Nicholas Trott	QLD
Dr Charith Weeraratne	VIC
Dr Kewei Xu	QLD

ORDINARY MEMBERS

Dr Salam Adil Naeem Al-Khoury	SA
Dr Deanna Ba-Pe	QLD
Dr Brigid Brown	SA
Dr Erin Kate Cameron	VIC
Dr Phui Leng (Lynn) Chan	NSW
Dr Mui Khoon Chang	QLD
Dr Sandra Derry	QLD
Dr Claire Louise Goldsbrough	NSW
Dr Nathalie Mei Gomes	VIC
Dr Anna Hickson	NSW
Dr Lisen Emma Hockings	VIC
Dr Geraldine V.S. Khong	NSW
Dr Rowena Lee Knoesen	QLD
Dr Monica M. Korecki	QLD
Dr Divahar Kumar	SA
Dr Hamish Meares	NSW
Dr Josephine Agnes Morrison	VIC
Dr Stephen Murphy	VIC
Dr Candice Peters	NSW
Prof Bernhard Riedel	VIC
Dr Katherine Anne Steele	QLD
Dr Christina Stuke	VIC
Dr Niklas Tapper	NSW
Dr Teik Guan Tay	NSW
Dr Eng Tiong	WA

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Ronald Dunbar Rae, TAS; 50 year member Dr William E. (Bill) Mann, SA; Dr Bruce Marks, WA; Dr John Patrick Thomson, QLD; Dr John Dennis Horton, VIC; Dr Peter Julian Duff, QLD.

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

INSIDE YOUR SOCIETY

UPCOMING EVENTS

JUNE 2018

Victoria New Fellows Forum

Date: 12 June, 2018

Venue: Neighbourhood Wine, Victoria

Website: www.asa.org.au/eventspage

B. Braun Anatomy & Ultrasound for Peripheral Nerve Blockade Workshop

Date: 30 June, 2018

Venue: University of Queensland, Queensland

Website: www.asa.org.au/eventspage

AUGUST 2018

Practice Managers Conference

Date: 17 August, 2018

Venue: Hotel Grand Chancellor Adelaide, Adelaide, South Australia

Website: www.asa.org.au/eventspage

OCTOBER 2018

ASA NSC 2018

Date: 6-9 October 2018

Venue: Adelaide Convention Centre

Website: http://asa2018.com.au/

Contact: events@asa.org.au

FEBRUARY 2019

Australasian Symposium on Ultrasound & Regional Anaesthesia (ASURA)

Date: 21-23 February 2019

Venue: Peppers Noosa Resort & Villas, Noosa Heads

Website: www.asa.org.au/eventspage

Children @ NSC 2018 Congress

The Parent & Baby Room

A parent and baby room will be available at this year's Congress. All plenary and lecture sessions in Hall C will be broadcast in realtime to the room, so parents can participate in the Congress whilst looking after their babies in an informal setting. Questions can also be asked in real-time through the Congress app. Recommended for children aged up to 3 years.

Onsite Crèche

Arrangements have been made for onsite crèche facilities staffed by professional childcare providers. Spaces will be limited and available on a first-come, first-served basis. Look out for more details when you register online for the Congress. Recommended for children aged 3-6 years.

www.asa2018.com.au

8 - 10
NOVEMBER
2018

NZ Anaesthesia ASM
Face the Future

Cordis Hotel, Auckland, New Zealand

KEY DATES:

Abstract submission open 20 March

Earlybird registration open 26 April

Adjunct/Professor Richard Beasley
Medical Research
Institute of New Zealand
Wellington, NZ

Dr David Auyong
Medical Director,
Lindeman Ambulatory
Surgery Centre
Seattle, Washington, USA

Associate Professor Duminda Wijeysundera
Department of Anaesthesia and
the Institute of Health Policy
Management and Evaluation
University of Toronto
Toronto, Canada

Dr Laura Duggan
Royal Columbian Hospital
Vancouver, Canada

www.nzanaesthesia.com
#NZASM18

SAVE THE DATE 6 – 9 OCTOBER 2018

AUSTRALIAN SOCIETY OF ANAESTHETISTS | 6-9 OCTOBER 2018

INTERNATIONAL INVITED SPEAKERS

A/Professor Duminda Wijeysundera

Dr Wijeysundera is an Associate Professor in the Department of Anesthesia and the Institute of Health Policy Management and Evaluation at the University of Toronto, as well as a Staff Anesthesiologist at the Toronto General Hospital, Canada.

Professor Joyce Wahr

Professor Wahr currently serves as Medical Director of the Perioperative Assessment Centre at the University of Minnesota, and is spearheading development of the Perioperative Surgical Home at the University of Minnesota.

Professor Lars Eriksson

Professor Eriksson is Professor of Anesthesiology and Intensive Care at the Karolinska Institute and Head of Research and Education in Perioperative Medicine and Intensive Care at the Karolinska University Hospital, Stockholm, Sweden.

AUSTRALASIAN SPEAKER

Professor Lorimer Moseley

Professor Moseley is a pain scientist and physiotherapist with 270 articles and six books, including Explain Pain and Painful Yarns (the two highest selling pain books internationally) under his belt. He has given 65 plenary lectures at major international meetings in 26 countries.

www.asa2018.com.au

For all enquiries contact Denyse Robertson
E: drobertson@asa.org.au T: +61 2 8556 9717

THE ASA NSC *future dates*