AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • MARCH 2018

Overseas Development and Education

- History of ASA Overseas Development and Education Committee
- The 20th ASEAN Congress of Anaesthesiologists 2017
- Education and training for the future – what is the WFSA doing?
- Ultrasound for anaesthesia in Mongolia

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Australian Society of Anaesthetists

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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

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

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INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

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 April 2018.
- Final article is due no later than 17 April 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 2018 Autumn edition of *Australian Anaesthetist*. The ASA is a strong supporter of providing aid in our region. The Overseas Development, and Education Committee (ODEC) is the group within the ASA which manages our aid programs around our hemisphere. This edition is devoted largely to their great work. When considering what ODEC has been doing for more than 20 years, the old saying "give a man a fish and he eats for a day; teach him to fish and he and his family eats for the rest of his life" comes to mind. The dedicated members of ODEC have been teaching our anaesthesia colleagues in the South West Pacific and South Asia to 'fish' for more than 20 years and the ASA is rightfully proud of their terrific work. Thank you to all the ODEC team, and keep up the outstanding work.

Dr Steve Kinnear writes of the opportunities and challenges of delivering the first Essential Pain Management (EPM) course in Bhutan, last year. EPM is a course developed by our College and provides excellent education to anaesthetists and their co-workers in the provision of high quality well supported acute pain management. Dr Dennis Millard writes of his experiences working at the Colonial and War Memorial Hospital in Suva Fiji and outreach work in Fiji. His perspectives of his time as the ASA fellow sound like it was an immensely rewarding experience, I recommend reading – especially if you are considering supporting this valuable program.

Dr Roger Gouke writes of his and David Pescod's experiences in Ulaanbaatar, Mongolia where ODEC has been active in helping establish specialist anaesthesia training. They write of the introduction of point-of-care ultrasound to this country and the great successes they have achieved. Drs Phil Blum and Andrew Fenton write about our work in the Solomon Islands and of the challenges faced by this island nation. The ASA has been working closely with the Solomon Islands' Ministry of Health, and RACS to develop speciality training in anaesthesia for the doctors in the Solomon Islands. This is a challenging task but we have done this in Fiji in the past; much work and support from the ASA and our members via ODEC is needed for some time!

Dr Derrick Selby writes of his long-term experiences in developing the speciality of anaesthesia in Tanzania, of how he overcame the challenges and achieved great things in that country. It's a fascinating journey through the culture and challenges of that part of Africa. He finishes with the challenge to our members: "Are you ready to contribute?". Following on from this if you think you might be ready to contribute, then get yourself onto the Real World Anaesthesia Course. Dr Linda Weber gives an account of her experiences attending the WRAC and of the truly inspirational presentations and learning she received.

Providing humanitarian aid in the form of direct care or in teaching your colleagues is a truly rewarding experience. My personal experience with the Military, and also on civilian missions to China, Vietnam and Fiji has left me wishing I could do more, and appreciating the skill and versatility of colleagues I have worked with there. If you have an interest in this area of our practice I strongly encourage you to learn more, get trained and prepared before you jump in. Good aid is invaluable, poorly planned one-off sojourns can be unhelpful and even dangerous, as is evidenced by the recent arrest of foreign doctors in Nepal. By all means do it – but do it well and the right way – with the support of the place you go to.

At the time of writing this editorial the ASA has been continuing negotiations with the MBS Review's Anaesthesia Clinical Committee's (ACC), the Department of Health and the Health Minister regarding the ACC report and its recommendations. The MBS review was set up to modernise the schedule, to delete out-of-date item numbers, to improve access for private patients and to ensure value for taxpayers. There has been a lot of work done by the ACC and the ASA to modernise the MBS for anaesthesia. At times our views have been quite divergent, it is likely however

that the cuts recommended in dollar terms to the anaesthesia budget by the ACC will be adopted. The ASA will be working hard to mitigate these effects to hopefully avoid large jumps in the Out-of-Pocket (OOP) costs to our patients.

As previously pointed out, the Medicare rebate system is there to reimburse patients who choose to access private healthcare for their medical costs. Medicare does not pay doctor's bills, patients do; for many procedures like endoscopy and cataracts the rebates from Medicare and insurers have almost always been acceptable to anaesthetists. Cuts to Medicare recommended by the ACC are likely to result in these patients facing a new OOP. This is something the ASA wishes to avoid, for the sake of our patients.

The ASA believes that we have been effective in having our assessment of the situation appreciated by the Department and the Minister and look forward to sharing the details of the way forward for the MBS review and the RVG into the future. Please stay tuned to the monthly eNews, and updates on our website.

This level of access and input to the Department and the Minister is unprecedented in the ASA and much of this is due to the excellent work from the ASA team, the HQ staff and the members of the MBS Review Working Group. I take this opportunity to express my gratitude to the staff and members of the working group for their support and advice during this challenging time. It is not over yet, but progress is being made. We are hopeful that an appropriate outcome will ensure the best results for our patients.

OOP costs continue to gain the attention of our politicians. Currently the government is undertaking a review into OOP costs and Private Health Industry and its value to the people of Australia. The ASA has been invited to provide a nominee to this working group and Dr Mark Sinclair will be an excellent delegate for the Society.

I do hope you enjoy reading this edition of AA and I invite you to write to us with your thoughts on our articles, and suggestions for our *Australian Anaesthetist*.

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

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Rupert Hornabrook Day Care Special Interest Group Prize

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REGULAR

ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

2018 – SHAPING UP AS A BUSY YEAR FOR THE ASA

Medicare Benefits Schedule

Members will be aware that the Medicare Benefits Schedule Review occupied a substantial amount of time and thought throughout all of 2017, with the President in particular, spending a significant amount of time in Canberra and other cities meeting with representatives of the Anaesthesia Clinical Committee Government and the Department of Health. I would direct members to the ASA website and the 'News' tab where you will find a full account of the ASA's activities, along with an infographic, highlighting each step of the ASA's work in relation to this important matter.

While at the time of writing, no final decision has been made on the direction of the Review, it is our belief that, arising from these discussions, there may well be the opportunity for the Society to be closely involved in any further deliberations with regard to this issue. As representation is one of the ASA's three key platforms, members should, I believe, feel pleased, that the Society has devoted such time, energy and resource to this matter, in order to try and ensure the best outcome possible for patients and anaesthetists. As always members will be kept up-to-date of any developments.

Governance structure

Late 2016 saw the ASA adopt a more contemporary approach to its governance structure with the establishment of a smaller Board of Directors, responsible for the business of the ASA and a Council whose focus is more the professional issues facing the specialty. It is fair to say that after eighteen months, this approach is working well, in particular the functioning of the Board.

In order to develop even further the role and activities of Council, a planning and strategy weekend will be held in late March. Its purpose is to focus on the activities of Council, in particular the initiatives it may wish to undertake in the next year and how it may wish to handle such matters.

Membership update

As we know this time of year is the membership renewal period and I would like to say thank you to all those members who have renewed already. It is very pleasing to see members availing themselves of the improved online renewal process, which now includes the opportunity to pay via a monthly direct-debit scheme. This was put in place at the request of members and does represent an improvement in service delivery. At the same time the Society reinstated the opportunity for members to pay via Amex, which has proven very popular.

While on the subject of membership it is indeed gratifying to note that already in the period July to December, 134 new members, across most categories, were welcomed into the Society. Such a strong level of membership uptake augurs well for the ongoing activities of the Society. I would certainly like to acknowledge the great efforts of the various State Committees of Management and the respective State Chairs who are all very active in encouraging new and existing anaesthetists to join.

National Scientific Congress 2018

The National Scientific Congress returns to Adelaide this year. Running from 6 to 9 October; Congress Convenor Dr Simon Macklin and his team, have prepared a wonderful program, and no doubt it will be a highly successful meeting. A highlight of the meeting will be the presentation to Dr Piers Robertson of the ASA President's Award. Dr Robertson has been a key figure in the delivery of the National Scientific Congress since 2003, and it is only fitting that this award coincides with his retirement from the position of National Scientific Congress Officer at the 2018 meeting.

Common Issues Group meetings

On numerous occasions in this piece, members will have noticed my references to the Common Issues Group meetings, held annually. In 2018 the meeting will be hosted by the AAGBI and held in London. The meeting is scheduled for 29 May-1 June.

These meetings provide a valuable opportunity to share with the other Societies initiatives and issues arising in each of our countries. This year the matter of greater collaboration – specifically in the area of providing opportunities for anaesthetists in low-resource countries, to attend educational events in Common Issues Group member countries is on the Agenda. No doubt this will prove a valuable discussion and I for one am looking forward to this.

2018 has definitely arrived and I am looking forward to a busy and rewarding year.

Mark Carmichael
Chief Executive Officer

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

REGULAR

LETTERS TO AUSTRALIAN ANAESTHETIST

LEADING FROM THE FRONT

I would like to commend Associate Professor Scott for his candid and heartfelt article in the last edition of *Australian Anaesthetist* reflecting on his personal experience with post-traumatic stress disorder.

I feel that this article says two important things. Firstly, it affirms that David is a person of honesty and integrity, with great strength of character. His clarity of reflection on what must have been a very difficult time is both sobering and encouraging for us all. Secondly, it suggests that our profession is turning a corner with regard to our cognitive biases towards mental health.

The importance of such an article cannot be overstated. It is through strong messages by way of example, delivered by our leaders, that fuel these changes in attitude. There is a lot of 'talk' about the importance of the mental health of doctors in the media – this article was an example of the 'talk' turning into a relatable reality. We inherently understand that none of us are immune from mental health stressors and illness. Our leaders sharing in such a way lends us hope that if we were ever in a position to require support, our families, colleagues and profession would be there for us.

Ben Piper
Darwin, NT

HAVE YOUR SAY

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

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

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

DAY CARE ANAESTHESIA OUTCOMES REGISTRY, THE DAYCOR REGISTRY

The Day Care Anaesthesia SIG is developing a Registry (DayCOR Registry) of outcomes of day care anaesthesia. We invite anaesthetists to request their hospitals to participate, particularly as we release the beta version of the program for use and appraisal.

An SMS survey software program has been developed enabling anaesthetists to investigate and record the outcomes of their day care cases. It is hospital based, with reports being available to the patient's anaesthetist and hospital.

ALERTS generated by unfavourable survey answers, are emailed immediately to the anaesthetist and hospital for action.

The information will be de-identified then entered into a registry from which reports can be generated for individual anaesthetist, hospitals, health departments and the public

This survey has a specific set of questions to be answered. Once these have been fully evaluated, there will be opportunities for additions or new small subsets of questions.

The Registry complies fully with guidelines developed for the Health Ministers Advisory Council by the Australian Commission on Safety and Quality in Health Care. In particular, this provides absolute safety and privacy of the information.

The reasons and methods of development are:

- There is a paucity of data surrounding any unfavourable outcomes of same day surgery and procedures.
- The number of work-days lost and the economic impact of this loss is unknown.
- Unfavourable outcomes could impact on their partner's or other members of their family's ability to attend work.
- There is a growing tendency to attempt more advanced procedures and operate on older and sicker patients as day care cases.
- Whilst the surgeon or proceduralist always reviews their patients, most are lost to follow up by their anaesthetist and the great majority of unfavourable outcomes will occur in the first few days after, usually before any review is undertaken.
- Hospitals and Clinicians will be able to compare outcomes within their institutions, or with other institutions prepared to share anonymous data pooled on a central server.
- This is an EDUCATIONAL program with the ultimate aim of improving outcomes, particularly with new procedures or with the moving of a surgical procedure to a Day Stay situation.

For all enquiries please contact the Day Care SIG Chair Ken Sleeman: kensleeman@gmail.com

Day Care Anaesthesia SIG needs hospitals interested in trialling the beta version before we launch mid-next year.

What does the registry do?

Uses a straightforward SMS survey to be completed by the patient on the day following their procedure, by SMS or email.

Provides immediate feedback to all anaesthetists including Registrars via:

- Immediate Alerts to the individual anaesthetist and the Hospital Steering Committee email.
- Statistical Reports available each day or as required.

Security and Privacy paramount. All cases de-identified before recording on the Registry

Method

Log page filled out by discharge nurse:

- Using hospital MRN to identify patient, plus mobile number and email address
- Age, gender, ASA status
- Procedure selected from a comprehensive drop-down menu
- Duration of anaesthesia, time in PACU
- Any PONV and severity
- Discharge pain score

Patient receives SMS request and email request the following morning, clicks on site and responds.

Follow up reminder the next day

Variances treated as alerts: pain, PDNV or inability to return to work when expected, or return to activities of daily living delayed.

FEATURE

SHOULD WE STAY 'ANAESTHETISTS' OR COULD WE BECOME 'ANAESTHESIOLOGISTS'?

The most widespread term globally for doctors who practice the specialty of anaesthesia is anaesthesiologists (or anesthesiologists).

This is a widely understood term and differentiates doctors in many countries from non-specialist, or even non-medical 'anaesthetists'.

In Australia and New Zealand this distinction is not as essential because our protected name (by the Australian Health Practitioner Regulation Agency or the Medical Council of New Zealand) is specialist anaesthetist. No one else is able to represent themselves using this term.

On the other hand, a strength of the title anaesthesiologist is that an -ology represents a discipline based on scientific rigour and research. It is certainly our research that has led to the sophisticated, safe and effective anaesthesia that we practice today. In the community, an -ologist is more instantly recognised as a specialist or expert in the area of the -ology.

In clinical practice we deliver anaesthesia. It has been historically the practice to call the provider of anaesthesia an anaesthetist. So, why should we even think about changing?

SOME BACKGROUND

Discussion on the title anaesthetist versus anaesthesiologist is not new. The following examples highlight this:

- In 1998, "Terminology – Anaesthetist/ Anaesthesiologist" was discussed at the October ANZCA Council meeting. The following is extracted from the minutes from this meeting:

  "During consideration by the August Executive of the President's Report on the ASA Federal Executive Meeting … the revival of the anaesthetist/ anaesthesiologist debate was

highlighted. It was suggested that to widen discussion on this issue, information on the pro and con arguments could be included in the publications of the College, ASA and NZSA. It was agreed by the Executive that the matter of terminology should be (highlighted) at Council for further discussion.

"(It was noted) that this topic is being increasingly debated and suggested that it should be undertaken in an open forum. He noted that only the UK, Australia and New Zealand now use anaesthetist as opposed to anaesthesiologist. Following brief discussion, it was agreed that a case 'for' and 'against' should be published in the Bulletin. Dr Thompson undertook to compile an article with input from interested parties."

No change ensued.

- In 2004, the then-ANZCA President Professor Michael Cousins established a taskforce chaired by Professor Guy Ludbrook to research, review and discuss broadly with the fellowship a name change to the speciality of anaesthesia to anaesthesiology and a name change from anaesthetist to anaesthesiologist. This taskforce did not make a firm recommendation for change but produced a report for ANZCA Council in September 2005 with the following recommendations in summary:
  - Scope of anaesthesia practice be clearly defined in our professional documents
  - A marketing or public relations group be consulted regarding the need for and impact of a name change
  - The marketing group advise on the best implementation of any such change
  - That the first item be reviewed every two years

The relevance of the first item was that the scope of practice of anaesthesia extended beyond the operating room into preoperative assessment and preparation, and into postoperative care and management, that is, perioperative care. However, again, no change ensued.

- In 2013 the College undertook a survey that identified that one in ten community members did not know that anaesthetists were doctors, and that 50% thought that only some anaesthetists were doctors.

Anaesthesiology is the medical science and practice of anaesthesia. It includes anaesthesia for surgical, obstetric and trauma care, and areas of practice such as perioperative medicine, pain medicine, resuscitation, and intensive care medicine

WFSA Position Statement on Anaesthesiology and Universal Health Coverage

- In 2017 a name change for the speciality and specialists has been raised again by:
  - The Australian and the New Zealand societies of anaesthetists following on from discussion at the World Federation of Societies of Anaesthesiologists (WFSA) 2016 conference and the European Society of Anaesthesiology in 2017.
  - Informal discussions by ANZCA with the College of Anaesthetists of Ireland (CAI) and the Royal College of Anaesthetists (RCoA) in the UK.
  - Feedback from ANZCA Fellows and trainees during the consultation period for the ANZCA Strategic Plan 2018-2022.
  - A specific request from Dr John Crowhurst through correspondence to the Australian Society of Anaesthetists' Australian Anaesthetist magazine and formally to the ANZCA chief executive officer and president at the 2017 ANZCA Annual General Meeting in Brisbane.
- In social media, an active Twitter conversation is ongoing debating the merits of a name change.

THE INTERNATIONAL SITUATION

A form of the words anaesthesiology and anaesthesiologist is used in more than 150 countries for specialists who practice anaesthesia.

In particular, it is used by the WFSA and most (but not all) of its member societies including the American Society of Anesthesiologists, the Chinese Society of Anesthesiology and the European Society of Anaesthesiologists. The Hong Kong college uses anaesthesiology, as do Singapore and Malaysia.

Anaesthesia remains for colleges and societies typically associated with English origins, that is, UK, Ireland, the South African college (not society), Australia and New Zealand as well as few other countries.

Anaesthesiology is the most frequent term used in journal titles.

As an example of public perception, understanding of the role of anaesthesiologists in India was generally very poor in the population, especially in those without university education, although the role of anaesthesiologists in the post-operative period and in pain management was also unclear to many medical undergraduates (Mathur 2009).

THE AUSTRALIAN AND NEW ZEALAND SITUATION

Throughout Australia and New Zealand, hospital department names are very variable with uses of anaesthesia, anaesthesiology, perioperative medicine and pain medicine. This variety also applies to the names of private anaesthesia groups with 'anaesthetic' or 'anaesthesia' being the most common.

FEATURE

ANZCA in 2017

The draft ANZCA Strategic Plan 2018-2022 includes the exploration of adopting anaesthesiology and anaesthesiologist for Australia and New Zealand, acknowledging that to do this there are a number of issues that need to be considered and that the appropriate amount of time needs to be dedicated to such a task.

It is not a matter that can be decided quickly and does require due diligence. Also, with the College playing a leading role in the development of a perioperative medicine qualification it is timely to consider any change in name.

Australian Society of Anaesthetists in 2017

The statement made this year by the WFSA (representing 130 Member societies in 150 countries) defined an anaesthesiologist as a qualified physician who has completed a nationally recognised medical residency training program in anaesthesiology.

Anaesthesiology includes: pain medicine, trauma management, resuscitation, perioperative, critical and intensive care medicine. It goes on to note that in some countries the anaesthetist is used, but this is a minority.

The future of the speciality importantly depends on us embracing this statement and expanding our routine clinical activities outside the operating room. Administration of anaesthesia is a vital part of what we do, however it is important that the role and perception of the anaesthesiologist is that of a wider function.

The Australian Society of Anaesthetists, like the College, understands this is a possibly contentious issue, and agrees that if a name change is to be made, it is best done together.

New Zealand Society of Anaesthetists in 2017

A possible change in name to anesthesiologist aligns with the increased emphasis on the perioperative care aspect of our specialty; and growing recognition of the value this brings to elevating patient-care outcomes.

It arguably better conveys our medical training and the excellence that underpins anaesthesia, highlighting the multidimensional nature of our role in medicine that goes beyond the administration of anaesthesia.

There is also a drive by our global body – the WFSA to attain internationally consistent terminology. As a specialty we should all be engaging in discussion and debate with our colleagues and exploring the possibility of a change.

The New Zealand Society of Anaesthetists believes that this is an issue in which it is vital that our three organisations work collaboratively, and if a name change is to occur, we need to do this collectively.

PROS & CONS

Positives

The potential positives of changing to anaesthesiology as a name include:

- It reinforces for the community the breadth of the clinical nature of anaesthesia as a speciality, that is, that doctors practise and deliver anaesthesia and in a broader sense perioperative care.
- Anaesthesiology encompasses more broadly the professional scope of the speciality – including but not restricted to: perioperative medicine, pain medicine, palliative care, hyperbaric medicine etcetera.
- It better reflects the academic and scientific basis of the speciality in line with cardiology, haematology and radiology.
- Negotiations with governments on the perioperative medicine care model and a name change to the speciality could be conducted concurrently. This would be a way of integrating both in the minds of governments who could then action health system change simultaneously.
- Using anaesthesiology would mean there is no need to change the acronym of the College or societies.
- A name change would be an opportunity for a marketing and communication campaign increasing the profile and knowledge of the speciality.
- The title specialist anaesthesiologist or anaesthesiologist would be distinctly applicable to a qualified specialist medical practitioner. Any other provider of anaesthesia services might then refer to themselves as an anaesthetist with less ambiguity (noting that the subtlety of this in the public eye would likely be lost without education).

An anaesthesiologist is a qualified physician who has completed a nationally recognized specialist training programme in anaesthesiology.

In some countries, the term anaesthetist is used instead of anaesthesiologist.

WFSA Position Statement on Anaesthesiology and Universal Health Coverage

Negatives

Potential negatives or challenges associated with a name change include:

External issues:

- Engagement with all anaesthetists across the College and the Australian and New Zealand societies of anaesthetists would be imperative in gaining a united voice and recommendation.

- Any debate about this change would need to be a respectful debate and not disenfranchise or divide the speciality.
- Engagement with health services and clinicians would have to be comprehensive.

Organisational for ANZCA

- There would be a significant financial outlay on behalf of the College including widespread changes to resources including:
  - Policies and procedures
  - Curriculum
  - Continuing professional development
  - Professional documents
  - Other ANZCA documents and website references
- Government and regulatory body changes would need to be formally made including:
  - Company registration
  - Medicare
  - Medical Board of Australia and the Australian Health Practitioner Regulation Agency
  - Medical Council of New Zealand
- A change to the protected specialist title to specialist anaesthesiologist would be required.

Organisational for the societies (ASA and NZSA)

- There would be some similar elements to the above with respect to websites, administration and resources and including:
  - Policies and procedures
  - Professional documents
  - Company registration

Other joint issues include:

- Grandfathering and transition plans.
- A comprehensive marketing plan as well as an engagement strategy tailored to a broad range of stakeholders should be developed and implemented.

