AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • MARCH 2016

PNG ANAESTHETIST
Women in medicine

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THE WORLD ANAESTHESIA ISSUE

ODEC • Profiling a PNG Anaesthetist • Lifebox

ASA
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DR DAVID CANTY

Dr David Canty is an anaesthetist and Director of simulation and senior lecturer for the Ultrasound Education Group, Department of Surgery, University of Melbourne, where he researches and teaches a wide range of ultrasound techniques, with a particular interest in echocardiography.

PROFESSOR STANTON NEWMAN

Professor Stanton Newman is Professor of Health Psychology and Dean of the School of Health Sciences at City University London. He has published over 350 research papers and chapters as well as 18 books. One of his areas of specialisation is the impact of surgery and anaesthesia on the brain.

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AUSTRALIAN
Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

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

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

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ASA
Australian Society of Anaesthetists

REGULARS

FEATURES

34 NATIONAL SCIENTIFIC CONGRESS

INSIDE YOUR SOCIETY

WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

The June issue features of *Australian Anaesthetist* will focus on anaesthesia in rural locations; the difficulty in obtaining and retaining anaesthetists, as well as the need for locums in these areas. There will also be a focus on the wider workforce issue that is a pertinent point of discussion. If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

- Intention to contribute must be emailed by 7 April 2016.
- Final article is due no later than 26 April 2016.

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

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ASA EDITORIAL FROM THE PRESIDENT

DR GUY CHRISTIE-TAYLOR
ASA PRESIDENT

In January of this year Oxfam published its briefing paper entitled "An Economy for the 1%: How privilege and power in the economy drive extreme inequality and how this can be stopped[1]." In this paper they assert that, "The global inequality crisis is reaching new extremes. The richest 1% now have more wealth than the rest of the world combined. Power and privilege is being used to skew the economic system to increase the gap between the richest and the rest. A global network of tax havens further enables the richest individuals to hide $7.6 trillion. The fight against poverty will not be won until the inequality crisis is tackled."

Oxfam has calculated that in 2015, just 62 individuals had the same wealth as 3.6 billion people-the bottom half of humanity. The wealth of these 62 people has risen 45% in the five years since 2010, meanwhile the wealth of the bottom half fell by just over a trillion dollars in the same period-a drop of 38%[1].

Oxfam has also recently demonstrated that while the poorest people live in areas most vulnerable to climate change, the poorest half of the global population are responsible for only around 10% of total global emissions. The average footprint of the richest 1% globally could be as much as 175 times that of the poorest 10%.

So, they assert, instead of an economy that works for the prosperity of all, for future generations and for the planet, we have instead created an economy for the 1%[1].

So how are they proposing to remedy this? They are calling on leaders to start building a human economy that benefits everyone. They suggest the following; pay workers a living wage and close the gap with executive rewards, promote women's economic equality and women's rights, keep the influence of powerful elites in check, change the global system for R&D and the pricing of medicines so that everyone has access to appropriate and affordable medicines, share the tax burden fairly to level the playing field and use progressive spending to tackle inequality.

It seems timely therefore that this edition of the Australian Anaesthetist provides us with an opportunity to reflect on how we are contributing to reducing inequality and to improving the lives of our neighbours in the less developed world.

The Society together with the American Society of Anesthesiologists, ANZCA, RACS and other organisations support the 2015 Bangkok Global Surgery Declaration[2]. This document is a call to the global health community to promote implementation of the World Health Assembly Resolution for Surgery and Anaesthesia Care. This resolution calls upon the world to "Strengthen Emergency and Essential Surgical Care and Anaesthesia as part of Universal Health Coverage."

In August 2015 the Lancet Commission published 'Global Surgery 2030: evidence and solutions for achieving health, welfare and economic development[3].' Notable amongst the authors of this document are the likes of Atul Gawande, David Watters (current RACS President) and Iain Wilson (Past President of AAGBI and Trustee of the Lifebox Foundation).

Much like the Oxfam briefing paper, Global Surgery 2030 contains some sobering statistics. Some of these include:

- In 2010, an estimated 16.9 million lives (32.9% of all deaths worldwide) were lost from conditions needing surgical care.
- This figure well surpassed the number of deaths from HIV/AIDS, tuberculosis and malaria combined.
- Each year at least 77.2 million disability-adjusted life-years (DALYs) could be averted by basic life-saving surgery.
- 5 billion people do not have access to safe, affordable surgical and anaesthesia care when needed.

In much the same vein as the Oxfam paper emphasising the inequality of the world economy, so this paper emphasises the inequality of surgical and anaesthesia care:

- Of the 313 million surgical procedures undertaken worldwide each year, only 6% occur in the poorest countries, where over a third of the world's population lives[3].

What is also very interesting to consider is the view the commission takes as to the value and cost effectiveness of surgical and anaesthesia care. They would affirm that surgical and anaesthesia care are cost-effective when compared with

many established common public health interventions.

They would estimate that the additional investment of $350 billion, to scale up surgical and anaesthesia care between now and 2030 to ensure the world's population access to safe affordable surgical and anaesthesia care, is a mere fraction of the $12.3 trillion loss of global GDP that would result if such an upscale is not achieved! Safe and effective anaesthesia and surgical care is very sound economic policy and provides a significant return on investment.

The ASA, together with many other like-minded organisations, endorses the implementation of minimum standards for safe surgical and anaesthesia care including: trained surgical and anaesthesia providers; functional infrastructure, equipment and supplies necessary to perform safe general anaesthesia, loco-regional anaesthesia, laparotomy, caesarean delivery, and open fracture fixation; functional equipment for materials decontamination and sterilization; access to safe and adequate blood supply; access to essential antibiotics, pain medicines and anaesthetics; postoperative nursing care which includes a record of appropriate physiological observations; 24-hour surgical coverage with the ability to review and respond to a deteriorating patient; preoperative risk assessment and operation planning for elective surgery; and adapted quality improvement processes including audit and reporting of perioperative mortality rates.

It would seem appropriate at this time and in this context to consider some of the issues facing our colleagues in the developed world as well.

The unprecedented strike by Junior Doctors in the NHS has and continues to cause alarm and anxiety within the NHS and the UK as a whole. Anaesthesia is the single largest specialty in the NHS (16% of consultants and approximately 4500 trainees, about 8.5% of the total)[4].

The AAGBI with whom we have close ties and with whom we meet annually at our Common Issues Meeting is the membership organisation that represents them with over 11,000 members, representing approximately 80% of anaesthetists.

In one of his reports, the President of the AAGBI, Dr Andrew Hartle, makes the following comments, 'If the Government engages with consultants, most of whom will work for the NHS for an entire career of 30–40 years (compared with the average few years in office of a minister), and without whom no reform of the NHS can be successful, it can achieve great things. If it chooses to impose change, despite the evidence and ignoring the expertise of the only people who can deliver healthcare, it risks a loss of confidence and respect which will take generations to recover; if the NHS as we know it can survive long enough to permit that[5].'

The AAGBI has expressed serious concerns about the new proposed trainee contract noting that anaesthesia trainees, including those working in intensive care units look after the sickest patients in hospitals at night and weekends and are at the heart of the 'seven day NHS' which the government says it wants to improve. The AAGBI makes the following points:

- 'All trainees are likely to see a 15% reduction in pay under the new contract, but anaesthetic trainees will be particularly hit, especially as they are almost always resident on call and do not benefit from an availability supplement. In addition there will be ramifications for pension contributions and earned pensions, with most having the additional burden of student loan payments[4].
- 'The new contract removes many of the contractual safeguards protecting trainees from working excessive hours. These safeguards protect patients as well. Doctors working a shift of up to 11 hours would be entitled to only one 20 minute break (in those few hospitals that still have one, it can take that long to reach the canteen). In addition, systems of monitoring hours will be removed, the penalties on employers for imposing excessive hours will disappear, and rest facilities for trainees are being removed. We are already concerned about doctors driving home tired from night shifts – nothing in the new contract makes this less likely[4].'
- 'We share the concerns of the Women's Medical Federation that the new contract discriminates against female doctors – loss of seniority whilst on maternity leave, and delayed seniority if working less than full time - will financially penalise our female trainees, at a time when the costs of childcare continue to rise[4].'
- 'Applications to the GMC for Certificates of Good Standing (needed by junior doctors who want to emigrate) have jumped dramatically in recent weeks. We live in an age of global healthcare, and the current generation of trainees may simply vote with their feet, and move if not to Scotland and Wales, then to Australia, New Zealand or other countries. The next generation of trainees are much less likely to choose an anaesthetic career if they know they will earn less, pay higher pension contributions, pay more interest on student loans and work longer, unsocial hours with less rest. What a future for the seven-day emergency NHS[4]!'
- 'The AAGBI believes it essential that the new proposed contract for trainees is modified[4].'

It is noteworthy that the BMA Council Chair, Dr Mark Porter is a consultant obstetric anaesthetist.

At the current time action by junior doctors has been suspended and progress appears to have been made, bringing hopes that a deal can be reached that secures a positive future for the NHS.

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In conclusion I would leave you with some remarks made by Professor Raymond Tallis in his book 'Hippocratic Oaths' published in 2004[6];

"There is a natural antagonism between politicians who have notional responsibility for the health service as a whole and those who are more closely responsible for parts of it. The Minister has to please a macroscopic abstraction-the electorate-while the clinician has to satisfy concrete individuals presenting with serious problems. This contrast is a recipe for mutual misunderstanding, hostility and contempt.'

"In the highly politicised debate about the NHS, the appalling responsibilities carried by clinicians are almost invisible-except where they are deemed to have failed to honour them. To clinicians aware of the complexities of medical care the nostrums of politicians and their advisors seem puerile and often dangerously disruptive and distracting".

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2. http://www.wfsahq.org/images/Bangkok_.Declaration__Endorsements_01_Dec_2015.pdf.
3. http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2815%2960160-X.pdf.
4. https://www.aagbi.org/news/aagbi-statement-proposed-trainee-contract.
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6. Tallis R. Hipporcratic Oaths, Atlantic Books, 2004. p 149.

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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ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

Following on from its Strategy and Governance Day in May 2015, the Board is currently considering governance reforms that would put in place more contemporary and best-practice governance structures. This consideration also reflects one of the five Strategic Priorities of the Society, which focuses on Governance.

The ASA is a company limited by guarantee and its Directors (office bearers and State Chairs) have various legal responsibilities, including an obligation to act in the best interests of the organisation as a whole. Part of this responsibility is ensuring that the Society adopts correct governance structure and processes.

The Australian Institute of Company Directors states that:

"Corporate governance refers to the systems and processes put in place to control and monitor — or 'govern' — an organisation. Good governance is embedded in the good behaviour and the good judgment of those who are charged with running an organisation."

Governance is not just "compliance or rules" — good governance can improve Board effectiveness and decision-making, through to improving the overall performance of the organisation and its effectiveness in achieving its objectives. Proper governance structures and processes are as important for a not-for-profit membership based organisation as for any company or organisation.

The key principles of good governance can be summarised as:

- Transparency — including structure, operations and performance throughout the organisation.
- Accountability — clarity of decision-making and responsibility of management and Board.
- Stewardship — protecting the assets of the organisation on behalf of its Members and acting in the interests of Members.

The benefits of good governance can include:

- Optimising decision making and performance.
- Encouraging agility.
- Better organisational strategies and plans.
- Improved operational effectiveness.
- More prudent regulatory compliance, financial and risk management.
- Improved Member and stakeholder engagement and communication flow.
- Increased likelihood and degree to which an organisation actually delivers on its purpose.

An important consideration is the size of the Board. Smaller Boards can be more effective and dynamic in decision making, and can enable higher levels of engagement and greater flexibility.

Following the May meeting last year, the Board decided to develop proposals which may lead to an improved governance structure for the Society. Arising from those discussions has been a proposal for a dual structure of governance. Under this structure, Members would continue to elect their State Chair and the Office Bearers who would be joined by among others, the Chairs of the key committees; e.g. PIAC and EAC, and the Specialty Affairs Advisor to form the Council. This Council would then elect a Board of Directors. The Board would be about eight in number, while the Council would most likely be around 17. A number of not-for-profit and membership organisations have adopted a similar model, examples include the Australian Medical Association — NSW and most recently, the Federal AMA, following a full governance review.

In each of these cases involving professional membership organisations, a small Board was established (with the legal responsibility of Directors, and responsible for "running the business of the association") and a larger Council responsible for policy matters relating to the profession. This dual structure enables delineation of duties between the two bodies (Council and Board), empowering each to be more productive and effective.

The Board is currently reviewing these proposed governance reforms, and if it decides to progress with these changes, members will be kept informed. Any proposed changes will be presented to Members for consideration and approval, at the Annual General Meeting later this year.

CONTACT

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

LETTERS TO AUSTRALIAN ANAESTHETIST

IN SUPPORT OF ASA'S ODEC

I have been very fortunate to have had opportunities, but also to have had the ASA's tremendous support over many years for the developing country work.

An individual can have all sorts of ideas and enthusiasm, but the multiplier effect of organisational backing significantly enhances these efforts. The ASA's ODEC* (previously the Overseas Aid sub committee) provides stimulus, resources and a community of like minded individuals to brainstorm and develop projects. Many nascent "developmenters" have started their "careers" under the auspices of the ASA. David Mawter, Steve Kinnear and Rob McDougall have all provided great leadership for this committee. I look forward to the stewardship of Chris Bowden.

The ASA is to be commended for its generous funding of ODEC and enabling long term support for projects which are sustainable in the true "development" sense of that much overused word. Sustainable development means sustaining financial assistance until the host individuals, organisations or systems can take over. The ASA provides more money (per member) for Aid projects than most other anaesthesia societies around the world. This is something which makes me very proud to be part of.

Dr Haydn Perndt

Clinical Associate Professor

University of Tasmania.

**ODEC: Overseas Development and Education Committee.*

This letter was written by Dr Perndt in reponse to Dr Guy Christie-Taylor's letter of congratulation to Dr Perndt on receipt of his World Federation of Societies of Anaesthesiologists (WFSA) award. Dr Perndt wished to make the point that individual effort can be effectively leveraged through the support of organisations such as the ASA.

DR DICK STEPHENS

Congratulations to Dr Frederick Richard Neason Stephens on reaching his 100th birthday on 19 January, 2016.

Dick Stephens, as he is more familiarly known, lived in the Rose Bay area where his father was a GP associated with the Eastern Suburbs Hospital. As a neighbour was Sir Ernest Fisk, a pioneer of radio in Australia as well as father of Dr Graham. Dick, after finishing school at Sydney Grammar, started Engineering at AWA, Ashfield.

On contracting TB four years into his training, he was treated at home by use of artificial pneumothorax. He was so impressed by the care of his medical attendant that Dick started medicine at the University of Sydney In 1941.

After graduation in 1946 and residencies at Eastern Suburbs and Royal Newcastle Hospitals, he was appointed Anaesthetic Registrar at the Royal Hospital for Women, Paddington, in 1950-51.

He was accepted as a member of the ASA on Wednesday 21 February 1951. Despite an initial start to gain a higher degree, economic circumstances prevented his ever succeeding in this goal.

After his appointment to the Mater Hospital, North Sydney, and while in partnership with the electronic 'whiz' Tony Balthasar, and friends of Dick Smith and Jim Loughman, Dick concentrated on the development of his tissue perfusion monitor, which measured capillary blood flow, a new concept.

For this achievement he was awarded the ABC Inventor of the Year Award in 1979.

His interest in this monitor and his love of things electronic has never left him as he still has on his bedside table at his retirement 'hotel', his multimeter in order to ensure that his hearing aid batteries are really flat and need replacement.

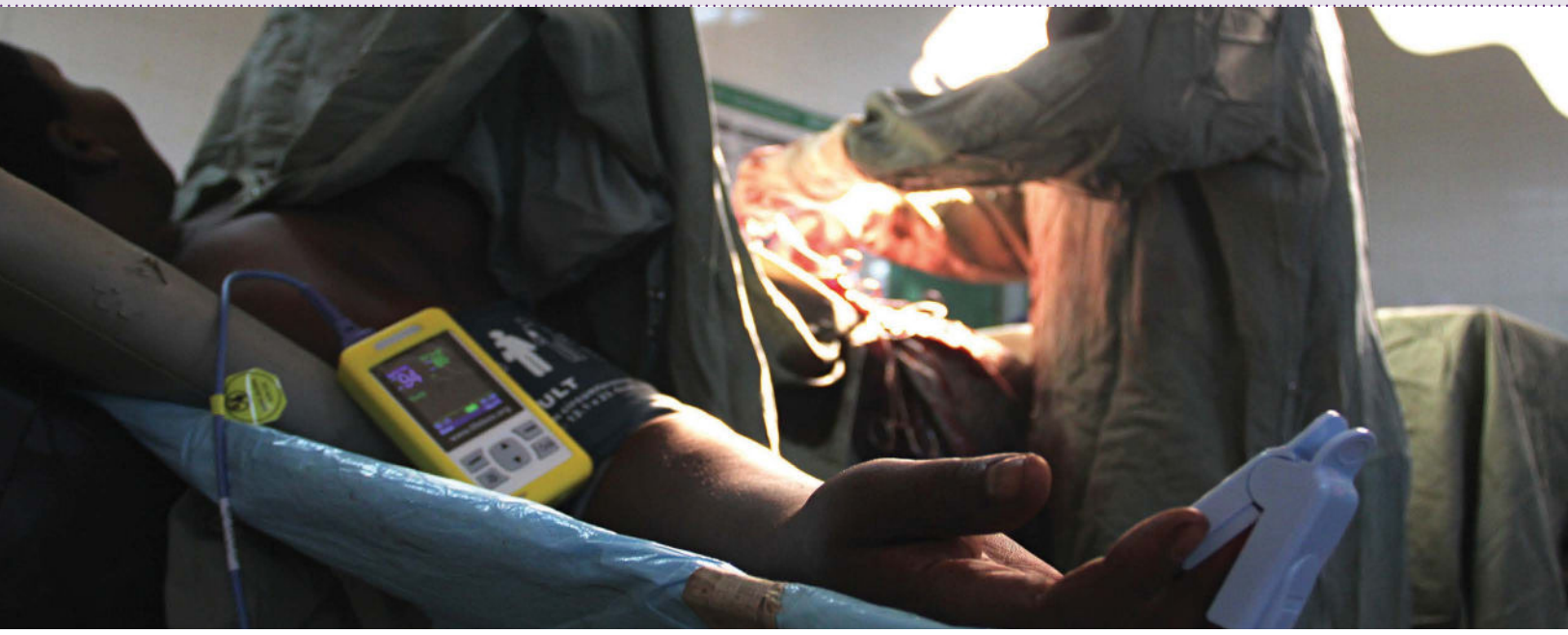
Enjoy many more stimulating days ahead of you, Doctor Dick!

