AUSTRALIAN
# Anaesthetist
THE MAGAZINE OF THE AUSTRALIAN SOCIETY OF ANAESTHETISTS • MARCH 2021


# CORPORATISATION OF MEDICINE

- Managed, bundled, corporatised care
- Corporatisation of medicine: an Australian perspective
- The US experience and lessons for Australia
- Bundled obstetrics care – throwing the baby out with the bathwater?

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## REGULARS



## FEATURES

# CORPORATISATION OF MEDICINE

## INSIDE YOUR SOCIETY



### WOULD YOU LIKE TO CONTRIBUTE TO THE NEXT ISSUE?

If you would like to contribute with a feature or a lifestyle piece, the following deadlines apply:

Intention to contribute must be emailed by 5 April 2021.
Final article is due no later than 16 April 2021.

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

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# EDITORIAL FROM THE ASA PRESIDENT

DR SUZI NOU
ASA PRESIDENT

**In this issue, we focus on managed care or the corporatisation of medicine. Call it what you will but nevertheless, it impacts the sanctity of the doctor–patient relationship. Most often, this is by the contracting of medical providers to health insurers.**

From a business perspective, an insurance company's purpose is to sell policies, collect premiums, and control costs. These goals are not moral or immoral in themselves.

We could easily argue that insurance companies add value by spreading catastrophic risks among all participants, making it more affordable for participants to have much-needed coverage. The presence of insurance companies, theoretically at least, could mean expanded healthcare coverage for a larger population, benefiting all parties in the healthcare ecosystem. Examples of this are compulsory health insurance schemes in Germany and the Netherlands.

However, when insurance companies insert themselves in the value-chain by buying health services or contracting providers, they change the dynamics of the entire ecosystem. These are the three key risks:

- Selling policies turns into owning and controlling the relationship between health providers and patients
- Collecting premiums and the drive to extract profit from the value-chain results in setting and controlling the price for procedures. For-profit insurers have fiduciary responsibility to their shareholders, not patients.
- Controlling costs means controlling access to care by approving or denying procedures, investigations etc.

There are countless examples of this occurring, mainly in the US. The Nataline Sarkisyan Foundation was established to seek healthcare reform after 17-year-old Nataline died awaiting a liver transplant. This transplant was denied by Cigna, her health insurer, despite letters of protest from her treating doctors.

> …when insurance companies insert themselves in the value-chain by buying health services or contracting providers, they change the dynamics of the entire ecosystem.

More recently, US doctors have changed the way they test for COVID-19 due to the low reimbursement rates from insurers

There is incredible complexity in the way health is funded in Australia with overlap and division between State and Commonwealth, private and public, community and hospital care. Anaesthetists are being increasingly asked to participate in bundled payment models which offer patients the attractive proposition of having a single insurance premium excess, or no out-of-pocket fee. In order to assist patients in navigating this environment, we need to better understand how our colleagues structure their invoices or billing. In this issue, obstetrician Andrew Zuschmann provides a spotlight on obstetric billing.

The threat of managed care is here on our doorstep and slowly prising open the door. Bundled payment agreements have been entered into and multiple offers, expressions of interest and contracts have been shared. Recently, the ASA became aware of an application made to the ACCC by Honeysuckle Health, which is a joint venture between nib and Cigna. The term 'value-based contracting' abounds throughout the proposal and signifies a shift from a fee-for-service model which incentivises volume, to managed care, as described by Jonathan Gal in this edition.

I was recently asked about how this might impact us, as anaesthetists. Clinician autonomy needs to be upheld in order to deliver quality care. Imagine providing anaesthesia for a patient booked for a laminectomy who only needed a microdiscectomy because the insurer will pay for one procedure but not the other. Or a young patient who will receive an inferior prosthesis (be it a joint replacement or intra-ocular lens) that will need to be revised in 10 years. Or being severely injured in a cycling accident and finding that the healthcare you have received is not covered by your insurer because the ambulance took you to the 'wrong' hospital. These are not imaginary examples but ones that have been relayed to me from colleagues who have lived

and worked in the US, where insurers have well and truly inserted themselves into the value-chain.

As described in *The US Experience and Lessons for Australia* the clinical and financial risk is transferred to us and our medical/surgical colleagues and away from the health insurers. We should also not underestimate the administrative costs that managing these contracts will bring.

It is time to take heed of this very real threat. Share your concerns with the ASA and encourage colleagues to join the ASA. Together we have strength in numbers as well the resources to engage the lawyers, health economists and other professionals we will need to tackle this issue.

## CONTACT

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

# OPPORTUNITY TO DONATE

The ASA encourages donations to the Harry Daly Museum and Richard Bailey Library, the Benevolent Fund or Lifebox charity.

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# ASA UPDATE FROM THE CEO

MARK CARMICHAEL, ASA CEO

"I can't wait to put 2020 behind me!" How often did you hear, or in many cases, utter that phrase during the last year? I am sure that despite that wish, many will have had their Christmas and holiday plans put on hold as the impact of COVID-19 remains ever present even now. Although we have now put 2020 behind us and 2021 is well underway, what it will look like who really knows, I certainly don't, but hopefully we will be somewhat more optimistic than we were during 2020.

Clearly COVID-19 will still be with us in one form or another. Uncertainty over border arrangements, travel restrictions, the wearing or not of masks in public places, will I am sure, still be very much at the forefront of our daily lives. The ray of hope though is the likely widespread availability of a vaccine. How that will be rolled out in Australia and the rest of the world will become clearer over time. Hopefully by the end of March, if the early statements by the Prime Minister Mr Morrison and the Chief Medical Officer Professor Kelly are anything to go by, then there will have been significant progress within Australia at least. It would also seem that even with an effective vaccine becoming available, the uncertainty created by the virus will remain for some time to come.

So, while we all continue to learn to live our lives with the virus as part of it, other issues still require attention. One of these is what appears to be the movement towards the corporatisation of medicine in Australia. Often people use the phrase 'managed care' to describe this phenomenon, however, it is possibly somewhat more complex than that. It is certainly an issue the ASA is focussing on at the moment. That is why this edition of *Australian Anaesthetist* has devoted its attention to this issue. It is hoped that the articles drawn from a variety of perspectives will provide an informed view of what this may mean within the Australian medical landscape.

In late 2019 the ASA made a significant decision to outsource the publication of *Anaesthesia and Intensive Care (AIC) Journal* to the UK-based firm SAGE. It is fair to say that initially there were some teething problems, in particular the time lag with production. It is pleasing to note that through the efforts of Editor-in-Chief Associate Professor John Loadsman, many of those issues have been gradually overcome and the relationship is working quite well. I make mention of this because change can often bring with it many benefits but also a number of unforeseen problems and the Journal change was no different. Through collaboration and patience, the outcomes for the Journal, the ASA and ideally the membership has been a good one, and supports the wisdom of the change made. We certainly hope that both the *Australian Anaesthetist* and the *AIC Journal* are on your reading lists for this year.

While speaking of change, the National Scientific Congress for 2021 has also undergone some significant changes. Members will be well aware that due to COVID-19 the 2020 Combined Meeting scheduled for Wellington, New Zealand was put on hold until 2022. With the uncertainty surrounding COVID-19 carrying forward into 2021, the Organising Committee made the wise decision to modify its plans for this year's NSC. As a result, it moved quickly to relocate the Congress from Cairns to Brisbane and to stage it in conjunction with the ANZCA Queensland Regional Committee meeting in July. This collaboration in these unusual times will ensure that members have the opportunity to have a high-quality educational meeting available to them during 2021. I would very much like to thank all involved from both ANZCA and ASA who have and are continuing to work closely to make this opportunity available. Further details will be shared with members in due course.

Let us all hope that developments in the COVID-19 space during 2021 will be of a nature that will allow all of us to lead a different life to the one we had during 2020.

## CONTACT

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

# AUSTRALIA DAY HONOURS

**Congratulations to Associate Professor David M. Scott, immediate ASA Past President (2016-2018), on his well-deserved Order of Australia Medal (OAM) for service to medicine, particularly to anaesthetics.**

Although he was quietly notified weeks in advance of the Australia Day Award, David was still shocked and stunned by the announcement on the day. He admitted being humbled not just by the award but also the number of people reaching out to congratulate him on the news.

"It is such an honour, I'm still in disbelief and suffering from a little imposter syndrome," he said from his Lismore home on the NSW North Coast where celebrations were somewhat subdued while he was, not surprisingly, on-call.

With an extraordinary career in anaesthesia, education and military service David strongly believes the award was also in acknowledgement of the considered approach he took representing the ASA throughout the MBS Review process. Tasked with speaking on behalf of the speciality he was incredibly diplomatic in dealings with the Minister and with the Health Department throughout the difficult and challenging period.

In true David M. Scott style, however, he is at pains to stress that this achievement came from a team approach. "I'd like to see this as recognition of a great team effort," he said. "It was a lot of hard work done by a team people including Andrew Mulcahy, Mark Sinclair and Mark Carmichael, and I just happened to be President at the time."

This diplomacy was no doubt shaped by David's military experience and years of dealing with trauma in war zones and natural disasters. He was commissioned as an officer in the Royal Australian Air Force in 1990 and has held several leadership roles in the ADF. His military and medical work took him on overseas deployments in a number of capacities throughout his career. David has instructed in anaesthesia at Harvard University and the Beth Israel Hospital Boston, was a Visiting Professor in Anesthesia at the University of California and is part of the instructor panel at Uniformed Services University of Health Sciences Bethesda USA.

His skills have also been harnessed by educational institutions in Australia where he is convenor and instructor with the Regional Anaesthesia Workshop Anatomy Department, University of Queensland since 2005 and an adjunct Associate Professor, Lismore Clinical School of Medicine, University of Western Sydney from 2015. David is also past and founding Chair of the ANZCA/ASA/NZSA Regional Anaesthesia Special Interest Group and is co-author of the *Oxford Pocket Guide to Regional Anaesthesia.*

Although the Australia Day Awards attracted more than the usual controversies this year, David remains unfazed about the ongoing debates. "It's not about the day, it's about service to the community," he said. On behalf of the ASA, thank you David Scott OAM for this impressive service.

Congratulations are also in order for AMA member Dr David Schuster who was recognised with an AM for his significant service to medicine as an anaesthetist and to the Dubbo community. The former Dubbo Base Hospital Director of Anaesthetics was an integral part of the local community after moving there in 1974. Despite retiring in 2015, David has continued his commitment to local service including volunteering with the rural fire brigade and supporting the work of a number of charities including the Royal Flying Doctor Service.