WHERE TO FROM HERE?

ANZCA, the ASA and the NZSA want to hear your thoughts and opinions.

This is not a trivial decision, and it is recognised that this should not distract us from many of the other large and important issues we are dealing with.

The three organisations have agreed to proceed down this line of inquiry together, noting that keeping the profession united is the most important thing for our external relationships and for our public perception.

A respectful discussion is the aim, and if the council and boards of all the organisations agree then we will proceed to finalise a decision with an online vote of the members of all the organisations by the end of 2018.

Consultation with our respective memberships, ANZCA trainees and other relevant stakeholders will occur over the next few months.

Professor David A. Scott
President, ANZCA

Associate Professor David M. Scott,
President, Australian Society of Anaesthetists

Dr David Kibblewhite
President, New Zealand Society of Anaesthetists

Reference:

Mathur et al Indian J Anaesth. 2009 Apr; 53(2): 179–186
https://www.wfsahq.org/images/UHC_Position_Statement_Final.pdf

This article appeared in the December 2017 edition of the *ANZCA Bulletin* and will be published in the *NZSA Magazine*

FEATURE

HISTORY OF ASA OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

This edition of the *Australian Anaesthetist* features several articles written by ASA members about key ODEC activities.

The Australian Society of Anaesthetists has a longstanding history of supporting anaesthesia development in less affluent regions. In the last two decades increasing attention has been drawn to the importance of global health issues, initially through the publication of the United Nations Millennium Development Goals in 2000, then subsequently with the more recent Sustainable Development Goals highlighted in the initial report of the Lancet Commission for Global Surgery in 2015.

Major international academic institutions and professional organisations have subsequently built global outreach faculties and departments with significant funding resources, and increasing effort is being spent on addressing the challenges of achieving universal access to safe and affordable surgical and anaesthesia care for people who live in low and middle income countries.

"The ASA has been quietly 'outreaching' for over thirty years" (personal comment, Dr Haydn Perndt).

Anecdotally the ASA's first grant in aid was an allocation of $500 to Dr Kester Brown in 1984 to allow him to speak at the first Paediatric Anaesthesia workshop in Santiago, Chile during the time of the Pinochet regime. Kester's association with Fiji and the Pacific began in 1985 when he visited at the invitation of the then chief anaesthetist, Dr Tu Mua, and this subsequently lead to the formation of the Overseas Aid sub-committee (OAC) within the ASA.

Kester was the inaugural Chair of what he describes as "a rather informal committee as others who had worked in the Pacific were allowed to attend as observers". He remained in the role for a number of years, but importantly was instrumental in building the committee budget by requesting initially $1, then $3 per ASA member to fund the committee's activities. This allowed each ASA member to directly 'contribute' to the long-term agenda-focussed programs that the OAC developed, and displayed considerable foresight. Subsequently the Committee was given a project-funding based

budget, which allowed more projects to be developed. This has grown very significantly over the years.

A New Zealand anaesthetist, Anthea Hatfield, and Michael Tronson from Melbourne were doing some ad hoc teaching in the Pacific in the 1980s and Kester decided that the ASA should run it's first Pacific Anaesthesia Refresher Course in Suva, in 1989. The course was organised by Chris Sparks, a Sydney anaesthetist who had worked as a volunteer in Vanuatu for a year and Haydn Perndt. Kester inveigled the then President of the ASA, Dr John Richards to also attend. This was a politically astute decision as it gave the ASA Executive a very useful insight into the nascent development activities of the OAC, and hence guaranteed support for the expansion of projects.

The Refresher Course has run every year since 1989, and has now evolved into the annual Pacific Society of Anaesthetists refresher course: this is the major South Pacific Anaesthesia academic meeting and continues to receive substantive ASA support.

Dr David Mawter took over from Kester as Chair of the Overseas Aid Committee in the early 1990s. This period saw a considerable growth in activities with the emphasis on teaching and mentoring the development of anaesthetic organisations in the Pacific region.

The first biannual Micronesian Anaesthesia Refresher Course (MARC) was held in 1994, and the ASA has continued to provide financial and administrative support for what is essentially the only opportunity for CPD for Micronesian anaesthesia providers. The Micronesian Anaesthesia Society was subsequently formed in 2005 and runs the course, with ongoing ASA and now Japanese Society involvement. Dr Arthur Vartis from Townsville has been instrumental in providing ongoing support to a fledgling and geographically challenged anaesthesia society.

Examination Committee, Fiji in 1996

In the early 1990s considerable energy was invested by the ASA OAC in developing an anaesthesia training program at the Fiji School of Medicine in Suva, Fiji. It was recognised that there was a clear need for a regional anaesthesia training program, and with WFSA support (Dr Haydn Perndt was the WFSA Education Committee Chair at the time) the Postgraduate Diploma in Anaesthesia (DA) was developed in conjunction with senior Pacific Island anaesthetists at the Fiji School of Medicine (FSM). Dr Steve Kinnear from Adelaide had spent a number of years working in the Pacific and decided to commit two years in Fiji to building the foundations for anaesthesia training as we see it today. The first DA exams were held in 1996, and the Examination Committee was chaired by Kester Brown.

Steve subsequently returned to Adelaide and became Chair of the OAC, a role he held between 1997-2008. During this time OAC activity remained focussed on supporting anaesthesia training and development in the Pacific region, with financial support provided for academic senior lecturers at the FSM, and the introduction of the ASA Pacific Fellowship in 2003. The concept of the Fellowship was devised by the OAC, and the inaugural Fellow was approached by Rob McDougall whilst working at the Royal Childrens Hospital in Melbourne in 2001 – that individual is the author of this article and current Chair of ODEC.

The first Primary Trauma Course (PTC) was held in Fiji in 1997 under ASA and WFSA auspices., It has been subsequently run in most Pacific Island countries with support from a number of OAC members and funding from the Australian government. PTC has spread throughout the developing world and has now been run in over 70 countries and has been translated into a number of languages.

Dr David Pescod returned from Mongolia in 2000 after attending the '40th Anniversary of Anaesthesia in Mongolia' meeting. David was asked to attend by Kester Brown, and was subsequently invited to return by A/Professor Ganbold Lundeg. This lead to a submission for new project funding to the OAC in 2006, and from this another long term anaesthesia development project commenced. Anaesthesia has since been transformed in Mongolia from an unrecognised and underappreciated practice to one of the leading specialties with concomitant dramatic reductions in maternal mortality and increases in anaesthesia provider numbers (over 200 physician anaesthetists trained). The ASA and Mongolian Society of Anaesthesia have worked closely together since David's first visit to Ulanbataar with the establishment of an memorandum of understanding (MOU) in 2008; his services to anaesthesia development were recognised with him being presented with the Order of Mongolia in 2010 at the 50th anniversary meeting.

FEATURE

Drs Steve Kinnear, Sereima Bale and Kester Brown

Inaugural six successful diploma graduates. L to R, back: Dr Narko Tutuo (Solomon Is), Dr Heidi Cayari (Fiji), Dr Ali Biribo (Fiji); Front: Dr Eloni Tora (Fiji), Dr Talia'uli Afeaki (Tonga), Dr Inia Seseni (Fiji)

Dr Rob McDougall became Chair of the OAC in 2009 and has overseen the further development of the committee until he stepped down in 2016. The committee was renamed the Overseas Development and Education Committee (ODEC) during this time to more clearly reflect its priorities. Further partnerships were fostered with Interplast and the Lifebox foundation, and committee activity grew in Southeast Asia with projects commencing in Laos, Cambodia and Myanmar. The Pacific Fellowship increased from one to three positions, allowing young ASA and NZSA members the opportunity to live and teach in Suva. In 2008 the Fiji School of Medicine became the Fiji National University College of Medicine, Nursing and Health Sciences, and 125 years of proud history as a highly progressive medical school was amalgamated with other elements of the University of the South Pacific. The ASA and the Fiji National University (FNU) subsequently signed a MOU in 2011 consolidating the Pacific Fellowship program established in 2003, and the MOU has just been updated to reflect the ongoing commitment by both parties to build anaesthesia capacity in the broader Pacific region.

The ASA Volunteer Database was developed by Dr Daniel Jolly and Dr Haydn Perndt to assist with sourcing volunteer anaesthetists for RACS and Interplast surgical missions and ASA-supported teaching and clinical activities. There are currently over 80 anaesthetists on the database, and further information can be found through the ASA website regarding joining the database. Membership is not restricted to ASA members: NZSA and ANZCA Fellows are welcome to join.

ODEC also became involved in supporting anaesthesia training in Timor Leste. Dr Eric Vreede worked in Dili with RACS as part of the specialist services program between 2003 until recently in 2017. Eric worked closely with the ASA and ODEC in developing nurse and physician anaesthesia training programs in Timor Leste, and was awarded the ASA medal in 2017 after having personally trained and mentored a new generation of Timorese anaesthesia providers.

2016 saw the first ASA Timor Leste Fellow to work in Dili alongside Eric and Dr Flavio Brandao (Timor Leste's first physician trained anaesthesia provider). Dr Sam Rigg was followed by Dr Chris Lack, whose report is featured in the current edition of the *Australian Anaesthetist*. The Timor Leste Fellowship is coordinated by Dr Brian Spain, and is similar in structure and function to the Pacific Fellowship in Fiji.

ODEC currently has 16 members, all of whom are involved with active projects throughout the Pacific and South East and Central Asian regions. ODEC remains well represented within the WFSA with Council, Education, Publications, Obstetric, Paediatric, Pain, Scientific Affairs and Equipment Committee representation.

Rob McDougall's article on the WFSA and its activities also features in this edition of the *Australian Anaesthetist*.

Today ODEC coordinates all aid directed outside Australia and New Zealand involving ASA members or resources. As illustrated above this includes educational, financial, material and skill-based support. ODEC acts in partnership with ANZCA, the NZSA and WFSA and other aid organisations in continuing to support anaesthesia development internationally.

Many of the established ODEC projects continue as long term ventures, but new ideas are always welcomed.

The ASA/RACS/WFSA Solomon Islands Anaesthesia Training Centre (SIATC) represents a collaborative initiative between the ASA and the Solomon Islands Ministry of Health, supported by RACS and the WFSA. A visit to Honiara by Drs Haydn Perndt and Phil Blum in 2016 identified a clear need to support anaesthesia training with the view to meeting the sustainable development goal of five anaesthetists per 100,000 head of population. There are currently four trained physician anaesthetists in the Solomon Islands (population 600,000); thirty by 2030 is the target. Achievable? We shall see. The ASA and the Solomon Islands Ministry of Health have signed a memorandum of understanding acknowledging the need to identify and train junior anaesthesia providers in Honiara. Phil Blum visited recently with equipment essential for anaesthesia training funded by both the ASA and RACS, and his report features in the current edition.

ODEC also supports a growing number of projects in Southeast Asia, and Dr Suzi Nou's considerable efforts in assisting the Cambodia Society of Anaesthetists hosting of the 20th ASEAN Congress of Anaesthesiology is outlined by her in a following article. Suzi and a small team of committed anaesthetists and intensivists have been visiting Cambodia for a number of years supporting anaesthesia training and development. Established projects are also running in Laos and Myanmar, and Drs Steve Kinnear and Roger Goucke have visited Bhutan in 2017 at the invitation of the Ministry of Health to run Essential Pain Management (EPM) course for the first time.

The most recent project to receive ODEC financial support is the SAFE Obstetrics course. This was run by Dr Terry Loughnan in Samoa in 2017, and will be held in Fiji in May 2018. This is an exciting initiative that will follow its successful introduction into Papua New Guinea in recent years.

ODEC always welcomes submissions of new projects for consideration, but preference is given to proposals which:

- Support the development of anaesthesia in the Asia Pacific region;
- Have limited alternative funding possibilities;
- Are sustainable over the long term, with good prospects of self-sufficiency;
- Have a strong teaching/education component;
- Involve members of the ASA or members of anaesthesia societies of the host country.

These reflect the ASA's core values through ODEC activity that has grown significantly since Kester Brown first formed the OAC over thirty years ago.

Dr Chris Bowden
Chair, ODEC

FEATURE

THE 20TH ASEAN CONGRESS OF ANAESTHESIOLOGISTS

SIEM REAP, CAMBODIA, 23-24 NOVEMBER 2017

The 23rd and 24th November 2017 were probably insignificant days to most of us but they marked an important milestone for the Cambodian anaesthetic community. These were the dates of the 20th Association of South East Asian Nations (ASEAN) Congress of Anaesthesiologists (ACA) in Siem Reap, Cambodia.

The origins of this meeting in Cambodia began in 2015, when the ASEAN political and economic and community, of which Cambodia is a member, sought to establish a common market that would ensure the free flow of goods, services, skilled labour and capital. There was much talk of the implications of this and the new economic and professional opportunities it might bring. It was an exciting development for Cambodia.

During that time, my colleagues of the Societe Cambodgiene d'Anesthesie, Reanimation et Medicine d'Urgence, asked if I thought they could host the ACA meeting in Cambodia. The ACA is a biennial event that is a premier meeting for the anaesthesia community of south-east Asia. I have been fortunate to attend a few of these meetings and knew of their importance and potential magnitude. Not wanting to dampen their spirits, I told the Cambodian society that yes, indeed, anything was possible. For them to host the Congress, I knew that they would need to attend one themselves, place a bid to host and be successful in their bid. Few on the committee had travelled outside of Cambodia and even fewer had ever attended an ASEAN Congress. Without significant sponsorship, it was unlikely that they would be attending the ACA that year, let alone bidding.

Despite my doubts, sponsors were sourced and at the eleventh hour, a delegation from Cambodia was indeed able to attend the 19th ASEAN ACA meeting in Indonesia. They were also

successful in their bid to host the next ASEAN Congress in 2017.

With this information at hand, I was fortunate to be able to join the organising committee of the Melbourne 2016 ASA National Scientific Congress. I am indebted to Drs Simon Reilly and Colin Royse and the rest of the committee for showing me what is involved with organising a large conference. Invaluably, I was also able to meet and work with Denyse Robertson, the Senior Events Coordinator at the ASA who continued to provide timely and important advice.

Despite my doubts, sponsors were sourced and at the eleventh hour, a delegation from Cambodia was indeed able to attend the 19th ASEAN ACA meeting in Indonesia.

In November 2015, I returned to Cambodia to provide pre-congress workshops for their annual Congress. In my view, the congress was a great success, with the largest number of medical and nurse anaesthesia providers and students ever attending. At the review meeting following the congress, I learnt that the funding of the congress was heavily subsidised and reliant on sponsorship such that extra registrations incurred a loss, rather than generate profit. So even though the congress had been a success in terms of attracting a large number of registrations, it had incurred quite a substantial financial loss, which was to be borne personally by members of the organising committee. My heart sank. However, at that meeting, with the help of a good friend and long-standing contributor to anaesthesia in developing countries, Assoc. Prof David Pescod, we were able to come up with a theme for the Congress: 'Towards Safer Anaesthesia'. The Cambodian ACA now had an identity.

Over the next year, progress was slow. At one stage, grave concerns were shared with me by some of the Presidents of the anaesthesia societies from other ASEAN nations, with possible contingency plans to host the meeting in another country.

I returned to Cambodia in November 2016 for their annual scientific congress. For the last few years I have been providing technical assistance to the Societe Cambodgiene d'Anesthesie, Reanimation et Medicine d'Urgence, by way of organising their pre-congress workshops and providing speakers for their annual scientific congress. For this, I am indebted to the support of the ASA and the Overseas Development and Education Committee and the many ASA members who have volunteered their time and expertise. The Cambodian Society asked if I could again organise workshops for the ASEAN Congress. It was clear though, that I would have to provide more assistance.

Over the next year, I went from being the pre-congress workshop organiser, to the scientific convenor. I was fortunate I could rely on experienced colleagues Drs Sathi Seevanayagam and Moira Rush to organise workshops whilst I focussed on the rest of the congress. At one stage I was listed as the co-Chair of the organising committee, although I asked for this to be changed as to be so usually requires an election. I also found myself taking on the role of what a professional conference organiser may do, negotiating contracts with the venue and suppliers, managing the sponsorship arrangements, preparing publicity brochures and presentations and designing the abstract booklet and also overseeing the budget. Apart from one visit to Cambodia in June, all of this was done via email. This was an incredible effort given the language difficulties and also the reluctance most Cambodians have in discussing business matters in anything other than face-to-face meetings.

Perhaps one of the hardest things to arrange was a credit card facility. Whilst this is something many of us take for granted, Cambodia largely operates on a cash-based system, including purchasing

Dr Nou presenting the ASA poster prize to the winner

The delegation from Brunei, who will be hosting the 2019 ASEAN Congress

FEATURE

Receiving a 'thank you' gift from the President of the Confederation of ASEAN Societies of Anaesthesiologists

Assoc Prof David Pescod presenting a gift to Dr Brian Spain for speaking in one of the sessions

luxury items such as sports cars. It took months of negotiating for me to impress upon the committee how important it was to be able to accept credit card payments and then a further four months before the bank was able to set up a secure payment link. This included having to rebuild the website only months before the congress.

There were also opposing pulls between what the international and local communities wanted. International visitors are attracted to the magnificent Angkor temples, located a few kilometres out of Siem Reap. All, bar one, of the medical anaesthesiologists in Cambodia work in the capital, Phnom Penh. Most regular attendees of the ASEAN Congresses would expect at least a three-day meeting. Cambodian anaesthesia providers have only ever known a one-day meeting. We did not know if they would be prepared to travel and whether their leave would be granted to attend a two-day meeting. We knew that from past ACA meetings that the bulk of delegates are from the host country. However, if the bulk were to be Cambodians, how could we budget so that it could remain affordable for local delegates, yet not incur a financial loss for the organisers?

As the days drew nearer, I found it hard to believe that despite all the challenges, the congress was indeed going ahead. In previous years, when I only had the workshops to prepare, my concerns were usually of how our Australian team would be received and whether I had briefed them sufficiently. This time, as we landed into Phnom Penh, I wondered if my colleagues on the organising committee were also feeling the same apprehension, excitement and nervousness as I. It was a great feeling of togetherness.

In the end, from what I can gather, the meeting was a great success. We welcomed 177 international delegates from 17 countries and 152 delegates from Cambodia, making this the largest anaesthesia congress hosted in Cambodia to date.

As is usual Cambodian hospitality, we were picked up from the airport by a local colleague. The mood in the car was different to previous times. He soon pointed out the political tensions. He was 'on duty' (on call) that day but there were no patients. The hospital had been quiet, the road unusually so, as the internal movement of people from 25 provinces to the capital had been restricted by road blocks. He told me how Facebook was limited, that radio stations and newspapers had been closed.

The feeling of togetherness I had only been reflecting on a few moments earlier burst like a bubble. I had been following recent political events in Cambodia from the safety of my existence in Australia. There was anger and frustration in my friend's voice that wasn't in mine; for I knew that I could leave this country whenever I chose, whereas he had no choice but to continue.

In the end, from what I can gather, the meeting was a great success. We welcomed 177 international delegates from 17 countries and 152 delegates from Cambodia, making this the largest anaesthesia congress hosted in Cambodia to date. As there are only about 150 medical anaesthesiologists and 100 nurse anaesthetists in Cambodia, this represents more than the total number of anaesthesia providers in the country. We officially had 85 participants in four pre-congress workshops, although there appeared to be many more, and heard from 67 speakers from 17 countries. I was particularly keen for the meeting to retain a Cambodian flavour and was pleased to have been able to include six Cambodian speakers in the scientific program. I am also indebted to the ASA for sponsoring the poster prize, which attracted 24 posters, including one local presenter. For the ASEAN region, this Congress marked other important

milestones, such as being the first ever international meeting attended by anaesthesiologists from Lao PDR.

I was hugely impressed with how the ASEAN community rallied to support this event on every level. They contributed the bulk of the scientific program and were also available for advice along the way. They provided great entertainment at the social events, including an impromptu band performance. During our preparations, I experienced, pondered and hopefully practiced doing things the 'ASEAN way':

> *A working process or style that is informal and personal. Policymakers constantly utilize compromise, consensus, and consultation in the informal decision-making process... it above all prioritizes a consensus-based, non-conflictual way of addressing problems. Quiet diplomacy allows ASEAN leaders to communicate without bringing the discussions into the public view. Members avoid embarrassment that may lead to further conflict.*[1]

For the ASEAN region, this Congress marked other important milestones, such as being the first ever international meeting attended by anaesthesiologists from Lao PDR.

What was hugely rewarding for me was seeing my Cambodian friends and colleagues working so hard to deliver things that must have seemed so foreign to them and then for all of us to watch it come together. What I perhaps had forgotten in the process, which they had brought, was the warmth and friendliness that Cambodians have, particularly for visitors. They are truly wonderful hosts and I was so happy that they couldn't help but bring their warm flavour of hospitality to the meeting – such as giving every delegate a local gift as a keepsake of the congress.

Cambodian dancers on stage at the gala dinner

One of my regrets was not being able to be in each room. Over the year, and the many emails back and forth, I felt like I knew every speaker on the program and I wish that I could have also heard them present. I did try to visit each session, even if it was for a brief moment as I tried to run other errands, but would have liked to stay for more.