Dr Richard Bailey

Sydney, New South Wales

Dr Stephens was awarded the ABC "Inventor of the Year" in 1979 for his invention of the tissue perfusion monitor.

FEATURE



LIFEBOX

Lifebox Australia & New Zealand is a joint project of the Lifebox Foundation, ANZCA, the ASA, Interplast and NZSA. Interplast has been working in collaboration with local partners across the Asia Pacific region since 1983, sending highly skilled teams of volunteer plastic and reconstructive surgeons, anaesthetists, nurses and allied health practitioners to deliver surgical activities and build local medical capacity with training and mentoring programs.

Lifebox Australia & New Zealand is a joint, regional project developed to ensure access to life-saving monitoring during surgery, through the purchasing and distribution of pulse oximeters to hospitals across the Asia Pacific region. The project also focuses on training local personnel in the science and use of the pulse oximeters. This project, building on the work of the Lifebox Foundation in the UK and US, enables supporters in Australia and New Zealand to make tax-deductible donations directly to this work, and for hospitals across the region to request pulse oximeters and support in their use.

Lifebox is an independent charity founded by surgeon and author Atul Gawande, as a joint initiative of the Association of Anaesthetists of Great Britain and Ireland, the Brigham and Women's Hospital, the Harvard School of Public Health and the World Federation of Societies of Anaesthesiologists. The Foundation is a registered charity in both the UK and the US. In Australasia, the projects have, to date, been coordinated through the ASA, ANZCA and the NZSA.

The first technical programme of Lifebox is the provision of environment-appropriate pulse oximeters and training to hospitals in developing countries, as part of a broader objective of ensuring safe surgery for millions of people worldwide.

A pulse oximeter is the most important monitoring tool in modern anaesthesia practice. It is a non-invasive medical device that checks the level of oxygen in a patient's bloodstream and sounds an alarm as soon as it detects the slightest unsafe change. A functioning pulse oximeter is the only piece of equipment listed on the World Health Organisation (WHO) Surgical Safety Checklist, an intervention proven to reduce surgical complications and mortality by more than 40%.

Funds donated to this project contribute to the purchase and distribution of pulse oximeters (with education materials), and initial and ongoing support and education to local medical personnel, as well as monitoring and evaluation of the project.

Over the past five years the ASA, NZSA and ANZCA have been involved in the donation of over 600 Lifebox oximeters to operating theatres and recovery areas throughout our region. Patients in Mongolia, Myanmar, Vietnam, Bhutan, Indonesia, Papua New Guinea, Fiji, Tonga, Samoa, Tuvalu, Nauru, Vanuatu, Solomon Islands and Timor Leste have benefitted from access to oximetry. Health care workers in these countries have benefited from education in oximeter use and have

had assistance in introducing the WHO Surgical Safety Checklist.The Lifebox oximeter has been proven to be durable, robust and reliable.

In April 2015, ODEC member Dr Steve Kinnear spent time in Bhutan teaching the local anaesthesia providers. As part of this trip he took four ASA funded Lifebox oximeters. Up until this time reliable oximeters were not available for every surgical patient at Jigme Dorji Wangchuk National Referral Hospital. Later they used an oximeter to help safely anaesthetise a two month old baby for removal of an arytenoid cyst. Steve said that "We used the portable Lifebox oximeter, as it was the most reliable oximeter in the whole OR block".

In 2011 thirteen oximeters were delivered to the Solomon Islands and were distributed throughout the country. Up until this time the only reliable oximeter at the main hospital in Honiara was a very robust early model donated by Dr Chris Sparks in the early 1990s. ODEC members Phil Blum and Haydn Perndt recently visited Honiara to find the Lifebox oximeters being put to good use. Dr Kaeni Agiomea, the Solomon's senior anaesthetist, when asked about his thoughts about oximetry has said: "Life ain't safe without a Lifebox oximeter"!

The largest request to date has been from Myanmar, for 850 oximeters. So far, over 75 have been distributed, with distribution taking place at the annual meetings of the Myanmar Society of Anaesthesiologists. This allows education to take place at the time of distribution.

Small Pacific nations are not forgotten and in 2014 Nauru accepted a donation of Lifebox oximeters from the ASA. Dr Christian Leepo, anaesthetist, said at the time of the donation "Lifebox has made anaesthetic and surgical procedures safer for patients not only because of its sensitive alarm settings and other specifications but because it promotes the implementation of the WHO surgical safety checklist".

The last five years has seen much Lifebox activity but our region still requires more help. Myanmar and Indonesia are just two countries with a requirement for oximeters to make surgery and anaesthesia safer. The partnership with Interplast is a great opportunity to help fulfil all the requests for help in Asia and the Pacific.

CONTACT

To make a donation, please visit the website below:

https://www.interplast.org.au/transforming-lives/lifebox-australia-new-zealand/

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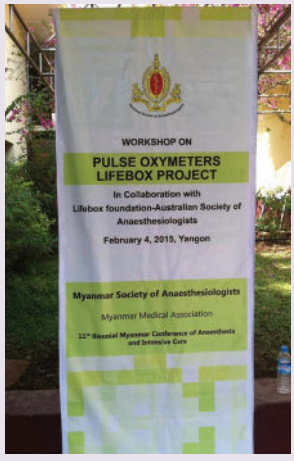
LIFEBOX

Pictured are attendees at the ASA-sponsored educational symposium in February 2014

A lifebox oximeter

RON Hospital



Lifebox banner advertising the Lifebox workshop

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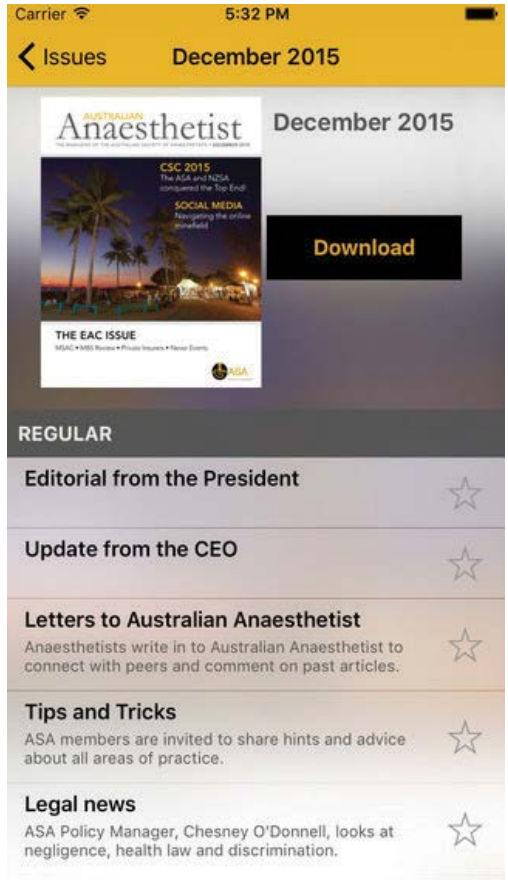

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Australian Society of Anaesthetists

FEATURE

KETAMINE IN RESOURCE-POOR SETTINGS—TONGA

Ketamine is used by medical practitioners as an anaesthetic. Alexandra Metherell examines the use of Ketamine in Tonga, in the following case study.

The South Pacific nation of Tonga has 36 inhabited islands, spread over 740 square kilometres.

Having a trained anaesthetist on each, let alone a hospital is not feasible. This makes ketamine vital for Tongans. Doctors on the small islands are trained to use it for short procedures, and also in cases where a patient needs to make the journey of up to three hours by plane to a bigger hospital.

"On the islands outside the main hospital they use ketamine a lot, for sedation and small procedures," says Dr Selesia Fifita, the only anaesthetist on Tonga's main island, Tongatapu. "It also helps them to do whatever they can to help a patient in terms of pain relief and sedation on an island before transferring them."

Ketamine raises blood pressure and acts quickly which makes it the anaesthetic agent of choice in patients who have lost a lot of blood. This sets it apart from other anaesthetics, which lower blood pressure.

Even at the country's main hospital Vaiola, in the capital, Nuku'alofa, Dr Fifita regularly uses ketamine, especially for emergency obstetric patients or patients who have been in car accidents.

She's lost count of how many mothers giving birth the hospital has saved using ketamine.

"Our doctors here are really used to using ketamine," says Dr Fifita. "It is often used in our emergency department, for anyone who needs sedation and pain relief. As the only anaesthetist here, it makes my job a lot easier."

Diabetes is a major health problem in Tonga. For short procedures to treat diabetic ulcers and infections Dr Fifita uses 'ketafol' – a mix of ketamine and propofol, which is an anaesthetic that, like ketamine, has fast onset. She says she has almost never seen anyone emerge from a ketamine anaesthetic hallucinating, which can be a side effect of the medicine. To reduce the risk of hallucinations, she gives patients a small amount of a sedative.

"Our patients are really satisfied," she says. "No one has complained to me about ketamine."

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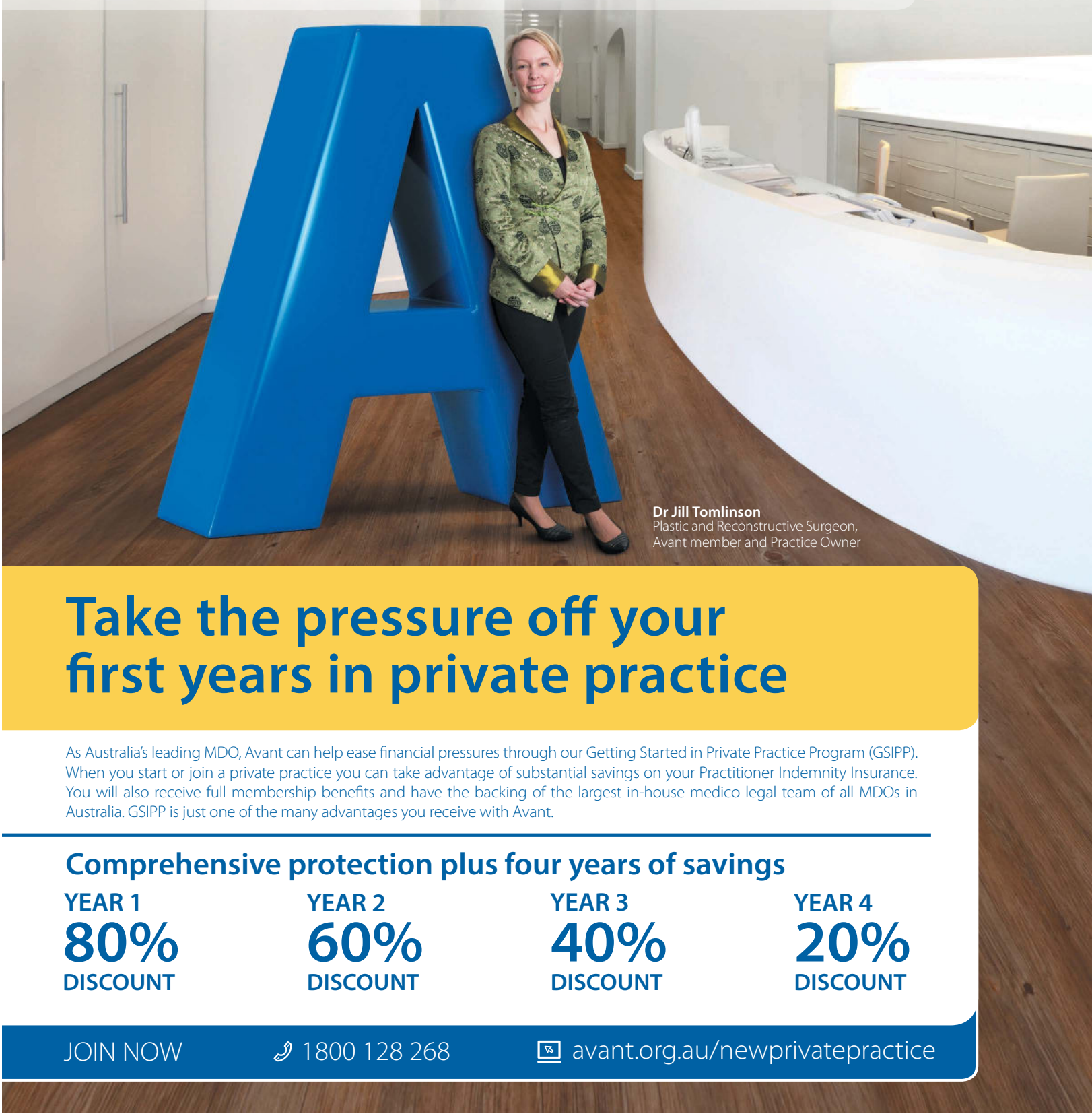

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FEATURE

TAKING LIFEBOX TO INDONESIA

Dr Mark Ng, Staff Specialist Anaesthetist at Box Hill Hospital in Victoria, provides a detailed account of the efforts of the Lifebox Foundation in the context of the recent training sessions held in Indonesia at a workshop at the 19th ASEAN Congress of Anesthesiologists (ACA) in Yogyakarta, Indonesia last year.

Lifebox Foundation, which has a vision to improve access to safer surgery throughout low-middle income countries, is achieving this through the provision of a robust pulse oximeter, along with training and implementation of the WHO Surgical Safety Checklist. On the 27th August 2015, the ASA sponsored Drs Rob McDougall, Mark Ng and Wayne Morriss to facilitate a "train the trainers" Lifebox workshop at the 19th ASEAN Congress of Anesthesiologists in Yogyakarta, Indonesia.

Indonesia is the world's fourth most-populated country with a population of 255 million spread over 18,307 islands[1]. Although the archipelago is the largest economy in South East Asia, and a member of the G-20 major economies, there is still significant poverty with >11% of Indonesians currently living below the poverty line and ~50% of all households clustered around the national poverty line set at 292,951 rupiahs per month ($24.4 USD)[2]. Of the 2454 hospitals in Indonesia, only 20 have been accredited by Joint Commission International (JCI), as of 2015[3]. Therefore, whilst major public hospitals with state-of-the-art medical equipment and training exist, there are also many that lack what we would even call "the basics" in the affluent world. What an exciting place, Indonesia is then, to bring Lifebox training to — not only for its need for Lifebox pulse oximeters, but also for its leadership role to other parts of South East Asia.

Lifebox had its origins at the 2004 World Congress of Anaesthesiologists, where the Quality and Safety of Practice Committee of the World Federation of Societies of Anaesthesiologists (WFSA) identified improved access to pulse oximetry during anaesthesia as a priority for patient safety in low and middle-income countries. From this, the Global Oximetry (GO) Project was then formed to investigate the feasibility and sustainability of pulse oximetry as a standard of care for all patients[4]. In 2008, Weiser et al. estimated the number of operations performed annually around the world as in the order of 234 million[5], with approximately 77,700 operating theatres worldwide lacking oximetry[6], equating to

approximately 35 million patients each year undergoing surgery without pulse oximetry monitoring[7]. There has been debate about how much safer surgery is with pulse oximetry, but there have been estimates of as much as a one-third reduction in mortality[8].

In 2007, the World Health Organization (WHO) launched its Second Global Patient Safety Challenge: Safe Surgery Saves Lives (SSSL). A key output of this project was the WHO Surgical Safety Checklist, with the recommendation that pulse oximetry should be used in all anaesthetics worldwide[4].

In 2010, Lifebox (www.lifebox.org) was formed as a new charity to take this work forward — that is, the introduction of the WHO Surgical Safety Checklist with environment-appropriate pulse oximetry. This was formed by the major stakeholders — the Association of Anaesthetists of Great Britain and Ireland (AAGBI), the World Federation of Societies of Anaesthesiologists (WFSA), the Harvard T. Chan School of Public Health, and the Brigham and Women's Hospital. It is chaired by surgeon, author and Checklist lead Professor Atul Gawande.

The Lifebox workshop was conducted on the 27th August 2015 at the 19th ASEAN Congress of Anesthesiologists in Yogyakarta, Indonesia's cultural capital, and highly supported by the enthusiastic ACA president Bambang Tutuko.

The purpose was to demonstrate to participants how to use the materials to conduct a Lifebox workshop. The aims of a Lifebox workshop being, to teach others in resource-poor environments on the WHO Surgical Safety Checklist and pulse oximetry (understanding pulse oximetry, using the oximeter, knowing how to manage hypoxia and use of a logbook).

The presentations given were on 'Using the Lifebox Pulse Oximeter' and 'The Surgical Safety Checklist'. The participants were then split into three groups, with further assistance from Dr Wayne Morris (WFSA board representative from Christchurch, NZ), for case-based discussions using the 'Action plan for $Sp0_2$ ≤94%'. This generated lively discussions.

Thirty-six participants attended, 25 from various regions of Indonesia, 10 from Cambodia (including the president of the Cambodian Society of Anesthesiology Critical Care and Emergency Medicine) and one from Myanmar. Whilst all participants had seen and used a pulse oximeter previously, there were several participants from Cambodia who said they did not have regular access to one in their hospitals. Five Lifebox oximeters were donated by the ASA to the Indonesian Society of Anaesthesiologists.

Interestingly, many of the feedback sheets indicated that the participants found the workshop useful for their own learning, especially the case-based discussion around the 'Action plan for $Sp0_2$ ≤94%' (with its stepwise ABCDE approach), but also even the pulse oximetry tutorial — underlining the benefit of the educational component of the Lifebox workshop for understanding and management of hypoxia, even for participants from low-middle income countries who already had access to pulse oximetry. Most sites had a surgical safety checklist already, although implementation was variable — and again this is an area that Lifebox can help improve.