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# LETTERS TO AUSTRALIAN ANAESTHETIST

## THE AS/NZS ELECTRICAL STANDARDS IN THE OR

I commend Edward Murphy from the Royal Adelaide Hospital for 'Electrical safety for staff and patients – what's the standard?' in the December 2020 issue.

His article is a textbook summary of what every specialist anaesthetist should know and understand. However, I would like to suggest another aspect be explored more deeply – the provision of emergency power.

Over the decade from 2002, I was a clinical surveyor for the ACHS and involved in 30 surveys within Australia and New Zealand, assessing compliance to the Standard AS/NZS. 3003.2003 'Electrical installations – patient areas of hospitals, medical and dental practices and dialyzing locations'. This also included standards relating to emergency power supply from diesel powered generators and I was able to educate about 50 surveyors of the critical importance of these Standards in patient safety.

The invitation to become an ACHS Clinical Surveyor came after a presentation of 'Hazards in operating theatres' at the Adelaide 2002, ASA ASM.

Established in July 1972, the Joint Steering Committee on Hospital Accreditation underwent a name change to the Australian Hospital Standards Committee, recognising the accreditation process should place its emphasis on education and publicity relating to the achievements of desirable standards.

In 1974, after much discussion, ACHS opened for business with an agreement between existing professional colleges and societies, with a vision for a set of standards. The Committee discovered that Dr Sidney Sax, Chair of the Hospitals and Health Services Commission, shared the vision to improve the quality of health services. He provided a grant of $25,000 to support further research into the development of a national accreditation program embracing public hospitals.

By October 1974, the Provisional Standards for Australian Hospitals was published. They were 100 pages in length (prepared on green paper using a manual typewriter) and within a month, Geelong Hospital in Victoria became the first hospital surveyed and accredited against the Provisional Standards for Australian hospitals.

In July 1988, reflecting its broadening constituency, ACHS, changed from Australian Council on Hospital Standards to Australian Council on Healthcare Standards.

During an Area Health Service survey at a regional hospital within NSW, I recall it was mid-afternoon when the survey coordinator requested the hospital engineer fire up the emergency generator. It did not work! The hospital was forced to finish the surgery in progress and cancel all others on the list. All routine logs had been signed for the inspection and agitation of the diesel oil in the tank, but on inspection it was green due to algae growth. The whole area was at risk of failing their accreditation.

I must confess this story was often the same elsewhere except this event was just three days prior to the State Parliamentary Elections.

I would recommend Anaesthetic Department senior members be aware of the standards that apply to their emergency systems (now available online) and personally check with those responsible for their integrity.

It is very costly in reputation for any government or institution to have an adverse ACHS report.

Tony Swain FANZCA (rtd)
Adelaide, SA

## IN RESPONSE

I thank Tony for the commendation on the article.

The original intent was to publicise the updated AS/NZS 2500 standard which covers safe use of medical electrical equipment by healthcare providers: something uncommon in the realms of medical electrical standards. Explanations were added to address common questions which arise clinically and are covered in that standard.

The relevant 2018 version general electrical and medical electrical standards (AS/NZS 3000 and 3003) do not specify an emergency backup requirement, and the outdated but still current (no pun intended) AS/NZS3009:1998 'Emergency power supplies in hospitals' does not reflect current technology; only referring to uninterruptible power supplies (UPS) in relation to computer systems. This latter one does at least address algal growth in stagnant diesel fuel.

Whilst it is important and straightforward for all anaesthetists to acquaint

themselves with power supply outlet colour coding, the task of overseeing generator maintenance is often delegated to hospital engineering and building management services and I agree that improved clinical engagement is a worthy target, both through ACHS processes and local hospital liaison.

Ted Murphy
Royal Adelaide Hospital, SA

## THANK YOU

Dear Dr Nou,

I am an Anaesthetist working in Sydney. I just wanted to say a massive thank you for the job you've done this year.

It has clearly been a difficult and extraordinary year, and those times require extraordinary leadership. I have valued your contributions from email information, to advocacy for our profession, to webinars where I felt you were a thorough, well thought out contributor.

You have demonstrated calmness but also concern at the right moments.

It has reaffirmed my commitment to being an ASA member.

I run Part 3 courses annually at Prince of Wales Hospital and advocate that the provisional fellows join the ASA. I will certainly continue this.

Once again thank you for your outstanding leadership and advocacy.

Dr Adam Perczuk
Sydney, NSW

## NOTE

The Medical Editor would like to advise readers that the notice about the ASA logo in the December issue included several pictures that were originally published in *Anaesthesia and Intensive Care*. The article, 'The Search for a Symbol' by Dr John Hains appeared in Issue 15, 1987 pp. 99-106 and provides fascinating reading about the development of the logo. The article about the development of the ASA logo can be found on the ASA website: https://asa.org.au/history-of-the-society-the-asa-logo/

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# WEBAIRS NEWS

## FIRST IMPRESSIONS OF THE ANAPHYLAXIS CASES REPORTED TO WEBAIRS

**WebAIRS has collected over 8,600 reports at the time of writing this report. The most common reported categories are cardiovascular (17%), medication (16%) and respiratory (30%) events.**

Anaphylaxis accounts for almost 7% of the first 8,000 reports submitted to webAIRS. This is made up of 1.3% classified as cardiovascular, 4% as medications, 1% as respiratory and 0.7% as other. In many cases the initial management targeted either the cardiovascular, respiratory or other manifestations. The ANZAAG/ANZCA Anaphylaxis Box has been mentioned as a useful adjunct to management, especially in later reports.

Early diagnosis and targeted management are key to a successful outcome in anaphylaxis management. The webAIRS reports highlight that the diagnosis of anaphylaxis is not always immediately obvious. Symptoms and signs of anaphylaxis such as cardiovascular collapse, hypotension or respiratory compromise may occur for many reasons during surgery. Multiple webAIRS reports describe hypotension which is refractory to usual intraoperative vasopressors and fluid boluses. The early appearance of a rash was not characteristic of many severe cases and commonly appeared as a later manifestation, frequently after the blood pressure was restored.

An incorrect initial diagnosis might lead to less effective immediate management. It is important to avoid fixation error and confirmation bias, which may lead to becoming stuck in a loop and trying the same strategy repeatedly despite a lack of response. Techniques to avoid these errors have been built into algorithms such as that for the management of a difficult airway. One possible adage is that if you treat something three times in the same way without success then stop, review, and consider trying something else.

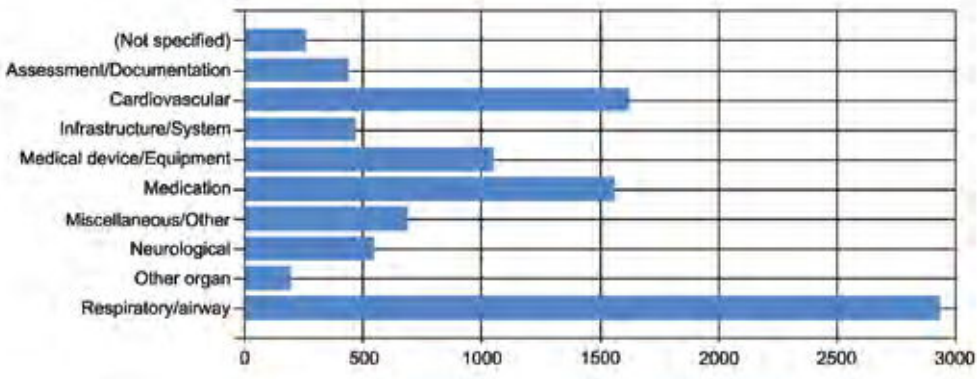
The ANZAAG/ANZCA Anaphylaxis Management Guidelines have been developed to assist clinicians to rapidly diagnose and manage this crisis. The ANZAAG/ANZCA Differential Diagnosis card in the Anaphylaxis Box is designed to aid rapid diagnosis and treatment when a patient presents with symptoms which may be due to anaphylaxis. Similar to the use of the Vortex Model in difficult airway management, the Differential Diagnosis card aims to prevent clinicians from becoming stuck in a loop, repeatedly using the same strategy without a response.

Where the diagnosis is thought to be anaphylaxis, it is essential to move on rapidly to the use of specific measures such as adrenaline and intravenous fluid boluses, which are titrated in accordance with reaction severity and response to treatment. The Immediate and Refractory Management Cards assist with timely delivery of all essential resuscitation measures. The cards are designed to be read aloud to allow team members to share a mental model of the resuscitation progress.

An interim analysis of the anaphylaxis cases was presented at the ANZCA ASM in 2017, and a further analysis is underway of the anaphylaxis cases reported amongst the first 8,000 reports to webAIRS.

ANZTADC Case Report Writing Group

**WebAIRS Dashboard January 2021**

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3. *The Anaphylaxis Box*. www.anzaag.com/AnaphylaxisBox.aspx

# SPOTLIGHT ON CONSENT

## Call to standardise consent process

**Obtaining clear consent from patients is a cornerstone of performing any major medical procedure and surgery, yet there is a lack of standardisation of consent procedures in Australia.**

That lack of standardisation contributes to problems with obtaining medical consent, according to Professor Kerry Sherman, Health Psychologist in the Centre for Emotional Health and Department of Psychology at Macquarie University.

Professor Sherman is a behavioural medicine researcher who has done extensive work researching decision-making in the medical context, and how people perceive health risks. Professor Sherman and her team have conducted a systematic review of the three existing measures of patient consent: information provision, comprehension of information by patients, and voluntariness of decision-making without coercion.

"Informed consent reflects all of these aspects, and so should the measurement of consent.

"We found that the existing measures were mostly inadequate - none assessed all three domains of consent, with little evidence for validity of these measures.

"There was also little consideration given to whether patients found these measures acceptable to use.

"We need to look at developing a new approach to measuring informed consent that reflects a psychometrically sound, valid and reliable measure that taps into all three domains of consent, that is easy for patients to use and is relevant for both patients and clinicians," she said.

## Patients don't always understand risk

**Professor Kerry Sherman**
**Health Psychologist**

Even with the best intentions of doctors and anaesthetists, patients don't always understand medical terminology or the statistics of risk, Professor Sherman says.

"From a legal point of view, they've ticked the box, but they are not actually comprehending the implications of what they've agreed to or haven't had or been given adequate time to think about whether that was the right decision."