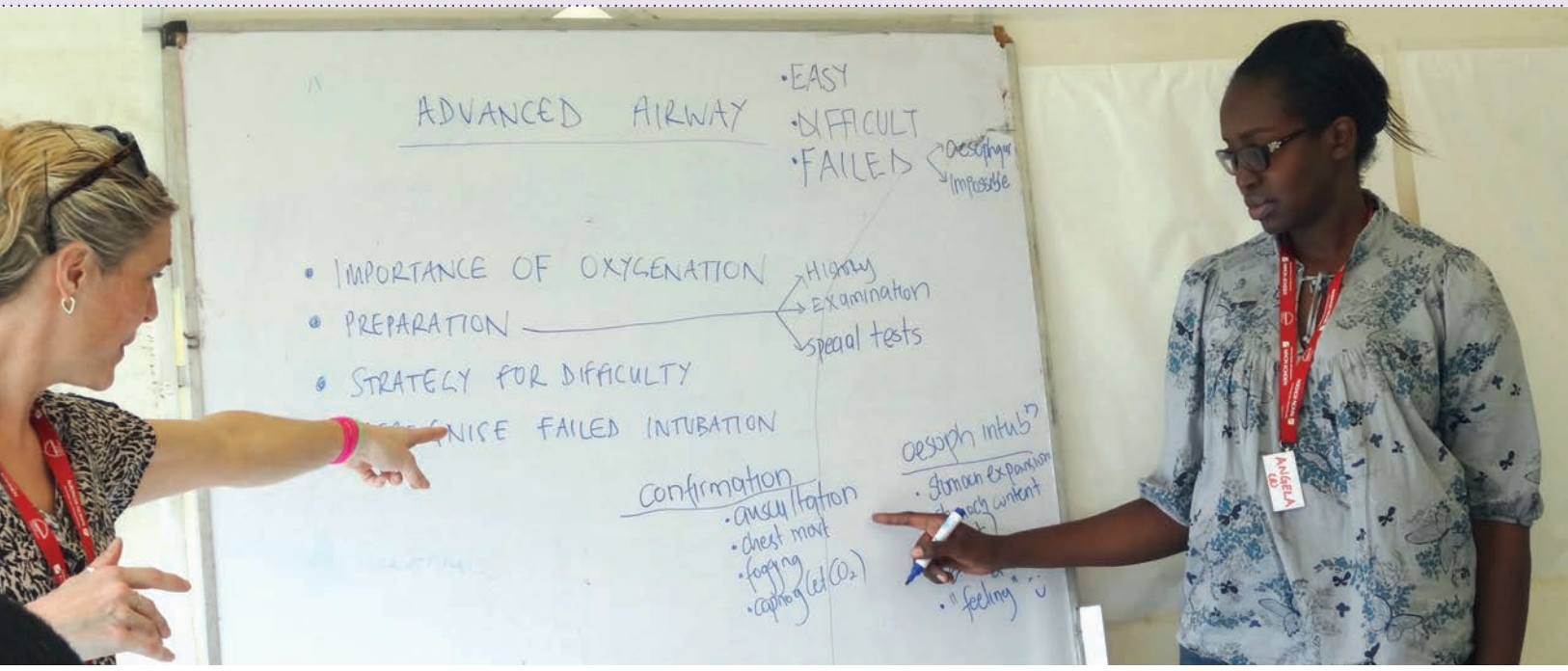
After the hectic pace, I enjoyed relaxing at the airport on the way home. I felt immensely relieved and floated in that comfortable numbness you feel when you've only heard praise and thanks from many around you. After boarding, I finally pulled out the Cambodian newspaper that I had picked up on my arrival. Political arrests, dissolving opposition parties and intimidation of human rights groups, all ahead of the July 2018 election. I continued safely on my way.

Dr Suzi Nou

Reference

1. Masilamani L, Peterson J (15 October 2014). '"The ASEAN Way": The Structural Underpinnings of Constructive Engagement', *Foreign Policy Journal*.

FEATURE



EDUCATION AND TRAINING FOR THE FUTURE – WHAT IS THE WFSA DOING?

The vision of the World Federation of Societies of Anaesthesiologists (WFSA) is universal access to safe anaesthesia and the WFSA's mission is to unite anaesthesiologists around the world to improve patient care and access to safe anaesthesia and perioperative medicine. With 5.5 billion people globally without access to safe surgery and anaesthesia, the WFSA task is huge but recent years have seen significant efforts and positive results.

The recent Global Anesthesia Workforce Survey of the WFSA argued that 10 anaesthesia providers per 100,000 population are required "to ensure effective leadership of anaesthesia services and delivery of emergency and essential patient care" but acknowledged that this is unlikely to be achievable in the next 12 years. A suggested interim target of five providers per 100,000 population would still require an additional 136,000 anesthesia providers now! This challenging goal requires coordinated action by governments, training bodies and anaesthesia professional groups. The WFSA is ready to be a significant player in this much needed workforce expansion.

In recent years the WFSA has focussed its work through four programmes: Advocacy, Education & Training, Innovation & Research and Safety and Quality. Education has traditionally been the largest activity of the WFSA and this remains so today.

TRAINING CENTRES

Twenty-one hospitals in fourteen countries are recognised as WFSA training centres. Each year up to 48 fellowships are offered and these vary in duration from three to twelve months. Fellowships are open to young anaesthetists who have completed their training in their home (low income) countries. Applicants must have the endorsement of their national society and commit to return to their home country following completion of the fellowship.

The longest running WFSA training centre is the Bangkok Anaesthesia Regional Training Centre (BARTC), which was established in 1996 and has trained over 80 anaesthetists from nearby countries including Cambodia, Vietnam, Bhutan, Laos, Myanmar and Mongolia. Nearly all fellows have returned to their home countries and are actively involved in anaesthesia and, possibly more importantly, in training young anaesthetists. The impact

on Mongolia deserves special mention. Over 25 Mongolian anaesthetists have spent twelve months at BARTC and this has created a critical mass of experienced anaesthetists who have returned home and developed the Mongolian anaesthesia training programme which has been long supported by the ASA.

In 2016, Dr Pauline Wake from Papua New Guinea (PNG), spent six months at the WFSA Training Centre located at Christian Medical College & Hospital, Vellore, India. This fellowship was in paediatric anaesthesia and was invaluable for her role in Port Moresby. Dr Wake has since been a key organiser in the inaugural SAFE Paediatrics course in PNG.

WFSA fellowships are excellent value for money – a living wage and accommodation in Bangkok is approximately US$15,000 for 12 months.

Recently, the WFSA has launched the "Fund a Fellow" campaign to raise funds for this important work. More information about both this campaign and the WFSA training centres can be found at: https://www.wfsahq.org/get-involved/fundafellow

SCHOLARSHIPS

Since 2008 Baxter Healthcare Ltd has sponsored over 150 young anaesthetists to attend major WFSA affiliated meetings, such as the World Congress of Anaesthesiologists. In addition to the direct educational benefits, these scholarships have allowed for networking opportunities for young leaders in anaesthesia from low and middle income countries (LMIC). When surveyed in 2014, 94% of scholars said that the scholarships had a positive impact on their patients and 98% would seize the opportunity for another scholarship.

The Asian Australasian Regional Section (AARS) of the WFSA has also been active in providing scholarships to its own Asian Australasian Congress of Anaesthesiologists and also to the World Congress. The Asian and Australasian Congress of Anaesthesiologists (AACA), held every four years, will be held in Beijing 1-5 November 2018 and the AARS has offered 15 scholarships for young anaesthetists in the region.

SAFE COURSES

Safer Anaesthesia From Education (SAFE) is a joint project between the WFSA and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). Courses are run in paediatrics and obstetrics and aim to equip anaesthesia providers with the essential skills and knowledge to provide safe paediatric and obstetric anaesthesia care. Each course runs for three days and involves small group teaching, scenario teaching and skills stations.

SAFE courses have been run in over 20 countries worldwide, including courses in and Samoa. These courses were run with the support of ANZCA and the ASA respectively. These courses have been highly popular and are relatively inexpensive, especially once local faculty develop the ability to run the courses.

More information about SAFE can be found at: https://www.wfsahq.org/wfsa-safer-anaesthesia-from-education-safe

ESSENTIAL PAIN MEDICINE (EPM)

ASA members will be well aware of the success of EPM, which has been a joint initiative of WFSA and ANZCA. The ASA has also had an important role in the development and delivery of this course, which aims to improve pain knowledge, implement a simple pain management framework and explore the barriers preventing recognition and treatment of pain.

The burden of chronic pain in LMICs has been estimated as having a prevalence of 34%. The projected need for surgery and anaesthesia will add to this burden of pain. Many health workers in LMICs have minimal education in the problem of pain and EPM attempts to address this.

EPM has now been run in over forty countries and has even been incorporated into medical school curricula in the UK.

PUBLICATIONS

The WFSA has for many years published the popular *Anaesthesia Tutorial of the Week* (ATOTW). Whilst aimed at anaesthesia providers from LMICs,

Paediatric resuscitation simulation session

FEATURE

the ATOTW series has proven popular amongst trainees from high income countries also. Currently there are over 7,000 from 100+ countries. ATOTWs cover a broad range of topics and are available free of charge from the WFSA website. The WFSA is always seeking volunteers to write and edit these online tutorials and ASA member involvement would be welcomed.

'Update in Anaesthesia' is the official education journal of the WFSA and over the past 25 years, 32 editions have been published. 'Update' is available for download from the WFSA website and contains high quality review articles of use to anaesthetists from around the world.

In 2016 the WFSA entered a partnership with the International Anesthesia Research Society (IARS) to establish a 'Global Health Section' in the widely read *Anesthesia and Analgesia (A&A)* journal. Already a number of important papers relating to education in LMIC have been published and April will see a special global health edition of *A&A*. This edition will attempt to define a roadmap to 2030 for safe anaesthesia and surgery.

ADVOCACY AND EDUCATION

It has been recognised that the WFSA, as one of the largest international medical federations, can have significant influence on health policy at a national and global level. An example is the WFSA's 'International Standards for the Safe Practice of Anesthesia', which has proved very important in assisting the development of anaesthesia in LIMCs.

Currently, the WFSA is working on the development of curriculum guidelines for anaesthesia training. It is expected that these guidelines will be very useful in assisting the establishment of new anesthesia training programs and improving the standards of existing programs.

One aspect of advocacy is educating policy makers, health workers and the public on the vital importance of safe anaesthesia. WFSA understands this role and is increasingly active through such activities as World Anaesthesia Day and the WFSA SAFE-T Campaign.

One crucial WFSA role is assisting member societies and governments in the development and implementation of national surgical and anaesthesia plans. The relationship between the WFSA and WHO allows the WFSA to have input into the World Health Assembly (WHA) which formulates global health policy. The WHA has recently resolved that national surgical and anaesthesia plans are essential for the strengthening of surgery and anaesthesia. These plans help countries determine how many anaesthesia providers are needed for the future and this informs training and education requirements.

The WFSA has a unique position in that it influences health policy at a national and

THE WFSA TRAINING CENTRE EXPERIENCE

"I never teach my pupils. I only provide the conditions in which they can learn", (Albert Einstein). I spent many years in Papua New Guinea learning and working with the different health challenges as an anaesthetic trainee and an anaesthetist. My decision to do a Paediatric Anaesthesia Fellowship in India with the support of WFSA was to motivate myself to do more, to expand my knowledge and skill beyond what I as learning in my country and to widen the experience of being a student under experts in a different learning environment.

So what did I learn in Vellore during my six months there? I learnt clinical skills that I was not able to experience in my country. I learnt epidurals, paravertebral blocks with ultrasonography in paediatric patients, I learnt anaesthetic services outside the control of the operating theatre like the radiological department, I learnt how a neonatal and paediatric intensive care unit operates and the care of different patients who presented, I learnt anaesthesia for day surgery, I learnt anaesthesia for neonates and paediatric patients requiring complex surgical procedures of the thoracic and abdominal region, chemotherapy, orthopaedic surgery, neurosurgery and cardiac surgery.

I also learnt invaluable non-clinical skills such as teaching and learning for trainees in the operating theatre with cases, communicating with non-English speaking patients, researching literatures, developing research questions while providing services, team work and organising of a large department.

How has this experience helped me now? On returning to Papua New Guinea, I have been able to provide services for neonate and paediatric population, change the way I teach in the operating theatre, change the way I approach postgraduate trainees, recognise the need for a structured learning for trainees and develop it (2018 is the first time we have a structured learning outline for postgraduate trainees in Papua New Guinea), demonstrate and teach trainees principles in anaesthetising neonates and paediatric patients and involve colleagues in feeling responsible for training.

What WFSA did was to give me an opportunity to be in a different environment where I could learn and change for the better, for the anaesthetic services and training in Papua New Guinea. And for that I am grateful!"

Dr Pauline Wake

supranational level, guides anaesthesia curricula development and assists the delivery of education. Education is one of the keys to achieving the required massive expansion of the global anaesthesia workforce and the WFSA is well placed to deliver!

This article has not mentioned the WFSA role in Lifebox education or the World Congress of Anaesthesiologists and other meetings. These are also important and will be discussed at another time.

See you in Beijing in November for the AACA.

Rob McDougall
Member, Scientific Affairs Committee, Equipment Committee, WFSA;
Immediate Past Chair, AARS, WFSA;
Associate Editor, Global Health Section, Anesthesia and Analgesia

Zambian SAFE Paediatrics course participants

FEATURE

SOUTH PACIFIC PEARLS – DELIVERING AID IN THE SOUTH PACIFIC

"Bula Dr Dennis!" That's what you will hear every day you walk through the doors of the Colonial War Memorial Hospital while working as a volunteer anaesthetist in Fiji. It starts from the hospital security guard, then the blood donation centre staff, then the orderlies and nurses as you walk down the corridor into the theatre complex, and finally from your medical colleagues in OT. With infectious smiles and a positive outlook on life, it is the people that make this place so special and unique.

The Colonial War Memorial Hospital (CMWH) is the largest teaching hospital in the South Pacific. It is located in Suva, Fiji's Capital in the south-east of Viti Levu island. Fiji is made up of 332 islands, with a population of over 900,000. The CWMH is the referral base for not only Fiji, but all of the South Pacific. It serves as a tertiary referral base for more than 4,000,000 people.

The minimum wage in Fiji is currently FJD $2.65 (A$1.85) per hour. The local people are poor, yet they will welcome you into their home and give you everything they have in order to put a smile on your face. In Fiji, family is everything. Not just your relations, but friends, neighbours, work colleagues and even complete strangers are greeted with a warm smile and a "Bula" or "Hello". The people always make time for you, even if that makes you and them both late for another engagement, resulting in a phenomenon known as 'Fiji time' (basically an excuse for being late to anything). 'Fiji time' is applicable to working hours, appointments, dinner meetings, arriving home, and even occasionally the airport flight schedule. Although initially frustrating, it teaches you to not sweat the small stuff and not worry about variables out of your control. It's something most of us in the fast-paced western world could benefit from.

NOW ONTO THE MEDICAL STUFF...

Fiji is an amazing place to go and perform volunteer work. There's an established hospital system, medical school, and medical training systems for staff. There is also a huge need for increasing their standard of care and education. This is not

FEATURE

Surgical outreach mission staff, Vunisea Hospital, Kadavut

Dr Luke Nasedra, Dr Deral Nand, Dr Ray Vuniwa and Dr Dennis Millard (ex ASA Trainee WA)

Above labour ward in Daviqele village, Kadavu
Below: operating by light of my smartphone during a power outage

from a lack of intelligence, desire or effort, but due to the lack of resources available to the local doctors and medical educators of Fiji.

People want to do volunteer work for many personal reasons: to improve their medical skills, perform interesting cases, and achieve immense satisfaction knowing that you have helped patients in dire need. The role of the ASA Fellow in Fiji allows you to achieve much more than this. Your primary objective is to teach anaesthetic skills to colleagues, and teach anaesthetists how to be teachers themselves. For this reason, the role for an ASA Fellow in Fiji is non-sustainable. Your skills will be perpetuated over time – as opposed to just fixing an immediate patient problem or patient complication. My goal while in Fiji was actually to make my own position redundant – which is what Dr Chris Bowden and Dr Justin Burke have been heavily focused on since taking over the clinical coordination of this role over 10 years ago.

During my three months in Fiji I was involved in more complicated, challenging cases than I would have encountered in three years working at a tertiary teaching hospital back in Australia.

This may make the role seem less appealing to prospective ASA Fellows. From personal experience I can assure you the sense of achievement will be far greater when you look back at this and realise that you played a role in improving the healthcare for future generations in the South Pacific.

Despite being heavily focused on sustainability and education, there is also a very heavy clinical component to this role. During my three months in Fiji I was involved in more complicated, challenging cases than I would have encountered in three years working at a tertiary teaching hospital back in Australia. Cases were varied – from neonatal tracheo-oesophageal fistula repairs, to paediatric neurosurgery, draining 2L amoebic liver abscesses and phaeochromocytoma surgery.

The scope of work is diverse – very clinically stimulating and interesting. This is challenged further by a lack of resources which would be considered as essential to perform safe anaesthesia in Australia – and this at the CWMH – the tertiary referral base for the whole South Pacific!

The clinical highlight for me was taking a team of doctors, nurses and support staff down to a remote island chain in southern Fiji, Kadavu. Nineteen staff planned the

Dr Dennis Millard teaching the anaesthetic trainees how to perform a spinal, Vunisea Hospital, Kadavu

Kavala outreach clinic, Kadavu, Fiji

trip – led by Dr Luke Nasedra, the Head of the Department of Anaesthesia in the CWMH hospital. There had not been a surgical outreach service in Kadavu for seven years, and over nine days we screened over 200 patients and performed over 70 surgeries.

Challenges included frequent power outages mid-surgery – resulting in us using my phone as the surgical light, while the patient was under a spinal anaesthetic. After finishing the surgery, I asked the patient if he was OK about the power outage, he laughed and said "this is normal". It's safe to say we didn't need to refer him to the hospital counsellor to avoid developing PTSD from a power outage mid-surgery – as one may expect in our Australian population.

While in Kadavu, we would travel every evening to a remote community and run health promotion and health education sessions with the local villagers. This would be followed by a long night of drinking kava (a local drink consumed as part of a celebration or ceremony – made from powdered roots of a kava tree).

Again, the highlight of this trip was the people. Not just the local patients, but also the staff we travelled with – a group of hospital workers from the CWMH. We all travelled together on overnight ferries to a remote part of the world, to offer medical services to people in need. We bonded and became great friends. The friends I made in Fiji will be lifelong, and it is a privilege that they allowed me into their community and culture and adopted me as their 'kevalangi' (white person) brother.

I highly recommend Fiji as both a medical volunteer destination and as a holiday destination. The people are wonderful and need help. Their country is dynamic and culture is family focused – and let's not forget the fact that it also has some of the best surf and kite-surfing conditions in the world! To future anaesthetic fellows looking at this position, I would highly encourage you to apply, provided you have the ability to cope with difficult medical situations and limited resources.

To the people of Fiji, I say "Vinaka vaka levu".

Dr Dennis Millard B.Sci MBBS FANZCA
Fiji National University School of Medicine, Colonial War Memorial Hospital, Suva, Fiji

FEATURE

ESSENTIAL PAIN MANAGEMENT WORKSHOP

THIMPHU, BHUTAN, 17-19 OCTOBER 2017

In October 2017 Bhutan became the 55th country to experience an Essential Pain Management (EPM) Workshop.

I first worked in Bhutan as a volunteer in 2011 and since then I have been trying to convince the powers that be at the Jigme Dorji Wangchuk National Referral Hospital (JDWNRH) in Thimphu (the capital city) that their health workers might get a lot out of this workshop. After my fourth visit, and discussions with many health workers and officials in the hospital, the idea finally got some traction and it was agreed to hold the workshop.

Dr Roger Goucke (experienced Pain Management Physician from Perth, and co-writer of the EPM programme) agreed to come, and with his contacts we enrolled two other speakers, Dr Palanisany Vijayanand, another pain management Physician from Ciombattore, India, and Ms Boontuan ('Lex') Wattanakul, an experienced nurse educator, from Bangkok, Thailand.

Bhutan has a population of approximately 800,000. The country, ranked 133 of 188 countries on the UN Health Development Index, is extremely mountainous and has numerous health development issues – compounded by the extremely tortuous and difficult to maintain roads. Patients can travel for days, often walking a fair part of the journey, to reach one of the four major hospitals in the country.

The day before the workshop began, Dr Goucke and I met with Dr Gosar Pema, the Medical Superintendent of the JDWNRH, Dr Jamphel Tshering, the Head of the Anaesthetic Department of the JDWNRH, and Mr Karma Jurmin, a Programme Officer in the Ministry of Health, who was delegated the responsibility of organising the attendees for the workshop, the venue and other local logistics.

We ran one three-day EPM workshop, from 16 to 18 October 2017, at the IMS Building, Thimphu, Bhutan. There were several logistics/organisational problems that only became apparent when we were checking the planning and venue the day before the workshop started. The main one was the complete lack of participants that had been organised for Day 3. However we were in luck as most of Bhutan's medical students train in Sri Lanka, yet due to a long-running strike of all the medical schools in that country, all these students were currently back in Bhutan with nothing to do. We discovered

this fact the day before the course started, and were able to organise some of these students to attend on Day 3.

Participants came from all over Bhutan. Day one and day two attendees were a mixture of nurse anaesthetists, nurse OT technicians, and a few doctors. This was impressive given that the country is very mountainous and the roads are so poor. Several participants from the eastern dzongkhags (districts) of the country travelled for three days to attend. The Day 3 audience was mostly fourth and fifth year medical students who had returned from Sri Lanka to Thimphu.

The 27 participants completed a pre-test at the start of the workshop, and a post-test at the end. There was a marked improvement. The mean pre-course test score was 13.1 (out of 25) and the mean post-course test score was 19.5.

Fifteen of these participants were taught the basics of giving a lecture and running a case discussion on Day 2. On Day 3, this same group, under the watchful eyes of the overseas tutors, taught a full-day EPM course to the group of medical students, plus a few hospital doctors who had heard what was going on and came to have a look.

Participants provided feedback by making comments on the whiteboard at the end of day one and day three, using the 'Delphi Wall' format. In this method, three headings are put up on a whiteboard, and participants are invited to make comments:

The headings are:

1. What I liked about the course.
2. What I learned.
3. What could be done better.

Feedback was very positive. Examples of participant responses were:

QUESTION 1:

- "Very good course".
- "I liked the interactive presentations".
- "I enjoyed the case discussions".

QUESTION 2:

- "I learned the RAT approach".
- "Placebo drugs should not be given".
- "I learned a lot about using opioid drugs in cancer patients".

QUESTION 3:

- "Could have had manuals for Day 3" (we ran out of these as the course was over-subscribed).
- "Needed more discussion on method of action of common drugs".