This workshop was exciting, in terms of the enthusiasm of the participants but also in capturing some of the leading anaesthesia providers of Indonesia and Cambodia — both countries which Lifebox would like to continue its work with, and which will be enhanced by the contacts and support we now have.

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For more information about Lifebox visit www.lifebox.org

FEATURE

SNAPSHOT OF 19TH ASEAN CONGRESS 2015

Dr Wayne Morriss hosts a case-based discussion

Dr Bambang Tutuko at the opening ceremony

Dr Bambang Tutuko's opening address

Dr Rob McDougall teaching on the WHO Surgical Safety Checklist

Dr Mark Ng hosts a case-based dicussion

FEATURE

REAL WORLD ANAESTHESIA COURSE DARWIN 2015

Dr Julia Slykerman, writes about current issues surrounding global anaesthesia, having attended the Real World Anaesthesia Course (RWAC) 2015.

I had been eager to attend the RWAC for several years and was delighted to get a spot in this year's course, held prior to the ASA/NZSA Combined Scientific Meeting in Darwin. 2015 is a particularly auspicious time to be learning about global anaesthesia, given the recent WHO Health Assembly meeting in May, which for the first time recognised the importance of access to safe and timely surgical services as a significant global health issue. In 2010, 33% of all deaths worldwide were from conditions needing surgical care; a figure that is now greater than the mortality related to HIV/AIDS, tuberculosis and malaria combined.

WHO Resolution A68/31 recommended strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage. The report highlighted that surgically treatable diseases are among the top 15 causes of disability worldwide. Obstructed labour, congenital anomalies (like club foot), diabetes, cancer, cardiovascular disease, hernias, cataracts, road traffic accidents and injuries due to burns and falls are common and affect people in all socioeconomic and ethnic groups. In many parts of the world, access to essential and emergency surgical services is extremely limited and often concentrated in urban centres. Strengthening surgical capacity at the district hospital level is a highly cost-efficient means of reducing disease burden.

The Lancet Commission on Global Surgery released their report in April last year collating information regarding gaps in knowledge, policy and action in relation to the development and delivery of surgical and anaesthetic care in low and middle income countries (LMICs). A two minute summary is available at https://www.youtube.com/watch?v=bRf8PbQgjGU

Its five key messages are:

- Five billion people do not have access to safe, affordable surgical and anaesthetic care.
- Of the 313 million surgical procedures undertaken worldwide each year, only 6% occur where a third of the world's poorest live, with low operative volumes contributing to high case fatality rates for common surgically treatable conditions.
- A quarter of people who have a surgical procedure will incur financial catastrophe as a result of seeking care.
- Investing in surgical services is

affordable, saves lives and promotes economic growth.

- Surgery and anaesthetic care are an indivisible and indispensible part of health care and essential for the full attainment of global health goals in areas as diverse as cancer, injury, cardiovascular health, infectious diseases, maternal and child health.

This year the Royal Darwin Hospital played host to 18 enthusiastic participants from Australia and New Zealand. The first course of its kind was convened in Tasmania in 1999, by Dr Haydn Perndt and Dr George Merridew and until 2004, was called the Remote Situations, Difficult Circumstances, Developing Country Anaesthesia Course (RSDCDCA). The RWAC is now run annually: in Darwin by Dr Phil Blum, in Frankston, by Dr Chris Bowden and in Christchurch by Dr Wayne Morriss.

The RWAC is unique in providing practical in-theatre sessions, utilising a variety of different vaporisers and equipment for drawover anaesthesia. We thoroughly enjoyed ourselves getting to know the equipment, with opportunities to practice pulling them apart, putting them back together again, troubleshooting and enhancing their output. A degree of flexibility and ingenuity is required in many developing world situations and it was interesting to see this in action with a number of attempts at improving the inspired oxygen concentration for pre-oxygenation with oxygen concentrators and large plastic bags or improving our volatile concentration by manipulating the heat capacity of the system with warmed hands or water baths made from Styrofoam cups. It was great to see all that primary examination knowledge about saturated vapour pressures and latent heat of vaporisation in action! Huge thanks must go to the operating theatre staff at Darwin Hospital for their enthusiasm and patience in accommodating our endeavours.

The course also utilised interactive lectures and problem-based discussions to cover essential issues such as global health, sustainability, equipment maintenance, tropical medicine, disaster management, teaching, ethics, motivation for going and the challenges of adaptation.

One of the strengths of the course is the incredible breadth of experience of the faculty and indeed of many of the participants, providing a rich learning environment based around "real world" experiences. This was highlighted by the unique involvement of Dr Meg Walmsley, Dr Steve Pickering and Dr Brian Spain, in response to the recent earthquake in Nepal, detailed in the June edition of the ANZCA Bulletin. Dr Walmsley was working at Everest Base Camp at the time of the avalanche and coordinated care for climbers blasted by ice and debris, in harsh conditions with little salvageable medical supplies. Dr Brian Spain was involved in the Australian government response to the disaster and reflected on the critical importance of liaising with local authorities as to what was required, rather than simply turning up with good intentions and inappropriate equipment, ultimately putting an additional strain on local resources. Dr Steve Pickering lives and works in Nepal and highlighted this important concept further with descriptions of the experiences of his local colleagues dealing with the aftermath of the disaster.

A highlight of each day was the opportunity to hear from Faculty members as they reflected on their experiences and reasons for becoming involved in anaesthesia in the "real" world. Amazing photos and anecdotes of living and working in far-flung places and medical pathology rarely encountered in the first world setting were shared. Key themes were the combination of a sense of adventure and the desire to do something to improve the lives of others less fortunate than themselves. For some it was a calling from childhood and a life of dedicated service, for others it was the result of meeting inspiring individuals during training or seeking a meaningful break from the sometimes disconnected experience of working in healthcare in the "unreal" (first) world.

The incredible and varied stories of the RWAC faculty reinforced for me that even small actions committed with regularity, in an ethically responsible way, can have lasting effects and lead to big improvements for patients.

Enormous thanks to Dr Phil Blum, as Course Convenor, and to the team of facilitators who came from far and wide, across the globe, to share their knowledge and passion for the provision and teaching of safe and ethically responsible anaesthesia in the developing world: Dr Brian Spain, Dr Chris Bowden, Dr Wayne Morriss, Dr Haydn Perndt, Dr Eric Vreede, Dr Dan Holmes, Dr Andrew Magness, Dr Andrew Fenton, Dr Michael Cooper, Dr Sarah Hodges, Mr Steve Threlfo, Dr Steve Pickering and Dr Jason Sly. Thanks also to WFSA President Dr David Wilkinson who joined us on the final day, for reiterating the importance of anaesthetists in improving patient care around the world, by ensuring safe and timely access to surgery and anaesthesia and the role the WFSA plays in this regard.

The next Real World Anaesthesia Course will be held in Frankston, Victoria, in 2016.

For details on the 2016 course please contact Dr Chris Bowden: cbowden@phcn.vic.gov.au

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SNAPSHOT OF THE REAL WORLD ANAESTHESIA COURSE 2015

Dr Steve Pickering overseeing equipment use

Attendees at the 2015 RWAC

Dr Sarah Hodges demonstrating to colleagues

2016 AWARDS, PRIZES & RESEARCH GRANTS

The Society awards a number of Prizes and Research Grants each year. In 2016 the following prizes are available:

Pre-NSC adjudicated

ASA PhD Support Grant

The Board approved the ASA PhD Support Grant Bylaw in 2005 in order to assist members of the Society to complete PhDs. Application is open to ASA members only. Preference will be given to applicants who can demonstrate that their research will advance the safety, delivery or efficacy of anaesthesia whilst having a favourable impact on society as a whole. The grant may be used to purchase or lease equipment, facilities or material; fund administrative or scientific support; offset research and other expenses or fund travel and accommodation. The recipient must provide a written report to the Board within six months of completion of the funded activity. Successful applicants will receive a cash grant of up to $10,000 each. Up to two Grants may be awarded annually. The application form can be found on the ASA website. Please see the 'Awards, Prizes & Research Grants' section under the 'About Us' tab on the ASA website: www.asa.org.au.
For further information please contact Sue Donovan sdonovan@asa.org.au. Applications close 30 June 2016.

Kevin McCaul Prize

This prize commemorates the late Dr Kevin McCaul who was, for many years, the Director of Obstetric Anaesthesia at the Royal Women's Hospital, Melbourne. He had a major and lasting influence on obstetric anaesthesia throughout Australia. The prize was instituted in 1978 on the occasion of his retirement as Director. The prize is administered by the ASA and is offered to ASA members who are registrars in training or junior specialists within two years of obtaining a higher qualification in anaesthesia. The prize is awarded for a written paper, critical review or essay on any aspect of anaesthesia, pain relief, physiology or pharmacology, with particular reference to the female reproductive system. The prize comprises a certificate and monies of $10,000. The application form can be found on the ASA website. Please see the 'Awards, Prizes & Research Grants' section under the 'About Us' tab on the ASA website: www.asa.org.au.
For further information please contact Sue Donovan sdonovan@asa.org.au. Applications close 30 June 2016.

NSC Presentation Awards

ASA Best Poster Prize

Description

Applicants should submit an abstract via the online submission process for papers to the annual NSC once the "Call for Papers" is issued. This submissions page is found by following the "Application" link for the Award on the NSC website. All papers submtted are reviewed by the committee as to their eligibility and suitability prior to acceptance. Those accepted for presentation at the NSC will deliver a three-minute oral presentation discussing the aims, methods and results and conclusions of their research. This will be follwed by a seven-minute question period. The precise presentation requirements for each NSC will be sent out prior to the Congress.

Eligbility

Application is open to ASA members only. Applications must be based on original research (the majority of which has been performed in Australia). The presenter must be one of the authors of the paper.

Award and Applications

Three prizes will be awarded comprising a certificate and a cash prize ot the value of $4000, $2500 and $1500 respectively for recipients judged first, second, third by the adjudicating panel. The awards will be presented during the NSC, usually prior tothe ASA's Annual General Meeting. Applications close 27 April 2016. To apply visit, www.asa2016.com.au/call-for-abstracts.

Trainee Poster Prize

Description

The Trainee Poster Prize was introduced in 2011 and is only open to ASA Trainee members who present a poster at the NSC. Applicants should submit an abstract via the online submission process for papers to the annual NSC once the "Call for Papers" is issued. This submission page is found by following the "Application" link for the Award on the NSC website. All papers submitted are reviewed by the committee as to their eligibility and suitability prior to acceptance. Those accepted for presentation at the NSC will deliver a three-minute oral presentation discussing the aims, methods, results and conclusions of their research. This will be followed by a seven-minute question period. The precise presentation requirements for each NSC will be sent out prior to the NSC.

Eligibility

Applicants must be ASA Trainee members. The majoirty of the research must have been performed in Australia (or as determined by the NSC Organising Committee). The principal content of the poster must not have been previously presented at a national meeting in Australia.

Award and Applications

The prize consists of a certificate and a cash prize to the value of $500. The award will be presented during the NSC, usually at the ASA's Annual General Meeting. Applications close 27 April 2016. To apply visit, www.asa2016.com.au/call-for-abstracts.

Gilbert Troup ASA Prize

Description

The Gilbert Troup ASA Prize commemorates the contribution to Australian anaesthesia by Dr Gilbert Troup of Perth, Western Australia. Applicants should submit an abstract via the online submission process for papers to the annual NSC once the "Call for Papers" is issued. The submission page is found by following the "Application" link for the Award on the NSC website. All papers submitted are reviewed by the committee as to their eligibility and suitability prior to acceptance. Those accepted for presentation at the NSC will deliver a ten-minute oral presentation illustrated by audiovisual support discussing the aims, methods and results of their research. This will be followed by a five-minute question period. Those papers not accepted may be offered a poster format - either in a ASA Best Poster Prize session or as static poster display.

Eligibility

Application is open to ASA members only. Applications must be based on original research (the majority of which has been performed in Australia). The principal content of the paper must not have previously been presented at a national meeting in Australia. The presenter must be one of the authors of the paper. Once a paper has been accepted for inclusion in the Gilbert Troup ASA Prize session, it will no longer be eligible for other NSC-judged awards.

Award and Applications

The Prize includes a medal, known as the Gilbert Troup Medal, and a cash prize of $7500. The award will be presented during the NSC, usually prior to the ASA's Annual General meeting. Applications close 27 April 2016. To apply, visit www.asa2016.com.au/call-for-abstracts.

Day Care SIG

Hornabrook Prize 2016

Description

The Day Care SIG welcomes the submission of abstracts for the Hornabrook Prize 2016.
Rupert Hornabrook was a pioneer of anaesthesia in Australia, devoting the bulk of his practice in the years following the Boer War to promoting the specialty. He was honorary consultant in anaesthesia to the Melbourne General Hospital for many years and published extensively on issues of safety in anaesthesia. He was an early advocate of improved cardiovascular monitoring and was influential in popularising ethyl chloride-ether as an alternative to chloroform. In 1935, Dr Hornabrook was unanimously elected to honorary membership of the ASA and this award in his name recognises his contribution to Australasian anaesthesia. The prize is offered yearly to junior specialist anaesthetists who are within five years of having obtained their higher qualification in anaesthesia and will be awarded for an original presentation on a day care theme presented at a national scientific meeting of ANZCA, the ASA or the Day Care Anaesthesia SIG. The prize is in the form of a one off registration to the Australian Society of Anaesthetists NSC in the year following the award. Please see the 'Awards, Prizes & Research Grants' section under the 'About Us' tab on the ASA website: www.asa.org.au. Applications close 30 May 2016.

For further details please contact Maxine Wade: mwade@asa.org.au.

For further information on these please visit www.asa2016.com.au

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- Association of Anaesthetists of Great Britain and Ireland GAT 15–17 June 2016, Nottingham, England (AAGBI)
- Canadian Anaesthesiologists' Society 24–27 June 2016, Vancouver, British Colombia, Canada (CAS)
- American Society of Anasetheiologists 22–26 October 2016, Chicago, Illinois, USA (ASA)

Applications are now open to all ASA/GASACT trainee members.

Click to view the CIG Scholarship Guidelines and the CIG Scholarship Application form.
Applications close 5pm on Wednesday 30 March 2016.
For further information visit www.gasact.org.au or gasact@asa.org.au or call (02) 8556 9726.

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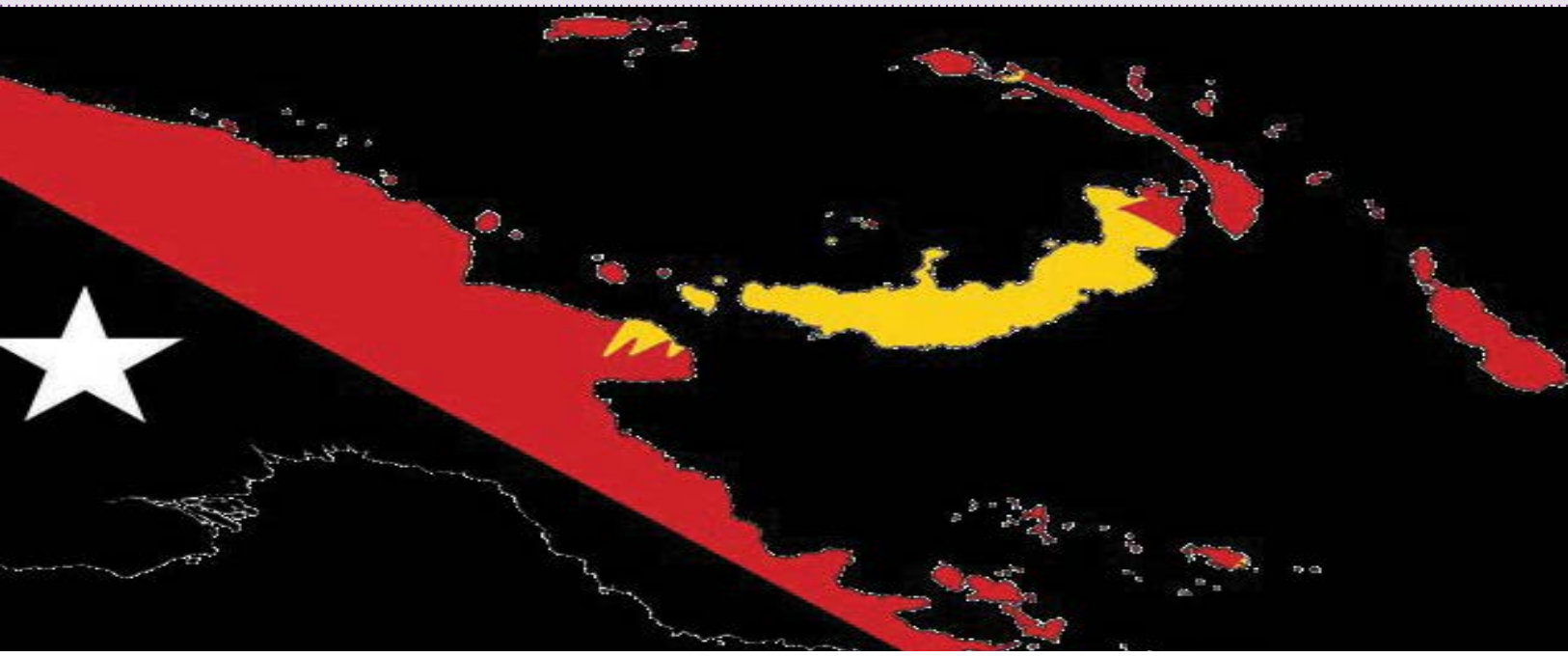
FEATURE



PROFILING A PNG ANAESTHETIST

Dr Lisa Akelisi-Yockopua is a Specialist Anaesthetist who works in Port Moresby General Hospital in Papua New Guinea. She is based in the Obstetric Building of the facility and coordinates anaesthetic services and care of obstetrical and gynaecology patients within that hospital.

Lisa is from the Island Nation of Tuvalu by birth but completed her medical training and Specialist Anaesthetic Training in Papua New Guinea. Lisa finished her anaesthetic MMed degree in 2010. She had a special interest in Head & Neck Anaesthesia, in particular Difficult Airway, under Dr Chris Acott mentorship. However, after a couple of months working as a Specialist Anaesthetist, she was assigned to look after Obstetrics & Gynaecology Anaesthetic services, and since then has sub-specialised in providing obstetric care to the local population. In addition to clinical work and administrative duties Lisa is also involved in teaching anaesthetic trainees and examining MMed and Diploma in Anaesthesia candidates. She has also recently been deeply involved in the organisation of the first SAFE Obstetric course to be run in the Pacific and the first to be run outside Africa and Bangladesh.