Research tells us that patients can have very different levels of understanding of risk, and varied perceptions of what that risk means, she says. For example, one patient might be very concerned about a 5% risk of complication, while another might not be concerned until there is at least a 30% risk.

Legally, while patients must give consent before any medical procedure, Professor Sherman explains there are a whole lot of holes and inconsistencies in the process. "There is increasing evidence demonstrating that patients will sometimes agree to procedures that they really don't understand.

Face-to-face consent does not always have to involve written consent, Professor Sherman says. In cases of minor procedures, consent can be implied, such as by a patient holding out their arm to receive a vaccination.

Informal or implied consent, however, is not sufficient for significant treatment and procedures such as operations and procedures requiring general, spinal, epidural, or regional anaesthesia, or intravenous sedation, or any invasive procedure where there are known significant risks or complications.

## Stress hinders patient decisions

A patient's ability to give informed consent can also be affected by anxiety experienced before medical procedures, particularly major procedures or surgery. The anxiety triggered by the need to undergo surgery can greatly affect their ability to understand complex information and make decisions.

Consent obtained just before surgery is problematic, as anxiety about the procedure may combine with the pressure to make a decision, which further impairs the patient's decision-making abilities. Even when written informed consent is obtained, patients may agree to the procedure with little understanding of what they are agreeing to, Professor Sherman says.

"Pre-surgery, most patients are experiencing heightened anxiety and are out of their comfort zone, so there is more likelihood that decisions will be made in haste," Professor Sherman says.

"We need to ensure that patients receive adequate information about the procedure, that this information is pitched at an appropriate level of complexity, that known risks to the patient are clearly outlined, and that the patient comprehends this information.

"There also needs to be adequate time for the patient to process the information and make a decision, without feeling any pressure from the clinician concerned - all of which should be measured with valid and reliable consent instruments.

"The decision-making must reflect the patients' values and preferences, and not just those of the clinician," she said.

FEATURE

# MANAGED, BUNDLED, CORPORATISED CARE – A ROSE BY ANY OTHER NAME?

**If 2020 taught us anything it's that we have strength in numbers when it comes to advocacy and how healthcare workers coming together, across specialties, can have the strongest voices. As we head into 2021 there is a new threat on the horizon requiring another active alliance.**

Over the past year 'under the cover of COVID' is how many practitioners have described the way in which the private health insurance industry has tried to introduce a new US-style system into Australia. While we were all busy in the face of a global pandemic, another menace to patient care and safety was looming. Insurers have tried without success for a number of years to bring managed care Down Under but in 2020 we started to hear of concrete initiatives. Many Australian anaesthetists were contacted by health insurers and hospital operators regarding bundled care service proposals.

Should we be worried?

Yes. Very much so.

This edition of *Australian Anaesthetist* contains a number of articles on what this will mean for our specialty and in particular for patients. These features will help explain why the ASA is determined to build a strong coalition against corporatised care.

Anaesthetists are in a unique position of working across many surgical specialties. We are well placed to reach 'across the drapes' and start having conversations with our colleagues about an issue that they may not fully appreciate. The role the ASA and our members now play will have enormous impact on the next generation of anaesthetists, so it is particularly important for our trainee members to also be part of this conversation. They need to understand the impact this could have on their future careers.

Over the past year 'under the cover of COVID' is how many practitioners have described the way in which the private health insurance industry has tried to introduce a new US-style system into Australia.

Our current fee-for-service healthcare system rewards patient contact and puts the patient's best interest first. Moving away from this and down the path of a US-style system could bring a frightening new reality of all the responsibility, risk and cost borne by individual practitioners. It would see the transfer of risk away from the health insurer to the health provider while at the same time transferring control away from the provider to the insurer.

With a strong and united voice, Australian doctors can help ensure that standards are not allowed to decline under managed care.

This would be a world where decision making is not based on patient care, there are no item numbers for post-operative care, and you can only work or refer 'in network' with preferred providers who follow an insurer's referral and billing practices. It will be the end of independent solo practicing specialists. Such models are a threat to the central place of the doctor-patient relationship as the foundation of medical care. They pose a real risk if clinical decisions are based on profitability. All the alarming American stories we have been hearing for so many years could soon be ours.

## WARNING FOR ASA MEMBERS

We urge members to consider the following when evaluating bundled care proposals:

- Freedom of patients to choose their doctors.
- Freedom of doctors to refer to colleagues on the basis of clinical judgement, without external interference.
- Freedom of doctors to provide care to patients without external restrictions.
- Remuneration based on the Relative Value Guide (RVG), free from arbitrary and non-indexed inventions such as 'uplift fees'
- Freedom to opt-out without penalty

Don't hesitate to get in touch if you are approached with a proposal so we can help address your questions and concerns. Visit the ASA website for more information or join the discussion on the ASA Forum.

Australia has an enviable healthcare system. We have universal healthcare and patient options. We must protect it. Presenting a united medical workforce on this issue will make all the difference in ensuring healthcare is decided between a patient and their chosen provider without interference from their insurer.

The ASA is already working closely with the Australian Medical Association (AMA), the Council of Procedural Specialists (COPS), health insurers, hospital operators and consumer advocates to raise our concerns. With a strong and united voice, Australian doctors can help ensure that standards are not allowed to decline under managed care.

In November last year we hosted a webinar on the corporatisation of medicine and this obviously hit a nerve with many ASA members – it was the most popular event outside of our respiratory protection webinars. Despite the 'cover of COVID' it was clear anaesthetists were starting to see the threat posed by US-style managed care and the presentations on the US lessons were certainly 'sobering' as many commented.

Additional webinars on this topic will be promoted to members in early 2021 and we encourage you to learn more about what the future could look like if we don't act now. Knowledge and information will be your new personal protective equipment this year.

# 2021 ASA MEMBERSHIP

Thank you for your ongoing support of the **Australian Society of Anaesthetists (ASA)**.

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

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FEATURE

# CORPORATISATION OF MEDICINE: AN AUSTRALIAN PERSPECTIVE

**Like all industries, the healthcare sector is constantly evolving. However, recent initiatives in private health funding could rapidly take our industry down a path to diminished autonomy for doctors and reduced choice for patients. Even those driving this process could ultimately suffer from the fundamental changes it will bring about.**

It's not too late to stop this process. Australia's healthcare system can maintain its standing as a world leader.[1]

The healthcare industry collectively must take stock of the strengths and weaknesses of our system. By identifying attributes essential to the success of Australian healthcare, reforms can be made without sacrificing the quality of care provided to patients.

Anaesthetists have more to offer in this process than many groups. We also have much to lose if the system spirals downward due to ill-considered changes.

## WHAT IS CHANGING?

Health insurance companies are seeking to expand their role. Traditionally, these companies existed to assist members meet the expenses associated with hospital treatment. In this system, treatment is directed by doctors who are independent from both the insurer and the hospital where treatment is administered. Similarly, hospitals are autonomous entities operating independently from doctors and insurers.

By engaging in bundled care, preferred provider agreements and hospital ownership, health insurers are attempting to take control of the entire process of healthcare provision.

In the background, the ownership of private health insurers has undergone a fundamental restructure in recent years. Until the early 2000s, health insurance was the domain of not-for-profit organisations and the Commonwealth Government. Today's largest insurers are listed companies with a duty to earn money for their shareholders. The majority of Australian health insurance policies are provided by such firms.[2]

## WHAT IS BEHIND THE CHANGES?

Health insurers desire greater control to contain costs.

While this sounds sensible and even

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In a system controlled by insurers, patients would be directed to preferred providers, who in turn would care for patients in designated facilities.

laudable, there is danger inherent in one group possessing complete control of any industry.

## THREE PILLARS OF PRIVATE HEALTHCARE

Power within the current system is shared by three influential groups:

- Doctors who bring patients to hospitals.
- Hospitals in which health fund members receive care.
- Health Insurers who assist policy holders to pay for their treatment.

In a system controlled by insurers, patients would be directed to preferred providers, who in turn would care for patients in designated facilities.

## HEALTH INSURANCE FUNDING VS HEALTHCARE INDUSTRY STRUCTURE

When questioned about their motivation for these changes, health insurers cite a crisis in healthcare funding. They point to premium rises and out-of-pocket costs turning patients away from private health insurance. The solution, they say, is for them to provide bundled care and take over funding of the entire healthcare experience, providing certainty and containing costs.

This strategy rests upon several dubious assumptions, and has demonstrably failed in the United States. Furthermore, this line of reasoning disingenuously marries the issues of health insurance funding and industry structure.

Nobody would assert that our current health insurance funding formula is perfect. Community rating, where individual patients' premiums are equal regardless of health status, places pressure on funding. Stories of patients purchasing insurance shortly before receiving expensive care underline the challenges of balancing access with sustainability. Compounding this issue is the ever-increasing demand for ever-more expensive medical tests and therapies.

However, to suggest that health insurance funding problems can be addressed by handing unchecked industry power to health insurers is illogical and unwise.

## A RACE TO THE BOTTOM?

The whole private healthcare sector is threatened by this ill-conceived strategy, not least the insurers themselves.

Australian patients have access to a world-class free public hospital system. Why then do people pay substantial premiums and out-of-pocket costs to obtain private health care?

Three factors account for the popularity of private healthcare in Australia:

- Choice
- Access
- Quality

Each of these attributes is threatened in an insurer-controlled system.

Patient and doctor choice will be the first casualty. Rather than referring to a trusted colleague or to one requested by the patient, general practitioners will need to check their patient's insurance before referring to a preferred provider for specialised care. Referrals outside these arrangements will likely attract less favourable rebates.

Access to care will also depend on the insurer, again obliging doctors to check their patient's eligibility for the recommended treatment.

Following the deterioration of choice and access, quality too is in the hands of health insurers under a bundled model. Reassurances about preservation of doctors' autonomy are hollow when the choice of specialist, hospital and treatment are subject to approval by an insurer holding all of the power.

Without three truly independent pillars, our system risks losing the very qualities to which patients are attracted.

## TIT-FOR-TAT BUNDLING

Hospital operators will feel pressure to follow the insurers' lead, against their better judgement. Of course they would prefer to retain their independence but faced with insurers who can direct vital revenue to competitors, they will feel obliged to respond.

It is conceivable that hospital operators will assemble their own stables of preferred providers in order to tender for work in bulk. Arthroplasty and obstetric care will be the first to go down this path.

Hospital operators will feel pressure to follow the insurers' lead, against their better judgement.