The participants identified a number of barriers to the improvement of pain management in Bhutan. These included:

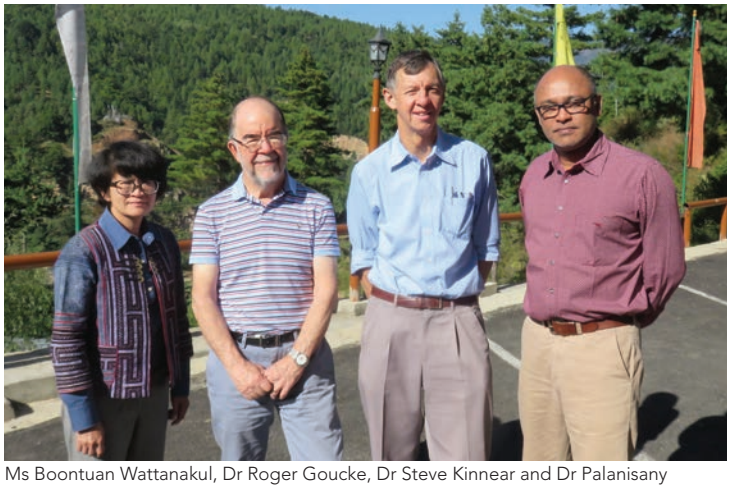
- Fear of addiction.
- Resistance from family to seek medical attention.
- Religious barriers (suffering as virtue/ bad to treat pain).
- Negligence (social barrier).
- Non-availability of drugs from time-to-time.
- Poor pain assessment.
- Poor recognition of pain as a problem area.
- Ignorance.
- Drug distribution problems.
- Manpower issues.
- Transport of medications (bad roads).
- Communication (poor mobile phone coverage).

In summary, this EPM course was a success, but we were lucky to obtain, at very short notice, a group of doctors and medical students on Day 3 that allowed our group of newly trained instructors to practice their teaching skills.

We hope to run another EPM workshop around this time next year, somewhere in Bhutan, perhaps in the eastern region, and to involve – if possible, some of the new instructors from this course.

Dr Steve Kinnear

Dr Palanisany Vijayanand conducting a workshop



Ms Boontuan Wattanakul, Dr Roger Goucke, Dr Steve Kinnear and Dr Palanisany Vijayanand

FEATURE

Dr Pedersen training a group of doctors in the use of the ultrasound machine

ULTRASOUND FOR ANAESTHESIA IN MONGOLIA

The use of ultrasound to facilitate regional anaesthetic procedures and venous and arterial access has become increasingly popular in Ulaanbaatar, Mongolia writes Dr Roger Goucke.

Several of the recent combined ASA/Mongolian Society annual refresher course meetings have included training in ultrasound. These meetings have been led by Dr David Pescod and Dr Amanda Baric. While there are some relatively modern machines in Mongolia, there is limited access to them, which makes it difficult to practise ultrasound-guided regional anaesthesia and disseminate this information throughout the Mongolian health system.

A Siemens Acuson Antares ultrasound machine has been kindly donated by Envision Medical Imaging (Perth, WA). Financial donations from the ASA ODEC committee; ASA members (Dr David Pescod and Dr Amanda Baric) and a number of individual contributions; (Dr Yayoi Ohashi, Dr Christopher Mitchell, Dr Debra Devonshire, Dr Grace Chang, Dr Samuel Kennedy and Dr Stefano Sabato) supported the ultrasound machine being successfully delivered to Ulaanbaatar in August 2017.

Many people were involved in the donation of the ultrasound machine to Mongolia. Firstly, Ms Kylie Williams (medical imaging technologist) at Envision Medical Imaging talked to Dr Chin-wern Chan (pain medicine specialist) at Sir Charles Gairdener Hospital regarding the donation of the

Ultrasound machine donated by Envision Medical Imaging

GREETINGS FROM MONGOLIA

Dear Dr Yayoi Ohashi,

The ultrasonography machine which you and your organisation donated arrived safely and we were cleared for the custom and taxes. It is great pleasure to express my and my colleagues' best appreciations for this sincere promotion and support.
I hope this machine will work for many other years and help to save many lives of Mongolia sick people while we will use it in emergency care area of university hospital. Thanks for the people and organisations who helped you to complete this mission. I will keep in contact how we are using the machine and what progress brought as outcome. I hope you and your husband will visit Mongolia in future and deliver even more contribution in Australia – Mongolia joint program.

With my best regards and wishes,

Dr G. Lundeg MD PhD
Lecturer
Health Sciences University of Mongolia
Division of Emergency Medicine and Anesthesia
Ulaanbaatar, Mongolia

ultrasound machine which Envision Medical Imaging no longer required. Dr Yayoi Ohashi (anaesthetist) at Fiona Stanley Fremantle Hospitals Group, liaised with Ms Jane Reid (operations manager) at Envision Medical Imaging to organise the transportation of the machine to Mongolia. In addition, Dr Ohashi organised the fundraising effort to raise money needed for transportation costs.

Dr Ohashi was involved in an early ultrasound workshop in Ulaanbaatar in 2014. In that workshop, ultrasound machines which were available in Mongolia were used. The machines were not as advanced as machines used in Australia, with inferior image resolution. The lack of appropriate ultrasound machines in Mongolia limited the training and effective use of ultrasound guided regional anaesthesia. Since 2014, multiple companies have been approached to source second-hand ultrasound machines and monetary support to assist the Mongolian doctors. Dr Brendan Adler (CEO, radiologist) at Envision Medical Imaging and the staff of Envision Medical Imaging were very happy to see their former ultrasound machine donated to Mongolia where the machine will be used in both clinical and research settings.

Doctors who attended the first ultrasound training. Front row: L. Unurzaya, Anna Pedersen, Yayoi Ohashi, U. Bilguun
Second row: S. Burmaa, R. Bazarragchaa, M. Ariuntungalag, Kh. Bayalagmaa, Soyombo, B. Odgerel, Mungun, G. Otgontuya

The lack of appropriate ultrasound machines in Mongolia limited the training and effective use of ultrasound guided regional anaesthesia.

Professor Ganbold Lundeg at the division of Emergency Medicine and Anesthesia in Health Sciences University of Mongolia is one of the key drivers of anaesthesia education in Mongolia. He facilitated the delivery of the machine to the nearby University Hospital.

We look forward to hearing how the ultrasound machine is being used and will continue our strong collaboration with Mongolian anaesthetists.


Practising on the ultrasound machine

FEATURE

SOLOMON ISLANDS VISIT

8-12 NOVEMBER 2017

The team flew from Darwin with donated equipment via Brisbane to Honiara, Solomon Islands (SI). The equipment included a Laerdal adult airway and resuscitation manikin, a neonatal intubation manikin, a Storz Cmac screen on a stand, a range of Cmac blades, 20 disposable Ambu intubating bronchoscopes and an Ambu screen.

We arrived in the afternoon on Wednesday 8 November and were met by Dr Kaeni Agiomea at Honiara Airport. All of the donated equipment arrived safely. We spent the afternoon unpacking and assembling the equipment. Dr Agiomea picked us up from the hotel at 0730 on Thursday 9 November and we transported the new equipment to the Honiara National Referral Hospital (NRH).

Dr Agiomea had organised the three anaesthetic consultants at the hospital to cover all theatre duties freeing up all four of the anaesthetic trainees in the Solomon Islands to attend a full day of teaching and training. The clinical work load for the week was lighter than usual as there was no elective cases booked because the surgical ward was closed for renovations

The four trainees were all Diploma of Anaesthesia candidates. Dr Una Gagahe was two years out from studying medicine in Cuba. He originally came from islands to the north of Honiara. He had done a year of anaesthetic training and was intending to sit his diploma in two years. Dr Ramo Buka was three years out from studying medicine in Cuba. He originally came from islands to the far east of Honiara. He had done a year of anaesthetic training and was intending to sit his diploma in two years.

Dr Patrick Haisoma was four years out from studying medicine in Port Moresby, Papua New Guinea (PNG). He originally came from an island far west of Honiara, near Bougainville. He had done two years of training and was intending to sit his diploma in 2018 in PNG. Dr Howard Marau was six years out from studying medicine in Suva, Fiji. He originally came from an island east of Honiara. He had done two years of training and was intending to sit his diploma in 2018 in Suva.

We had been in contact with Dr Agiomea before travelling and had asked about what topics they would like to cover.

The morning session (0830-1230) covered basic cardiac physiology, anaesthesia for valvular disease, difficult airway assessment and exam preparation. Teaching was predominately problem-based round-table discussion. The trainees were enthusiastic and easily engaged.

The afternoon simulation session (1300-1600) took place in an empty operating theatre. The new adult and neonatal training manikins were placed on the

Dr Jack Puti and Dr Kaeni Agiomea

Dr Howard Marau, Dr Phil Blum, Dr Patrick Haisoma, Dr Una Gagahe, Dr Andrew Fenton and Dr Ramo Buka (seated)

operating table. The registrars were given practical hands on training on the use and care of the new airway equipment using the new airway manikins. Difficult airway scenarios were simulated and management of these scenarios practised.

On Friday 9 November we spent a productive and enjoyable morning (0830-1200) with the only consultant anaesthetists in the entire Solomon Islands, Dr Kaeni Agiomea, Dr Bata Anigafutu and Dr Jack Puti. The four registrars ran the operating theatres giving the consultants time to familiarise themselves with the new airway equipment using the manikins in an empty theatre. We talked about care, maintenance and sterilisation of the new kit. We talked about keeping a logbook tracking the use of the new equipment to assess how helpful it had been to their practice. We discussed some of the difficult airway cases they had encountered and how they had managed them. They are the experts in their environment and we learnt from them.

The consultants returned to cover the theatre work in the afternoon (1300-1500) allowing us to continue further registrar training. Hands-on practical training again took place in an empty theatre. Anaesthetic machine check, cardiac arrhythmia recognition, basic and advanced life support and cardiac defibrillation were covered. Safe use of their theatre defibrillator was practised.

At 1600 a formal 'handover of equipment ceremony' in the theatre tearoom took place. Ms Natalia Hepp, from the Royal Australasian College of Surgeons was present along with Dr Rooney Jagilly, the hospital superintendent as well as a Department of Foreign Affairs and Trade representative, the anaesthetic department, senior nursing staff and a reporter from the local newspaper.

Informal discussion with the three consultants occurred around further development of a long-term collaborative partnership between the Anaesthetic Department of RDH and Solomon Islands Anaesthetic Training Centre (ATC) supported by the Australian Society of Anaesthetists and Royal Australasian College of Surgeons. The three consultants are extremely busy providing clinical anaesthetic services at NRH and would appreciate assistance with training their future anaesthetic providers. A plan was formulated where we could send written exam questions via email to the registrars sitting their diploma. They can email their answers to Darwin where we can mark them – a small but helpful step. Longer term plans includes providing viva practice using Skype, as NRH is in the process of upgrading its internet access.

Dr Agiomea was keen to have us return within six months to continue to assist registrar training and evaluate how the equipment has been used.

Dr Agiomea has accepted an invitation to travel to Royal Darwin Hospital to speak at the next ASA Real World Anaesthetic Course (RWAC) in October 2018. Funding for this will be covered by course participant registration and will be cost neutral.

We had an informal discussion with Dr Scott Siota and Dr Agiomea about the current staffing situation at NRH. The number of surgeons, anaesthetists and obstetricians in the SI continue to be hugely inadequate for the rapidly growing population. The population of the SI

REAL WORLD ANAESTHESIA COURSE (RWAC)

17 - 21 September 2018 • Royal Darwin Hospital, Australia

This is the 27th Australian course and the sixth to be held in Darwin.

The aim of RWAC is to prepare anaesthetists for work in low and middle income countries ("the real world') in a variety of humanitarian aid situations. The course consists of a series of interactive lectures, case based discussions, hands on practical equipment sessions and in-theatre teaching of drawover anaesthesia.

Some topics covered include:

- Drawover equipment
- Equipment maintenance
- Oxygen supply
- Electrical supply
- Ketamine and halothane
- Psychological adaption to austere environments
- The good , the bad and the ugly of humanitarian aid

The number of participants is limited to 18 to maximise interaction and hands-on learning. The course has regularly been oversubscribed in the past, so to be fair, places are allocated on a "first in first on" basis. Application forms are available from on the ASA website (asa.org.au).

The course cost is AUD$3300 (including GST) and is payable if your application is successful. Applications open on Monday, 12 March 2018.

For further information please contact:
Dr Phil Blum
philip.blum@nt.gov.au
Darwin RWAC course convenor
Royal Darwin Hospital

ASA
Australian Society of Anaesthetists

New Zealand Society of Anaesthetists
(Incorporated)

NATIONAL CRITICAL CARE AND TRAUMA RESPONSE CENTRE

FEATURE


Dr Andrew Fenton, Dr Kaeni Agiomea, Dr Jack Puti and Dr Bata Anigafutu


Dr Kaeni Agiomea, Dr Bata Anigafutu, Dr Phil Blum and Dr Jack Puti (back)

has doubled from 300,000 in the early 1990s, when the ASA became involved in teaching in the Solomon Islands, to 600,000 today. The number of theatres at NRH has not changed in that time. There are still only three theatres and an extreme lack of space for patient care, storage of equipment and teaching. There are three other provincial hospitals in the Solomon Islands. There is one surgeon and a GP anaesthetist on Malaita, the second most populous island (population 200,000), doing basic surgery. The other two provincial hospitals (Buala, Gizo) are staffed by GPs and can provide an emergency caesarean section service using spinal anaesthesia and ketamine for minor surgery. The surgeons, anaesthetists and obstetricians (SAO) ratio per 100,000 population is currently only approximately two. The target WHO SAO ratio is 20. Access to safe surgery and anaesthesia in a timely manner remain unavailable for the majority of the population of the Solomon Islands. High level efforts to convince the Solomon Islands Ministry of Health of the significant public health and economic benefits of adequately funded surgical and anaesthetic care must continue.

Funding was provided by the ASA to purchase the adult and paediatric manikins. RACS/DFAT provided funding to purchase the Storz Cmac videolaryngoscope, Ambu intubating bronchoscope and screen. RACS covered airflight costs for the team members between Brisbane and Honiara.

Many thanks to Dr Chris Bowden, Chair of ASA ODEC, Dr Rob McDougall and Dr Haydn Perndt for their tireless behind-the-scene efforts to secure funding for the equipment. The visit would not have been possible without their efforts.

Dr Phil Blum FANZCA
Senior Staff Anaesthetist, Royal Darwin Hospital (RDH), ANZCA final examiner

Dr Andrew Fenton FANZCA
Deputy Director, Department Anaesthesia, RDH, University PNG Diploma and Masters pre-exam revision tutor


Western Province, Solomon Islands


Two days by boat to the capital Honiara

FEATURE

THE TEN As – TEACHING ANAESTHESIA TO NURSES IN EAST AFRICA

'A' is for atropine; I also called it Vitamin A as it is an essential part of every anaesthetic given at the Bugando Medical Centre (BMC) in Mwanza, Tanzania. My Tanzanian experience can be described as the 'ten As' which helped shape my four-and-a-half years there.

My (medical) wife and I volunteered to work at this hospital through connections my wife made at a mental health and missions conference in Indiana, USA. Our daughter had married a Tanzanian doctor, who was completing his training as a physician at BMC, and we were soon boarding a plane to East Africa. Mwanza is the capital of the Lake Zone, so named because it is situated on the south-eastern corner of Lake Victoria. BMC sits on the top of a hill so it is easily visible as the tertiary referral centre for the north-western region of Tanzania. The catchment area population is approximately 14 million people. The hospital, constructed by Israeli and German builders in the 1970s, is now run by the government in partnership with the Catholic Church: http://bugandomedicalcentre.go.tz/ & http://bugando.ac.tz/

Until very recently, anaesthesia in Tanzania has been managed by nurses who undertake a one-year certificate course at one of three accredited sites. Over the past 18 months, with assistance from a variety of international visitors, a standard national curriculum has been written and plans to introduce a three year course are well advanced.

Now that the number of doctors graduating from Tanzanian universities has increased, more medical graduates are looking at careers in anaesthesia and critical care. The existing graduates tend to cluster around the big cities, leaving the district and rural hospital anaesthetic services to be delivered by nurse anaesthetists. This means that nurses will need to be trained for many years to come, and there is as yet no system for the nursing colleges to train their own students in anaesthesia and critical care.

My job training nurse anaesthetists commenced in October 2012 as a volunteer with an open job description. I was warmly welcomed by Dr Michael Matasha, who had been head of the anaesthetic department for many years. Sporadic visits from 'Westerners' had

helped with teaching and professional development. As a Mzungu (white person) visitor it took me a while to realise that Tanzanian medicine works like the rest of the culture, i.e. it is based on relationships. To achieve goals (which in my Mzungu way I regularly listed) such as breaking the 'addiction' to atropine, I learned that I would depend heavily on these relationships. By the time Dr Matasha retired, atropine still had a high profile, but we had developed a rapport which enabled the teaching program to progress. Dr Matasha's place was taken by Dr Benard Kenemo, whose youthful energy will be necessary to tackle the ever increasing demands being placed on the departments of anaesthesia and intensive care across Africa.

My teaching day began at 7am in the recovery ward, where the trainees gathered after having reviewed the elective cases for the day. Tanzanians come to work early without breakfast and then break about 10.30am for chai. Needless to say, I had to have my porridge (ugali) at home before starting work. The early morning session was an opportunity for the trainees to learn how to speak in front of their peers and for me to discuss with them aspects of anaesthetic management. Unlike the educational practices we are used to, these students are not encouraged to speak in class nor to ask questions so it was challenging for them to present cases in English, their second language. The surgical case load was fairly predictable, sometimes interrupted by the presence of visiting overseas specialty surgical teams or the description of an unfortunate hippo victim who had been fatally bitten in the abdomen. BMC also serves as the tertiary referral centre for ENT, orthopaedic and obstetric fistula surgery. We saw a lot of surgery for goitre, hydrocephalus and neural tube disorders. The most common operation by far was caesarean section, managed under spinal anaesthesia in the majority of cases.

Class of 2015

Patients at BMC

Rural hospital surgical ward

Draw-over circuit

Walk to work

FEATURE

Reunion with past students at a conference in Dar es Salaam, Tanzania

The second 'A' is for audit. In developed countries we have come to accept the audit process as a valuable teaching tool and a way to improve our performance. In 2012 the Department of Medicine had succeeded in running audit sessions. By early 2017 the O&G and surgical departments were also running audits. This concept was not easy for East Africans to embrace due to cultural factors where the fear of 'shame and blame' is very real. The concept of who (or what) was responsible for the outcome in episodes of patient care was threatening. By the time I left in February 2017, the anaesthetic department was not running audit sessions, however, with the increasing number of local medical graduates now training in anaesthesia the time is hopefully not too far away.

The next 'A' is for airway, now such an important part of training in the developed world and a vital component of our CPD. Anaesthetic nurses are taught about airway assessment (Mallampati) however have little access to devices such as the LMA and no access to video-laryngoscopes or surgical airway kits. However the older, very experienced nurse anaesthetists could intubate many of the difficult airways that were encountered.

'A' is also for analgesia. The introduction of effective pain management (EPM) in Western Tanzania has been very slow. There is a great reluctance to use opioids, pethidine being the drug of choice (if it is available). Fear of addiction, regularity of supply and the cost are important barriers. Post-operative pain relief was often not charted. However I am optimistic that the increasing numbers of doctors working in the specialty will permit the introduction of EPM in a safe manner, to the benefit of thousands of surgical patients each year.

The fifth 'A' is for angst. For teaching to succeed there has to be a teacher, a classroom and resources such as computers and data projectors. Like the rain and the crops in Tanzania, these entities do not necessarily coincide, so a lot of teaching time is lost. After some negotiations (worthy of the UN General Assembly), I eventually managed to ensure the provision of our own departmental data projector at the time the lectures were scheduled. Anaesthesia has not had a high profile in East Africa so other departments' needs often took priority.

Another 'A' is for appropriate teaching material. We made good use of the textbook 'Safe Anaesthesia', although we did not always have enough copies for the increasing number of students. The author (Dr Jean Lees) kindly allowed me to use the electronic version free of charge, enabling students to read the text on their smart phones and on the hospital library computers. Anaesthetic and nursing text books written for the developed world are too difficult for the nurse trainees, so the material has to be considerably simplified. In addition, these students had been exposed mostly to classroom teaching with chalk and blackboard, so being confronted with Powerpoint slides is a big challenge.

The next 'A' is for achievement. We did not have the resources to grade the students so it was pass or fail. Those who achieved a pass had to overcome many barriers and could truly be described as resilient. Some of these barriers included language and funding. Postgraduate nursing training in Tanzania is undertaken in English. For many students, especially those from the remote regions and those a bit older, language was the chief obstacle to their learning. Some quit after a few weeks for this reason. Others struggled on even though we knew that they could never pass the examinations at the end of the course.

Funding was another barrier to course completion. Many students started with a promise of funding from their 'sending' hospital. Often the money never arrived and sadly the students had to quit. On one occasion the hospital catering

contract was renewed, suddenly leaving the students without enough money to purchase their lunch, the main (and often only) meal of the day.

Students who failed were given the option of staying on for another six months to improve their grades; an offer not often accepted as their 'sending' hospital wanted them back and would certainly not want to pay any more fees. Wages and conditions for anaesthetic nurses in Tanzania are not attractive, so there are always some who do not continue in the job. Others enjoyed the course so much that they undertook further study if they could afford the course fees.