Lisa works with 2-3 Anaesthetic trainees and 1-2 Anaesthetic Scientific Officers (Nursing Degree background) every monthly rotation who support her in provision of clinical services. These trainees will then go on to provide anaesthetic services throughout the country, especially amongst the more remote and less well-resourced areas. Papua New Guinea has major challenges in transport because of minimal major roads throughout the country caused by mountainous terrain and tropical weather that washes away roads that have been built. As such, practitioners in this country are often far more isolated and remote than many parts of Africa. Air travel is really the only reliable option and that is extremely expensive so opportunities for anaesthetists to travel throughout the country are somewhat limited. As such, nearly all education occurs in Port Moresby.

The Obstetric Hospital is busy with 173 beds (include 36 beds in Labour Ward and 106 beds in the post natal ward), excluding the gynaecology ward which consist of about 35 beds. On average, from last year's report, 15,108 deliveries and 4.5% Caesareans were performed per year. Most Caesareans are performed under spinal anaesthetic, which is well accepted and tolerated by local parturients.

The Obstetrics & Gynaecology Operating Theatre has three operating suites, however, for nearly four years now only two have been used. On average,

the number of cases per day is estimated to be as follows: elective list is about 10-12 booked, while emergency cases make up 4-6 booked and are all done. About 20-25% of elective cases are usually cancelled due to emergency cases. On a monthly basis on average 440-480 patients are booked, of which about 70% are elective. Elective cases range from Family Completions (sterilisation procedures) to major cases such as Wertheims hysterectomies, whereas emergency cases range from EOUs (evacuation of uterus) to Caesarean sections.

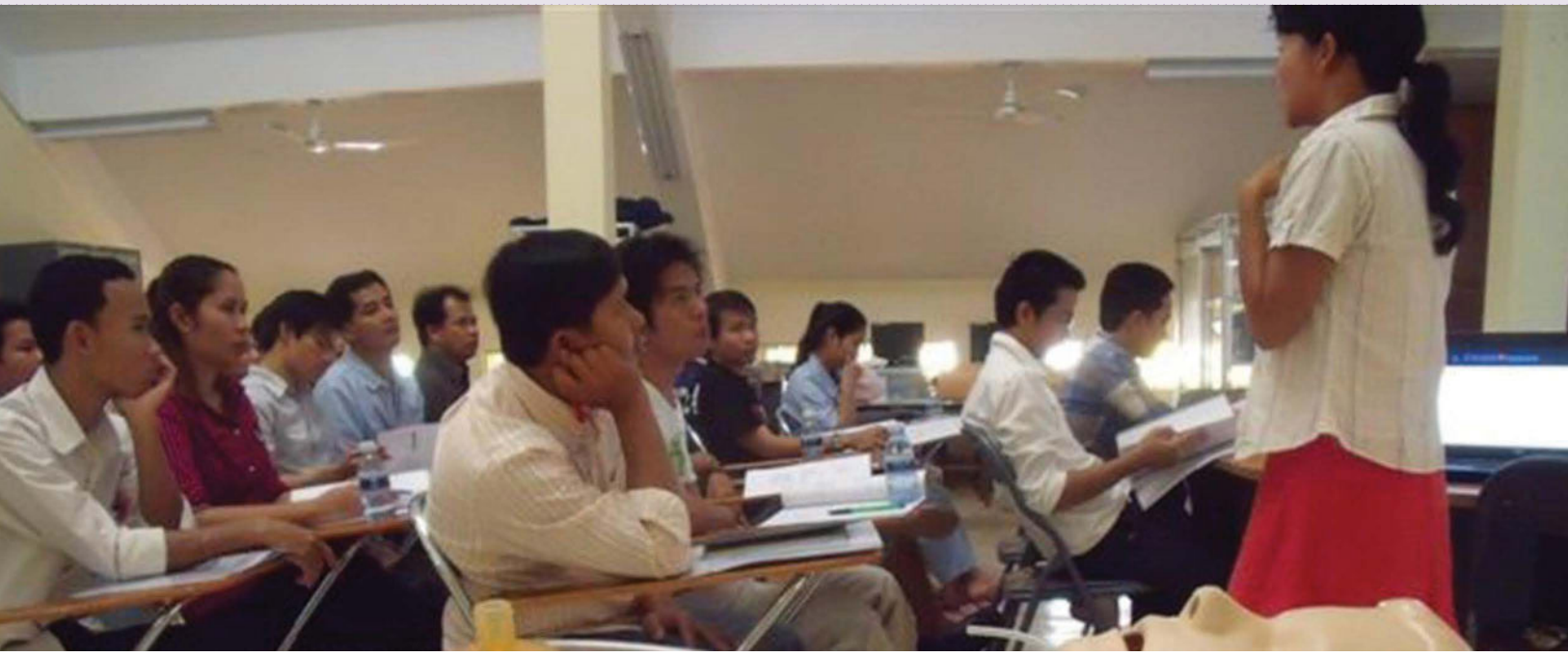
Regarding man power, for more than a year Lisa was the only Specialist Anaesthetist overseeing services and training for Obstetrics & Gynaecology, with a monthly rotation of 2-3 Registrars (one service and two trainees or all trainees), 1-2 Resident Medical Officer/s, one Anaesthetic Scientific Officer and two ASOs trainees, 1-2 medical student/s and two Anaesthetic Technical Assistants (or Anaesthetic nurses) to train and assist with the services.

Lisa has had the opportunity to attend conferences supported by ASA in 2012 and ANZCA in 2014. She has been accepted to complete an Obstetric Anaesthetic Fellowship for six months to begin in January, 2016 in Kuala Lumpur sponsored by WFSA. Lisa has also agreed to be a facilitator on the first SAFE Obstetric course to be conducted in Indonesia that is being held in Jakarta in February 2016.

On a personal level Lisa is married to Dr Sam Yockopua who is a PNG national and currently the Chief Emergency Physician for the country and also oversees the Emergency Department at Port Moresby General Hospital. They have four children.

DR LISA AKELISI-YOCKOPUA

FEATURE



WORKING IN UNIFORM—MOTHERS AND OVERSEAS WORK

Dr Suzi Nou writes about her mother's time working as a volunteer doctor in the Thai-Cambodian refugee camps during the 1980s. Dr Nou provides an account of the significance of her mother's experiences working in the medical profession overseas.

Whilst attending the Combined Scientific Congress in Darwin last year, I was fortunate to take some time out to visit my Mum, who moved to Darwin over ten years ago.

During the visit, she asked me to have a look at the "uniform" that she had worn whilst working as a volunteer doctor in the Thai-Cambodian refugee camps during the 1980s. She asked me "do you know how many thousands of lives I saved in this uniform"? The question just left me speechless.

As she looked at it, she then went on to ponder whether this had more meaning to her than the Khmer samput (skirt) and white top and scarf that is traditionally worn to the temples and for significant ceremonies.

The "uniform" was modest. Resembling what I would describe as a pair of scrubs, made from blue and white-checkered cotton; the same light fabric from which a Khmer kromar (traditional scarf) is made and that would be familiar to anyone who has travelled to Cambodia. It was a little threadbare in a few places but my Mum said that she still wore it, particularly on hot days.

Mum's simple question left me wondering. I have never really asked her about her work in the refugee camps, and not since becoming a doctor myself. Her "uniform" reminded me of the red scrubs that I like to wear when I work in operating theatres in developing countries. I saw an opportunity to catch up on those stories and discovered that we have even more in common than I thought. Thank you for this opportunity to share some of them with you.

My mother graduated from medicine in Cambodia in the late 1960s. At that time, it was the only medical school in Cambodia. It still exists today, and remains the sole institution which provides postgraduate specialist medical training in Cambodia. It is an important institution with which I, with assistance from the ASA and ANZCA, collaborate to strengthen the quality of anaesthesia and ICU training.

As Cambodia had been a French colony, Mum was educated in French, under a French system. Memory can be a mysterious thing. As she recounted to me her experiences, she occasionally lapsed into French, something that I have never noticed before.

After completing her medical degree, Mum hoped to pursue a career in obstetrics and gynaecology. After completing her final exams and defending her thesis she went to commence her residency at the specialist women's hospital. Her Obstetrics and Gynaecology Professor had planned for her to undertake two years of training in Singapore and then one year in the UK but after only a few months she was sent to work in the Emergency Department of the Military Hospital, effectively ending her hopes of specialising in Obstetrics and Gynaecology.

At the time, civil war was raging through Cambodia, between the communist Khmer Rouge and the Government forces. The newest graduates were forced to join the military, and Mum was no exception. Straight after medical school, she was made a sub-lieutenant in the Cambodian Army. The rule was that the youngest were sent first. She didn't want to join the Army, nor work in emergency.

Until I interviewed Mum in preparation for this story, I never knew that we had this shared experience of military service. But that is all we share in this area. Mum was conscripted. I joined the Air Force voluntarily. Mum resented having to wear military khakis to work everyday. I am proud whenever I get to wear my ADF uniform. She couldn't wait to leave the military yet I look forward to contributing into the future.

It wasn't easy for Mum to leave the military. She petitioned the Ministry of Health, who were unable to assist since she was regarded as belonging to the Ministry of Defence. Through luck and persistence, she was eventually granted a year's leave to be reunited with her husband. She left, with my older brother to join him in the Philippines, where he had moved a year before to commence a PhD. As she left, she carried with her the opportunity for our family to escape the horrors of the Khmer Rouge. She did not know then that she wouldn't be able to return to her home country for nearly twenty years.

My mother was in her early 30s when she left Cambodia. Coincidentally, I was a similar age when I left Australia to join the faculty at the Fiji School of Medicine. Within months of my arrival, Emergency Regulations were introduced and the rule of law broke down. I remember reflecting at the time on what I would do if war broke out in Australia and it was too unsafe to return. I recall feeling an immense sense of gratitude and luck that I had been able to complete my specialist training before I moved overseas, something that civil war had denied my mother.

After my Dad completed his studies in the Philippines, our family applied and was accepted for migration to Australia. My dad's student visa would expire and the Khmer Rouge was recognized as the official ruling party of Cambodia. My Dad had correctly deemed it too unsafe for us to return.

Within months of moving to Australia, Mum completed an intensive English language course then set to work as a Resident Medical Officer in various Sydney hospitals. She endured long hours and 60 hour weekend shifts, now with two young children. After a few tough years, my parents, not ones for big cities, had saved enough money and decided to move to Canberra. It was here that Mum got her opportunity to return to the South East Asia region. Tired of the long hours and the struggle of juggling family and career, Mum was contemplating changing professions into something like computing, which was emerging as an exciting new technology.

My brother had a fondness for riding his bicycle on the main road in front of our house. With Mum still finishing the last few months of her residency contract in Sydney and Dad raising two young children on his own, it could be difficult to supervise my adventurous brother. Our kindly neighbor one day spotted him on the street and started talking with him. She learnt that we were Cambodian and that our Mum was a doctor, something that Mum had stopped telling people. Our neighbour eventually met Mum and suggested she return to the South East Asia region and work in a refugee camp. Eventually my Mum accepted and was put in contact with World Vision.

In March 1980, Mum flew to Bangkok then boarded a train to Aranyaprathet, a border town in the east of Thailand. Often abbreviated to "Aran" it would also be the location of my first border crossing into Cambodia, 30 years later.

On arrival in Aran, the World Vision Program Director greeted Mum. He took her to one of the World Vision Houses, which she shared with about a dozen other volunteers from around the world and would be her home for the next seven months.

From there, she was driven to Khao-I-Dang (KID) refugee camp, where she would be working. KID became a unique camp and the longest running and largest of the border camps. It was controlled by the United Nations High Commissioner for Refugees (UNHCR), rather than by the Khmer Rouge or one of the other resistance factions. If you made it to this camp, you were more likely to be granted refugee status and be resettled in a third country. The population was in flux, but averaged about 40,000 refugees and hundreds of expatriate volunteers on any day.[1,2]

World Vision was one of many agencies providing humanitarian assistance in the refugee camps, alongside the Red Cross, MSF and Catholic Relief Service, to name

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a few. They provided rehabilitation and medical services as well as conducting cultural and nutrition programs. At that time, over 1000 refugees arrived each day, most severely dehydrated and in severe states of malnutrition. There were many injured from the fighting, the long journey and landmines. The severely injured patients were treated at the Red Cross Hospital, which had surgical capacity.

My Mum worked six days a week, mainly looking after inpatients. She increasingly was called upon for her translating services and would often be asked by the Japanese team to assist with gynaecological exams. Cervical cancer was, and still is one of the most common cancers affecting Cambodian women. A usual day would start with breakfast in the World Vision House at 7 AM, followed by the 30 minute drive to KID to commence work. Lunch, usually consisting of Australian style sandwiches, would be brought out to them. At the end of the day, they would be transported back to Aranyaprathet. Some evenings they would have a team meeting or prayer group. Many evenings, Mum would be called upon to teach the expatriates some Khmer words or answer questions about the Khmer culture. Although I have a mere slip of the knowledge that my Mum has in this area, this is something I often find myself doing when I return during one of my volunteer trips to Cambodia.

Life in the camps was dangerous for the refugees. In her first few weeks, Mum came across a man who had just been shot dead. The rumour was that a man had wanted his wife. Refugees told stories of being moved out of the camp at night, believing they were moving on to their third country, only to find themselves back in Cambodia and having to make the dangerous border crossing again. Sexual assaults were common. Mum, realising that the patients were left in the care of volunteer refugee paramedics overnight under the supervision of a volunteer nurse, asked her Program Director if she could use her language skills and teach them the basics of medical and nursing care. Her wish was granted. One of the anaesthesia nurses I now work with in Cambodia started his career as a volunteer paramedic in a refugee camp. Occasionally at the neckline of his scrubs I catch the glimpse of a large scar on his chest. I have never dared ask about its origin.

Over the next four years, my Mum returned another two times. Each time returning to a different refugee camp along the Thai-Cambodian border and with a different agency. World Vision requested she join them on numerous occasions but she was reluctant to as they only accepted team members for six months and she was concerned about the impact on her young family. My dad in this time was an absolute pillar. He started work early every day, which meant he would be home early to look after my brother and I. I recall coming home every night to a lovely home-cooked meal. He was a meticulously tidy man, each night the dishes would be done, the kitchen bench tops wiped clean and the rubbish emptied without fail. With a Mum pursuing a career in dangerous foreign locations and a father who gently raised us without a voice of complaint, needless to say, my brother and I grew up without the usual gender stereotypes!

During her work in the refugee camps, Mum was reunited with her parents whom she had not seen in seven years and whose fate during the Pol Pot times had been unknown to her. Unfortunately all four of her brothers had not survived. She was also reunited with sisters, nieces and her mother- and brothers-in-law. Many of them were able to join us in Australia and I fondly remember my extended family growing during that time, as they would initially come to stay with us. However, for our own family, there were some sacrifices. Mum came home to find her children no longer speaking Cambodian, a disharmonious marriage and a medical career that was hard to resurrect.

Needless to say, my Mum found her time working in the refugee camps immensely worthwhile and one of the happiest times of her life. This is something I can relate to and what motivates me to work and volunteer in Cambodia at least twice a year. As a returning Cambodian, Mum thought that she had a beneficial impact, both with the refugees and the foreign volunteers. She says that it was never easy for her to juggle her work and her family commitments, whether they were overseas or when she was a Resident Medical Officer in Australia. She maintains that it is realistic for women, as well as men to want to do this as we are all born "with a body, mind and spirit and choices. If you want to do this work, you have a choice, even if you are not lucky, you have a choice." Perhaps I share her naïveté too, for I believe that women can do this kind of work, with family. Although, unlike my Mum, I am fortunate that I can do it with the full encouragement of my supportive husband, for which I am eternally grateful.

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WORKING IN UNIFORM

Dr Suzi Nou's mother in uniform

Dr Barb Robertson

Dr Suzi Nou in red scrubs in Cambodia

Dr Suzi Nou and fellow team members

Happy times in uniform

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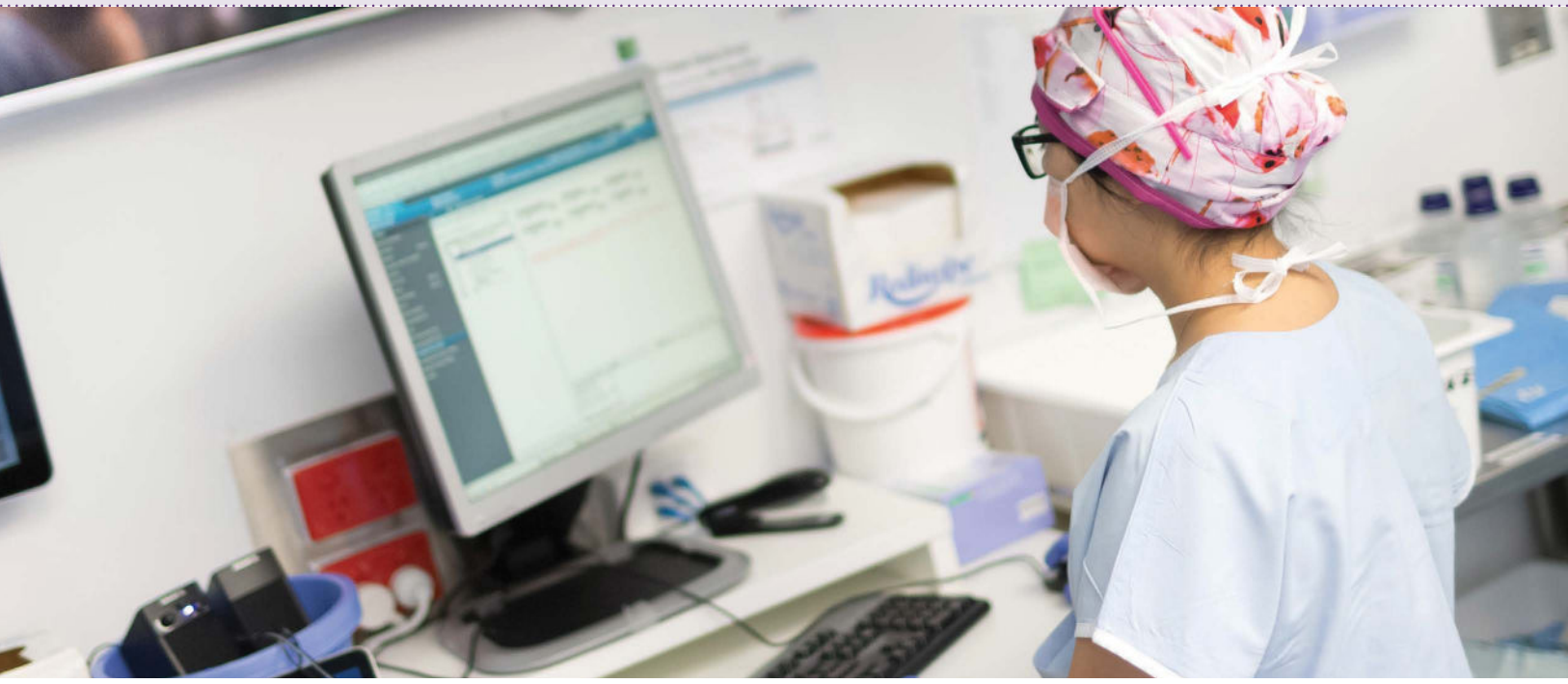

THE ODEC VOLUNTEER DATABASE

Dr Daniel Jolley (FANZCA) is a Hobart anaesthetist with interest in online education, low-resource settings and founder of metajournal.com

Finding volunteer anaesthetists on short notice to assist with overseas education, surgical missions and related humanitarian work can be a challenge. Traditionally, Australian and New Zealand surgical groups have sourced anaesthetic team members from their own hospitals, from within NGOs, or simply by luck and word of mouth.