## WHAT DOES THIS MEAN FOR ANAESTHETISTS?

Health insurers are not able to affect all of the above changes at once. Opening moves have been focused on bundled care in obstetrics and arthroplasty. Individual doctors have been sounded out about no-gap arrangements where an 'uplift fee' is paid in return for signing up as a preferred provider. Although total remuneration would be considered satisfactory by most, acceptance of these offers is the first step in surrendering control to insurers.

## LOOK FORWARD TEN YEARS

Australian anaesthetists enjoy the freedom to work as they choose. You may pursue full-time private practice, a mixture of public and private sessions, or a salaried public position with occasional private cases. Our fee-for-service payment model efficiently compensates you for the service

In order to avoid passively handing over control of Australia's private healthcare system, the whole industry needs to decide what is essential to preserve our excellent standards, and what is open for modification.

you provide. You are free to choose your surgeons and the hospitals in which you work.

The administrative burden on anaesthetists is modest. It is possible for a sole practitioner with a light workload to undertake his or her own office duties. Even large group practices are usually collections of individuals with unique practices and fees, simply sharing rooms and staff.

If health insurers are successful in their attempt to control our industry things will be very different. Practice administration will be more complicated as the universal structure of the Relative Value Guide (RVG) gives way to insurer-specific remuneration schedules.

The very nature of private practice will inevitably evolve to meet new challenges. Like the hospitals, doctors will find it necessary to bargain collectively for bulk work. The notion of being invited by a surgeon to do a regular list together will become antiquated as logistics are worked out at a group practice or hospital level, leaving little room for individuals. It is likely that most anaesthetists will be quasi-employees of large group practices, or actual employees of hospitals.

## ANAESTHETISTS LEADING THE CONVERSATION

Why must anaesthetists become involved in this debate? What influence do we have?

Anaesthetists make up the largest group of hospital-based specialists, numbering over 5,600.[3] We also enjoy strong professional representation, with roughly half of ANZCA fellows choosing ASA membership. We are vital to the daily operation of hospitals and we have strong relationships with other key stakeholders including surgeons of all disciplines, procedural physicians and hospital administrators. We are ideally placed to have a strong voice in the conversation about the future of hospital care in Australia.

## BIG QUESTIONS

Anaesthetists and other groups must use their voice to ask important questions about the nature of health insurance:

- How important is the doctor-patient relationship in private healthcare?
- Is it acceptable for insurers to pay vastly different rebates for identical services based on restrictive preferred provider agreements?
- Who decides what treatment is offered to patients?
- Who decides where patients receive treatment?

## THE NEXT STEPS

In order to avoid passively handing over control of Australia's private healthcare system, the whole industry needs to decide what is essential to preserve our excellent standards, and what is open for modification.

The ASA is already working with medical associations, hospital operators and consumer advocates on this issue. If consensus can be found then a unified approach to the government can be made. In the short term a moratorium on further health insurance expansion would be helpful to facilitate a calm and thorough examination of the issues outlined above.

With a co-operative approach, Australian patients and doctors will continue to enjoy our world-class system.

Peter Waterhouse
*Chair, Professional Issues Advisory Committee*

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FEATURE


# THE US EXPERIENCE AND LESSONS FOR AUSTRALIA

"These may not stop the slow-moving train but at least you'll know what's happening when it hits you". New York based Dr Jonathan Gal, Vice Chair of the American Society of Anesthesiologists' Committee on Economics did not mince his words during a presentation to the Australian Society's webinar on managed care late last year. He shared some valuable insights from a healthcare system that has been transformed over many years on the path to corporatisation and it's a concerning vision of what could be the future for Australia.

## MORAL HAZARD

While our two healthcare systems may appear poles apart there are still striking similarities in what patients want from health insurance. The US patient priorities include:

- Choice of hospital or doctor.
- Control over visiting any specialist.
- Freedom to travel with coverage across the country.
- Flexibility to choose from different standardised plans.
- Value with help for out-of-pocket medical expenses.

To understand how the US insurers respond to this demand for choice means understanding their reliance on 'moral hazard'. Dr Gal explains insurers define this as the change in behaviour that occurs when a person becomes insured. For example, spending an extra day in the hospital or purchasing a good or service he or she would not have otherwise purchased had they not had the insurance.

"Basically, if the patient didn't have any insurance, they wouldn't actually be using it," Dr Gal said. "We see so much of that in the US. Those patients with insurance are more likely to then go for their follow-ups, go for their screens, colonoscopies or mammograms. Those without insurance wind up skipping all of that so this is part of the moral hazard insurers all lean on."

To the insurance companies the solution is to impose cost-sharing on consumers to constrain any unnecessary services. "They don't want patients just going for any check-ups or getting random services they may or may not need, and so as a result they try and impose some of the cost onto patients to try and make sure they don't take advantage. Every time you want to see your primary care provider or any sort of provider for that matter, you wind up having to pay even a little bit out of pocket each time."

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Managed care takes this one step further where insurers can sometimes deny care based on medical necessity when they believe it might be 'waste'. While this is the popular image that many Australian patients may have of US-style healthcare and can ring alarm bells for the public, there is a whole lot more at stake for healthcare providers.

Addressing the 'moral risk' of patients has seen insurers pushing more financial risk onto the providers, especially as the US healthcare system moves increasingly away from fee-for-service based systems. "There seems to be a big theme of transfer – transferring risk away from the insurer to the provider and transferring of control away from the provider to the insurer."

## VOLUME TO VALUE

One of the many hats that Dr Gal wears is that of Medical Director, Clinical Revenue Initiatives for Mount Sinai Health System. From this position he has been able to closely study the large shift from volume-based healthcare to value-based healthcare causing many providers to fundamentally rethink their whole business model.

"Instead of just trying to get as many patients in the door as possible and charge a fee for service when they're here, the main drivers are now volume and efficiency. The faster you can do the cases, the more cases you can do, and the higher revenue you can earn. They'll give you money for the care, but you and the hospitals are the ones who need to try and keep the cost of the care down as much as possible. They've really shifted the risk away from themselves and onto the providers."

According to Dr Gal the shift from this fee-for-service to value-based healthcare is increasing exponentially in the US. In 2016, only about 30% of alternative payment models were based on value. In 2018, it jumped to 50%, and within the next four or five years, it is expected to be at 100% with not a single patient beneficiary not having some sort of value-based payment model associated with their care.

The fundamental restructuring of the relationship between these health plans and providers is having a major impact on the health workforce. Hospitals are increasingly becoming part of networks so they can mostly refer inside and to take care of their own population of patients. "The old model had a bunch of solo practitioners, solo smaller hospitals all by themselves, not collaborating. Shifting over to the new model where physicians are in groups, they're now in multi-specialty organisations, independent practice associations. They're joining together to try and help coordinate care much better as opposed to doing it one-by-one".

## Rethinking business models from volume to value based

| | Volume based | Value based |
|---|---|---|
| Incentives | • Share of high margin services<br>• Optimise practice or department cost structure<br>• Highest reimbursement rates | • Share of population managed<br>• Optimise overall community health<br>• Lowest total cost of care |
| Reimbursement | • FFS/DRGs<br>• No payment for readmits, never events, etc. | • Outcomes & Quality based<br>• Global payments |
| Organisational model | • Departmental<br>• Specialty | • Populations<br>• Conditions<br>• Focused factories |
| Cash drivers | • Volume<br>• Efficiency (on a procedure level) | • Quality and low variability<br>• Population-level efficiency |
| Profit drivers | • Visits<br>• Surgery / Procedures<br>• Outpatient ancillary | • Wellness and prevention<br>• Population management<br>• Chronic condition management |
| Investments | • Capacity (in profitable services)<br>• Revenue-producing assets<br>• Patient referrals | • Health IT<br>• Clinical integration<br>• Commercialisation |

## BUNDLED BAIT AND SWITCH

Bundled payments are increasingly common in the US where an entire episode of care can either be related around the hospitalisation or the entire 90-day period associated with the hospitalisation. Dr Gal explained patients can come in for a surgery and any readmissions, rehab or other post-operative care they might need (at a skilled nursing facility for example) can be included in the bundled payments.

Although this plan is incentivised by volume, the insurers are taking a bait and switch approach. The example Dr Gal gives is an insurer approaching five different hospitals with 10,000 patients who are beneficiaries on their health plan. Each hospital is told they can get a 20% share and that's where the volume negotiations begin. "If you want to get more like 30% of the share of our 10,000 beneficiaries let's enter into this contract, and now 30% of our 10,000 are going to go towards you as opposed to just 20%. They'll negotiate a price, suppose it was going to be $1,000 an episode, and then say 'Okay, we're going to send you more patients, but we want to only pay you $950 per episode'."

In this scenario it is easy to see the hospital agreeing as they are going to get 1,000 more patients and will take $50 less for more in total aggregate revenue. The insurer is in a position to attract more beneficiaries with the lower-cost health plan with decreasing costs over these different bundled payment models. Then comes the catch. "Next year when we come back, we have 12,000 beneficiaries as opposed to just 10,000 because more people signed up with us as opposed to our competitor. It's how everyone increases their market share. But eventually, the margins start getting less and less. With each year they need to start keeping the premiums down and down, further and further. And so, 'Last year we paid you $950, this year we want to go $875. But you guys can do it, right? We're going to give you another 1,400 patients this time'. And so, it's a lot of that bait and switch that just keeps squeezing the margins more and more."

## VALUE ADDING

Dr Gal said it is usually surgeons who often get approached by insurers because they're the attributing providers. The US experience saw the early adopters of managed care with primary care providers and some of the main specialty providers like obstetricians and orthopaedic surgeons doing some of the highest volume of care through the different insurance policies.

Those late to the table tend to be the non-attribution providers who do not initiate the episode of care like anaesthesiologists, radiologists or pathologists. When the episode of care or admission to hospital is not attributed to these providers it is essentially a cost for the insurer. And that's where margins really get squeezed.

"You need to demonstrate all those extra areas of value that you're providing for that entire episode of care, and why you deserve to be at the table for those conversations. Those value conversations at the hospital and health system level are going to be huge for every anaesthesiologist. This is when you start getting into the conversation – Okay, so for your total joints, I give you your actual anaesthesia, I give you a regional anaesthetic such as an adductor canal block so you can do physical therapy on day zero, have a length of stay of just two days, those are associated with less complications and you need to basically draw out for them all the extra value that you're providing so that all the other costs can come down."