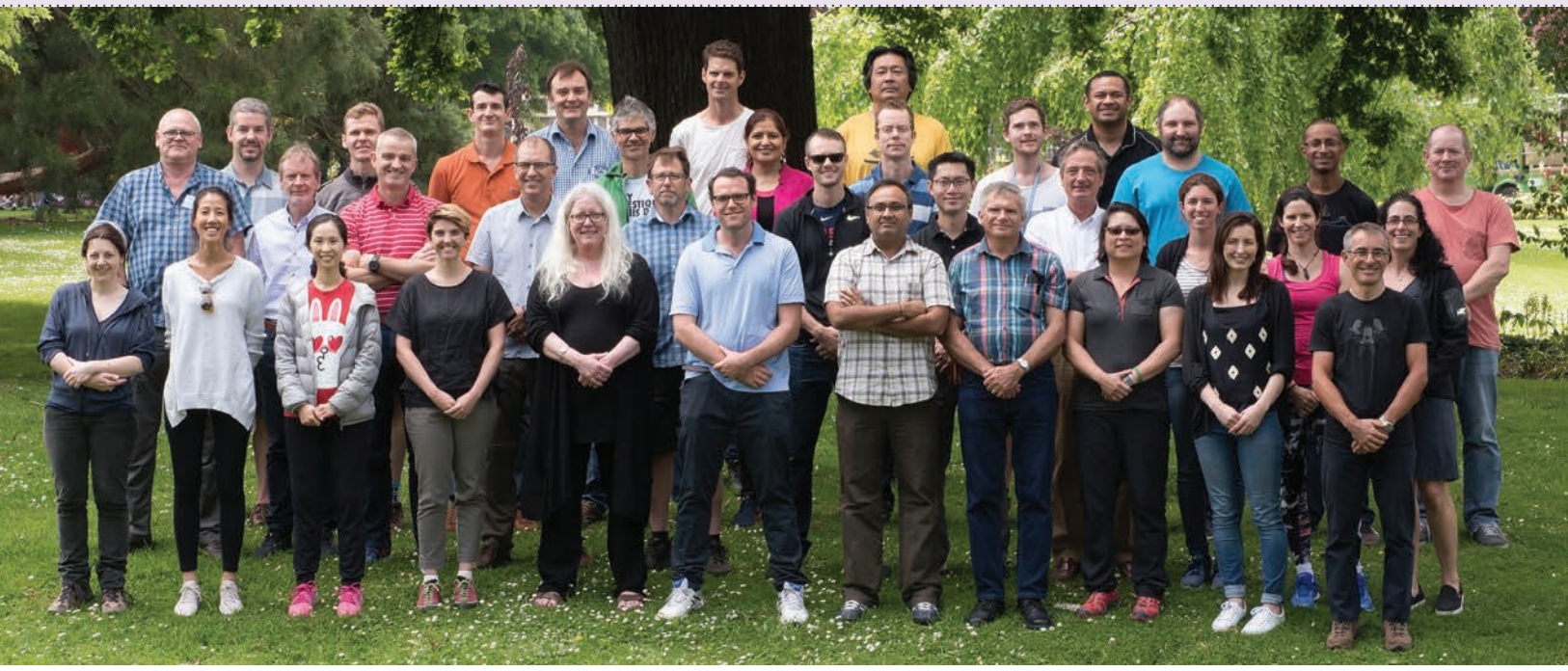
The next 'A' is for access. There are many challenges for Mzungus living in low and middle income countries. From September 2016 up to early February 2017, the dirt road connecting our compound property to the rest of the world was reconstructed. This required the building of drains at the sides of the road then paving the entire road surface with bricks – completely done by hand. For most of this time we could not drive our car out of the compound. If we did drive out there was no guarantee that we could get back in! Fortunately we lived within walking distance of the hospital and the long rains were delayed. Excursions were few and visitors rare.

The penultimate 'A' is for 'absolutely amazing'. The gratitude and generosity of the students, who usually could not afford more than one meal each day, will never be forgotten as they farewelled me at the end of February 2017. My wardrobe now boasts a collection of vibrantly coloured shirts, with our tables covered by Maasai cloth, resembling the tartan of the Scottish clan I hail from.

The final 'A' is for action. The task has really only just begun; the curriculum is written, the text books and a bank of examination questions available. Are you ready to contribute?

Dr Derrick Selby
January, 2018

FEATURE



REAL WORLD ANAESTHESIA COURSE

OCTOBER 30-NOVEMBER 3, 2017

I was able to tick an item off my bucket list this year, having managed to get a place on this year's (2017) Real World Anaesthesia Course (RWAC), held in Christchurch from October 30 to November 3. It was everything I hoped it would be and then some.

This course was first held in Hobart in 1999 by Drs George Merridew and Haydn Perndt, with the fearsome moniker of Remote Situations, Difficult Circumstances, Developing Country Anaesthesia Course, a title retained until 2004. Having evolved into the Real World Anaesthesia Course, it rotates on an annual basis between Christchurch, Darwin and Frankston. This year's course was the third held in Christchurch.

My personal motivation for wanting to attend this course was an uncomfortable awareness of the dependence of my skills on electricity and compressed gas. More recently I have become a Board member of the John James Foundation in the ACT, which as part of its charity work sends surgical and educational missions to the Solomon Islands; I was fortunate enough to anaesthetise for a week-long gynaecological mission to Honiara in 2016. My future involvement in such work is something I'm now considering.

The RWAC is an intensive five-day course involving lectures, theatre sessions, workshops and discussion groups. The first two days start at 0700 to allow demonstration of the workings of the drawover systems before heading to theatre at 0800. On the first day, there I was doing a gas induction at 0800 with sevoflurane using the Diamedica Portable Anaesthesia System (and it went very nicely, too!). Over the first few days, we got to examine and use a variety of drawover systems, and take apart and put together the vaporisers and circuits.

The course covered a wide range of technical, ethical, medical and personal subjects. Technical sessions included drawover apparatus, oxygen supplies and concentrators, vaporiser and Boyles' machine maintenance, electrical safety, and cleaning and sterilisation. Ethical matters included consideration of whether all aid is good aid, followed by discussion groups featuring various ethical dilemmas. Practical and medical sessions included anaesthetic management of paediatric and obstetric patients, anaesthetic drug choices, pain management, intensive care, tropical medicine, teaching,

disaster assistance, and trip preparation. Personal issues such as the psychology of adaptation, living and working in the real world, and how to make it happen, were complemented by end-of-day reflections from members of the faculty describing aspects of their own experience in overseas aid.

The faculty, almost as numerous as the students, brought a vast breadth and depth of experience to bear, generously sharing their knowledge, insights and wisdom, as well as the personal gains and challenges in their own journeys providing anaesthesia in low- and middle-income countries around the globe. These people embody altruism, passion, humility and humour. The Course Convenor was Dr Wayne Morriss, with anaesthetist instructors Drs Chris Bowden, Tony Diprose, Faye Evans, Ron Pereira, Indu Kapoor, Phil Blum, Justin Burke, Eric Vreede, Maurice Lee, David Pescod and Shem Bavou. We were also fortunate to have as instructors biomedical engineers Steve Threlfo and Robert Neighbour.

This year saw the introduction of a simulation session, which from all reports was very successful and brought together many aspects of work in an unfamiliar environment with limited resources. There were two scenarios – a bleeding obstetric patient (every anaesthetist's nightmare) and a case in a theatre with unreliable equipment (enough said!).

A course of this nature is necessarily intrusive on the workings of the department hosting it. Drs James Dalby-Ball, Bryce Curran and Dan Hartwell, ably supported by Sally Gelton Smith, worked tirelessly to make the week happen. A big thankyou to the members of the Department of Anaesthesia at Christchurch Hospital, who tiptoed around us all week without making us feel unwelcome or a nuisance. Ditto to the operating theatre staff and surgeons, not to mention the patients who allowed us to practise on them.

The course is limited to 18 students. Most were anaesthetists, but we also had one intensivist, and a number of trainees and provisional fellows. The majority were Australian, with a few New Zealanders, and one participant from Hong Kong. There was a great vibe amongst the faculty and students with lively conversation during all the meal breaks.

The social functions included a welcome dinner on the Sunday night, which was held at a funky city Indian restaurant, and the Course dinner on the Thursday night, a little more formal at a local hotel, where students were presented with a certificate of participation and an RWAC 2017 coffee mug. The Wednesday afternoon excursion began with a euphemistically-termed gentle stroll, which offered breathtaking (and, in my afraid-of-heights case, heartstopping) scenery of the coast and city of Christchurch; following this was a 'Clip'n'Climb' session, where the more energetic members of the faculty and student body climbed walls of varying difficulty, and a few reckless souls took on the 'Leap of Faith', throwing themselves off a platform 10 m in the air out to catch a trapeze. The afternoon wrapped up with a wine-tasting session featuring wines from the Marlborough district.

I highly recommend this course to anyone considering an overseas placement in a low- to middle-income country. This course is also extremely valuable for senior trainees and provisional fellows. As a College Examiner, I warn Second Part candidates that I can feel some multiple choice questions coming on…

Dr Linda Weber

Indu Kapoor on the 'clip 'n' climb'

Students on lunch break

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FEATURE

Apothecary, c1906, Adler Museum of Medicine, Johannesburg Academic Hospital, South Africa

MEDICINE, MEDICAL AND MILITARY HISTORY TOUR OF SOUTH AFRICA

In January I had the pleasure of leading 20 medical and allied health colleagues on a tour of South Africa. The aim was to combine an exciting African holiday with opportunities to learn about the challenges of medical care in a rapidly changing country, and to visit major hospitals, medical and military museums, and Anglo-Zulu War and Boer War battlefields.

Baragwanath Hospital in Soweto began as an Allied military hospital in 1942, and now serves an estimated three million people. It is said to be the third largest in the world; 3,200 beds, 6,800 staff, 150,000 inpatients/year, 350 emergencies/day, 160 gunshots/month. The modern, well-equipped adult and paediatric burns units have highly competent staff, with impressive standards of care. Electrical burns are common, incurred while stealing copper electrical cables. Many of the children we saw had extensive burns from kerosene, used for cooking and lighting. Necklacing (a tyre filled with rags and petrol forced down around a victim's chest and arms, then set alight) still occurs, although less frequently than during 'the struggle' to bring down apartheid. Necklacing and kerosene both cause extensive surface burns, as well as inhalational airway burns from aspiration of super-heated gas and flames. Former South African anaesthetists will remember these well!

There are separate medical, paediatric and surgical emergency departments. The 'surgical pit' and resuscitation unit are manned not by emergency medicine physicians but by surgeons, providing continuity of care from admission to triage, resuscitation, and surgery. The 15-bed resuscitation unit handles over 5,000 resuscitations/year, and performed 5,000 x-rays/year within the unit – until told they could not operate their x-ray machine.

Johannesburg Academic Hospital's Adler Museum of Medicine houses a treasure trove of medical equipment, an early 1900s apothecary and a dental suite, and displays of traditional African medical practitioners, or witchdoctors. The sangoma reads the neck bones of a chicken or perhaps the entrails of a goat, sees the future, and casts spells for good or evil. He or she can send a tokoloshe, a small spirit being, to deliver harm. The inyanga dispenses medicines for all ails, some benign, some beneficial, some lethal; 'Spirits of Life', caustic soda,

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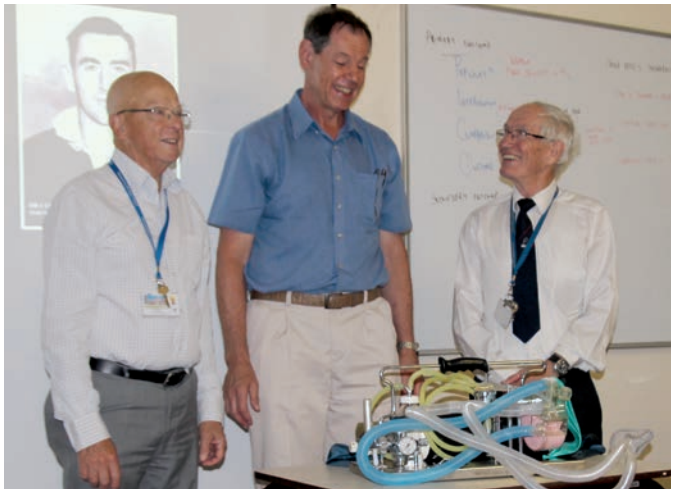

Far left: Presentation of Komesaroff Resuscitator; Prof Mike James, Dr Paul Luckin and Prof Peter Gordon

Left: Presentation of the ASA Medallion to Prof Peter Gordon by Dr Paul Luckin

causes oesophageal burns, stricture, and usually death. It is not unusual to see a witchdoctor within the wards; traditional and modern co-exist.

On the battlefield at Isandlwhana we found where Surgeon Major Peter Shepherd fell in 1879, when the British Army was defeated by a Zulu army. Peter Shepherd took the Prussian surgeon von Esmarch's principles of battlefield medical aid, included medical emergencies, and adapted them to teach civilians. He first used the English term "First Aid for the Injured"[1], conducting the first public first aid classes. Shepherd, evacuating an ambulance wagon of wounded, was speared when he dismounted to assist a wounded trooper. His notes were published, and soon taught throughout Britain by the newly-formed St John Ambulance.

Groote Schuur Hospital in Cape Town houses the Nagin Parbhoo History of Anaesthesia Museum, with equipment dating from 1847 – one year after Morton's use of ether. Surprisingly, many pieces have an Australian connection, such as Dr Anthony Cohen and his Minivent[2]. Our hosts were Emeritus Professors Peter Gordon (curator) and Mike James (Chair, Scientific Committee, 2008 World Congress), both well known to many Australian anaesthetists.

On behalf of Ian Donaldson, curator of the Ambulance Service Melbourne Museum, I presented the museum with a Komesaroff Resuscitator. Dr David Komesaroff, anaesthetist, engineer, and Hon Senior Anaesthetist, Ambulance Service Melbourne, taught me endo-tracheal intubation as a paramedic in the early '70s. He designed the resuscitator for pre-hospital and disaster resuscitation and analgesia[3]. It incorporates low flow oxygen with a CO_2 absorber and a methoxyflurane vapouriser. It was used in Melbourne's Mobile Intensive Care Ambulances from 1972 onwards. Dr Brian Pezzutti recently referred to the role of anaesthetists in training paramedics[4].

Groote Schuur also houses the Heart of the Cape Museum, with tableaux in the theatres where Professor Christiaan Barnard performed the first human to human heart transplant in 1967. The anaesthetist, Dr Joseph Ozinsky, used a technique of thiopentone and suxamethonium, nitrous oxide, oxygen and halothane, without opiates or non-depolarisers. (Pethidine 25 mg IM was given post-operatively to suppress shivering)[5]. The recipient survived for 18 days, dying of pneumonia but with a functioning donor heart.

On behalf of the President of the ASA, Dr David M. Scott, I presented Emeritus Professor Peter Gordon with a medallion bearing the insignia of the ASA. The presentation honours the collegial relationship between the Australian Society of Anaesthetists and the South African Society of Anaesthesiologists – the term was adopted some years ago, and is currently being discussed in Australia.

An extensive and stimulating academic programme of formal and informal presentations added interest and value to the professional aspects of the tour. We also visited game reserves in South Africa and Swaziland, with sightings of leopard, cheetah, lion, elephant, giraffe, many species of antelope and bird, and other game. Waking early to find zebra, warthog and blesbok grazing beside your traditional Swazi grass hut is a memorable experience!

Dr Paul Luckin AM FANZCA

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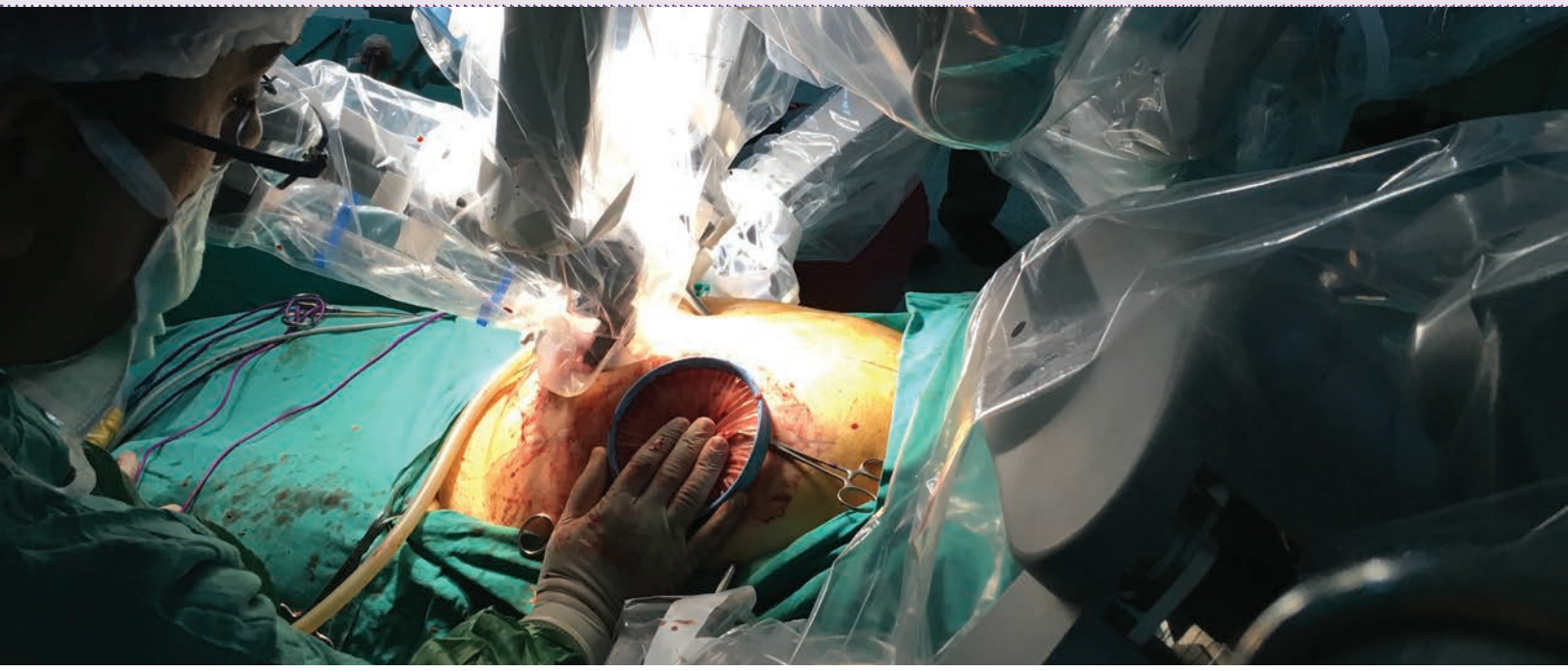
FEATURE



ANAESTHESIA EX MACHINA – WILL ROBOTS TAKE OUR JOBS?

Technology is the greatest workforce disruptor the world has ever seen. People have feared the loss of jobs brought by automation since at least the early 19th century, when the original Luddites destroyed mechanised looms[1].

Mainstream and social media now serve us endless stories on the mechanisation of work traditionally done by humans – 'Almost 40 per cent of Australian jobs could be replaced by technology by 2025'[2], 'How To Keep Your Job When Robots Take Over'[3], 'Vending machines can do a pharmacist's job'[4]. Yet, throughout all of this, economists have reassured workers that new jobs would be created as others become obsolete. So far, they've been right; however, it's far from certain that this trend will continue.

Even some highly skilled roles could become redundant over the next decade. A 2015 report from the Committee for Economic Development of Australia (CEDA) found a "high probability" that more than five million Australian jobs will be replaced by automation within 10 to 20 years[5]. While the greatest risk is faced by those working positions with "low levels of social interaction, low levels of creativity, or low levels of mobility and dexterity," the health sector is also thought to be set for significant technological disruption – akin to the overhauls already seen in agriculture, manufacturing and mining[2]. The rapid progress of clinical data systems, wearable health technology, predictive diagnostics, surgical robotics and computerised pharmaceutical dispensaries are indicators of the headway being made in the mechanisation of healthcare.

Silicon Valley investor Vinod Khosla predicted that technology will soon replace all but "the best 20% of the human breed doctors" due to their superior speed, accuracy, objectivity and cost[6]. The potential for computers to be pre-programmed with a comprehensive library of medical texts offers a significant advantage over human clinicians. Factoring in the ability to rapidly learn new information and to regularly update its knowledge based on the latest research, an electronic database has a number of critical benefits. Even when it comes to understanding natural language, artificial intelligence is rapidly catching up to us: IBM's Watson computing system utilises linguistic algorithms to differentiate the meaning of words and phrases based on contextual nuances and idioms, allowing it to rapidly evaluate large volumes of unstructured data to determine meaning and emotion[5]. Watson can learn and adapt to new data throughout the process, opening up endless possibilities for new functions. Digital health software might initially provide 'bionic assistance'

FEATURE

to doctors, then offer referrals and give second opinions on diagnosis and treatment, and ultimately provide independent medical services. Eventually, Khosla claimed, human doctors may be completed superseded by 'Doctor Algorithm', though each step towards this will likely face significant opposition and criticism.

Conversely, medical futurist Dr Bertalan Meskó suggests that technology won't replace doctors. Rather, it will help us focus on the heart and soul of medicine – treating patients and innovating – while computers, machines and artificial intelligence perform the menial and repetitive roles[7]. Tasks that require no creativity or empathy will be the earliest and simplest for technology to perform. Gathering basic data, providing routine education and instructions, completing paperwork – these will offer an easy 'foot in the door' as most medical practitioners will gladly offload such work. Essentially, machines will be our interns. They can already make coffee, after all.

"As an example, consider the medical profession. A proportion of each doctor's time is spent examining patients, ordering tests and performing diagnoses. Consider a world where patients are constantly being monitored by biosensors on their bodies and the data from those sensors is being assessed in real-time by machine-learning algorithms looking for anomalies, and diagnosis is performed by a Watson-like computer. Under these circumstances, the number of patients each physician can deal with will rise and thus there will be a need for fewer physicians per head of population than today. Furthermore, the major demand on a physician's time will not be technical skill but social intelligence, leading to the need for different selection processes and different skillsets to be taught to medical students."

Committee for Economic Development of Australia[5]

Not all areas of healthcare are equally vulnerable to technological disruption. Radiology is perhaps one of the specialties most at risk of losing scope of practice to technology. Artificial intelligence systems are increasingly capable of recognising complex patterns and subtle differences between images. With the growing potential of machine-learning algorithms, their diagnostic sensitivity and interpretational accuracy will soon exceed that of human clinicians for many imaging modalities. Medical Sieve, for example, is a 'cognitive assistant' from IBM capable of rapidly analysing radiological images and employing analytical processes to filter significant information and reduce the number of images needing to be reviewed by a radiologist[8].