Mostly this has worked, but problems inevitably arise when life and circumstance intervene and anaesthetic support is needed on short notice. Add to this the existence of Australian Government funded anaesthetic positions aiming to build capacity in Pacific and South East Asian countries, and immediate sources of volunteer and aid-focused anaesthetists can be quickly depleted.

While FANZCA anaesthetists in general, and ASA specialists specifically, have maintained a strong contribution to anaesthetic aid in the region, the laissez-faire way in which anaesthetists were matched with need has often proved problematic.

At the extremes, sometimes surgical trips would need to be cancelled or postponed for last-minute lack of a suitably experienced anaesthetist, and longer-term expat positions could often go unfilled for significant periods of time with critical consequences for the delivery of local healthcare.

Members of the ASA's ODEC would often be approached by surgical colleges, NGOs, overseas departments and even surgeons directly in an effort to suggest a suitable anaesthetist to be asked to join a team. Often an available and suitably experienced anaesthetist could be successfully found, but the process was inefficient and somewhat random — and relied entirely upon the collegial networks of the committee members. With modest success more organisations came knocking when seeking an anaesthetist, and it was quickly obvious that such a method would not be a suitable long-term process.

Enter the ODEC Volunteer Database!

Now four years old, the ASA's ODEC volunteer database was created by the committee to solve this problem. The database serves as an "introduction service" between FANZCA anaesthetists and humanitarian organisations and groups seeking specialist anaesthetic expertise.

FANZCA anaesthetists simply enter their contact and professional details into the online database, and when the committee is contacted by a group seeking an

anaesthetist an email is sent to all in the database with details of the position.

Committee members assess the suitability and consistency of the request with the ASA and ODEC's own humanitarian mission, but otherwise do not interfere with the process. The database is completely confidential and no one outside the committee is given access.

To date, there are almost one hundred FANZCA anaesthetists who have registered with the database, which over the four years since inception has helped fill over a dozen positions of need both within the Asia Pacific region and further afield.

Situations requiring an anaesthetist have included short-term periods, such as for service missions (plastics, urology, orthopaedic surgery, etc.), conference leave cover for local anaesthetists, continuing medical education provision, and disaster response; and medium to long-term positions focusing on longer-term service provision and capacity building.

It is estimated that over 300 million anaesthetics are provided worldwide each year, many in low-resource countries without the same access to an anaesthetic workforce as in Australia. Underpinning this is the growing appreciation of the global burden of surgical disease – more than one tenth of the world's total disease burden — and the essential part that anaesthetists must play in helping to address this.

Many FANZCA anaesthetists and ASA members already make significant and worthwhile humanitarian contributions. Nonetheless the ever-present need offers a unique opportunity for anaesthetists new to overseas practice to make a small and yet immensely fulfilling contribution to communities beyond our own.

More information on the ODEC Volunteer Database can be found on the ASA website under Membership and Volunteering, or interested ASA members can register their details directly online at eepurl.com/bsvXGL.

FEATURE

NATIONAL SCIENTIFIC CONGRESS 2016— MELBOURNE

Simon Reilly, Convenor of this year's National Scientific Congress (NSC), highlights some of the key reasons you should attend the event in September.

The NSC is coming to Melbourne in September and on behalf of the organising committee I invite you to attend what will be a stimulating and informative meeting. This year marks the 75th anniversary — our Diamond Jubilee, of the first Australian national meeting in Anaesthesia held as part of the British Medical Association Conference in Melbourne in 1935. Coincidentally we are holding this year's congress over the same dates as that in 1935.

This year we will showcase the incredible developments in anaesthesia with the highest level of academic presentation and interaction. The main congress streams will highlight perioperative medicine and clinical ultrasound along with other important areas. Professor Colin Royse has put together a stimulating program of themes and speakers which you can read about in the registration brochure.

My job however is to highlight other reasons to come to Melbourne.

Melbourne is a great place to visit having been voted again one of the world's most liveable cities due to its stability, health care, culture, environment, education and infrastructure. It has everything for the visitor to enjoy.

We are a global sporting location supporting some of the most iconic events in Australia. I type this with the Australian Open playing in the background, our conference dinner will be held at the tennis centre — Melbourne Park. However, during the conference it will be AFL finals time with the second semi-final being played over the weekend of the Congress. Always worth taking some time off if you can score a ticket and participate in a Melbourne ritual.

Melbourne is a stunning gourmet food destination representing every culture and land in the world. From eclectic small restaurants, to impeccable cafes, to fine dining at restaurants rated as among the best in the world.

The shopping is some of the best in Australia with the big department

stores of David Jones, Myer and Zara, and clearance chains such as DFO, but Melbourne is also the home of many boutique and unusual areas to shop. Many of these are located in small shopping strips or arcades such as Chapel Street, the Block Arcade, Brunswick Street or Gertrude Street. Melbourne's latest offering there is the new Emporium with its multiple levels of high end fashion and food.

Then of course, there are the incredible laneways of Melbourne where you can explore great restaurants, fantastic cafes, iconic buildings and eclectic art work located within these hidden pockets. Hosier Lane famous for its art work, Flinders Lane with its restaurants and Rankins Lane or Somerset Place for superb coffee.

Our social program at the conference is designed to highlight many of these aspects of Melbourne. We have always prided itself on having a more holistic view of our working lives. It is not possible to enjoy the rigors of anaesthesia without a balance. We have tried to combine first rate scientific programs with excellent social interaction to allow time to digest the information and form new bonds across the anaesthetic communities.

Our gala dinner will be held at Melbourne Park and will include exciting music and entertainment, fine food and excellent wines from Victoria, which the committee has handpicked and tasted! The dresscode will be formal, and as it is our diamond jubilee year, we will have a diamond theme. Take your inspiration from wherever you like whether it's Bowies 'Diamond Dogs' or James Bond's 'Diamonds Are Forever', it is up to you. The band will produce some amazing dance music later in the night but we will also have a quieter area for those not keen to boogie where you can converse with friends. In addition, there will be an opportunity for those who arrive a little early to do a tour of some of the tennis stadiums.

To tempt you further, on the Saturday we have a family orientated cocktail party at the Australian Centre for the Moving Image (ACMI) located right in the heart of Melbourne at Federation Square. As well as all the permanent exhibitions at ACMI there will be a special presentation to which we will have exclusive access and this year we will feature Martin Scorsese. This function will run until 9pm and will include excellent food and wine and some musical entertainment. However, there will still be time to enjoy many of the other nearby entertainment, theatres, eating and drinking establishments with friends later in the night.

On Sunday night we will have the Health Care Industry drinks at the Melbourne Exhibition and Convention Centre finishing early enough to give you time to enjoy the nightlife of Melbourne with your friends and colleagues.

We have included a comprehensive alternative program for partners (and delegates) in the brochure. These activities are expanded and will be updated on the website www.asa2016.com.au as more details come to hand. On the website you will also find many suggestions for eating out and entertainment in Melbourne, alternative shopping such as Victoria and Camberwell markets, as well as excursions to the Mornington Peninsula, The Yarra Valley or the Great Ocean Road.

We look forward to seeing you all in Melbourne in September at the 75th ASA National Scientific Congress.

CONTACT:

Web: www.asa2016.com.au

Registration brochures will be with members 1st week of April

Please forward any enquiries to Denyse Robertson, Senior Events Coordinator:

drobertson@asa.org.au

FEATURE

MEMBERSHIP SURVEY

In March 2016, the Australian Society of Anaesthetists will undertake a new member survey. Unlike many surveys you have previously received from the Society, this one will focus purely on the products and services we provide as part of your membership. The survey will be sent to all members as a link in an email on 14 March 2016. Please keep an eye out for it in your inbox.

PURPOSE

The purpose of the survey is for us to get a better understanding of the things you value most as part of your membership with the Australian Society of Anaesthetists. The results will assist the Board and the staff at the Society develop appropriate strategies and business plans to ensure your needs are being met.

THE QUESTIONS

There are a combination of simple tick box questions and free text fields where we'd like you to provide further information. Questions marked with a red * are compulsory and you will not be able to move on to the next page without answering these questions.

Your responses will remain confidential unless you choose to provide your details in response to questions in the survey or wish to enter the prize draw.

The survey has been broken up into nine key areas:

- Communication
- Branding
- Membership Services
- Publications
- Policy
- Website
- Education and Awards
- Events
- General ASA questions.

It is estimated the survey will take you approximately 20 minutes. If you need to stop the survey midway through, please just close the survey – your results up to that point will automatically save. When you are ready to complete the survey please click on the link in the email again and simply click 'next' on each of the pages until you find where you were up to.

What will happen with the results?

Once collated and reviewed, the results of the survey will be made available to members through the President's enews and in future issues of Australian Anaesthetist. The valuable information will be used by the staff and the Board to help guide the organisation.

PRIZE DRAW

The survey will be available from midday Monday 14 March and close at midnight AEST Sunday 30 April 2016.

We appreciate your time is valuable so as a thank you prize for entering we will be giving away three complimentary full registrations* (valued at up to $1550 incl GST) to attend our upcoming National Scientific Congress in Melbourne from 17-20 September 2016.

The prize draw will take place at the ASA Head office on Friday 6 May at 10am and winners will be notified shortly after.

** If you have already registered for the event you will receive a full refund of your fee — excluding any additional workshops or SGDs you have paid for.*

Important Dates:

Survey sent out: 14 March 2016

Survey closes: 30 April 2016

Results available:

June issue of the Australian Anaesthetist

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INTRODUCTION TO SECONDARY BOYCOTT

Chesney O'Donnell, ASA Policy Manager, provides an introduction to secondary boycott.

Ever since the creation of the Australian Competition and Consumer Commission (ACCC) in 1997, the evolution of competition and consumer rights have developed into a matrix of legalities and compliance. Alongside these developments are numerous anti-competition laws that the ASA has tried to abide by and lend additional guidance to our members who work in the private sector. In 1992, the Council of Australian Governments (COAG) recognised the need for a national competition policy. This resulted in the Hilmer Report and the Trade Practices Act becoming applicable to professionals, unincorporated associations and government business enterprises. Professor Hilmer expressed the view that: "Competition policy covers a broad set of laws, policies and government actions that should be seen as an integrated whole[1]." For this to occur, the Trade Practices Act would need to apply to "individuals" as well as to "corporations". A national agreement was reached on 11 April 1995. The Trade Practices Commission ('TPC') and Prices Surveillance Authority then merged and was replaced by the ACCC. The Trade Practices Act (Cth) 1974 has since been replaced by the Australian Competition and Consumer Law on 1 January 2011. Here is an example of anti-competitive behaviour.

When at least two individual parties act in a concerted effort to prevent or hinder a third party from acquiring goods or services from a fourth party resulting in a substantial loss or damage to their business then this is called secondary boycotting.

Boycotts are considered as purely exclusionary and is strictly prohibited under s45 of the Competition and Consumer Act 2010 (the "Act") "Contracts, arrangements or understandings that restrict dealings or affect competition'[2] and defined in part under s4D 'Exclusionary Provisions"[3]. The definition is that exclusionary provisions occur when in the course of making a contract or arrangement its purpose is to deliberately prevent, restrict or limit supply of goods and services to a particular person or class of person based on particular conditions.

CASE STUDIES

ACCC v CFMEU (proceedings commenced November 2014 Federal Court, Melbourne)

The ACCC instituted proceedings in the Federal Court against the Construction Forestry Mining and Energy Union (CFMEU) over alleged secondary boycott conduct directed at Boral Resources (Vic) Pty Ltd and Alsafe Premix Concrete Pty Ltd (collectively Boral) as being in breach of the Act. It was alleged that "between February 2013 and April 2014, the CFMEU instructed shop stewards to ban the use of Boral concrete at commercial construction sites in metropolitan Melbourne[4]." The ACCC sought pecuniary penalties alongside declarations and injunctions against the CFMEU with the intention of suing the CFMU for over $10 million[5]. Proceedings commenced back on November 2014[6] against John Setka, Secretary of the Victoria-Tasmania Branch of the Construction and General Division of the CFMEU, and Shaun Reardon, Assistant Secretary of the Victoria-Tasmania Branch of the Construction and General Division of the CFMEU. The alleged offences are contravention of s45E of the Act "Prohibition of contracts, arrangements or understandings affecting the supply or acquisition of goods or services" and "undue harassment or coercion of Boral in connection with the supply of concrete by Boral to Grocon" in contravention of s50 of the Australian Consumer Law which "prohibits a person from using physical force, undue harassment or coercion in connection with either the supply of goods or services to a person or payment by a person for goods or services." Provisional contravention penalties will be $750,000 for s45E (or s45D) where the ACCC alleges 14 breaches by the CFMEU and $1.1 million for s50 of the ACL alleging one breach. The union officials may face fines of $250,000 each for contravening the ACL[7]. The case is currently ongoing.

Hughes v Western Australian Cricket Association (WACA) (Inc) (1986) 19 FCR 10

Cricketer Kim Hughes took part in a rebel tour of South Africa against an international cricket ban designed to end South Africa's apartheid policy[8]. The WACA and other clubs followed rules and regulations which would have led to disqualification. This was what eventually transpired with Hughes and his fellow rebels. Hughes argued that the agreement was exclusionary and in contravention of the Trade Practices Act 1974 which has since been replaced by Competition and Consumer Act 2010 (the "Act") (the principles in this instance remain the same). The test applied at the time was whether the WACA corporation (or any other club) was a "trading corporation" which was dependent upon the activities of a sporting body. It was also argued

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that the clubs were "competitive with each other for the services of cricketers" despite the relative informality associated with the recruiting process. However the WACA would argue that there was no competition to begin with since the services of such players like Hughes ceased after he played on the rebel tour of South Africa anyway. Toohey J held that this did not matter. The issue was whether the competitiveness for services were affected by the rule and "whether they entered into a contract or arrived at an understanding (more accurately, a provision of the understanding) for the purpose of preventing, restricting or limiting the supply of services from the applicant."

The ruling did contain an exclusionary provision resulting in the applicant being entitled to damages in the rather nominal sum of $250. This case was complicated due to the international outcry associated with the Apartheid regime of South Africa at the time. However if one were to break things down in the context of exclusionary power we end up with the following: the claim failed based on breach of right to work, conspiracy, bad faith and bias, equal opportunity and deed of settlement. It succeed on procedural ultra vires (beyond one's legal powers or authority) where there had been a failure to comply with the mandatory requirements of the rules of the Cricket Council. Hughes by letter dated 11 November 1985 sought the consent of the Cricket Council to play in South Africa. It was argued that the Council "failed to reply to that request or to give it any proper consideration." It is then argued that the "respondents failed to inform the applicant or his club of the fact of his purported disqualification." In regard to secondary boycott under s45 of the TPA, Hughes won the case in the Federal Court of Australia citing restraint of trade with the WACA who subsequently lost several hundred thousand dollars in court costs. By December Hughes made his way back into the WA team as an opener but performed poorly with an average of only 22.30.

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FINANCE NEWS

BUILDING PERSONAL WEALTH

Stuart Wemyss, of ProSolution Private Clients, discusses various approaches to the "job" of building personal wealth and financial security.

Have you ever met a tradesman that has many unfinished projects at home? They have the knowledge, experience and tools to do this work themselves but fail to do so. Isn't it ironic how these tradesmen will make improvements to a customer's home but not their own? Why is it they put their customers before themselves in this regard (hint: it's not just about getting paid).

The same can be said for many of our clients, too. Most medical specialists spend 60 plus hours per week looking after their patients' health. There's nothing wrong with this, of course. Investing energy in your career and doing work that you are passionate about and proud of is often a necessary prerequisite to feeling truly happy and fulfilled in life. However, it doesn't mean that it should come at the cost of your own financial health. How much time do you spend looking after yourself and your personal finances?

What do you need to spend time on? In essence you need to take a portion of your income and invest it wisely so that when you want or have to stop working, you will be able to live a comfortable and secure life. If you approached this job in the same way you would approach a project at work, you would probably:

- Develop a strategy or plan.
- Find the right team to help you execute the plan.
- Seek professional and expert advice on any matters that were outside your expertise.
- Produce regular reports on your progress to ensure you are on track to achieve your goals.