And for all the added value that you can demonstrate, there will be the added joy of much more paperwork. Dr Gal admits under this new regime that practice administration has become rather burdensome between documentation, billing, claims, adjudications and legal paperwork. He warns Australian practitioners that any overheads they now have to take care of billing practices will probably have to triple within ten years.

"That's actually one of the highest rising costs in healthcare every year inside the US. There's a lot of just bureaucratic negotiations that you need to do. You have to enforce the contracts while you're just trying to provide quality care inside of an operating room or inside of a pain medicine suite. You're going to need to have a lot more of an administrative overhead for that."

For the Australian anaesthetists who have seen Dr Gal's presentation on the ASA webinar, these administrative overheads are probably the least of their worries.

### About the presenter

Dr Jonathan Gal is an Assistant Professor in the Department of Anesthesiology, Perioperative, and Pain Medicine at the Icahn School of Medicine at Mount Sinai in New York. He is the Department's Director of Governmental and Reimbursement Affairs and also the Medical Director, Clinical Revenue Initiatives for Mount Sinai Health System in the Department of Clinical Business Intelligence & Implementation.

FEATURE

# BUNDLED OBSTETRICS CARE – THROWING THE BABY OUT WITH THE BATHWATER?

Obstetricians have been the early adopters of managed care options overseas and Australian practitioners are watching closely as Sydney obstetrician Dr Andrew Zuschmann explains.

Anaesthetists work with a lot of different Medicare Benefits Schedule (MBS) item numbers as it was once explained to me by an old anaesthetist colleague who described himself as a taxi driver charging a flag fall and then a per-kilometre rate. I'm not sure what analogy would best suit the complicated billing practice of obstetricians but hope the following provides insight into our long and winding road.

Much of the complication comes from the fact that our care occurs partly in the community and partly in the hospital. In the community, we'll have the initial visits where the pregnancy is diagnosed and investigations ordered. Then there will be a number of routine antenatal appointments. Typically, this might involve eight or ten of these episodes during a pregnancy. There will also be bloods and scans, so we will be involving pathology, ultrasound and radiology colleagues, along with GP and paediatric appointments in the postnatal period as well.

Sometimes women present at the hospital during the antenatal period, which also attracts a fee-for-service. The actual birth itself will involve the obstetrician, the anaesthetist and a number of other specialties. Typically, it will also include the paediatrician who would review the baby after birth. If the woman is unwell with something like preeclampsia, she may also have an ICU admission.

## OBSTETRIC ITEMS

Before the Extended Medicare Safety Net (EMSN) came into existence in 2004 simplified gap billing was common. Obstetricians would typically divide their fee over a number of visits during the pregnancy, and the patient would pay certain amounts per visit. The EMSN brought in item number 16590 for the 'Planning and Management of a Pregnancy' and this was basically to capture the gap payment that occurred in the community setting.

Initially, it was suggested this be split into the gap attributed to the antenatal and birth components so a typical pregnancy billing would look like:

- 16401 for an initial attendance;
- 16500 for each antenatal attendance;
- 16590 for planning and management of the pregnancy;
- 16519 for a simple birth;
- 16522 for complicated birth;
- 16404 postnatal attendance (in rooms).

Note that vaginal birth and caesarean sections attract the same fee. The complicated birth numbers include things like diabetes, significant hypertension, multiple pregnancy or bleeding. An elective caesarean in somebody with diabetes might be a fairly straightforward procedure and no different in those without diabetes.

We are all familiar with the different patient rebates between the MBS and the no or known-gap procedures, but you may not be aware of the true impact of going even a little over the no-gap rebate for birth as our patients are getting significant out-of-pocket costs.

The MBS rebate versus HCF no-gap, for example, has quite a difference:

- 16519 – MBS $536 vs HCF $1,908 or;
- 16522 – MBS $1,260 vs HCF $2,315.

## COMMUNITY CARE

With there being three main types of private health insurance in Australia – hospital, extras and ambulance – there is nothing that covers care in the community. This feeds into one of the major public misconceptions about why their health fund is not paying more obstetric cover.

The majority of pregnancy care including 24/7 access to a specialist obstetrician and gynaecologist actually occurs in the community and is outside the remit of private health insurance. So we can see that health funds are really looking at ways of clawing this back to reduce members out-of-pocket expenses.

With most of the care being provided in the community, the community portion tends to attract a bigger gap, with a smaller gap being apportioned to hospital services. There's a big insurer mark-up on the 16519s, which prevents the large out-of-pocket costs or large out-of-pocket gaps in hospital because many obstetricians, certainly around Sydney, will no-gap the birth based on reasonable rebates.

## UPLIFT FEES

It is becoming increasingly obvious that when it comes to bundled care arrangements the provision of uplift fees is dependent on all community consultations with the obstetrician service bulk billed, which means the EMSN rebate is lost for the patient. All bloods and scans must be at a bulk bill provider already in place with the health fund. Many pathology services will bulk bill, but high-quality pregnancy ultrasound typically has a gap because ultrasound and radiology rebates have been neglected. All anaesthetic services must be provided at no out-of-pocket cost to the patient, and this includes the no-gap plus and uplift fee.

From an obstetrician's point of view, the uplift fee is significantly less than many currently charge for the package of obstetric care we provide. Although there's a wide variation of fees charged in Australia for private obstetric care, for many this would represent a significant 25% reduction in income per pregnancy.

As a busy obstetrician, I'm comfortable with the workload that I'm doing and for me to take a 25% reduction in fees with the expectation that I'm actually going to increase the workload, is really challenging. Especially in the era of safe working hours and of work-life balance in medicine, it's just not particularly acceptable.

The other challenge that bundled care can create at some hospitals is needing to run two on-call rosters. One for the obstetricians, anaesthetists and paediatricians who want to participate in a bundled care arrangement and another for those who don't. You can imagine the issues this creates having to potentially run two anaesthetic rosters.

One of the key considerations to be taken into account is that many health funds consider women who are participating in a bundled care arrangement need to have exactly the same care arrangement from the obstetricians.

From the maternity care provision point of view, no two pregnancy journeys are the same. That the insurers are attempting to homogenise a woman having a baby speaks volumes to what their approach could be to so many other areas of healthcare.

**About the author**

Dr Andrew Zuschmann is an obstetrician, gynaecologist and fertility specialist working in both public and private practice in the Sutherland Shire, Sydney. He is Head of Department at The Sutherland (public) hospital, and O&G representative MAC, Kareena Private Hospital. Andrew is also Vice-President AMA (NSW), NASOG Councillor, and Chair RANZCOG NSW/ACT Training Accreditation Committee.

# INSIDE YOUR SOCIETY

# ECONOMICS ADVISORY COMMITTEE

DR MARK SINCLAIR
EAC CHAIR

## MEDICARE BENEFITS SCHEDULE (MBS) ITEM AUDITS – FEDERAL DEPARTMENT OF HEALTH

As members will be aware from previous reports, a number of anaesthetists have been subject to audits of their Medicare claiming patterns. In particular, the situation where an anaesthesia claim is lodged, but with no matching surgical claim, was investigated. It soon became apparent that the vast majority of these claims involved dental extraction procedures by oral-maxillofacial (OMF) surgeons. The anaesthesia services were claimed under item 20170 (anaesthesia for intra-oral procedures not otherwise specified). The OMF surgeons billed dental items, with no applicable Medicare item or rebate.

There have been further similar audits since the last report. The ASA has engaged the services of the law firm HWL Ebsworth Lawyers to assist. (Again, it should be emphasised that any member subject to a Medicare audit should immediately contact their medical defence organisation – MDO – as well as informing the ASA, before making any contact with Medicare).

The Department of Health (DoH) is fully aware of the issue. At this stage, as far as we are aware, there have been no demands for repayment of funds. However, DoH is still concerned about incorrect claiming patterns, regardless of the fact that there has been no financial loss to Medicare in this situation (Item 20170, and item 22900 for anaesthesia for dental extractions, have the same Medicare rebate). DoH has informed us that ongoing compliance monitoring will occur, and that this will include audits of situations where there are anaesthesia-related Medicare claims with no procedural claims. At this stage the outcome from DoH appears to be as follows:

- Audits of claiming patterns which may be non-compliant with MBS requirements will continue. This could involve audits of claiming patterns for item 20170.
- There will be a specific broad-based educational program on Medicare compliance which may commence in March 2021. It will likely involve a targeted letter activity, in order to support early intervention and awareness raising in an attempt to reduce the likelihood of anaesthetists being subject to more intensive compliance action.
- Anaesthetists receiving such letters will likely be those who have exhibited similar claiming behaviour to those who are subject to the audit but to a considerably lesser extent.
- These anaesthetists will be asked to take a self assessment approach in order to review their claiming and ensure that it has met the relevant MBS requirements.
- DoH has also informed us that the letter will be accompanied by a factsheet which will include information about the correct claiming of MBS Item Numbers 20170, 22900 and 22905.
- DoH has welcomed ongoing discussions between the ASA and the DoH Compliance Education Section, with the aim of working with stakeholders to support accurate claiming by providers.

## MEDICARE BENEFITS SCHEDULE (MBS) ITEM AUDITS – PRIVATE HEALTH INSURERS

Unsurprisingly, monitoring and assessment of Medicare claim patterns by doctors is also undertaken by private health insurers (PHIs). As with the DoH, there are specific departments within the various PHIs, dedicated to this task.

The PHI nib has approached a number of anaesthetists about their claim patterns. Unfortunately, they were worded as a 'request for repayment' rather than a request to review billing patterns. There were also a number of inaccuracies in the 'request', demonstrating a lack of awareness of the clinical nature of anaesthesia services. The ASA wrote to nib about this and our concerns were acknowledged.

In these cases, the issue related to anaesthesia time items. The nib 'Provider Audit' team noted a series of cases in which the anaesthesia time claimed was

significantly greater than the operating theatre time. The anaesthetists were asked to "review the billing outlined" and "resubmit an amended invoice where necessary and refund any monies which may have been paid to you due to billing errors."

It is notable that PHI auditors have access to various hospital records, including the data kept on theatre arrival times, operating start and end times, and theatre departure times.

Sensibly, the ASA members involved approached both the ASA and their MDO before replying to nib. In all cases brought to our attention so far, the times claimed were correct.