TECHNOLOGY AND ANAESTHESIA

Overall, anaesthesia has tended to embrace innovation and technology. Our specialty is a leader in advancing patient safety and improving the quality and efficiency of the care we deliver. Many of the gains we have made in these areas are attributable to technological advances. In particular, the complex equipment we use on a daily basis for delivering anaesthesia and monitoring patients has evolved rapidly in recent decades. Consider the programmable target-controlled Infusion pumps used for intravenous anaesthesia and the widespread use of simple processed EEG devices to assist in monitoring depth of anaesthesia. Electronic anaesthetic records are a prime example of the application of technology to improve accuracy and reduce the cognitive load on clinicians, though it's surprising that they haven't been more widely adopted in the interest of patient safety and quality of care.

So, how susceptible is anaesthesia to digital disruption? For better or worse, machines could foreseeably perform a number of tasks currently within our domain. Studies have already demonstrated the feasibility of computer-based decision trees in gathering preoperative assessment data[9]. It would be a small step to link these systems to personal health tracking technology and electronic health databases to produce a comprehensive pre-anaesthetic record. This data could then be run through a series of predictive algorithms to assess perioperative risk (based on existing scores, such as the American College of Surgeons NSQIP Surgical Risk Calculator[10]) with outcomes continuously fed back to improve the algorithms.

…one can at least imagine the possibility of a robot able to utilise ultrasonic imaging to guide vascular access and regional anaesthesia.

In the operating suite, electronic systems can already produce detailed summaries of intraoperative measurements. While still many years away, one can at least imagine the possibility of a robot able to utilise ultrasonic imaging to guide vascular access and regional anaesthesia. Similarly, a computer could plausibly titrate and deliver drugs and fluids based on patient variables and continuous physiological monitoring (at least for young healthy patients who typically receive drugs 'titrated' over half a second). Airway management, though generally not too technically complex for a machine to feasibly perform, would require overcoming a particularly large cognitive barrier to be acceptable to patients and clinicians and is perhaps one of the final procedural tasks we might relinquish.

What anaesthetic roles will technology not take over? Discounting the Asimov-esque potential for sufficiently advanced artificial intelligence and robotic technology to eventually be indistinguishable from humans, there are some distinctly human roles performed by anaesthetists. It's hard to imagine a machine making a meaningful emotional connection with a patient, developing

rapport and providing comfort and reassurance through the perioperative journey. However, while these important tasks may continue to require a human worker, they don't necessarily require a highly-educated and highly-trained medical professional. Indeed, some might consider these skills traditionally more in line with nursing than medical practice.

Undertaking original clinical research is also only a fairly distant possibility for mechanisation. With current technology, it would already be possible to develop algorithms to identify gaps in the existing knowledge base and find research questions that have been posed but lack high quality data. It wouldn't take a great leap for a computer to then develop a research plan based on these areas of interest. Actually gathering new data presents a more challenging task though, except where the data can be readily retrieved from an existing database – a situation likely to become more common with time.

Many other non-clinical roles are at least theoretically open to technological disruption. Teaching has been growing ever more digital in recent years, for example through online lectures, electronic examinations and educational apps. Embracing this could further increase the reach of each educator and thus reduce staff requirements – does every medical school in Australia really need a completely separate teaching faculty? Rostering would be perfectly amenable to computerisation, which could readily generate allocations based on leave, experience, preferences and supervision requirements. Digital assistants can respond to emails and manage appointments. Recording and auditing clinical practice could be undertaken by digital systems, with results easily pooled by department, institution, region, nationally or globally. The potential is endless.

CONCLUSIONS

Technological disruption of healthcare is inevitable. It would be naïve to believe that our work as anaesthetists will be immune to these changes. In 20 or 30 years our job is likely to look vastly different from today. Burying our heads in the sands of technophobia and protectionism will help neither us nor our patients. The disruption of other industries has taught us that those of us who fail to be aware of the changing nature of work will be left behind, while those who embrace new developments will continue to succeed. Historically, technology has been a net job creator[3], though there are always those who lose (or willingly leave) their jobs due to the changes.

The digital health revolution will open the door for incredible new opportunities to increase healthcare quality, efficiency and access. Technology has already made significant inroads into these areas, including through electronic medical record systems, electronic anaesthetic records and digital radiology software. Our responsibility, for the benefit of our patients, is to carefully observe the changing landscape of healthcare, objectively consider each new development and embrace those that provide real benefits. We should avoid carelessly embracing novel technology in the name of progress though, as some politicians and executives seem prone to do. We should constantly review which tasks we relinquish to technology and whether it truly offers superior safety, quality, efficiency and costs. Reducing the need for doctors to perform menial tasks holds promise in improving efficiency and boosting societal return-on-investment for time and resources spent educating and training medical practitioners by allowing us to focus on work that truly demands our level of knowledge and skill.

Richard Seglenieks
Chair, Trainee Members Group

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REGULAR

WEBAIRS NEWS

Professor Neville Gibbs retired from the position of Chair of ANZTADC in December 2017. ANZTADC is grateful for his outstanding contribution and the achievements made under his leadership. Prof Gibbs oversaw the streamlining of the webAIRS ethics approval process and formation of the publications group. He was instrumental to the analysis process for the first 4,000 incident reports to webAIRS. Numbers of registered sites and reports increased substantially under Prof Gibb's leadership of ANZTADC – the sites growth is a testament to his leadership and management.

If you haven't visited webAIRS of late you may notice some changes. It is now possible to track the number of sites and incidents on the Homepage www.anztadc.net as well as access recent publications via the green quick link buttons.

Also accessed via a green quick link button (that of 'Incidents') is graphic display of the main categories of bi-national incident reports. Site local administrators are able to drill down further to view the subcategories of local incident reports. Local administrators will also note that the Review Incidents tool has been extended. It is intended that this tool support the presentation and analysis of incidents at local morbidity and mortality meetings.

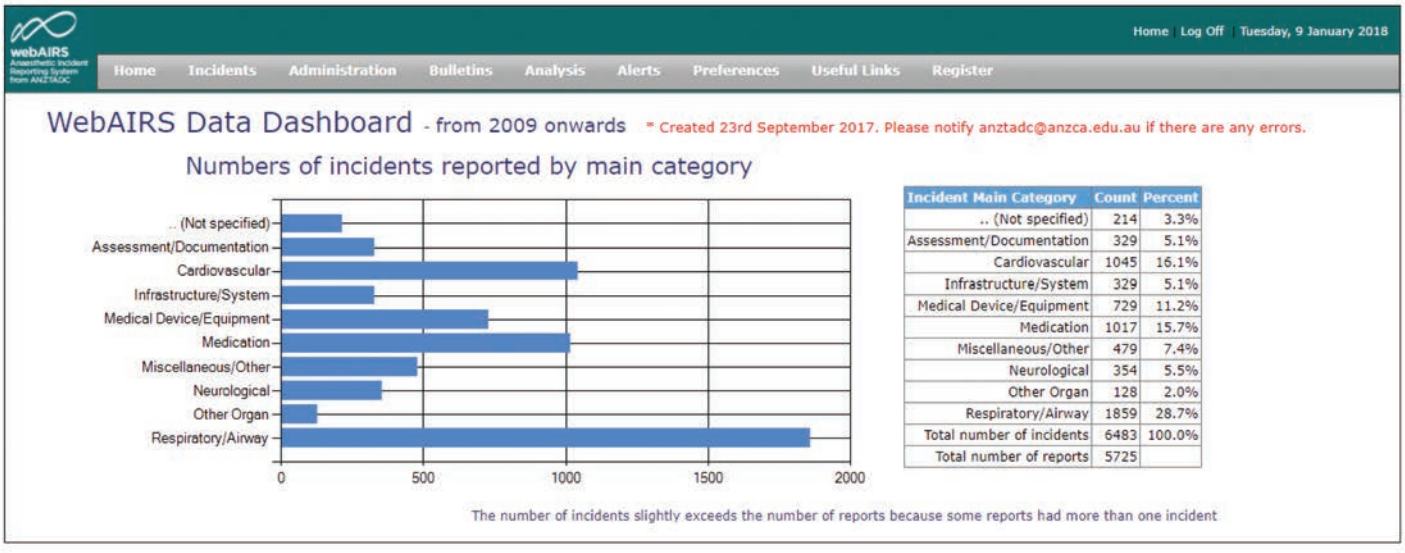
A preview of features is available for all webAIRS users on the webAIRS Frequently Asked Questions pages.

webAIRS is undergoing constant evolvement, and it is feedback from users that drives this. Please send any ideas for improvement that you may have to: anztadc@anzca.edu.au

M. Culwick
ANZTADC Medical Director

P. Peach
ANZTADC Chair

S. Walker
ANZTADC Co-ordinator



Incident Main Category	Count	Percent
.. (Not specified)	214	3.3%
Assessment/Documentation	329	5.1%
Cardiovascular	1045	16.1%
Infrastructure/System	329	5.1%
Medical Device/Equipment	729	11.2%
Medication	1017	15.7%
Miscellaneous/Other	479	7.4%
Neurological	354	5.5%
Other Organ	128	2.0%
Respiratory/Airway	1859	28.7%
Total number of incidents	6483	100.0%
Total number of reports	5725	

POLICY UPDATE

REVALIDATION: MEDICAL BOARD TO INTRODUCE NEW PROFESSIONAL PERFORMANCE FRAMEWORK FOR CPD

In November, the Australian Society of Anaesthetists attended the Medical Board of Australia Stakeholder Briefing for the unveiling of the final report and recommendations on revalidation by the Expert Advisory Group (EAG). In response, the Medical Board of Australia has proposed the new Professional Performance Framework[1]. This Framework will comprise of five pillars as shown in the figure. It aims to maintain and enhance the performance of practising practitioners; and reduce the risk and preventing harm to the community.

The report by the EAG flagged inconsistencies in the quality, accessibility and requirements of CPD for medical practitioners as aspects that needed improvement. In order to boost and strengthen CPD, a number of provisions were recommended to the Medical Board. These include the completion of at least 50 hours of CPD per year at an accredited 'CPD home', the development of a Personal Professional Development Plan to outline the current scope of practice and document the individual professional development needs with a mixture of activities the medical practitioner plans to undertake.

The EAG also identified factors that underpin poor performance to include individual risk factors, practice context, and the underdeveloped fragmented health system and its culture.

Individual and practice risk factors were highlighted to be:

- Older age – physical and cognitive factors associated with increasing age may contribute to the decline of clinical performance and reduced patient outcomes. In managing this, it is proposed that doctors aged 70 years and every three years thereafter will be required to undertake confidential health checks and cognitive screening tests.
- Complaint-prone – EAG observed that nearly half of the complaints received were attributed to only 3% of doctors, indicating that early intervention was needed to prevent escalation of future complaints. It is proposed that those at-risk doctors will be more closely assessed for patterns and frequency of complaints about poor performance to identify potential unsafe practice.
- Professional isolation – practitioners whom worked in collegially unsupported environments, such as in part-time, after-hours, locum work, tend to be under-performing. To foster a supportive and positive practice environment, it is proposed that CPD activities for individual practitioners will be strengthened to proactively mitigate the risks of isolated practice.

It was acknowledged that the current systems for identification of poor performance and remediation were fragmented and underdeveloped. Highlighting these risk factors encourages "upstream identification and action" whereby early proactive identification of poor performance can be intervened by peer groups in the workplace.

There will be an emphasis on the accessibility of 'large data', as the Board will be working towards unifying patient outcome data from different sources, such as health departments, Medicare, hospitals and clinical registries, to support individual clinicians' audit and reflective CPD activities.

The next phase will involve determining the action and implementation of the proposals outlined for the Professional Performance Framework. Considerations will be given to matters such as how the mandatory health checks will be conducted, defining the threshold for multiple complaints, guidelines on identifying and managing risk from professional isolation. The Medical Board have organised a workshop for colleges, associations and stakeholders to contribute ideas on processes needed to build and administer the new Framework.

SKILLED MIGRATION OCCUPATION LIST REFORMS

With the abolition of the 457 visas in April 2017 and introduction of the new Temporary Skill Shortage (TSS) visa in early 2018 by the Federal Government, there are now two new temporary skilled visa options[2]:

INSIDE YOUR SOCIETY

Professional Performance Framework

Strengthened continuing professional development	Active assurance of safe practice	Strengthened assessment and management of practitioners with multiple substantiated complaints	Guidance to support practitioners	Collaborations to foster a positive culture
• All doctors to have a CPD home • CPD to be relevant to scope of practice • CPD to be based on personal professional development plans • 50 hours CPD per year, a mix of: – performance review – outcome measurement, and – educational activities. • CPD home to report to the Board where medical practitioners have not completed their CPD program requirements.	• Board to identify risks to patient safety and define the principles for screening those at risk • Increasing age is a known risk factor: – peer review and health checks for doctors who provide clinical care aged 70 and three yearly after that – Board will not receive the results of peer review and health screening unless there is a serious risk to patients. • Professional isolation is a known risk factor: – education on how to identify and manage this risk – increasing peer-based CPD for professionally isolated practitioners.	• Board to strengthen its assessment and management of practitioners with multiple substantiated complaints • Board to require practitioners with multiple substantiated complaints to participate in formal peer review.	• Board to continue to develop and publish clear, relevant and contemporary professional standards including: – revise *Good medical practice: A code of conduct for doctors in Australia* – refine existing and develop new registration standards – issue other guidance as required.	• Promote a culture of medicine that is focused on patient safety • Work in partnership with the profession to reshape the culture of medicine and build a culture of respect • Encourage doctors to: – commit to reflective practice and lifelong learning – take care of their own health and wellbeing – support their colleagues. • Work with relevant agencies to promote individual practitioners accessing their data to support practice review and measuring outcomes.

Pillars of the Professional Performance Framework (2017). Reproduced with permission of the Medical Board of Australia

- the Short Term Skilled Occupations List (STSOL): this permits a maximum visa period of two years, which can be renewed once only, and replaces the Consolidated Sponsored Occupation List.
- the Medium and Long Term Strategic Skills List (MLTSSL): this permits a maximum visa period of four years, which can be renewed multiple times and will enable access to permanent residency. This is replacing the Skilled Occupations List (SOL).

During the latter half of 2017, the then-Department of Employment (now called the Department of Jobs and Small Business) held two consultations to reform the skilled occupation lists for employer-sponsored permanent and temporary skilled visas. The first of these consultations was on the methodology and the second was in relation to specific occupations under consideration[3].

According to the information provided by the Department of Home Affairs, anaesthetists are listed on the STSOL with a duration of two years unless "a longer period is required to meet international trade obligations"[4].

Caveats can be applied to occupations listed on the STSOL and MLTSSL which may allow for the use of the occupation under certain circumstances such as in addressing maldistribution shortages facing regional, remote and rural areas.

The development of a regional migration occupation list is also underway to target workforce scarcity in regional areas.

The lists will be reviewed every six months, based on advice from the Department of Jobs and Small Business. As part of these reviews, the Department will consult widely with stakeholders, including the ASA, to ensure the lists remain responsive to genuine skill needs and regional variations across Australia. Based on projections reported by the National Medical Training Advisory Network (NMTAN) that the anaesthesia workforce is heading towards oversupply[5], and with the ASA Members' Workforce survey supporting those findings, the ASA will be advocating for the removal of the profession from the STSOL.

Elaine Tieu
Policy Officer

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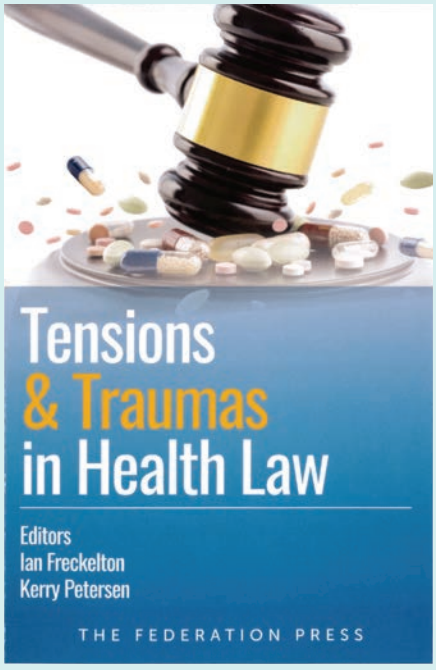


BOOK REVIEW

***Tensions and Traumas in Health Law* edited by Ian Freckelton and Kerry Petersen**

Published by The Federation Press, November 2017. ISBN 978 1 76002 149 8; PB. 832 pages; rrp AUD$145.00.

Academic texts on medical law have in the past been commonly associated with issues to do with malpractice and negligence while referencing legalities such as the Bolam Test or issues concerning the maxim *res ipsa loquitur.*

Tensions and Traumas in Health Law edited by Ian Freckelton and Kerry Petersen, deals with that as well as more specific ethical issues corresponding to biobanking, assisted dying and euthanasia laws to name a few. It is a collection of 37 essays written by high-profile legal and medical practitioners and widely published senior academics – dealing with controversial health law policies while attempting to take matters concerning lost chance litigation and informed consent to their legal endgame. The book is surprisingly easy to navigate given its size – divided by topics (Part A to J) and relevant associated chapters.

Topic examples include the advancement in technology – raising the question of privacy and confidentiality as demonstrated in chapter 14, by Danuta Mendelson and Gabrielle Wolf – whereby the therapeutic relationship between patient and health practitioner has been challenged by encroaching third parties and government bodies.

In the wake of Victoria's Voluntary Assisted Dying Bill, chapter 26; authors Lindy Willmott and Ben White become more prescient as they wrestle with proposed changes and comparisons with other international jurisdictions. Cameron Stewart writes on consent in chapter 11, titled 'Cracks in the Lintel of Consent', presenting the dualism between negative and positive rights and the seminal case of Rogers v Whitaker about the duty to inform and how it stacks up today.

Tensions and Traumas in Health Law is a comprehensive and informative text, covering a wide range of issues involving medicine and law. The book provides an intellectual/principled basis on how to seek the best outcomes in areas of 'tension and trauma' in matters of health and law.

This book is recommended for anaesthetists who are currently working in teaching hospitals or are in the midst of writing a thesis or journal article based upon the relevant topics in this book. It is a good resource to start off with – depending on which areas you may choose to pursue.

Chesney O'Donnell

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

As members will recall, the Anaesthesia Clinical Committee (ACC), which has performed a review of the MBS items covering anaesthesia services in the private sector, completed its draft report in mid-2017. A group of ASA office bearers was given the opportunity to review this draft, on the condition that it not be distributed further. The ASA has significant concerns about the overall direction of the report, as well as numerous concerns regarding specific ACC recommendations. This culminated in the production of a detailed analysis and rebuttal document by the ASA, as well as a set of alternative recommendations which the ASA feels are more appropriate, and much more likely to be acceptable to the specialty as a whole.

Representatives of the ASA met with ACC representatives again in early November, to discuss the ASA documents referred to. Essentially, the ACC rejected the idea of any real changes to the draft report. ASA Past President and former EAC Chair Dr Andrew Mulcahy was however given the opportunity to address a meeting of the ACC via teleconference, also in November. Again, while the ACC was interested to hear what the ASA had to say, little or no change to the draft report is likely.

The Federal Minister for Health (Hon. Greg Hunt, MP) has remained very engaged with the ASA and is fully aware of our concerns. This is in large part due to the efforts of ASA President A/Prof. David M. Scott, who has kept the Minister up to date via regular direct contact, including with meeting personally with him on more than one occasion.

At the time of writing, the timeline for release of the ACC draft report for public consultation remains uncertain. Regardless, the engagement and dialogue between the ASA and the Minister and his staff remains very constructive. As always, members are advised to check their email inboxes for the President's regular 'E-news' releases, and to check the ASA website (asa.org.au) regularly.

PRIVATE HEALTH INSURANCE (PHI) INDUSTRY

During 2017, the Senate Standing Committee on Community Affairs held an inquiry into the PHI industry. The matters to be considered were "the value and affordability of private health insurance, and out-of-pocket costs". The full terms of reference and the final report can be found at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance

The Committee has made 19 recommendations to the federal government. Key recommendations include:

- That private health insurers be required to publish a list of all rebates by policy and item number.
- That public hospitals provide equality of access for public and private patients, based on need, not insurance status.
- That regulations preventing private health insurers from covering outpatient services be reviewed.
- That private health insurers be required to provide adequate written notice of changes to policies and eligbility.
- That additional measures be introduced to make private health insurance easier to understand.
- That any limitations to treatment arising from contractual arrangements between insurers and hospitals or providers be disclosed.
- That individual medical practitioners' fees be published in a searchable database.