What if you approach this job (the job of building personal financial security) with the same enthusiasm and drive that you do your job? If you are not doing this, ask yourself why? Why when the stakes are so high and it will have a major impact on the rest of your life? The 40 odd years we spend at work have to fund 20 to 30 years in retirement — so don't leave retirement planning to the last five to ten years of your working life. If you do well you can get paid twice; now and again when you are retired because you invested so well.

Here are some common reasons I have heard from clients about why they didn't start on their wealth accumulation journey sooner.

I don't have the time right now. I'm so busy at work and home!

There is a misconception that taking control of your finances and ensuring you are regularly investing for the future takes a lot of your time. If it does, you are doing it wrong. Most of the clients we work with do not spend more than three to five hours a year on their personal finance — that's equates to less than six minutes per week. There are over 10,000 minutes in each week so I'm sure you can find a spare six!

Possibly the most time consuming aspect is finding an advisor and developing a plan with them. For most of the clients I work with, that takes two hours of a client's time (i.e. two one-hour meetings). I can develop a plan a lot quicker than you because I have been doing it every day for over 13 years. I know what questions to ask, what to think about, what possible options might suit (and the ones that don't) and what possible future changes in circumstances we need to consider when developing a strategy (which is often overlooked).

A good strategy is simple, clear, based on proven fundamentals and low risk. Because of this, it is easy for you to understand and feel comfortable to proceed with. Avoid complexity wherever possible. It's almost always unnecessary.

It's not urgent

Author of *A Random Walk Down Wall Street*[1], Burton Malkiel uses a very powerful example in his book:

William and James are twin brothers who are 65 years old. 45 years ago (at the end of the year when he reached 20), William started a superannuation account and put $2k in the account at the end of each year. After 20 years of contributions, William stopped making new deposits but left the accumulated contributions in the superannuation fund. The fund produced returns of 10% per year. James started his own superannuation account when he reached the age of 40 (just after William quit) and contributed $2k per year for 25 years, making his last contribution today. James invested 25% more money in total than William. James also earned 10% on his investments. What are the values of William's and James's funds today? William has $1,365,227. James has $218,364. James invested 25% more than William, but through the magic of compounded returns, William's fund is worth more than six times as much!

REGULAR

One of the necessary ingredients of a low-risk investment strategy is time. The more time you have the less risk you have to take — but the reverse is true also. Developing your own retirement strategy might not feel urgent to you but it definitely should be.

Don't ever try to convince yourself that you can make up for not saving/investing for a few years by saving/investing more later. It will snowball and be harder to make up as your living expenses inevitably rise with growing family commitments and/or your desire for a better standard of living.

You fear making any compromises on your standard of living

There is no point living poor to die rich. Life is all about balance and moderation and you need to enjoy the nice things in life, regularly. Wealth accumulation is a marathon, not a race and that journey should be enjoyable. That said, spending everything you earn will not work out well for you in the long run. At some point, you will pay the price for this poor decision and that price becomes higher and higher the longer you leave it. I find that most clients can have their cake and eat it too i.e. invest and maintain an enjoyable standard of living. Of course, there are some people that truly do need help prioritising wealth accumulation over instant gratification. If you are one of these people then there are strategies that you can employ to make it easier.

I'll do it when the kids finish high school

Often we meet clients when their children are close to finishing high school, particularly if they are in private schools. In this situation, the clients realise that very shortly their cash flow will improve (because school fees end) and that they can allocate some of this money towards their financial security.

Let me explain the problem with this approach by way of a real-life case study:

I have a client, Keith who purchased a one bed apartment in Mathoura Rd, Toorak for $327k in 2008. It is worth about $450k today and it's a great property. Since he purchased this property he has started a family (two kids), upgraded his home (higher mortgage) and has recently completed some renovations to their home (more borrowings). In the coming years they need to plan for private school fees too. Keith has admitted to me that if he hadn't bought the investment property back in 2008, he probably wouldn't be contemplating doing it now. His Mathoura Rd apartment should (conservatively) be worth around $1.15 million by the time Keith's kids are close to finishing secondary school. At this time, Keith will have more than $850k equity in this property. So if, back in 2008, Keith had procrastinated and not invested in a property, that mistake would have cost him $850k! Well done Keith on following our advice.

Probably two of the most common tightest cash flow situations in life are when you start a family and when kids are in private school. If you can invest before these events occur, you will be duly rewarded.

I'll wait for [insert possible change here] to see what happens first

If there is one thing that is constant in our world today, it's change. New governments, new laws, interest rates, tax rules, domestic and world stock markets yo-yo around and so on. Over the last decade plus, I have heard clients tell me that they aren't ready to begin investing because they are concerned about short term market movements. These issues are meaningless for long term investors because there's always going to be "changes". Far more important than "timing" the market is actually investing and making a start — probably more important by a factor of 100.

Smart investors live with a level of uncertainty and understand that they cannot worry about things they cannot control. I cannot control or predict markets — no one can. The best thing is to focus on the two most important things that you do have full control over: how much and how often you invest and the quality of the assets you invest in. If you spend all your time focusing on investing regularly in quality assets, you will generate more wealth than 95%+ people. It is truly that simple.

I planned to get started in 2016 but…

Was your New Year's resolution to start taking control of your finances and investing? We are nearly 25% of the way through the year — how are you going? If you have not made a start yet, let me share something that works for me. What I do is write down all my (personal, professional and financial) goals and stick them up in the shower to force me to read them every day. I review and update my goals every four to six months and I achieve at least 90% of my goals each year. That works for me — you need to find whatever works for you.

Decide to make your money the same priority as your career

As discussed above, lots of "stuff" and "excuses" seem to stop people making the most of their financial opportunities. However, it typically comes down to just a lack of prioritisation. My advice is to make your money (and how hard it works for you — not the other way around) the same or higher priority as your career. It doesn't take a lot of time but it does take discipline — discipline to make timely decisions. The discipline to spend less than you earn and invest the difference in high quality assets. It's simple but it does require discipline which most people lack — don't repeat this same mistake!

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REGULAR

ANAESTHETISTS IN TRAINING
CANBERRA FINAL EXAM BOOT CAMP

Dr Vida Viliunas, ASA Education Officer and Boot Camp Convenor, provides a wrap-up of the recent Anaesthetists in Training Boot Camp held in Canberra in February 2016.

A final exam preparation boot camp weekend was held in Canberra in February.

The weekend was supported by the ASA for logistics and publicity and open to all candidates sitting for the exam – Australian anaesthetic trainees, International Medical Graduate Specialists and any other candidates sitting the Final Fellowship exam.

Outstanding exam performances often look quite ordinary. This program aimed to demonstrate very good viva performances for candidates preparing for their final anaesthesia exams. Presentation skills for investigations interpretation were also covered. We all agree that content trumps performance tricks, but that in combination, they are unbeatable!

PRESENTERS AND OTHER SUPPORTERS

Four real-life, (AND in-the-flesh), current final examiners were kind enough to donate their time for the entire weekend for this enterprise: Drs Nicola Meares, Stephen Davies, Prani Shrivastava (who came all the way from WA) and Linda Weber. Dr Carmel McInerney lent her expertise as a teacher, consultant and character actor to the cause.

The John James Foundation is a leading Canberra medical charity that kindly donated their theaterette and breakout rooms on the campus of the John James Hospital in Deakin, Canberra.

Overseas Trained Specialist Anaesthetists Network (OTSAN) president (otsan.org.au) Dr Sanjay Sharma represented his organisation in support of the international medical graduate specialists attending.

VIVAS

The final examiners and consultants role-played as examiners and candidates presenting 'very good' performances for both medical and anaesthesia vivas. A range of techniques was showcased, including:

- The "expected" CVS/ respiratory viva… and the warning to ALWAYS expect the unexpected.
- The "I have never done/ seen such a case" and what to do then viva.
- How to recover from a brain-stall.
- Anaesthesia vivas as a spectator sport and as practice vivas with feedback.

The aim was to pull together the theory and practice of what is required of candidates in the real-time dynamic situation of a viva. Practical solutions for what is probably the most stressful section of the exam were presented; how to recover from and deal with situations when candidates feel uncomfortable or uncertain in a viva were covered.

These sessions were followed by analysis, discussion and myth-busting.

The aim was for candidates to take home some 'performance jewels'.

INVESTIGATIONS

Investigations occur and recur in all sections of the exam and play an important role in our profession. Having a systematic and confident approach ensures that candidates do not miss important findings and are able to showcase their knowledge.

A targeted, systematic approach to the 'black spots' of exam investigation was presented. There were a number of quizzes throughout the two days that gave candidates a chance to review the material covered.

STUDY AND EXAM TECHNIQUE

The weekend offered candidates the results of the world's best research in this field!

Thank you to all who supported the weekend to make it a success.

Best wishes to all candidates for the upcoming examinations.

REGULAR

SNAPSHOT OF THE BOOT CAMP

GASACT representative Dr Dennis Millard

Final Examiner Dr Linda Weber, hard at work

Dr Stephen Davies

Dr Nicola Meares and colleague

Dr Farhood Tofighi and Dr Kalyna Harasymiv

Dr Koo Boon Chan

Dr Stephen Davies, with fellow colleagues

Dr Nicola Meares presents to the group

Slideshow shown at the boot camp

INSIDE YOUR SOCIETY

POLICY UPDATE

The ASA Policy Manager Chesney O'Donnell attended the 11th National Allied Health Conference in November 2015.

11TH NATIONAL ALLIED HEALTH CONFERENCE

In short, an allied health professional is trained to work with other healthcare practitioners to best support a patient's holistic care with a good degree of success. However speculation abounds with the following issues being examined:

- Compliance and Regulation of qualifications with the potential of affecting MBS rebates.
- CPD and inconsistent provisions which are poorly regulated, affecting the calibre of graduates with too many courses in certain fields being provided.
- Workforce Problems with oversupply of certain allied health professionals as a result of the numerous courses being provided.
- Maldistribution in rural and regional areas which is not uncommon with anaesthesia.
- Scope of Practices possibly impinging upon medical practitioners and doctors due to future cost cuts in health. With allied health professionals possibly competing for rebates and roles in carer roles that nurses have traditionally occupied. Retention issues may see nurses jostling in a similar strategic fashion for roles previously occupied by anaesthetists, such as endoscopies.
- UK comparisons and the influence of the NHS funding which has been substantial, however, how long will the NHS survive as a purely government funded system?
- Refugee services which provides good outcomes and positive PR for related professions.

As you can see healthcare issues and systemic problems run parallel to the profession of anaesthesia. For example, when you take a broader view and examine the healthcare workforce in general, problems exist all around. Vice President of the AMA, Dr Stephen Parnis, had argued in the past that new doctors while being trained to meet community needs were hindered by projects like WA's creation of a new medical school. This counters what the Australian Future Health Workforce Report has stated in that Australia will see an oversupply of doctors come 2030.

In 2014 it was estimated that "240 medical graduates could be left stranded without an intern place[1]." In 2015, 336 graduates missed out on internships with Dr Parnis adding that "we've gone from 1400 doctors graduating from medical school in 2004 to 3700 in 2015 — a 250 per cent increase. At the moment, we cannot train all of those graduates to independent practice[2]." The evidence shows that our healthcare system might experience something likened to a workforce service provider domino effect.

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CONTACT US

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Email: policy@asa.org.au

Phone: 1800 806 654.

INSIDE YOUR SOCIETY

ECONOMICS ADVISORY COMMITTEE

In this edition of Australian Anaesthetist, EAC Chair, Dr Mark Sinclair, reports on the MBS Review.

MEDICARE BENEFITS SCHEDULE (MBS) REVIEW

As members will be aware, the formal review of all 5,700 individual MBS items by the Department of Health (DoH) is underway. At the time of writing, the initial group of review committees, for groups of MBS items deemed as needing "priority" review, have produced their first reports. A February 8 deadline was given for responses to these reports; stakeholder responses will be considered by the review taskforce before a final recommendation is made.

The reports from these review committees have been summarised in a document entitled "MBS Review — Obsolete MBS Items Tranche #1". Recommendations have been made for deletion of specific items from the following specialties, on the basis that they represent services that are "obsolete" or "no longer part of contemporary clinical practice":

- Diagnostic Imaging
- ENT Surgery
- Gastroenterology
- Obstetrics
- Thoracic Medicine.

A full copy of this document can be obtained online at:

http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce.

In some cases, basic details are given as to why the recommendation for deletion has been made (eg, the service is now covered by other MBS items, or there are safety concerns about the procedure in question). However in other cases it appears the recommendation has been made simply on the basis that there are very few claims for the item, and/or that there is "expert opinion", which is not detailed.

The ASA will submit that in all cases where recommendations for deletion have been made, the full explanation for this (including "expert opinions") is given. Also, a low incidence of claims does not necessarily mean the service represented by an item is "obsolete". The service may indeed be necessary, albeit for only a small number of patients. While none of the items recommended for deletion are of immediate interest to anaesthetists (apart perhaps from item 11500 for bronchospirometry, for which anaesthetists were responsible for 300 of the 1000 claims made in the 2014-15 financial year), it is important that the ASA makes such points prior to the review of the MBS version of the Relative Value Guide (RVG) for anaesthesia. The ASA has also had to repeatedly request to be included in the discussions on any MBS item which might be relevant to anaesthetists. We were not consulted on the proposed deletion of item 11500, nor on item 18246 for glossopharyngeal nerve block. This item is almost exclusively claimed by ENT surgeons for analgesia post-tonsillectomy, rather than anaesthetists or pain medicine physicians. Nevertheless, it is listed in MBS Group T7 (Regional or Field Nerve Blocks), along with the various other blocks frequently or exclusively performed for anaesthesia/pain medicine. This lack of consultation will be highlighted in the ASA's response to the "Tranche 1" paper.

The ASA Policy team has been in regular contact with the review taskforce secretariat, in order to keep us informed as to the plan for the RVG in the MBS. At this stage we have been informed that this review will not be commenced until "the second half of 2016". It may be that anaesthesia is not seen as a high priority area for review, but as discussed in previous reports, at present we are still unaware at of what the focus of the RVG review will be.

There remain significant concerns

about the overall aim of the review, in particular the repeated statements that cost savings are not a priority. The Minister for Health has again stated that only a certain proportion of any savings realised (around half) will be reinvested into health services. Clearly cost savings are an expectation, and the aim is to use some of these savings to bolster general revenue. It is of note that the proposal to remove certain "obsolete" ENT items has been justified on the basis that other current MBS items better represent the services in question. These items happen to have lower Medicare rebates. The cost saving from this single initiative for the ENT items would be over $7 million.

The AMA is convening another stakeholder forum in Canberra on February 11th. The ASA will certainly be represented at this forum, and ASA members will be kept up to date with any developments.

MEDICAL SERVICES ADVISORY COMMITTEE (MSAC)

As members are aware, the MSAC application for the addition of two ultrasound items to the MBS (for ultrasound guidance for major vascular access, and local anaesthetic nerve blockade) was rejected in 2015. A number of reasons given for the justification of this rejection were surprising to say the least. In particular, statements were made which bear no relationship to the available evidence. For example, that anaesthetists charge "very high" out of pocket fees (which is not borne out by the statistics collected by federal government agencies, covering the 2.3 million anaesthesia services provided annually in the private sector), and that adding new items would only encourage us to charge even more (again not supported by actual statistics, when new MBS items have been added in the past). Members should refer to Queensland EAC Officer Dr Tim Wong's article in the most recent edition of Australian Anaesthetist, (available on the ASA website, under the drop-down menu "Publications" or via the App) for a more detailed appraisal.

The ASA challenged MSAC on these issues prior to the release of the final report by the MSAC committee reviewing the service, and has since written directly to the Chair of MSAC to outline our concerns. A reply to this letter has now been received. At no stage has there been any response to the specific questions on MSAC's "evidence" on out-of-pocket expenses, and only vague statements have been made in relation to our other concerns. It is clear MSAC is firmly against the notion of multiple MBS items applying to a single episode of care (which is an essential component of a fee-for-service system), and indeed appears motivated to move away from fee-for-service overall (again, see Dr Wong's 2015 article for more details). Clearly, dealing directly with MSAC on our concerns has proven fruitless. While the EAC holds out very little hope for the ultrasound issue specifically, it is essential that our overall concerns about MSAC's processes receive attention. The EAC is currently discussing other ways to have our message heard.

What all of this will mean for the ongoing MSAC application to extend Medicare funding for local anaesthetic nerve blockade (beyond the current limitation to certain sciatic, femoral and brachial plexus blocks), and indeed to the formal review of the MBS, remains to be seen.

PRIVATE HEALTH INSURANCE

Members will no doubt recall the controversy over the plan by Medibank Private (MBP) to cease paying hospitals when a so-called "preventable" complication occurs. At this stage the plan has not been fully implemented. However MBP released a statement in December 2015, stating that it has reached agreement with approximately 70% of Australia's "leading private hospitals" regarding reduction in complications for which they state there is "good evidence that they can be reduced or avoided if clinical guidelines are followed".

The exact details of these agreements have not been released. MBP has however stated that rebates paid for doctors' services will not be affected, but also that "Medibank is asking hospitals to take responsibility for the additional hospital costs associated with hospital acquired complications". MBP has also stated that the broad range of conditions include:

- Sentinel events.
- Pressure injuries.
- Falls resulting in fracture and intracranial injury.
- Healthcare associated infections.
- Surgical complications including haematoma and haemorrhage.
- Venous thromboembolism.

Naturally, the ASA supports adherence to evidence-based guidelines in order to maximise patient safety. However, MBP has given no indication as to exactly how they will review compliance with guidelines, which specific "guidelines" will actually be used to make judgements, or exactly which person or persons will perform the review.

The AMA has also expressed its concerns regarding the lack of details in the proposed process. There is uncertainty about the job title and qualifications of the MBP employee who will review hospital claims where there are complications, information about how the MBP employee will determine that a hospital did not follow the "appropriate guidelines for the care of the patient", and how MBP will obtain patients' consent to access medical records. MBP also appears to be acting in isolation to the work that is being done by bodies such as the Australian Commission on Safety and Quality in Healthcare (ACSQHC). There is also concern that a

punitive approach to complications goes against the evidence in the literature, which shows that safety and quality in healthcare is a shared responsibility at all levels within organisations

The ASA, among other bodies, is very concerned that an insurer, whose reason for existence is financial profit, wishes to take control over funding decisions relevant to patient safety. In particular, it is most concerning that MBP has emphasised that it will not release the details of its assessment processes, and that its contracts require the hospitals to agree to confidentiality clauses.