This is a fairly common source of queries from both DoH and PHIs. They do now understand that there is no recorded time on operating theatre computers which accurately reflects anaesthesia start and end times. This is especially common in more complex cases, where procedures such as local anaesthetic nerve blocks or invasive pressure monitoring is required. In some cases, transport to ICU and handover to intensivists was required, all of which of course counts towards the billed anaesthesia time. However, where the time discrepancy is, in the PHI's view, 'significant', they will ask questions.

Fortunately the anaesthetists involved had kept very good anaesthesia records. The importance of good record keeping cannot be over-emphasised, for this and numerous other reasons. In some cases in the past, it has been difficult to defend ASA members' billing patterns, due to less than ideal record-keeping.

This situation also reminds us that, where a provider utilises a PHI's 'no gap' schedule, such as the nib 'Medigap' product, he or she has automatically fully agreed to the terms and conditions placed by the PHI. These T&C virtually always include a clause giving the PHI the right to engage in such audits.

## PRIVATE HEALTH INSURER (PHI) INITIATIVES

As members will be well aware, there has been a concerted push from some PHIs for what can be politely described as 'novel' approaches to the funding of healthcare in the private sector.

Professional Issues Advisory Committee Chair (PIAC), Dr Peter Waterhouse, has written extensively on the issue, as well as organising meetings with the relevant stakeholders (including the PHIs) so I will not duplicate his efforts here. Clearly, the issue raises concerns far beyond those related simply to fees, rebates and out-of-pocket (OOP) expenses to patients. The very nature of the doctor-patient relationship could be under threat at multiple levels.

From the EAC point of view, it is important that members note certain specific concerns.

Often, the initial proposals by PHIs may seem attractive to doctors. The offer by Medibank Private of an 'uplift' fee in return for a guaranteed 'no OOP' experience by the patient is, at first glance, one such proposal. The same could be said for the nib application to the Australian Competition and Consumer Commission (ACCC) to engage in collective bargaining with doctors and hospitals on the issue of fees and charges. (At the time of writing this proposal is very new and has not been fully analysed, but it is of significant concern and the ASA certainly intends to make a submission to the ACCC).

There are, however, no guarantees as to what will happen in the future. The bottom line is that these PHIs are motivated purely by – the bottom line. Their entire focus is on financial profits. All of their initiatives and proposals must always be viewed in this light. Once doctors and hospitals are signed up in sufficient numbers, with doctors in particular tempted by the financial aspects of the initial offers, the PHIs will have the control they desire. Anaesthetists should carefully consider this before entering into such agreements.

## CONTACT US

If you have any comments or queries please contact Policy.

**Email:** policy@asa.org.au

**Phone:** 1800 806 654.

INSIDE YOUR SOCIETY

# PROFESSIONAL ISSUES ADVISORY COMMITTEE

DR PETER WATERHOUSE
PIAC CHAIR

While it is obvious from the content of this issue that Corporatisation of Medicine is a major focus for PIAC and the wider Society, important work continues in the background.

## PUBLICATIONS

Several publications to assist members are nearing completion. They include:

- A guide to the anaesthetic trolley.
- An Australian summary of recent international guidelines for the management of post-operative nausea and vomiting.
- A patient information leaflet regarding pain relief in labour. Another devoted specifically to epidural anaesthesia is also being prepared.

This year several existing ASA documents will also undergo review. My thanks to all who participate in the very important task of maintaining the Society's professional documents.

## PUBLIC IN PRIVATE WORK

Several members have contacted the ASA for support in this area. Concerns include medical indemnity cover, patient selection, list structure and payment.

Arrangements for surgery on public patients in private facilities vary between jurisdictions. However it is popular for state health departments to delegate as much responsibility as possible for each episode of care to the private hospital in which the care is provided. For many private hospitals this is unfamiliar territory, so processes are still evolving to manage the new service.

Under some arrangements indemnity is provided by the state government to doctors undertaking this work. However, just as it is wise for full-time salaried anaesthetists to possess their own indemnity insurance, private practitioners are urged to inform their medical indemnity provider of their intention to treat public patients in the private setting. Public liability insurance is not a core component of medical indemnity cover, so the need for this should also be considered.

Lack of attention to patient selection and limited access to medical records have convinced many anaesthetists that public-in-private work carries a higher risk of complications than traditional private practice. This risk can be mitigated by several strategies:

- Surgeons treating their own public patients as opposed to simply taking a cohort form a waiting list.
- Public-in-private work being undertaken by surgeon-anaesthetist teams already working together in the hospital in which the public patients will be treated.
- Timely access to lists so that adequate pre-operative assessment can be undertaken.

Allocating entire lists to public work rather than inserting public patients into routine lists makes these cases easy to identify as the list approaches. Administration and billing can also be simplified by taking this approach.

Public liability insurance is not a core component of medical indemnity cover, so the need for this should also be considered.

Payment for public in private work is variable. Some hospitals continue to invoke 'COVID' arrangements intended to provide a structure for reducing the burden on public hospitals in the event of an overwhelming pandemic. These arrangements are not suitable for routine elective work. Unsurprisingly, there has been only modest interest from hospitals, surgeons and anaesthetists in these arrangements.

Before committing to public-in-private work, members are advised to review the clinical and medico-legal risks presented above. Remuneration negotiated for such services should take into account these risks and be comparable to that for similar work undertaken in traditional private practice.

## ON CALL ROSTERS

Several member enquiries have been related to hospital after-hours rosters.

On-call arrangements vary widely dependent on local factors including hospital size, surgical case mix and the presence of on-site emergency and obstetric services.

While it is reasonable for hospital operators to expect after-hours cover to be provided by anaesthetists undertaking regular work in their hospitals, a flexible approach is required. It is not usually appropriate for all accredited anaesthetists to participate equally in the after-hours roster.

Factors including age, health, usual caseload and familiarity with the hospital in question will influence an anaesthetists' ability to participate in after-hours rosters. It is possible for anaesthetists to make a positive contribution to their hospitals even if it is not appropriate for them to assist with the provision of after-hours emergency services.

Negotiation in good faith between hospital administration and the anaesthesia committee of the hospital is the best way to achieve safe after-hours cover. ASA PS 01 provides guidance in this area.

While local solutions are always preferable, the ASA is available to assist members with negotiations if required.

## INDIVIDUAL ASSISTANCE

The themes above represent the majority of recent enquiries to PIAC.

However a diverse range of issues from legal problems to medical board notifications have also been addressed.

Remember to get in touch with the ASA if professional assistance is required. It is surprising how often we can help.

Contact the ASA Policy team by email: policy@asa.org.au or telephone: 1800 806 654.

# INSIDE YOUR SOCIETY

# POLICY UPDATE

## COVID-19 VACCINE – HOW MANDATORY COULD IT BE?

There are frontline workers with top-priority access to the COVID-19 vaccine, but are refusing to take it. Roughly 20% to 40% of LA County's frontline workers who were offered the vaccine refused it according to county public health officials.[1]

Now that the vaccine rollout is about to commence in Australia (late February at time of writing this article). What are your rights should you decline the shot?

The scientific evidence is clear regarding the safety and efficacy of the vaccines after trials involving tens of thousands of participants, including elderly people and those with chronic health conditions.[2] The shots are recommended for everyone except those who have had a severe allergic reaction to any of the ingredients.

This is a question that remains untested in Australian courts. As the much-hyped COVID-19 vaccine approaches in 2021, what legal rights do Australians have to refuse a vaccine?

## CAN AN EMPLOYER DIRECT EMPLOYEES TO BE VACCINATED?

Here is where it gets complicated. Employers have a right to issue lawful and reasonable directions to employees – but what is lawful or reasonable can look very different in different workplaces.

> "Where an employee routinely works with at-risk individuals such as children or the elderly, a direction to receive a vaccination may be lawful and reasonable."[3]

To date, only Victoria has addressed the question of mandatory vaccination from a legal perspective, with the *Health Services Amendment (Mandatory Vaccination of Healthcare Workers) Act* 2020 requiring vaccination against 'specified diseases' of all workers employed or engaged in public hospitals, denominational hospitals and health service establishments.[4] At this stage it doesn't extend to include COVID-19 vaccinations but obviously, when a vaccine rolls around, it may be added to the list of vaccines required for healthcare workers.

Some jurisdictions may pass legislation to require employees in health or care sectors to be vaccinated. But Jewell Hancock Employment Lawyers believe employers in other sectors may have grounds to ask their employees to be vaccinated.[5]

Employees have a legal obligation to comply with their employer's directions if those directions are lawful and reasonable. An employee who fails to do so may be subject to disciplinary action, up to and including dismissal.

> "Employers have an obligation to provide a safe working environment, and employees have an obligation to assist their employer to provide that safe working environment. A reasonable question to be asked is, 'Is the working environment safe when we have employees at risk of quite a serious disease being spread?' You may have elderly or compromised people in that workplace."[6]

Various factors may impact the lawfulness and reasonableness of a particular direction, including:

- the employer's workplace health and safety obligations;
- the employer's common law duties of care;
- whether the direction constitutes discrimination of the sort prohibited by Australia's anti-discrimination regime;
- human rights legislation such as Victoria's Charter of Rights and Responsibilities (depending on the jurisdiction and the nature of the employer);
- any relevant provisions in an applicable employment contract, modern award or enterprise agreement;
- any relevant consultation obligations;
- the availability of reasonable exemptions to the direction, and the availability of effective alternatives to vaccination (such as the use of personal protective equipment); and
- whether the employee can perform the inherent requirements of their position without being vaccinated.

## PRACTICAL ISSUES

Even if it is determined that a particular employer can lawfully and reasonably direct their employees to be vaccinated, other practical issues need to be considered. For example:

- How will the employer determine whether their employees have actually been vaccinated? One option is to simply take employees on their word, or to require employees to provide a written acknowledgement that they have had the vaccine. Some employers will be comfortable with that option, but it is likely that others will want more. A second option is to require employees to complete a statutory declaration confirming that they have been vaccinated. A third option is to require formal medical evidence or certification.
- Privacy is another significant issue that employers must consider. Australian law regulates the collection, use, storage

and handling of personal or health information. Employers must ensure that they are complying with those laws. This may require specific legal advice in that regard.

- Employers must consider how they will respond to employees who refuse the vaccine. One option that may be available to some employers is to move, or formally redeploy, the unvaccinated employee to a part of the business in which the employee would be physically distanced from others. Disciplinary action including dismissal is another option. Each response to refusal poses different risks to the employer, and should therefore be considered carefully. Additionally, employers must ensure that they are consistent in their response to refusals. If one employee's refusal is dealt with more aggressively than the refusal of another employee in similar circumstances, that kind of differential treatment might expose the employer to liability. Developing a workplace policy on vaccinations may be helpful in that regard.