This last recommendation listed here has been the subject of considerable ongoing debate, as has the issue of the complexity of health insurance products. AMA President Dr Michael Gannon and Vice-President Dr Tony Bartone have been quoted regularly on these subjects, both in the print and broadcast media. Naturally, the ASA supports the need for patients to have access to quality information, regarding both their level of insurance cover, and the likely costs of medical services. However, there is a huge range of different insurance policies available. There is also significant variation in the available rebates for medical services from insurer to insurer, and doctors can

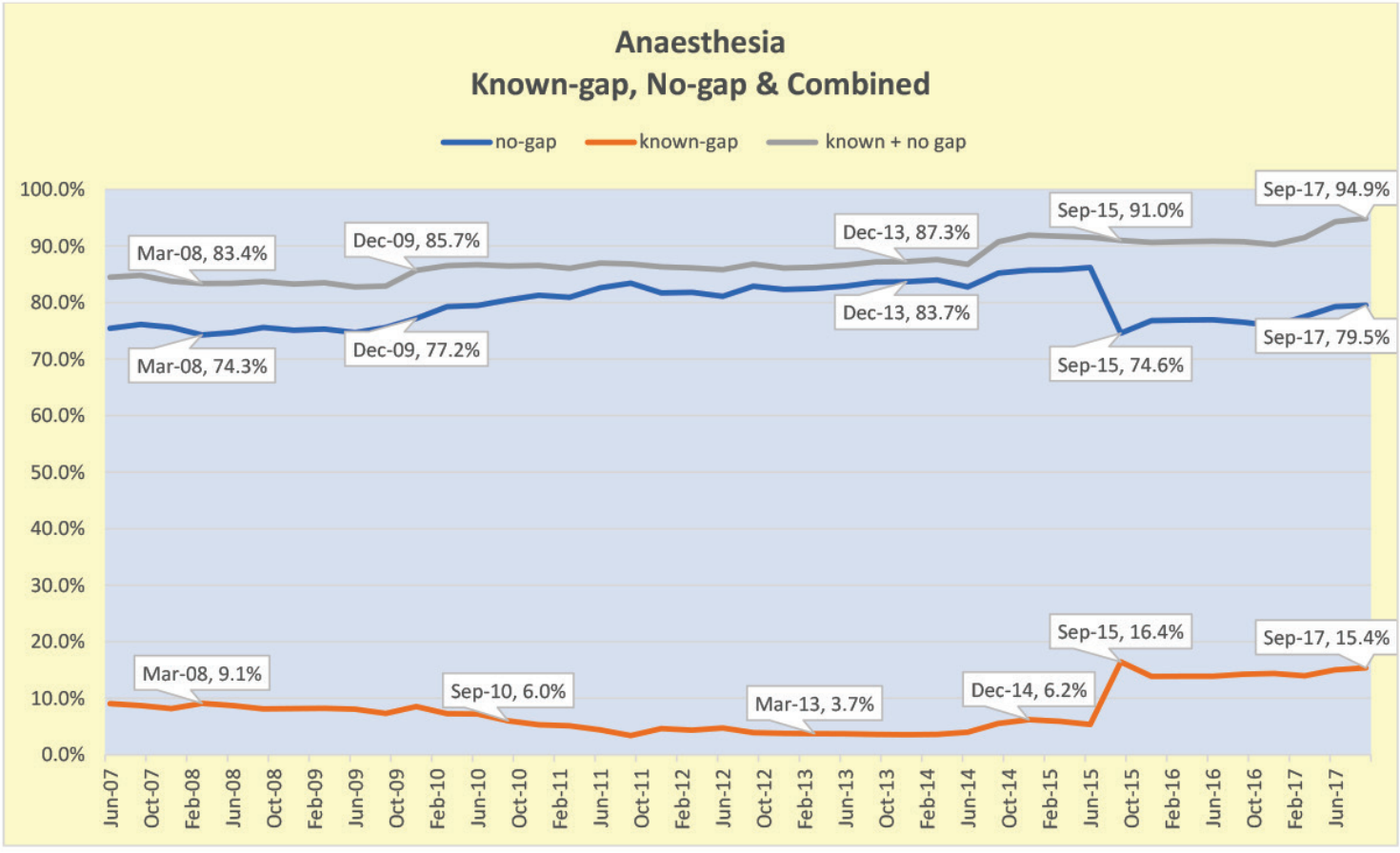


Figure 1: Anaesthesia gap 2007-2017

and do vary their fees depending on individual patient circumstances. This form of informed financial consent for medical services would clearly be very complex to initiate, and in all likelihood would not be as useful to health consumers as it may appear at first glance.

The Minister for Health is now in the process of establishing a Ministerial Advisory Committee on the issue of out-of-pocket expenses for medical services. The ASA was pleased to receive an invitation to join this committee, and I will attend the first meeting on February 8. Representatives from the surgical specialties, health consumer groups and the PHI industry will also attend.

Obviously, it is essential that the medical profession is well represented on such bodies. Those outside the medical profession have a long history of trying to convince the public that it is doctors' fees, and in particular the out-of-pocket expenses which may occur, that are at the heart of all problems in the private healthcare system. Anaesthetists are constantly referred to as being problematic in this regard, despite the existing statistical evidence to the contrary. It seems that once such statements are made, they have a way of self-perpetuating. By way of example, Dr Tony Bartone appeared on ABC TV *News Breakfast* on 17 January, to discuss the next round of health insurance premium rises, and the importance of simplifying the PHI system. His host Ms Ali Moore stated outright during the interview "it has to be said – the doctors and the anaesthetists have still been hiking their prices".

The existing statistical evidence tells a different story. At the time of writing, the latest available statistics from the Australian Prudential Regulation Authority (APRA) cover the quarter ended September 2017. The data show that 86% of medical services in the private hospital sector involved no out-of-pocket (OOP) expense. The figure for anaesthesia was lower, at 79.5%, after a sudden drop in 2015 (see Figure 1; our thanks to Dr Andrew Mulcahy for this graph). Interestingly, this drop coincided with a similar increase in the use of 'known gap' products by anaesthetists. The reason for this sudden change is not known, although it did immediately follow the announcement that the Medicare freeze, then in place for around two years, would be extended to 2020 (this date has since been revised, to 2019).

INSIDE YOUR SOCIETY

The data for the incidence and level of out-of-pocket expenses have been called into question, but they are the only such data currently available, and even if the raw figures are questioned, their trends are certainly interesting.

Also, these data indicate that lack of informed financial consent (IFC) is not the major problem that some would like us to believe. As the use of a 'known gap' product mandates IFC, approximately 95% of anaesthesia services involve either no OOP, or an OOP with appropriate IFC. However, the remaining 5% of services, where there *may* have been an OOP and IFC *may* not have been obtained, does still represent a large number of individual services (over 100,000). The ASA reaffirms its position that all anaesthetists should strive to obtain appropriate IFC for all patients. The ASA website and the RVG booklet contain advice as to how this aim might be achieved.

Figure 2 shows the specialty-by-specialty figures for out-of-pocket expenses recorded by APRA, where out-of-pocket expenses do actually exist. These data clearly counter the criticism of 'very high' out-of-pocket expenses for anaesthesia – a criticism that has been made regularly by a number of different groups, including taxpayer-funded government bodies such as the Medical Services Advisory Committee.

Specialty	Average gap – 'known gap' agreement	Average gap – no agreement*
Plastic surgery	$397	$2,253
Orthopaedic surgery	$355	$1,892
Neurosurgery	$171	$1,666
Urology	$232	$1,310
Ophthalmology	$292	$1,192
General Surgery	$171	$993
O&G	$247	$992
ENT	$134	$912
Vascular surgery	$179	$819
Colorectal surgery	$149	$436
Surgical assistance	$90	$368
Anaesthesia	$96	$141

* This refers to the situation where a doctor does not utilise a health insurer's 'no gap' or 'known gap' product.

Figure 2: Average out-of-pocket cost by specialty. Available online: http://www.apra.gov.au/PHI/Publications/Pages/Industry-Statistics.aspx

It is interesting to note that the same APRA reports from which these data are sourced also show that the after-tax profit of the for-profit PHI companies (which frequently refer to the 'problem" of out-of-pocket expenses for doctors' services) was $1.4 billion over the previous 12 months, with Medibank Private pocketing $450 million, and Bupa $397 million.

Australian Historical Association awards and prizes

The Australian Historical Association would like members of the ASA to know about the range of prizes it awards annually and biennially. You or your colleagues could be eligible for one of these awards, so check out what's on offer for 2018 by going to: https://www.theaha.org.au/awards-and-prizes/

ASA MEMBER'S GROUPS UPDATE

ASA TRAINEE MEMBERS UPDATE

Richard Seglenieks, Chair

Welfare

The Trainee Members Group continues to be keenly interested in the welfare of trainee anaesthetists. We understand that training can present a myriad of challenges to maintaining good mental health and wellbeing. We are currently awaiting the results from a survey by the ASA Council to better understand the current and future directions of the ASA regarding welfare. The ANZCA Trainee Wellbeing Working Group is also undertaking important work in this area and we look forward to seeing their recommendations.

Practical support is currently available for ASA members. We have a partnership with the recruitment agency Wavelength, which in turn has partnered with Select Wellness, a corporate wellbeing company. Select Wellness works with doctors to develop a tailored support service to improve wellbeing, including stress and mood management, relationships, life purpose and lifestyle habits. For more information or to book in for a Wellbeing Management Plan, email info@selectwellness.com.au or call Select Wellness on 0407 005 701.

Immediate Past Chair of the TMG, Dr Scott Popham, wrote a detailed feature article in the December 2017 issue of *Australian Anaesthetist* covering key insights into trainee wellbeing. Dr Popham has also developed a Welfare Wiki as a local resource for Gold Coast University Hospital. It contains a wealth of useful information and resources for all trainees regarding welfare and can be accessed at https://sites.google.com/view/gcuhwelfare

Trainee member international scholarship 2018

Applications for this year's round of International Scholarships have now opened and will close Friday 20 April 2018 at 5pm. Three successful applicants will be awarded $4,000 towards travel and accommodation to attend international meetings. This year, one ASA Trainee Member will be sponsored to attend each of the following meetings:

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

This is a great opportunity for trainees to broaden their horizons and gain valuable exposure to contemporary global ideas and practice in anaesthesia. All of these conferences are consistently high-quality events with broad-ranging sessions to appeal to every attendee. Previous scholarship winners have reported very positive experiences, with reports published in past editions of *Australian Anaesthetist* (available online through the ASA website). The host societies are very welcoming and appreciate the mutual benefits of international guests attending scientific meetings. They also count towards the required attendance at regional or greater conferences/meetings for the Scholar Role component of training.

Application guidelines are available from our website or by contacting trainees@asa.org.au

New committee members

The Trainee Members Group welcomes four new trainees to our national committee this year: Dr Myat Aung and Dr Rebecca Zhao (Victorian Representatives), Dr Nik Fraser (SA/NT Representative) and Dr Elizabeth Judson (Tasmanian Representative). We thank them for volunteering their time and look forward to working together over the coming months and years.

ASA Website

The ASA website is currently undergoing a major redesign and upgrade from the current version, which has been in place since November 2013. The redevelopment is a major project and is expected to be completed later this year. As part of this process, we are working to build the trainee section of the site to be as useful as possible for you. If you have any ideas or suggestions for what you would find helpful, please email us at trainees@asa.org.au or speak with one of your local ASA Representatives.

INSIDE YOUR SOCIETY

Other events

The ASA has a strong tradition of organising and supporting events for trainees. Many of you will be familiar with the Part Three Courses held around the country to help trainees with the personal and professional aspects of transitioning to specialist practice. There are also a number of short courses to help prepare for the final examination, including the highly successful Boot Camp held annually in Canberra and a Medical Viva Boot Camp in Melbourne. The 2018 National Scientific Congress in Adelaide (6-9 October) will continue the tradition of featuring a series of trainee-focussed sessions, addressing key issues across health, examinations, research and finances.

Details regarding upcoming events can be found on our website, in the TMG eNewsletters or by contacting events@asa.org.au

Professional citizenship

An important and often overlooked benefit of ASA membership for trainees is embodied in the concept of professional citizenship. Political decisions made today can affect the working lives of anaesthetists for decades, long after we transition from training to specialist practice. As such, it's invaluable to have a motivated, politically-savvy Society advocating for the interests of the profession, which are ultimately your interests. ASA President A/Prof. David M. Scott outlined the roles and importance of professional citizenship in his editorial in the December 2017 issue of *Australian Anaesthetist* – I want to stress how important this facet of the ASA is for trainees.

The ASA is always looking for enthusiastic and motivated members to get involved at every level of the Society. We are a member-driven organisation and as such rely on all of you to help us support, represent and educate anaesthetists and anaesthetic trainees nationwide. Our trainee member benefits make membership cost-effective, though the greatest advantage is intangible: the vital but largely unseen advocacy undertaken on your behalf.

RETIRED ANAESTHETISTS GROUP

SOUTH AUSTRALIA

Dr John Crowhurst

Our group in SA meets for lunch on the second Monday of every odd month at the Kensington Hotel, where we have our own private dining room, and from time-to-time, a guest speaker. Our membership, comprised of colleagues from anaesthesia, intensive care and pain medicine, now numbers more than 80.

The guest speaker at our November meeting was Prof. David Cherry, former head of anaesthesia at the Repatriation General Hospital and Director of Pain Medicine at Flinders Medical Centre. His presentation was entitled 'The Censorship by British Generals in World War 1', and reviewed the details of their decisions kept from the public and the British politicians. In just one battle, that of Bullecort, involving the 1st, 2nd, 4th and 5th Australian Army Divisions, there were 10,000 Australian casualties; 2,500 listed as 'missing' and more than 1,500 taken POW. Those thousands of deaths in the trenches in France and Belgium and at Gallipoli in Turkey will never be forgotten, and most of them were due to the poor decisions made by those military leaders. David presented a most revealing insight into one of the most secret aspects of that terrible war. David has toured most of the well-known memorials, battle sites and trenches which he featured in his lecture.

Last September the foundation teaching hospital in South Australia, the Royal Adelaide was relocated to its new multi-billion dollar home as part of the 'Transforming Health' programme of the State Government. That programme is receiving much criticism still, and the new Royal Adelaide Hospital is functioning with many difficulties. In the coming months, senior Royal Adelaide Hospital colleagues and Professor Warren Jones will update us on this most controversial topic and give us some insight into the many ongoing problems.

Also this year, the related topic of difficulties, hazards and inefficiencies resulting from the commercialisation of blood services in Australia will be presented by Dr Richard Davis and Prof. Bill Runciman will talk to us about his career and the Australian Patient Safety Foundation, which he founded in 1988.

Finally, Dr Graeme McLeay, an active member of Doctors for the Environment Australia, has published in *The Advertiser* a comprehensive case for electric vehicles to significantly reduce air pollution and the consequent extensive respiratory and other diseases and subsequent health costs – article published on 30 January.

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

For further information, please contact:
Dr John A. Crowhurst, Convenor,
SA Retired Anaesthetists' Group.
Telephone (08) 7225 1390 or 0400 804 294.
Email: jacrow43@gmail.com

QUEENSLAND

Dr Col Busby

A very successful luncheon for retired anaesthetists was held in Brisbane on Thursday 9 November at Va Bene Restaurant. The 17 present were unstoppable in their enthusiastic reminiscing, as can be seen in the photo taken by the extremely patient waitress who just could not convince people to look her way.

There was enthusiastic endorsement for continuing these events.

The generous organisation and financial support of the ASA to the Retired Anaesthetists Group was gratefully acknowledged by all present.

Those present were: Alex Alcock, Rhonda and Terry Boyle, Col Busby, Lou Ferrari, John Haines, Murray Kelly, Don Logan, Vera Lukursky, Tony Lynch, Dave McConnel, John Murray, Dave Palethorpe, Barb and Bill Power, Michael Tuch and Rob White.

Apologies: Colin Orr, Andrew Mercer, Phil Allen, Ian Colbert, John Board, Graham Smith, Colin Norgate, Maurice Coutanceau, David Wylie, Imelda Bourke (Gellender), Eric Hewitt, Vic Callanan, Joan Webster, Ken McLeod, Rad Petrovic.

Queensland RAG lunch, Va Bene Restaurant, Brisbane

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

VICTORIA

Dr Jenny King, Chair

Happy New Year to all our Victorian members.

Our year started off with the Med Viva Bootcamp on the 27th January for our 2nd part ASA exam candidates.

Many thanks to our contributors and sponsors for the day and we wish good luck to the examinees.

The Victorian AGM will be held on February 25th at our hallowed historical tennis venue – Kooyong Tennis Club. We will be celebrating some major milestones of some of our members, and look forward to sharing fine food with good company.

Farewell dinner for Dr Jean Allison. From left, front: Grace Gunasegaram, Vanida Na Ranong, Jean Allison, Andrew Schneider. Back: Jenny King, David Knott, Michelle Horne, Peter Seal, Mark Sandford, Craig Horne, Rod Westhorpe and Margot Westhorpe.

Participants, organisers and sponsors at Med Viva Bootcamp

Our committee celebrated the committee retirement of Dr Jean Allison. She has been a long-standing member, and with her vast experience internationally and locally, has been a healthy contributor.

We have a change of guard with our new trainee committee members, and some newer committee members, and we look forward to an engaging year. With the aid of the Federal office, we are planning some social occasions with guest speakers. We also welcome input from our members.

In November, 2017, was the annual 3rd part day. Ably organised by Dr Andrew Schneider, it was an invaluable day for our new Fellows, giving the practicalities of setting up practice in public and private practice, maintaining continuing professional development but also a reminder to take care with their general health . Many thanks to all the speakers and sponsors. I would like to thank Andrew for making it a successful day.

Again, I look forward to seeing our members at the AGM.

NEW SOUTH WALES

Dr Ammar Ali Beck, Chair

We had a few busy months leading to the end of 2017. The NSW committee has expanded its members to include Dr Douglas Dong, who has a keen interest in teaching, simulation and airway management. Dr Dong will be representing the ASA on the newly formed Safe Airway Society. It is a multidisciplinary venture aiming to harmonise airway management across different societies and colleges.

Dr Katherine Jeffery (NSW Senior Trainee Representative) has been spending some of her time in Melbourne with the Victorian ASA branch in an effort to facilitate the flow of ideas and strengthen the relationship between NSW and Victoria. Katherine has large experience in advocacy and welfare of doctors through her previous roles within the Australian Medical Association (AMA). She will be complementing Dr Ian Woodford's outstanding work within the AMA.

Dr Bruce Graham has replaced Dr G. Purcell on the NSW Medical Service Committee, Bruce is interested in management and legal issues. Finally, I am pleased to note that Dr Gabrielle Bullock is the new representative from ANZCA to our ASA NSW committee. Her contribution has been invaluable as she possesses great energy and wisdom.

In October, an ASA Member stepped down from The Australian New Zealand Tripartite Anaesthetic Data Committee (ANZTADC) creating a vacancy in the organisation representation. It was pleasing to see large interest from our members to fill that role. NSW has managed to put forward five nominations. It will be exciting to know who will win the prestigious appointment.

The public private partnership between NSW Health and private health providers continue to be of an interest to our committee, the outcome of these adventures will have a deep impact on the future of anaesthesia. The ACCC has granted five years authorisation to the AMA to negotiate with Healthscope on behalf of all the Visiting Medical Officers the terms and conditions of contracts including remuneration for the Northern Beaches Hospital. We view this as an excellent outcome for our members and everyone involved in the negotiation. The ASA will continue advocating for a fair, equitable and transparent process.

Dr Andrew Emanuel our Junior Trainee Rep, represented ASA in the ANZCA Part Zero Course which was held at the ANZCA office on the October 21.

Dr Michael Levitt and team organised a very successful Part 3 Course. It was held at the Sydney Hilton on the 11th of November. We had very positive feedback from the delegates and industry. In the coming few years I would like to see improvement in the number of trainees attending the meeting. The job of developing the course will be tasked to Dr Adam Hill.

I would like to congratulate A/Prof John Loadsman on his new role as the Chief Editor for the Anaesthesia and Intensive Care Journal, and Prof Alwin Chuan on his nomination to an advisory role on the American Society of Regional Anaesthesia (ASRA).

Finally, I would like to remember two of our longstanding members who recently passed away, Dr Robert John Green and Dr Adrian Selwyn. Our deepest condolences to their immediate and extended families.

I am looking forward to 2018, wishing everyone a great and productive year. Your feedback and contribution are very important to us, so please keep coming. We love to hear back from our members.

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

THE LONG TERM VIEW – LOOKING AFTER BOOKS

Books are still important is this digital age. They have value for their content, design, scarcity and association. The ASA's Richard Bailey Library (RBL) has many valuable books. Many of them have been donated to the Society from members. Anaesthetists often have sizeable collections of books.

This article is about caring for your books – one day you might want to make a donation to the RBL and we would prefer them to be in good condition, and hopefully written or at least signed by you. Such books have an unique value.

Books become scarcer and increase in value over the years if they have been well cared for. Books and ephemera once relatively common and so frequently discarded may, years later, become collectible.

Books hate sun, dust, food, insects, common sticky tape, baths or beaches. They dislike being squeezed, creased, dropped, or having things permanently inserted inside them. They are not mats on which to stand a mug of coffee or a plate of cake.

Please make sure your bookcases do not face sunny windows (summer and winter, when the sun's trajectory is lower). If this is not possible close curtains or pull down blinds when possible.

Dust is an insidious enemy. Books prefer a bookcase which has doors. Open bookcases used to have fabric curtains or leather scalloped fringes below each shelf to keep dust from collecting along the top edge of the volumes shelved below. The fringes were flexible to allow maximum use of height between shelves. Fringes have fallen from fashion so always try to size the books so that the tops nearly reach the upper shelf and place them back from the front of the shelf (but not so far that the touch the rear of the bookcase – see why below). Keep books of a similar height on the same shelf as far as possible. Oversize books should have their own shelf or should be laid horizontal. Take your books out and look at them and dust them at least once a year (if you haven't touched a book for over a year, do you still need it?). If a book has a dust jacket, retain the jacket and protect it with a non-adhesive plastic cover.

Do not force more books onto the shelf than it can comfortably hold. Tightly squeezed books break the bindings, especially at the hinges of the covers. Old leather bound books are particularly vulnerable. Crushing a book into a shelf tends to tear or crease unprotected dust jackets.

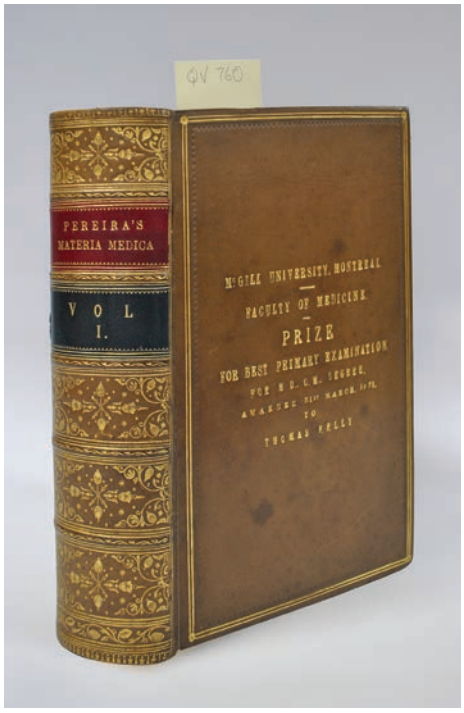
Books are hard to remove from a tightly squeezed shelf and many a head band has been damaged by trying to prise a book from a packed row. A safer way to remove a book from the self is to extend the finger at least an inch along the top of the closed pages, or better still have a thumb on one side of the spine (in the middle) and the forefinger on the other side. If your fingers will not fit either side of the spine (are there too many books on the shelf?), push back the books on either side and pull out the book required with a firm hold.