The AMA intends to hold further meetings with MBP in early 2016. Also, representatives of MBP have indicated a willingness to meet with the ASA. Again, members will be updated as further information comes to hand, via the ASA President's regular e-News releases, among other methods.

MINISTER FOR HEALTH AND SPORT

Drs. Guy Christie-Taylor, David M Scott, Jim Bradley, and Mr. Mark Carmichael, along with myself, met with The Hon. Sussan Ley in her Parliament House office in November 2015. A number of issues were discussed, and we emphasised that the ASA is the clear "go to" body on these, where relevant to anaesthesia practice. This included the MBS review, MSAC's processes, and the role and function of the RVG in calculating anaesthesia fees and rebates. The Minster was left with no uncertainty as to our low level of confidence in MSAC (see above). Dr Bradley also had the opportunity to discuss broader issues such as the future of the anaesthesia workforce, and the Minister is keen to continue dialogue with the ASA here.

Opportunities to meet face-to-face with federal health Ministers do not come along very often, but are most valuable in raising the profile of the ASA, and ensuring that those in power know who we are and how we can assist with important issues. Again, the EAC thanks our Policy team, Chesney O'Donnell and Josephine Senoga, for their past and ongoing efforts in repeatedly liaising with various Ministerial advisors and assistants, in order for our voice to be heard.

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INSIDE YOUR SOCIETY

PROFESSIONAL ISSUES ADVISORY COMMITTEE

PIAC Chair, Dr Antonio Grossi, provides an update on various issues.

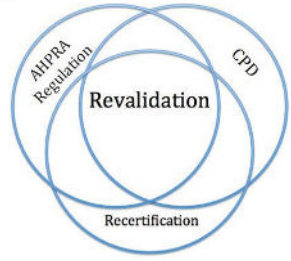
SENATE SELECT COMMITTEE ON HEALTH: PUBLIC HOSPITAL FUNDING

PIAC presented to Senators Deborah O'Neill (ALP), Jan McLucas (ALP), and John Williams (The Nationals) on rural issues including maldistribution of the medical workforce and service provision, workforce issues, funding and maintaining professional standards in an era of cost containment. The full presentation is available on the Hansard public record.

POSITION STATEMENTS AND REVALIDATION

PIAC recently reviewed a number of ASA position statements including revalidation. Revalidation refers to the process by which medical practitioners demonstrate that they are 'up to date' competent and 'fit to practice'[1].

Revalidation is an attempt to detect underperformance. With appropriate regulatory mechanisms in place such as mandatory reporting[2], investigation of patient complaints[3], validated comprehensive CPD[4] including blended learning, multisource feedback, quality improvement activities such as clinical audits and peer reviews[5], as well as formal national credentialing standards detailing scope of practice requirements[6], the proposed revalidation models are unnecessary. The costs and opportunity costs[7] will ultimately be reflected in less resources being available for patient care. The bureaucratic burden of proposed revalidation is duplicative, difficult to implement, lacks evidence-base regarding[8] its own efficacy, validity and effect on standardised key performance indicators such as patient outcomes[9] and is not consistent with a cost containment healthcare culture. Anaesthetists need to remain involved in the revalidation conversation. PIAC will continue to engage stakeholders on this issue.



HEALTH PROVIDER PAYMENT AND COST CONTAINMENT

High quality and affordable universal health care coverage is essential to maintain political, social and economic stability[10]. Due to changing demographics with an ageing population, the burden of chronic disease, developing new technologies[11] and rising community expectations[12], health systems are under increasing cost containment pressure. Paying healthcare providers through a fee for service model which lacks a realistically indexed government rebate[13], will likely lead to increased patient out of pocket expenses. The government is under pressure to explore other provider payment options such as salaries, capitation and bundled payments[14].The constitution[15] precludes the government from conscripting doctors to set fees. Whatever payment system anaesthetists choose to accept, consideration needs to be given to having the appropriate conditions to practice professionally and deliver quality anaesthesia care.

PROFESSIONAL AUTONOMY

Anaesthetist's professional autonomy is increasingly challenged due to increasing regulatory compliance, proscriptive scope of practice and accreditation requirements, industrial and workplace changes. Some of these changes have been introduced as quality improvement initiatives to deliver more patient-centred care. Other socio-political changes such as workforce oversupply, potential for task substitution, corporatisation and bureaucratisation of medicine[16] have placed more stress on anaesthetists. Maintaining clinical contact with patients, particularly through the preoperative consult, remains an excellent opportunity to promote anaesthesia professionalism.

WORKFORCE ISSUES

PIAC has been considering the stabilisation and transfer of unstable paediatric patients from outer metropolitan and rural centres. Mechanisms to improve the sustainable safety and training of anaesthetists involved in these cases are being explored. On call requirements continues to be an industrial issue that requires the committee's attention. The effects of fatigue[17] need to be considered in the context of patient safety, service delivery and anaesthetist availability.

Maldistribution of anaesthetists continues to be a problem and PIAC is working with stakeholders to identify some practical solutions. Maintenance of adequate clinical experience may be challenged by relative oversupply of anaesthetists in metropolitan centres.

BULLYING

Bullying has emerged as an issue for the medical profession. Various specialist colleges are advancing their own position statements on bullying. The 'anaesthetist' might be in an unenviable position to witness bullying and have an obligation to speak up[18].

PATIENT VALUE

Adding genuine patient value through quality anaesthesia care remains an important way of addressing professional issues in anaesthesia.

LOOKING AHEAD

2016 is forecast to be another busy year with a number of submissions and meetings scheduled with government and key stakeholder organisations. These include the Medical Board of Australia, NMTAN, Australian Private Hospital Association, Skilled Occupation List, ANZCA, RACS, Senate Select Committee, Ministers of Health, ACSQHC, ACCC and MABEL. In this way the committee continues to advocate for the profession to facilitate the delivery of the best anaesthesia care for patients.

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INSIDE YOUR SOCIETY

SENATE SELECT COMMITTEE MEETING — 27 NOVEMBER 2015

Senators John Williams, Deborah O'Neill, Jan McLucas

Dr Simon Macklin, Dr James Bradley, Dr Antonio Grossi

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INSIDE YOUR SOCIETY

TRAINEE MEMBER UPDATE

GASACT has had yet another busy year end to 2015. As the new year begins, Dr Ben Piper reflects on the end of his tenure as the Chair of the trainee committee.

Sadly, this will be the end of my time as Chair of the GASACT Committee and I will selfishly take this opportunity to reflect on what the ASA has to offer the trainee experience and the opportunities that are on the horizon. At a time when there is anxiety with regard to work opportunities with particular regard to public positions the time has never been more important to be a member of your Society.

The new year will bring many opportunities for ASA Trainee members. The Melbourne National Scientific Conference in September is set to be very well attended with free registration to advanced trainee members with two years of membership. Further to this, the NSC look to expand its trainee representation in poster prizes and offer a stream of dedicated seminars tailored to trainee needs and interests.

Professionally, the ASA offers a uniquely positioned body removed from the training environment. This affords the ability to provide:

• Advice on Careers:

o VMO vs Staff Specialist — which is the best fit for my circumstances?

o Structuring your practice.

o Employment opportunities.

o How do you get work… and keep it?

• Advocacy:

o Trainees are encouraged to be involved in advocating for our profession with regard to training issues, workforce or broader professional matters.

o Being an ASA Trainee offers leadership opportunities for trainees in each state/territory.

• Access to the ASA Advantage Program (Personal Financial, Automotive and Travel services).

• Mentoring from leaders in the profession outside of your training environment.

It's not all about the business of post fellowship life either. The ASA has as one of the jewels in its crown an in-house peer reviewed journal publication in the form of the *Anaesthesia and Intensive Care Journal*. The journal has at its core a dedicated local team that does everything from typesetting, reviewing and providing editorial services. The New Year will bring trainees the opportunity to engage directly with this unique publication.

To add to this, trainees are also offered three $4000 scholarships yearly to attend the top international conferences in the US, UK and Canada. Such opportunities are rare in the sub-specialty medical world and we are very fortunate to have a society that places value on trainees attending these events.

So what can you do to help?

Trainees:

• Engage with your local State and Territory members. You can find them on our website (https://www.asa.org.au/ASA/Trainees/GASACT.aspx) or email gasact@asa.org.au. Ask what opportunities are available in your area, events, leadership roles and educational events.

• Join as a trainee member: It is FREE for basic trainees — there is little to lose! As an advanced trainee the cost of membership is less than the FREE registration to the NSC — you literally come out ahead!

• Attend the National Scientific Conference — hear from world leading experts and local trail blazers. Network with peers and join in the enthusiastic and friendly atmosphere!

Consultants:

• Encourage your trainees to be a members, explain why it is important to have BOTH a College and a Society.

• Advocate for them within your departments to be granted leave for NSC attendance.

So in summary, our Society has much to offer us as trainees. I have had the excellent opportunity to be supported by the State and Territory Chairs. I thank them for their dedication to a cause that we believe serves the interests of the profession. I look forward to encouraging my trainees to join the ASA and to promote Australian anaesthesia as the safe, challenging and enjoyable profession that it is.

Australian Society of Anaesthetists Member Achievements

Australia Day Honours:

Dr Brian Spain (AM)

For significant service to medicine in the discipline of anaesthesia, as a clinician, to healthcare standards and to professional medical bodies.

Professor Katherine (Kate) Leslie (AO)

For distinguished service to medicine in the field of anaesthesia and pain management as a clinician and researcher, to higher education and to professional medical groups.

Dr John Tucker (OAM)

For service to medicine, particularly anaesthetics, to the blueberry industry and to the community.

ASA 50-year membership:

Dr Richard John Bailey
Professor Barry Arthur Baker
Dr Colin Montague Orr
Dr Barbara Leonie Slater
Dr Helene Mary Wood
Dr Kenneth James Williams
Dr Anthony Alder Kelly
Dr David Henry McConnel
Dr David Ian McCuaig
Dr Joseph Marich
Dr Kester (TCK) Brown
Associate Professor David P Crankshaw
Dr Vivien Mary Hollow
Dr Naham Warhaft
Dr Ian Rechtman

All 50 year members receive a certificate and lapel badge.

ASA
Australian Society of Anaesthetists

INSIDE YOUR SOCIETY

RETIRED ANAESTHETISTS GROUP

WESTERN AUSTRALIA

Dr Wally Thompson

Gathering September 2015

An informal and convivial gathering of members was held at the Café at the University Club on September 24. Fourteen members attended.

New Members

During the second half of 2015, eight new members joined the RAG. We continue to try to get in touch with retired anaesthetists and to expand the ranks.

Luncheon October 2015

A luncheon was held on October 22 at the Restaurant at the University Club. This proved to be a very popular event with 22 people attending including six new members.

November 2015

Dr Geoff Clarke is one of our regular attendees and members were delighted in November when his book entitled 'A history of the Intensive Care Unit within the family of Royal Perth Hospital' was launched on November 26. The very informative book details the origin and development of the Unit from 1963 to 2003.

Christmas Function

A Christmas Function was held on December 16. Members were delighted that Nerida Dilworth and Max Sloss were able to attend what proved to be a very enjoyable evening.

VICTORIA

Rod Westhorpe

I commence this report on a sombre note by remembering the recent loss of Patricia Mackay. Not only was Pat our dearly loved President, she had limitless enthusiasm for the Retired Anaesthetists Group, and for the specialty of anaesthesia. She had made many important and lasting contributions to our specialty over many years, in an active life that continued until just before her death. I therefore prepare this report on Pat's behalf. The Group acknowledges her passing with great sadness.

The Victorian Group had a successful year in 2015. The numbers attending meetings have maintained a steady number around 30. The mailing list has just been revised and updated, with 65 names at last count.

The first 2015 meeting in February was addressed by Bob Hare, with an emotional and enlightening talk of his father who was killed during WW2. "In My Father's Words: His experience of the Second World War from his diaries and letters."

The second meeting in May was addressed by Pat Mackay and by Peter Seal, the Chairman of the Victorian Section of the ASA. They gave their perspectives of Melbourne anaesthesia "then and now". Pat described practice in the 1950s and 1960s, while Peter gave us an insight into today's practice.

In August, members were enthralled by Prof Paul McMenamin from the Monash University Centre of Human Anatomy Education, describing "The Body Man – How to produce body parts using a 3-D printer"

The venue at the Lyceum Club has served us well with good projection facilities, and excellent dining at a very reasonable price. We are most indebted to Christine Sweeney for the organisation and menu selection. We also applaud the attentive service provided by the ever friendly Lyceum Club Staff.

The committee remains small but active, and David Crankshaw was co-opted to the committee early in the year. Special mention should be made of Christine Sweeney who keeps our finances in such good order.

The Group is privileged to be represented on the review panel for the ANZCA Melbourne Emerging Anaesthesia Research Award, under the direction of Prof David Story. Pat had been our representative, and Michael Davies has agreed to take on the role.

The Retired Anaesthetists Group maintains a close liaison with the Victorian Section of the ASA, and Jean Allison is a member of their committee. I have been co-opted onto the organising committee for the 2016 NSC, to be held in Melbourne in September, 2016.

I would also like to personally thank Mary Vasillacos, the secretary for the Victorian ASA, who kindly prepares the flyers and does the mail-out for our meetings. We have an excellent liaison with the federal ASA through Maxine Wade, who is responsible for SIGs and other groups.

I know Pat would have liked to thank the committee for their work during the year, and trust you all had a safe and happy festive season.

SOUTH AUSTRALIA

Dr John A Crowhurst

Our Group meets for lunch on the second Monday of every odd month at the Kensington Hotel, where 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 Group congratulates Associate Prof. David Cherry, formerly Chief of Pain Medicine at Flinders Medical Centre, who was honoured in the recent Australia Day Honours List as AM – Member in the General Division of the Order of Australia. Since 1982, David has been Associate Professor, Anaesthesia and Pain Medicine, Anaesthesia, Flinders University; Director, Pain Management Unit, Flinders Medical Centre, 1982-2008 and Senior Visiting Anaesthetist and Senior Specialist.

The guest speaker at our 14th March meeting will be Professor Ian Symonds, newly appointed Dean of the Medical School at University of Adelaide. He will discuss 'Contemporary Trends in Medical Education', a topic of great interest and controversy, especially among most of our (older) members. Educated in Adelaide, Ian graduated and completed his speciality training in O & G in Nottingham. He is also a Visiting Consultant Obstetrician/Gynaecologist at the Women's & Children's Hospital here in Adelaide.

Prof. Symonds's father is Prof. Malcolm Symonds, former Professor of O & G in Nottingham and in the 1970s, Reader in O & G at the University of Adelaide and well known to most of us. Malcolm too will attend our March meeting.

Later in the year we will hear from Professor Warren Jones, former Prof. of O & G at Flinders University, who, now in retirement, is a vehement critic of the S.A. Government's controversial 'Transforming Health Programme'. That, along with much confusion about the contentious advantages of the new $1bn. Royal Adelaide Hospital, due to open later this year, will generate much vigorous discussion.

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.

GET IN TOUCH

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

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

INSIDE YOUR SOCIETY

HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

HARRY DALY MUSEUM

Since the introduction of bronchoscopy in the late 19th century, visual access inside the patient's airways has led to more accurate diagnoses and more effective treatments.

Following the discovery that the bronchi and trachea have elastic qualities, the first rigid bronchoscopy was performed in 1897 by German born Dr Gustav Killian. The procedure successfully removed a pork bone from the right bronchus of a 63 year old patient who was anaesthetised with topical cocaine.

In the early 1960s, Japan based Dr Shigeto Ikeda's experience of rigid bronchoscopy under a local anaesthetic in the sitting position was cumbersome. On a quest to improve the equipment for the procedure, Ikeda began development of a solution with the Machida Endoscope Company and the Olympus Optical Company. By 1964, a prototype for the flexible bronchoscope was created. Measuring less than 6 mm in diameter, the instrument was smaller than its predecessors.

Following further improvements and almost seventy years after the first rigid bronchoscopy was completed, Ikeda presented his invention of the flexible bronchoscope in 1966. The flexible tube could be straightened via a locking mechanism allowing for a rigid optic to still be introduced. The invention made for an easier inspection of the patient's airways and whilst the number of rigid bronchoscopy procedures reduced at this time, they were not replaced entirely.

By 1968, the flexible bronchoscope was made available commercially and began to be used worldwide. Not satisfied to stop at one success, Ikeda continued to make improvements to the design and in the 1980s introduced the video-bronchoscope.

This year we celebrate the 50th anniversary of the introduction of the flexible bronchoscope. To represent this significant advancement, the Harry Daly Museum would be interested in obtaining a flexible bronchoscope for the collection and to include in our display of the history of anaesthesia timeline. Should you wish to discuss making a donation to the collection please contact our Curator via email jkiely@asa.org.au.

Visits to the Harry Daly Museum are welcome between 10am and 4pm every Thursday and Friday by prior appointment. Contact us at asa@asa.org.au - we look forward to showing you around.

Julianne Kiely

Curator, Harry Daly Museum

Rigid Bronchoscope

SIGNIFICANT GIFT TO THE SOCIETY'S LIBRARY

In honour of his 50 year membership award on 5 December 2015, Dr Richard J Bailey responded with a gift for the ASA's Library.

As the chosen items were to be sourced from the United States there was a race to see which arrived first and hopefully in time for the occasion.

The first to arrive was a text on mesmerism in fragile condition. It was quickly conserved in a protective jacket and wrapped in paper with an owl motif, a reminder of two previous ASA patient relations programs, "Your Anaesthetist is Watching You"!

When the second parcel arrived on 4 December, the significance was such that Dr Bailey generously decided both items should be donated. The second gift was a medical graduation certificate from Harvard University of Cambridge Massachusetts dated 1865 and signed by nine signatories. It is of importance to the Society as the majority of those signing wrote books or articles about the introduction of ether anaesthesia held in the Richard Bailey Library.

Further research will be undertaken to link the names with the demonstration of ether in Boston on 16 October, 1848.