However, for some employers dealing with vulnerable people, the answer is more likely to be yes for most of their workforce.

Whilst the principles that courts will apply to resolving this question are well settled, unfortunately, the lack of available scientific data about the effect of the COVID-19 vaccines means that the ability to direct employees to take the vaccine remains both uncertain and subject to an employer's particular operating environment. The clarity regarding the answer to this question may evolve as we learn more about the clinical effect of the vaccine in the coming year.

## PUBLIC HEALTH ORDERS – AN EASIER WAY OUT?

This approach demonstrates that navigating the path to a successful compulsory vaccine rollout in a workplace is likely to be fraught with complexity and danger.

The same outcome could be achieved by employers more simply if Public Health Orders are issued requiring persons to be vaccinated before entering particular workplaces. This type of approach was adopted by Victoria with respect to healthcare workers taking influenza vaccines in 2020.[7]

It is possible State Governments might regulate in this space, particularly if the early disputes surrounding COVID-19 vaccinations are not determined in favour of employers looking to implement safer workplaces.

Public Health Orders in New South Wales, Western Australia, South Australia, the Northern Territory, the Australian Capital Territory and Tasmania require workers in residential aged care to be vaccinated against influenza where a vaccination is available, unless an employee has a medical contraindication to vaccination.

Relevantly, two unfair dismissal claims were filed in 2020 by employees in childcare centres who were respectively stood down after refusing a free flu vaccination their employers had directed them to receive amid the COVID-19 pandemic. However, both applications were filed out of time and ultimately dismissed, meaning the reasonableness of the direction was not examined.

Deputy President of the Commission, Ingrid Asbury, did note in one of those cases:

> "It is my view that it is at least equally arguable that the Respondent's policy requiring mandatory vaccination is lawful and reasonable in the context of its operations which principally involve the care of children, including children who are too young to be vaccinated or unable to be vaccinated for a valid health reason."

The COVID-19 vaccine legal challenges will be unprecedented for employers and the Fair Work Commission.

In the absence of State or Federal Government guidance, or any clear judicial statement on the circumstances in which a COVID-19 vaccination could be an inherent requirement of an employee's role, employers should be cautious in mandating a COVID-19 vaccine for employees.

Although there are only a couple of case law around workplaces and vaccines as it stands there are more flu vaccines cases in the pipeline. These cases will likely have an impact on how employers can approach the COVID-19 vaccine.

Jacintha Victor John
*Policy Manager*

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## CONTACT US

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

**Email:** policy@asa.org.au

**Phone:** 1800 806 654.

# INSIDE YOUR SOCIETY

# TRAINEE MEMBER'S GROUPS UPDATE

Welcome to 2021! What a challenging year 2020 was! I know I learnt a lot more about strategies for coping with stress and unexpected roadblocks than I anticipated. I'm sure we are all hoping for a better year ahead.

## EDUCATION

Expressions of Interest are being sought for a trainee representative for the ASA Online Education Committee. This committee is looking at how we can better structure and utilise the ASA website to provide educational resources and as the trainee representative, you would have a significant role in providing relevant and highly useful educational resources for other ASA trainees. You would work side by side with passionate and highly experienced anaesthetic educators such as Vida Viliunas, Frank Sun and Natalie Marshall in delivering educational content to your fellow trainees.

ASA President Dr Suzi Nou is putting together a podcast aimed at junior doctors aspiring to enter anaesthetic training. It would cover tips for improving your chances for a successful application (suggested courses, experiences etc) and how to gain the most from your anaesthetic training from the outset. It is also planned to cover some interview tips that will surely be useful for everyone.

Common Interest Group (CIG) scholarship applications are currently open and close COB Monday 1 March 2021. These scholarships are valued at $4,000 each and are designed to assist a trainee to attend an international conference hosted by one of our sister organisations in the UK, USA or Canada. Obviously, the pandemic has put up a bit of a roadblock to international travel and conferences, which is why the successful recipients will be able to take the scholarship in subsequent years. Please head to the ASA trainee webpage to read the application guide.

During 2020, the ASA arranged and hosted multiple primary and final exam vivas via Zoom. These were well regarded and highly valuable for the exam candidates. We are hosting vivas again this year so if you are planning an examination please head to ASA events webpage to sign up. My thanks to all the viva examiners and facilitators who are involved.

Part 3 courses have recently been held all over the country and have been thoroughly recommended by those who have attended. Aimed at provisional fellows with content that covers the move into consultant positions, the Part 3 courses provide valuable information for the beginning of your careers.

The *Trainee Members Group Handbook* has been well received and later this year we will start the process of developing the next version. If you have any suggestions for areas to cover, we would love to hear from you.

## REPRESENT

During 2020 we regularly advocated for anaesthetic trainees in relation to exams, workplace issues and a range of other areas. Trainee representatives are on many committees in the ASA, ANZCA and AMA, ensuring that we have a strong voice and excellent representation on issues that matter to us directly. We continue to work together to provide for all of our colleagues across Australia and are currently looking for passionate ASA trainee members to join the TMG as state representatives from NSW and ACT. If you are keen to be involved, please contact our TMG Committees Assistant: mwade@asa.org.au

## SUPPORT

The Mental Health First Aid for Trainees course was held via Zoom in 2020. It was, by all accounts an exceptionally valuable course that provided those who attended valuable insights and skills on how to approach a range of issues relating to mental health. We plan to host more of these events in the future, please keep an eye out.

While 2020 was a bit of a buzzkill on social events, we did host an online wine

tasting session. Hopefully 2021 will prove to be a bit more socially friendly and we can host safe and socially-distanced events across the country. Stay tuned for plans.

A reminder for those sitting exams this year to take advantage of the corporate discount offered by the Accor hotel group to ASA members. Contact TMG Committees Assistant: mwade@asa.org.au for further information.

There are some changes afoot in the industry that may have a significant impact on our future careers. If your colleagues don't know of the benefits and advocacy that the ASA provides to members please encourage them to get involved. I wish you all the best for the year ahead and I look forward to the challenge of being the ASA TMG Committee Chair for 2021.

Dr Alexander Courtney
*ASA TMG Chair*

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INSIDE YOUR SOCIETY

# OVERSEAS DEVELOPMENT AND EDUCATION COMMITTEE

## N95 DONATION TO THE SOLOMON ISLANDS

**In March 2020 the Solomon Islands Ministry of Health requested the assistance of the ASA in preparing for the pandemic.**

An initial request was made for oxygen concentrators, pulse oximeters and N95 masks. Through Lifebox Australia and New Zealand, ten oximeters were donated and are now in service on the COVID-19 isolation ward at the National Referral Centre, Honiara. The DAK Foundation agreed to donate a number of portable oxygen concentrators, which are also now in service. Sourcing N95 masks was much more problematic. At the time, the Solomon Islands' national stockpile held around 2,000 N95 masks and making a significant contribution, when there was such a shortage in Australia, was a challenge!

In November, Dr Martin Nguyen and his team at Medical Pantry received 24,000 surplus, high quality 3M N95 masks and offered these, via the ASA to the Solomon Islands. The Department of Foreign Affairs and Trade agreed to deliver these to Honiara from Brisbane and the ASA shipped these from Melbourne in late December. The next step is education in their use and the ASA Overseas Development and Education Committee is working with Dr Kaeni Agiomea, the country's senior anaesthetist to ensure that the masks are used correctly when required.

As background, the nation of Solomon Islands (population 650,000) is a large archipelago of over 900 islands lying between Papua New Guinea and Vanuatu. The Solomons is considered a low middle income country by the World Bank, however, considerable advancement has been made in health in recent years but surgery and anaesthesia is lagging behind other areas. The country has five qualified anaesthetists, led by Dr Kaeni, who has been the mainstay of their service for over thirty years. The ASA, along with RACS and the Fiji National University has worked with Kaeni and colleagues to improve the ability of the Solomon Islands to develop Honiara as a training venue and foster the next generation of Solomon Islands' anaesthetists.

Rob McDougall
*ODEC member*


24,000 N95 masks at the Medical Pantry awaiting transfer to Honiara

# INSIDE YOUR SOCIETY

# AROUND AUSTRALIA

## NEW SOUTH WALES

### Lan-Hoa Le, Chair

Welcome to the State Committee's news. I hope you and your close ones had a safe and well-rested season. Happy New Year, and here is hoping for a less chaotic and more predictable 2021!

### Support

There were many activities last year. The year closed with multiple interactive events including a Wellbeing Forum. There were practical tips on mindfulness-based anxiety therapy. We continued with another wellbeing platform specifically for trainees preparing for their exams in early February this year.

Our NSW Trainee Representative joined ANZCA NSW at the Part 0 to guide doctors thinking of joining our anaesthetic profession. We hosted the Part 3 for the advanced trainees/provisional fellows and new consultants to prepare for life as a junior consultant in the public and private sectors. A special thanks to our Chair of the ASA Economic Advisory Committee, Dr Mark Sinclair, for presenting the Society's *Relative Value Guide (RVG)* for members with private practice billings.

We kicked off in January with a NSW Medical Virtual Viva Preparation Course. We hosted it at the request of the organisers, who are members wishing to support our future anaesthetists. I thank and commend their philanthropy, and it was a successful example on how the ASA can further look after our members' interests.

The ASA Public Practice Advisory Committee (PPAC) had provided an inaugural (4D) Directors of Department Development Day in November last year. NSW PPAC hosted the next 4D in February 2021 as a hybrid event face-to-face and Zoom. This event is designed for immediate past, present and potential Directors and Deputy Directors of Anaesthetic Departments in the public sector across Australia. It is also for the Medical Advisory Committee (MAC) anaesthetic representatives at private hospitals. The workshops are designed to share skills as leaders, learn the latest developments in anaesthetic practices and build a strong network of professional connections.

### Represent

#### COVID-19: PPE Fit-testing and Vaccination rollout

Choice of masks for fit-testing are inadequate and the program completion rate is variable across NSW. It will require attention from the Ministry of Health for standardisation.

NSW Health is engaging with clinicians on the COVID-19 vaccine program and the ASA has released a Position Statement on COVID-19 vaccination.

#### Reduction of elective surgery waiting lists and VMO contracts at private hospitals

NSW Health is providing TMF cover for public patients in private facilities. For private practice anaesthetists only, don't forget to ask your private hospital(s) or LHD executives for the conditions required and TMF insurance form to sign for acceptance.