On a shelf with few books bookends should be used to prevent books leaning and damaging themselves.

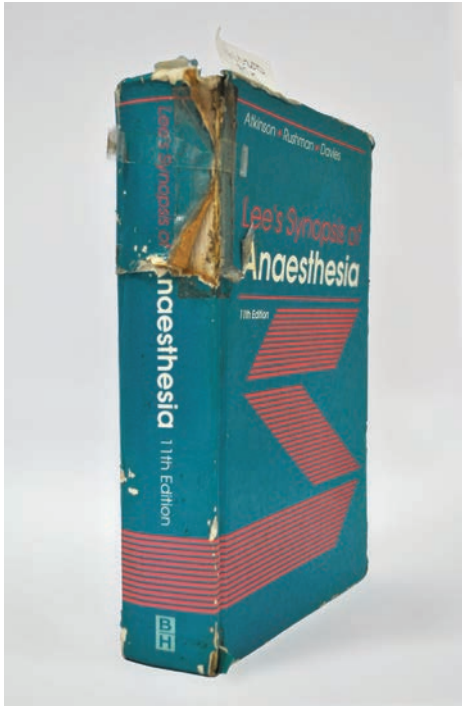
Books are strong, but not as strong as you. When photocopying or photographing a book take care not to crack its spine permanently. New or rarely read books are especially vulnerable. Do not dog-ear pages, please use a book mark. Do not write comments or underline in biro, ink or colour. If necessary please use a pencil. You may sign your name and/or address in ink on a flyleaf or, if you are the author, on the title page. An artist designed bookplate placed inside the front cover will elegantly identify your property and in time enhance its value.

Do not pile books in a tower on the floor where they may be vulnerable to a kick. Books hate coffee, tea, water, newspaper, metal or plant bookmarks, beaches and sunbathing. If you put a review, a photograph, or a scientific article in a book for many months, the adjacent pages will probably discolour.

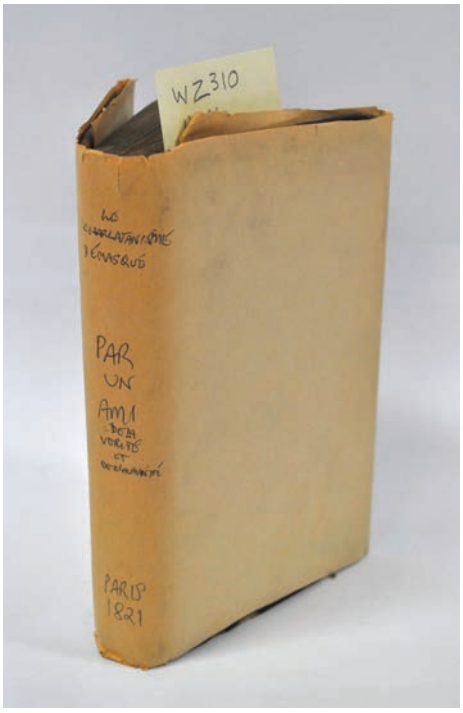
Silverfish, cockroaches and other insect pests enjoy eating the paste or binding fabric of some books, especially of Victorian or Edwardian vintage. Discourage them by cleanliness, careful use of insecticides or by simple home remedies such as borax powder (sodium tetra-borate). Sprinkle a little powder on



Fine bindings should be looked after with care



Headband torn by careless removal from shelf



A homemade dustjacket will provide protection

the shelf behind books that are vulnerable.

Valuable or books of particular importance to you should be completely encased in a box or wrapped; a slip case does not protect the spine, often the part of the book most attractive to humans and insects.

Mould may be a problem in damp environments, especially where airflow is restricted. Wipe mould off with a clean dry cloth or gently vacuum the surface. Do this outside and if possible wear a mask – mould is a human health hazard. Then expose the book to winter sun for fifteen minutes. Repeat once if necessary. If the book has a smell offensive to you, enclose it in a box with a little baking soda (sodium bicarbonate) for twenty-four hours.

If a book has unsightly damage, unless you have knowledge of bookbinding, please consult a librarian or a conservator before trying to repair a binding or even a damaged page. The Richard Bailey Library belongs to members; as a resource it is always at your service. Please consult us if you need advice or wish to make a donation (pstanbury@asa.org.au or 0419 607 027).

Dr Peter Stanbury
Richard Bailey Librarian

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.

In this issue and the next I will explore a few of these items briefly and acknowledge the donors. If you would like to read more about any of the items below please use the object number to search the eHive database available at https://ehive.com/collections/4493/harry-daly-museum. Many of the new acquisitions are relatively recent inventions, thus if you have additional information about the object please leave a comment in the appropriate box on the objects eHive page; alternatively, you can email me at agebels@asa.org.au or better still give me a call or visit the museum in person.

continued on next page

INSIDE YOUR SOCIETY

NEW EXHIBITION IN THE HARRY DALY MUSEUM

Sonomatic Confirmation of Tracheal Intubation device (SCOTI)

Manufacturer: Penlon Ltd, UK, c. 1995. Donated by Dr Rajesh Haridas; Object number: 2018.1

The Sonomatic Confirmation of Tracheal Intubation device (SCOTI) was designed to assist in the correct placement of endotracheal tubes. The battery-powered device emits sound waves into the tube and analyses the reflection. Clinical testing of the device was not favourable with a 20% failure to indicate tracheal intubation. Research favoured other available devices such as the Oesophageal Detector Device.

Cuffed Oropharyngeal Airway (COPA)

Manufacturer: Mallinckrodt Medical, USA, c. 1996. Donated by Dr Rajesh Haridas; Object number: 2018.3.

The COPA, introduced in 1996, was intended for 'hands free' spontaneous ventilation anaesthesia. It is an adaptation of the Guedel airway with the addition of an inflatable cuff at the distal end and a circuit connection at the proximal end.

LMA® Gastro™ Cuff Pilot™

Manufacturer: Teleflex medical, c.2016. Donated by Dr Rajesh Haridas; Object number: 2018.4.

Introduced in 2016 the LMA® Gastro™ Cuff Pilot™ was designed to provide access to, and functional separation of, the respiratory and digestive tracts in adult patients undergoing endoscopic procedures. The device is single use and supplied in sterile packaging. It consists of an inflatable cuff with inflation line and inflation pressure valve, endoscope channel, airway tube, built-in connector and bite block. The strap and adjustable holder allowed hands free operation.

The device can be used for either spontaneous respiration or positive pressure ventilation.

Cyclopropane Cylinder

Manufacturer: Commonwealth Industrial Gases, c. 1950. Donated by Dr Richard Morris; Object number: 2018.9.

Cyclopropane was originally thought to be the toxic compound within propylene from which it was isolated by George Lucas in 1927, working with Professor V. Henderson and W.E. Brown in Toronto, Canada. It was, however, the anaesthetic. 'Cyclo' was first used clinically by Ralph Waters in Wisconsin in 1930 and was introduced in Australia by Gilbert Troup in 1935. It had numerous benefits over

ether, chloroform and nitrous oxide and so became the favoured agent of many anaesthetists.

Cyclopropane was used with a high percentage of oxygen, which was of advantage to patients. Its high cost was a blessing in disguise by helping to lead to the introduction by Ralph Waters of 'controlled' (by inducing hypocapnia) respiration in anaesthesia and the gas could be used in a closed circuit with little wastage. Its disadvantage was its flammability - an issue that could (and did on occasions) prove lethal to both patients and theatre staff.

Cyclopropane and others were replaced by Halothane in the 1950s.

Additional items newly accessioned for which we heartily thank our donors include; Augustine Guide (2018.2), Versatile Rebreathing System (VRS) (2018.5), LMA Fastrach Reusable (2018.6), Nonconductive Disposable Bacteria Filter (2018.7) as donated by Dr Rajesh Haridas and Double-Stick Discs No. 2181 for stethoscope and electrode attachment 3M Brand (2018.11) donated by Dr Richard Bailey.

Anna Gebels

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).

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from December 2017 to February 2018.

TRAINEE MEMBERS

Dr Sarah Ashcroft	VIC
Dr Aradhana Behare	NSW
Dr Rachel Bourke	QLD
Dr Hanna Burton	QLD
Dr Zoe Daskalopoulos	NSW
Dr Conor Dowdall	QLD
Dr Jonathon Fanning	QLD
Dr Amit Ganguly	TAS
Dr David William Healy	NSW
Dr Yena Hwang	QLD
Dr Lee Imeson	QLD
Dr Ashton Jeffery	QLD
Dr Rupali Rajesh Kini	NSW
Dr Kamal Kishore	TAS
Dr Anisha Kulkarni	SA
Dr Dinesh Kumara Kumarage	NSW
Dr Andrew Peter Lindberg	NSW
Dr Juan Sebastian Lopera Alvarez	QLD
Dr Mrinal Madireddi	QLD
Dr Joel Brian Menzies	NSW
Dr Olivia Millay	VIC
Dr Martin Misevski	QLD
Dr Jonathan David Moore	NSW
Dr Shannon Morrison	QLD
Dr Dash Newington	QLD
Dr Michelle Nguyen	VIC
Dr Verity Nicholson	VIC
Dr Dana Perrignon Roth	NSW
Dr James Preuss	WA
Dr Blaine Robson	VIC
Dr Christopher Slattery	QLD
Dr Michael Tran	NSW
Dr Nilru Vitharana	NSW
Dr Bernadette Mary Wilks	VIC
Dr Charles Williams	QLD
Dr Gillian Wright	QLD
Dr Myat Thant Aung	VIC
Dr Melissa Chin	NSW
Dr Laura Fisher	SA
Dr Thomas Goddard	SA
Dr Thomas Grosser-Kennedy	SA
Dr Simon Kelaeng	NSW
Dr Joshua Reid Lun	VIC
Dr Thomas David Maycock	SA
Dr Jinesh Patel	VIC
Dr Mitchell Keith Petersen Tym	SA
Dr Lincoln Pike	NSW
Dr Daniel James Stone	SA
Dr Dorian Wenzel	WA
Dr Simone Young	NSW
Dr Rebecca Beiyi Zhao	VIC
Dr Lee Jervis	WA
Dr Sam Phillips	NSW

ORDINARY MEMBERS

Dr Daniel Banyasz	VIC
Dr Jolyon Jay Bond	QLD
Dr Sean Robert Duncan	NSW
Dr Yael Katinka Fiebelkorn	WA
Dr Melissa Gildenhuys	WA
Dr David Forbes Hamilton	WA
Dr Anna Karen Hayward	WA
Dr Gowri Jegasothy	NSW
Dr Ilamurugu Kaliaperumal	QLD
Dr Blake Kesby	NSW
Dr Su-May Koh	NSW
Dr Sarika Kumar	QLD
Dr Amy Louisa Lawrence	NSW
Dr Andrew John Marriott	VIC
Dr Daniel John McGlone	TAS
Dr Chantal McNally	VIC
Dr Francis Christopher Parker	VIC
Dr Shanthi Widana Pathirana	NSW
Dr Andrew Woolley	VIC

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Alan Gerrard Bond, TAS; Dr Adrian Selwyn, NSW; Dr Robert John Green, NSW; Dr Richard Hugh Connock, VIC; Dr Robert William Cowie, VIC; Dr Rudolf Duncan Anderson, WA.

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

LIFESTYLE

LATER YEARS OF RETIREMENT

I wrote an article on retirement (*Australian Anaesthetist*, March 2011) covering topics such as organising finances and about many of the things one can do to maximise enjoyment in these valuable years of one's life, hoping that one will remain healthy.

Unfortunately, as age advances, health issues become more prevalent for many people. These may cause physical disability which limit activity, or impair mental activity when memory declines, or possibly dementia may take over, with the very sad situation of memory failure and the loss of the ability to communicate, even with loved ones, occuring. As the years pass, more and more acquaintances die leaving those who remain with fewer and fewer friends and colleagues – an increasingly lonely situation. It is then that the friendship of younger people and relatives becomes so important.

Retirees in their sixties and seventies, provided they remain in good health, have so many opportunities to enjoy life and activities for which time has previously been limited. Make the most of this time before disease creeps in and old age intrudes. More and more time spent on doctors' visits and treatment can be disruptive quite apart from any pain or misery that can aggravate the situation. It is wonderful how well many people cope with these downsides, accepting them as part of life. On the other hand it is sad to see someone who has had a happy and successful life end up in abject misery unable to do for themselves.

The decline in physical ability, the diminution of memory and mental acuity or the lessening of one or several senses such as hearing or sight leads some 80 or 90 year olds to say that "aging is not for wimps".

There are others who live long lives (into their nineties or even older), who do well, retaining their faculties although physically weaker. During my retirement I have visited many of these people to provide company when many of their friends or partners had passed away. This was very rewarding especially when the individuals remained alert and spoke of a wide range of events in their interesting lives. Jack was one of these. His father built bicycles in Williamstown where Jack grew up. We used to go there for lunch. On one occasion he told me that his father took him to the Steam Packet from the age of five – he was then nearly ninety. When the man serving us heard this he provided complimentary coffee! Jack had been to sea as a radio operator for seven years, much of the time around the Baltic Sea on Swedish ships. In 1950 he spent a year on Macquarrie Island with ANARE. In 1954 he spent another year at the Australian base at Mawson in Antarctica. He had done a short librarian course and on his return he applied for the advertised position as librarian at the Royal Melbourne Institute of Technology. To his surprise he was appointed and thereafter improved his qualifications. He continued there until he retired by which time he had computerised the library. Being a man of many interests

made my visits with him very enjoyable. He was one of the lucky ones who retained a clear mind until he died aged almost 93 sitting in his chair waiting to be taken to a concert.

Jim died the week before his 96th birthday. He was a small ginger-haired man who was an outstanding maths teacher. He never raised his voice but maintained discipline by the respect he engendered. He was a great organist and a keen and successful gardener, which may have helped him maintain his tranquility. He had been a navigator in the Air Force during World War II. His wife told me after he died that he was the sole survivor when the plane was shot down. He suffered 40% burns. Despite this and consequently suffering nightmares for the rest of his life he kept the information private.

Douglas died the week before his 98th birthday. He was a world-renowned paediatric surgeon who maintained a research interest in urogenital anatomical abnormalities for many years after formal retirement. He continued to play tennis until 93 and golf to 94. He was also a painter and had his last watercolour exhibition when he was 96 although he continued painting later than that.

Others included a 93-year-old lady whom I took out painting. The last time was four weeks before she died. Another friend continued to go the gym three times a week in his mid '90s. A man who began as an office boy in a bank and rose to be managing director regaled me with tales of his war experiences with the Air Force in London – his billet was bombed during the Blitz, so they were re-billeted in the Savoy Hotel!

My old uncle was gassed in the First World War and was advised to take an outdoor job – he became a postman. He was a keen gardener and when he retired he moved to a cottage surrounded by fields where he developed a magnificent garden. When his wife died he moved to a flat in town. His memory began to fail but on moving to a country house which became an old folks home he was able to resume gardening and his intellectual acuity returned. He remained alert until he died 23 days short of a century.

None of these people were fat and all retained their memory. How lucky they were except that most of their friends had died before them.

On the other hand those whose memories fail, who become repetitive in their conversation and decline into dementia, are hard to watch for friends and especially for family who are their carers. It is terribly sad to see people who have had brilliant careers decline in this way. Death may be a blessed relief for these individuals and especially for family and friends who care for them, but there are many who see this as their lot in life and regard it as a special privilege to care for them. Then there are others who develop debilitating diseases such as cancer, neurological ailments and others, which may be accompanied by pain, whose ability to enjoy life to the full is gradually withdrawn. It is important to continue visiting and supporting such people but this may become increasingly difficult for the visitor.

Those who die suddenly, are in some ways lucky, being relieved of the problems of the world without much misery but it is often those who remain that are bereft and may be traumatised.

Sometimes failure to resolve conflict can keep people going, like one old lady who was asked if there were any problems in the family. She said that her daughter had not talked to her for 20 years. The daughter was contacted and asked to visit. Reconciliation was reached and the old lady died peacefully the next day.

One of the first patients I looked after had arterial bypass surgery in the early days of such surgery. He became confused, abusive and his behavior did not match his normal, but he finally recovered and went home for three months. He returned to hospital and during his final admission I asked him if the extra time at home had been worth it after all his trials and tribulations. "Definitely," he said. It made me realise that a flexible view on such questions is needed. As I have grown older, more and more elderly people have indicated to me that they are ready to conclude this phase of their existence even though they still derive some enjoyment from life. Others are content to wait for their time to come. It is a very individual matter.

Another frustration of old age is a decreasing ability to manage simple tasks such as dressing, doing up buttons, putting on socks, dealing with ablutions until the day comes when one has to be helped. This may seem demeaning at first but later acceptance develops, often as mental function deteriorates.

Ultimately one should try to make the best of one's circumstances and hope for a peaceful ending. One should be allowed to die with dignity, not necessarily with the heroics of modern resuscitative methods if one does not want them to be used. Allowing one to die with dignity may relieve anguish in the relatives, particularly if they are not sure whether the time has come to discontinue treatment.

Palliative care is a welcome option for many who do not want to go through the "keep alive at all costs" routine often followed in hospitals. Palliative care provides for a more peaceful transition from life to death.

In conclusion, it is important for younger people to recognise the benefits of visiting the elderly and how it helps to relieve loneliness when many of their friends have gone. They may also learn much of interest from them. It is good for old people to have younger friends.

Kester Brown
MBChB, FFARACS, MD, FANZCA,
Hon FRCA, Hon FCA SA
Retired anaesthetist and
Life and 50 year member ASA

UPCOMING EVENTS

JUNE 2018

History of Anaesthesia Seminar

Date: 3 June 2018

Venue: Harry Daly Museum, Richard Bailey Library

Contact: Museum Curator Anna Gebels or Librarian Peter Stanbury on: 02 8556 9700.

Invitation to speakers: If you are interested in presenting at this meeting please contact Rajesh Haridas: rajesh.haridas@bigpond.com

The Part 3 Course SA/NT

Date: 16 June 2018

Venue: AMA House

Cotact: events@asa.org.au

AUGUST 2018

Practice Managers Conference

Date: Friday 17 August

Venue: Adelaide

Contact: events@asa.org.au

OCTOBER 2017

ASA NSC 2018

Date: 6-9 October 2018

Venue: Adelaide Convention Centre

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

Contact: events@asa.org.au

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 real-time 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.

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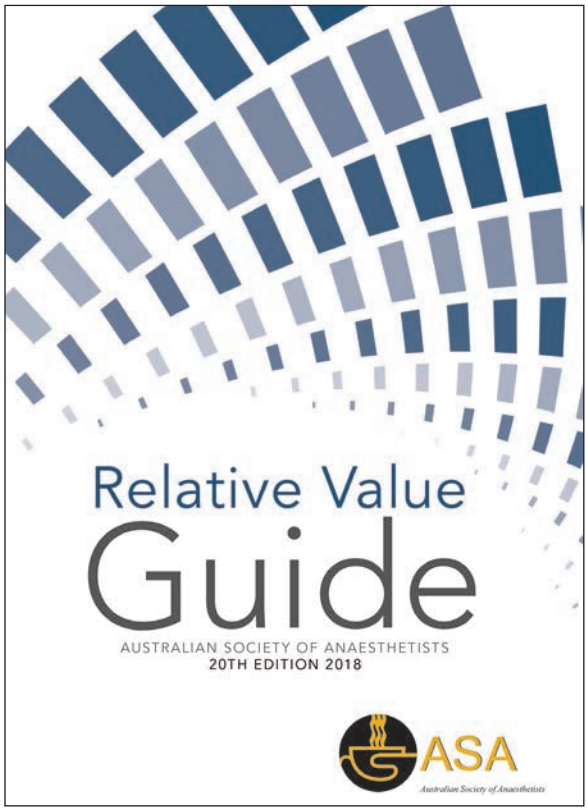

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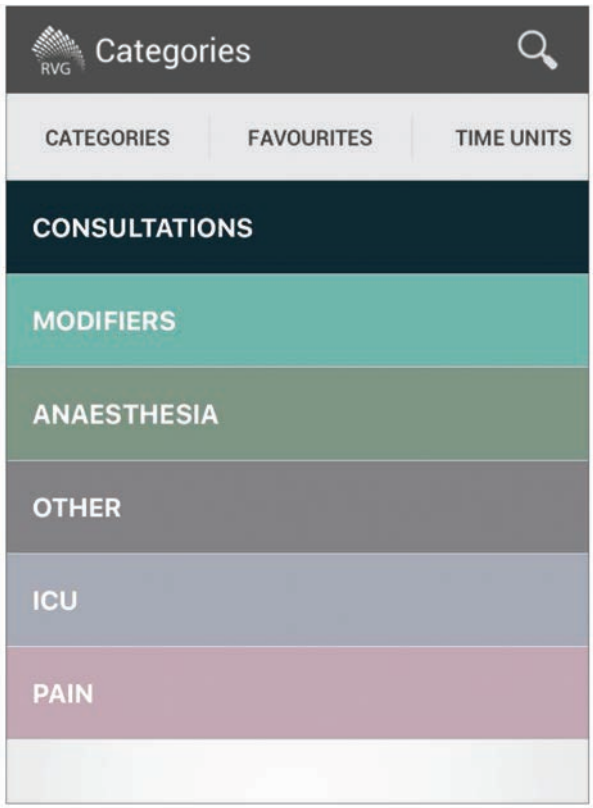

The app can be accessed using your ASA member logon details.

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

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

RVG

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SAVE THE DATE 6 – 9 OCTOBER 2018

ADELAIDE NATIONAL SCIENTIFIC CONGRESS

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*