Peter Stanbury

Librarian

INSIDE YOUR SOCIETY

NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from December 2015 — March 2016

TRAINEE MEMBERS

Dr Kirsty Georgina Belfrage	SA
Dr Laura Bordoni	WA
Dr Kevin Chan	WA
Dr Angela Chang	NSW
Dr Julia Jane Cox	SA
Dr Josef Ferguson	WA
Dr Emma Ford	VIC
Dr Justin Wei Swoon Hii	WA
Dr Zaki Ibrahim	WA
Dr Steven James Klupfel	QLD
Dr Ottilia Ananda Anna Elvira Magnusson	WA
Dr Monique Genevieve McLeod	NSW
Dr Graham O'Connor	NSW
Dr Erica Remedios	WA
Dr Sam Rigg	NT
Dr Brenton Sanderson	NSW
Dr Matthew Spencer	NSW
Dr Joel Thomas	QLD
Dr Daniel Trevena	VIC
Dr Matthew Josiah Vandy	WA
Dr Solomon Chelvanishan Yogendran	NSW

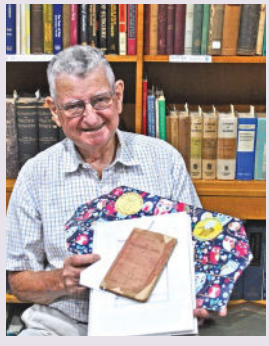
ORDINARY MEMBERS

Dr Andrew Gene Allenby	NSW
Dr Duane Elijah Anderson	WA
Dr Lakmini De Silva	VIC
Dr Saubagya Lakshmi Mestiyage Do Gunatilake	NSW
Dr Lan-Hoa Le	NSW
Dr Ronita Majumdar	NSW
Dr Tilottama (Tilu) Prashant Mangeshikar	NSW
Dr Brendan Moore	QLD
Dr Ajintha Pathmanathan	WA
Dr Bjorn Pederson	SA
Dr Laurence Brendan Yew Cheong Poon	VIC
Dr Peter Gregory Ridge	QLD
Dr Nathan Peter Royan	NSW
Dr Hutchinson Thurairajah	VIC
Dr Marianne Ivanova Vlaskovska	WA
Dr Timothy Joseph Weston	NSW

IN MEMORIAM

The ASA regrets to announce the passing of ASA members Drs George Charles Alchin (NSW), Donald Lang (NSW), Andrew Belessis (NSW), Tuyen Minh Ngoc Tran (SA) and Professor Tess Cramond (QLD).

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



Dr Richard Bailey's gift

Dr Richard Bailey's certificate

INSIDE YOUR SOCIETY

AROUND AUSTRALIA

NEW SOUTH WALES COMMITTEE

Dr Michael Farr, Chair

The NSW Committee wishes to extend our best wishes to members and their families for the new year ahead. Since our last report the NSW Committee has enjoyed a relatively quiescent period over the festive season particularly with regard to new local issues.

NSW Department of Health

In the last edition of the 'Around Australia' report we noted there has been an extensive and ongoing NSW Health project to develop model Scopes of Clinical Practice (SoCP) in NSW public hospitals "for Local Health Districts and Specialty Networks to apply when undertaking their credentialing and re-credentialing processes." The ASA had appreciated the opportunity to provide some input towards the production of this document with respect to guidelines regarding anaesthetists. We believe a finalized version will be presented during this year.

Industrial and Workplace Issues

Whilst not a lot has become apparent recently by way of newly emerging local state issues, the NSW Committee anticipates this will likely be short-lived. In the meantime there are of course always ongoing issues worthy of consideration. For example we continue to observe developments regarding after hours loading, on-call and call back rates for VMO anaesthetists in NSW. This is but one of many issues that remain on the ASA's radar.

GASACT

We thank Dr Adam Hill as immediate past NSW GASACT Chair for his significant contribution not just in this last year but over the past several years, and in addition congratulate him on progression to the role of consultant. We in turn welcome Dr Brenton Sanderson and Dr Andrew Emanuel as the respective Senior and Junior NSW GASACT representatives in 2016.

The NSW Committee looks forward to contributing once again this year to promoting the interests of our local NSW members and encourage you to contact us at sdonovan@asa.org.au regarding issues with which we may be able to assist.

SOUTH AUSTRALIA AND NORTHERN TERRITORY COMMITTEE

Dr Simon Macklin, Chair

We look forward to 2016 with great anticipation. There will be many changes which always bring with them a frisson of nervous anticipation as we step into the 'New World'.

In the Public Sector, the new Royal Adelaide Hospital is taking shape and our move into our new home draws closer. There are rumours that the EPAS system may not be introduced, but there is no word from SA Health to confirm this. The 'health hub' will bring new life to the west end of town with not only a new hospital, the South Australian Health and Medical Research Institution (SAHMRI), the new West End building of the University of Adelaide that will hold a new medical, dental and nursing school (housed in the University of Adelaide Health and Medical Sciences (AHMS) Building, which will also be home to 400 health sciences researchers as part of the South Australian Health and Biomedical Precinct (SAHBP)), the revamped Adelaide Convention Centre that will compliment the new Adelaide Oval and the new footbridge that links Adelaide Oval with the Casino/ Convention centre. It will be an exciting place to be!

We welcome an exciting ASA/ANZCA Combined CME program for 2016 that kicks off with 'Anaesthesia and Recreational Drugs' on March 30 at the Women's and Children's Hospital, Queen Victoria Lecture Theatre. This is a timely presentation from Dr Tony Chadderton of the SA Drug and Alcohol Service. I hope you will join me in continuing to make these meetings well attended and show your support for the local CME organising committee.

Finally, I would like to express my thanks and those of SANT ASA to Kerri Thomas who has stepped down from her position as ANZCA SANT Events Coordinator and CME Committee Support Officer to resume full time study. We wish her well in her future endeavours and thank her for her many years of service to the Anaesthetic community in SANT.

WESTERN AUSTRALIA

Dr David Borshoff, Chair

It has been a relatively quiet period in WA after the onslaught of events marking the end of the year. New hospitals and industrial uncertainty continue to dominate the healthcare landscape.

GASACT

The Gasact Part 3 Course was held at the Cottesloe Beach Hotel on November 14. There was an excellent turnout by interested and engaged anaesthetic registrars (about 30) who listened to talks on workforce issues, job prospects, how to present for interviews, managing private practice, financial planning and ultimately surviving a career in Anaesthesia.

A networking evening followed in the hotel's recently opened and very popular beach bar. It was another very successful event.

It was also noted that there was a perceived gender imbalance in the speaker line up and an attempt to recruit more female speakers will be a priority for the next event.

Morbidity Mortality

The last SJGHC/ASA combined Morbidity and Mortality meeting was held Monday 23 November at the SJGSH Auditorium. There was plenty of discussion amongst the 92 attendees following the presentation of some fascinating cases.

These included adult congenital heart disease – anaesthetising a single ventricle patient, very adeptly researched and presented by Ross Ireland, and amniotic fluid embolism with massive haemorrhage, presented by Ass. Prof Nolan McDonnell. The significant role of TEG when managing bleeding in large private hospitals was noteworthy.

Western Australian Department of Health

Perhaps the biggest news over the last 3 months has been the very significant budget deficit in WA – Initially flagged at $431m in September by the treasurer Mike Nahan, it was then announced on December 21 that it will be $3.1 billion by the end of the financial year. On top of this, the State debt has risen to $39 billion!

The end of the mining boom, the massive spending undertaken by the Barnett Government and, some would say the lack of foresight, has resulted in the Government scrambling to turn these figures around before the next election.

Needless to say healthcare cost cutting is at the forefront. After spending at least $2 billion on the Fiona Stanley Hospital, and despite its many architectural awards, the cost of running it is now deemed too much. Of course, according to government, it's due to 'inefficiencies in the system'. Perhaps conveniently, according to the Health Minister, WA is not as efficient as other states.

It was announced that 1136 FTE jobs will be cut from the workforce. Redundancies are being offered, contracts are not being renewed and recently advertised positions are no longer viable. Advertising for any position has been put on hold until July 2016. There is considerable uncertainty for many experienced and newly qualified anaesthetists.

Oh well, at least people can drown their sorrows with a drink down on the river at the new Elizabeth Quay – relatively cheap for WA at about $440m.

Meetings

The Part Zero course will be held on Friday 5th February – there will be an opportunity for the State chairman to give new trainees a brief run down on the role of the Society.

The WA ANZCA/ASA Autumn Scientific Meeting is scheduled for March 12th and this is on 'Anaesthesia Updates'. It will be held at the UWA's University Club. Given the rather full meeting timetable, there will be no winter meeting but we can look forward to the Bunker Bay Country Conference at Pullamn Resort in October.

INSIDE YOUR SOCIETY

TERESA RITA O'ROURKE CRAMOND, AO, OBE 1926–2015

Professor Teresa Rita O'Rourke Cramond was born on 22 February 1926 and passed into eternal life on 26 December 2015.

Tess was born in Maryborough, Queensland, in February 1926. She was the third of four girls and was immensely proud of her Irish heritage and her parents' belief that the girls should receive a tertiary education at a time when this was not always the case. She was educated at St. Ursula's in Toowoomba and won an open scholarship to the University of Queensland where she enrolled in Medicine.

Following graduation she became a resident and then an anaesthetic registrar at the Brisbane General Hospital (now Royal Brisbane and Women's Hospital). The Faculty had just been formed and there was some ill feeling concerning the awarding of Fellowships so she was advised to travel overseas to complete her training.

She originally worked at Poplar, attended a garden party at the Palace, and with a reference from a senior surgeon whose only comment to her had been "start missy" became a registrar at the London. She worked there for two years (1955-56) before returning home. She defined a work ethic that established a path for 16 Queensland anaesthetists to follow her to the London.

She returned home in 1957 and took up appointments at the Mater Children's, where she convinced the Sisters to abandon the use of explosive anaesthetics, the Neurosurgical unit at the Brisbane General as well as entering private practice with the 'Girls' group. She was casually invited to a local meeting of the ASA and when the secretary failed to appear she was asked to take some notes. Her attitude was 'if you do a job, do it well'. She became Federal secretary from 1960-64. The President at the time was Roger Bennet (1962-64), a Brisbane anaesthetist and family friend. They formed a partnership which took action, following legal advice, against the Faculty over the right to determine terms and conditions for anaesthetists. They considered the Faculty would lose its tax free status if it was involved in financial matters. Only in later years would she discuss this action, as the Dean of the Faculty was her great friend Mary Burnell. She was elected to the board of the Faculty in 1965 and was able to correct this impass when she was Dean (1972-74).

In 1964 she resigned as ASA Secretary to accept an invitation to establish a neuroanaesthesia unit in Dallas. This was different from what she had come to expect. There was racial and sexual discrimination as well as severe violence. "Awful". She declined offers to stay.

Roger was also interested in Life Saving. At the time the method of resuscitation was to lie the patient prone and elevate their arms. The importance of an adequate airway and now expired air ventilation became the preferred methods of resuscitation. They organised a demonstration, which would not achieve Ethics Committee approval today, but convinced members of the Life Saving and Electricity Board to upgrade their lifesaving techniques. They produced a format which ultimately was accepted as the Australian standard and became the foundation for the Australian Resuscitation Council.

Combined with her neuroanaesthesia practice was an interest in pain management and research into drugs used in the treatment of pain, notably morphine, fentanly and droperidol. She enjoyed visiting the pain unit at St.Vincent's set up by another friend, Brian Dwyer, and this subsequently became the prototype for the Multi Disciplinary Pain unit at the RBH which now bears her name.

Tess said that some people thought that to be polite, small and female meant you were weak. This certainly was not the case with her as she was a strong protagonist

for the policies and procedures she believed were correct and would advance the interests of the organisations she was representing.

Her interests were now extremely wide and recognition began to flow. She was awarded an OBE in 1977 and the following year was made the Foundation Professor of Anaesthetics, a position she held until 1993. In 1982 she was President of the local branch of the AMA. Professional Activities associated with medicine were extensive. She was a Member of the Medical Board, the Medical Defence Society, Editorial Committee of Anaesthesia and Intensive Care, Selection Committee for the Rhodes Scholarship, Senate of UQ and the Catholic University and the National Anaesthetics Mortality Committee. Tess was the first female to be commissioned Colonel as a consultant to the Royal Australian Medical Core. And this list is not complete.

She received the Orton Medal, the Order of Australia, and was inducted into the Life Saving Hall of Fame as well as receiving awards from The Red Cross, St. John's Ambulance, Order of St. John of Jerusalem, the Resuscitation Council and the Pain Society.

In 1985 she married Humphry Cramond who had been at medical school with her and was then current president of the Queensland branch of the AMA. A devoted Catholic she listed audiences with two Popes in the highlights of her life. Although she supported female practitioners she was not a rabid feminist and changed her name to Cramond immediately after her marriage.

Following the sudden death of Humphry in 2014 her physical condition deteriorated quite rapidly although her mental state remained sharp. This was an extraordinary life of someone who worked tirelessly to protect and improve the life of our current generation, to educate the next and to establish a safe and respected community in which we can all exist.

INSIDE YOUR SOCIETY

UPCOMING EVENTS

MARCH 2016

Part 0 Victoria

Date: 4 March 2016

Venue: ANZCA House, Victoria

Contact: vic@anzca.edu.au

Part 0 NSW

Date: 5 March 2016

Venue: Royal Prince Alfred Hospital

Contact: tpapadopoulos@anzca.edu.au

Rural Anaesthetists Conference

Date: 5 & 6 March 2016

Venue: RACV Goldfields Resort, Creswick, Victoria

Contact: Carolynne/Leonie - Anaesthetic Secretary (03) 5320 4590

JUNE 2016

NSW Regional Conference (CME)

Date: 18 June 2016

Venue: Hilton Sydney

Contact: nswevents@anzca.edu.au

02 9966 9085

JULY 2016

VIC 37th Annual ANZCA/ASA Combined CME Meeting

Date: 30 July 2016, Melbourne, VIC

Venue: Sofitel Melbourne on Collins

Contact: vic@anzca.edu.au

OCTOBER 2016

ANZCA/ASA Continuing Medical Education - Art of Anaesthesia

Date: 15 & 16 October 2016

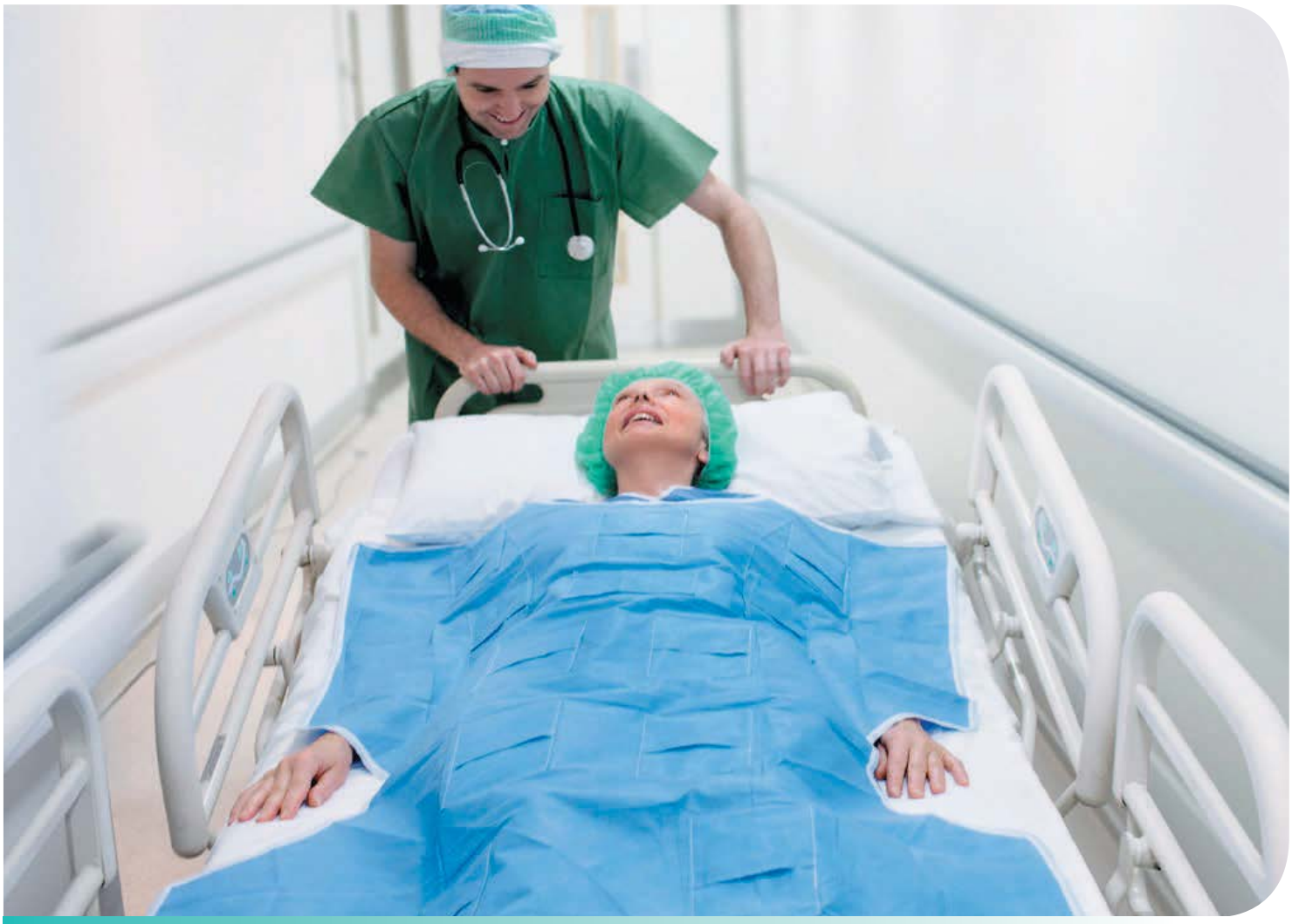
Venue: John Curtin School of Medical Research, Acton, ACT

Contact: act@anzca.edu.au

** Our Part 3 Courses are yet to be finalised however most will be in November **

ACECC
Anaesthesia Continuing Education Coordinating Committee

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



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MELBOURNE 2016

AUSTRALIAN SOCIETY OF ANAESTHETISTS

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