#### NSW Committee of Management (COM)

Our immediate past chair, Dr Ammar Beck, has retired from the Committee. A/Prof Stephanie Phillips has also moved away from the NSW COM. She remains as the ASA Chair of Science Prizes Awards Research Committee (SPARC). On behalf of our team, I'd like to express our sincere thanks to both for their many years of service dedication to NSW members. I wish you both unlimited professional and personal success and happiness in the future. Congratulations to Dr Nishan Yogendra for completing his fellowship. He'll transit from being a trainee's representative to represent our fellows in the NSW COM.

### Education

#### ASAEd

Visit our new library for education resources for members only. Congratulations to our ASA Education Officer, Dr Vida Viliunas, and her team in this development.

## WESTERN AUSTRALIA

### Mike Soares, Chair

The snap lockdown as of January 31 has ceased all elective surgery except for Category 1 and Urgent Category 2 surgeries. Fortunately there does not seem to be community spread and the hope is that lockdown will be completed by 5th February.

The ASA committee is advocating at a state level for anaesthetists on intubating teams to be included in category 1a for vaccinations.

## QUEENSLAND PART 3 COURSE – 28 NOVEMBER 2020

The Qld Part Three course was held face-to-face at the ANZCA Regional Office on Saturday 28th November 2020.

Organised by the Trainee Members Group representatives, the course was attended by 16 advanced trainees and provisional fellows and was very well received by all attendees. The day consisted of a number of sessions in the form of lectures and panel discussions.

Topics included CV and interview skills, private practice, billing and financial matters, as well as medicolegal tips for anaesthetists and other career options outside public and private work such as retrieval and military anaesthesia.

Special thank you to Jenn Burgess and Rhian Foster for their assistance in organising the day, and a big thank you to all the anaesthetists who contributed to the excellent educational content on the day. Thanks also to our wonderful sponsors MIGA, MIPS and Walshs.

Dr Hannah Bellwood
and Dr Matthew Bright
*Qld Representatives*
*ASA Trainee Members Group*


Dr Matthew Bright, Dr Hannah Bellwood, Dr Graham Mapp, Jenn Burgess and Dr Jim Bradley

Dr Kerstin Wyssusek chairs the panel discussion on CV and Interview Skills

INSIDE YOUR SOCIETY

# HISTORY OF ANAESTHESIA LIBRARY, MUSEUM AND ARCHIVES NEWS

## MUSEUM – OBJECT OF THE QUARTER

The faded blue and white label on the hand-sized glass bottle proudly proclaims that Dr Sheldon's Magnetic Liniment 'BANISHES ALL PAIN'. Rheumatism, lumbago, neuralgia, stings of insects, sore throat, swellings, sprains were all ailments this elixir was said to cure for the small price of £1/6 per bottle. The eye-catching label on our object dates it to c. 1914.

Sheldon Drug Co was founded in 1904 by American-born, Sydney-based chemist Samuel Sheffer. The Magnetic Liniment was among their earliest products and was manufactured between 1904 through to 1944. The company also made Gin Pills and Digestive Powders. The popularity of these products peaked in the early 20th century and waned after World War II due to increased drug manufacturing regulations.


A Gallant Anzac Praises
Dr. Sheldon's New Discovery
STOPS COUGHS — BANISHES COLDS
DR SHELDON'S NEW DISCOVERY FOR COUGHS AND COLDS

*Bulletin* 24 May, 1917, page 22

While the liniment's healing properties were claimed to be from its unique electromagnetic formulations, the heavy marketing campaigns were the real magic of the product. In Australia, newspaper advertisements regularly appeared in Sydney, Melbourne, Adelaide and even from Cairns to Bendigo. The happy customer testimonial was the default advertising strategy. During World War I, the happy customer whose pain was banished by the tonic, transformed into the solider on the frontline sent a bottle by their caring family. The 1920s and 1930s saw a pivot towards theatre, vaudeville and film stars promoting the benefits of the concoction.


Today the bottle is more than three-quarters full with a dull amber liquid, trapped by a broken cork in the neck. The label is still fetching and rarely fails to catch your eye in the Harry Daly Museum.

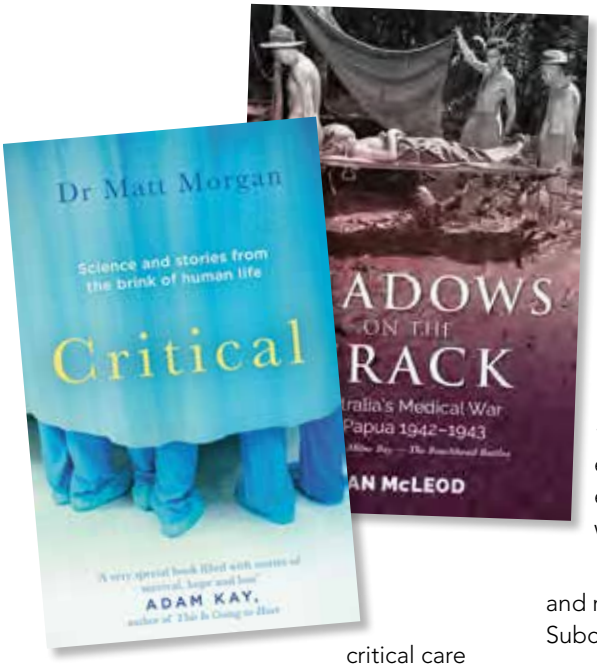
You can view the object online at https://ehive.com/collections/4493/objects/367551/dr-sheldons-magnetic-liniment

## LIBRARY – BOOKS OF THE QUARTER

The library welcomes two new books to our collection, both exploring anaesthesia in high pressure working environments – the intensive care unit (ICU) and the war front.

### *Critical – Science and Stories from the brink of human life*

Dr Matt Morgan takes readers on a deeply empathetic tour of the ICU, conveying to the non-medical reader how the unit really works and gives an insight into the mind of intensive care staff. It opens with the rush to treat a young girl with polio in 1953 Copenhagen (leading anaesthetist Dr Ibsen to establish an early form of




critical care ward to sustain the ventilation of the patient for months on end), and progresses to cover the treatment and complications of the heart, lungs, brain, skin and bone in the ICU. Problem solving and intensive training underscore the ability of the teams to respond to complicated and critical cases. An emotive book which moves at a quick pace.

### *Shadows on the Track – Australia's Medical War in Papua 1942-1943*

Jan McLeod explores the dire and difficult conditions faced by the Australian Army during World War II, when 30,000 soldiers fell victim to tropical diseases and illness. It is estimated that the six-month campaign led to 6,000 deaths and McLeod underscores that while death and disease are inevitable outcomes of war, the scale of suffering during the Papua campaign was preventable.

The book traces diaries and other primary sources from the field ambulance units. This focus on frontline medical personnel presents a different view of the Kokoda Track, Milne Bay and Beachheads campaigns bringing to life stories of the Australians who tended to the sick, healed the wounded and buried the dead.

## ARCHIVE – THE ASA IN MARCH 2001

The new millennium had truly arrived – without the Y2K – and Australia was radiant after the Sydney Olympics. The ASA was preparing for the October National Scientific Congress in Canberra and Joseph A. Dalzell's director's report included an early call for member email addresses, in an effort to take advantage of the rise of electronic commerce (the ASA had a website since 1998).

Highlights were also adventures and reports from the Overseas Aid Subcommittee.

Dr Steve Kinnear summarised the difficult situation in East Timor: "Since the establishment of independence in East Timor, there have been a number of anaesthetists from Australia who have been to that country for short periods to help out. The country is in turmoil and will continue at least until the elections due to be held in the next few months. Hopefully it will then become clearer as to the best way in which we can assist East Timor re-establishing some sort of an anaesthetic service, and then perhaps training of Indigenous anaesthetists."

Terry Loughnan reported on his trip to Tanzania in late 2000 to teach at Kilimanjaro Christian Medical College, in Moshi, Northern Tanzania: "The teaching that I was to be involved in included both discussions in the operating theatre itself, as well as more formal lecture-tutorial situations outside of the operating room. Each day commenced at 7.00am in the hospital with a one-hour meeting which involved reviewing the cases performed the night before…Operating theatre commenced at 8.30am and went through until 1.30pm. I then taught for an hour from 2-3pm, then the trainees did their preoperative round until 5.00pm…Most of the population are able to understand English although greetings etc in Swahili helped the patients feel at ease. I found the enthusiasm of the trainees and their desire to learn very refreshing…"

Kate Pentecost
*Curator, Librarian and Archivist*
*Harry Daly Museum, Richard Bailey Library and Gwen Wilson Archives*

Anaesthetists and trainees at the Kilimanjaro Christian Medical College, Moshi, Northern Tanzania

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ASA Australian Society of Anaesthetists

# INSIDE YOUR SOCIETY

# NEW AND PASSING MEMBERS

The ASA would like to welcome all new members from December 2020 to January 2021.

## TRAINEE MEMBERS

| | |
|---|---|
| Dr Alex Michael Bennett | WA |
| Dr Allan Hurley | QLD |
| Dr Amlah Najmudeen | SA |
| Dr Anita Maria Flynn | QLD |
| Dr Benjamin Sheung Kai Wan | NSW |
| Dr Bhuwan Sareen | TAS |
| Dr Bing Hui Chang | TAS |
| Dr Brianna Jo Lindley | SA |
| Dr Brigit Ann Ikin | TAS |
| Dr Claudia Alexandra von Peltz | WA |
| Dr Cristy Jane Rowe | ACT |
| Dr Ellie Patricia Skacel | NSW |
| Dr Erika Strazdins | ACT |
| Dr Evelyn Joy Timpani | SA |
| Dr Gregory Leeb | WA |
| Dr James Manil Joseph Navaratne | SA |
| Dr James Marcus Mccredie Dando | ACT |
| Dr Jessica Mary Walker | SA |
| Dr Jillian Cornelia McCool | QLD |
| Dr Joseph Hodgson | NSW |
| Dr Julie Isbill | WA |
| Dr Karen Wong | NSW |
| Dr Kate Louise Brown-Beresford | SA |
| Dr Keiran Luke Davis | QLD |
| Dr Kieran Raleigh Easter | NSW |
| Dr Lara Schemeczko | SA |
| Dr Lisa Cristina Allen | TAS |
| Dr Luke Daniel McCarthy | NSW |
| Dr Madeline Grace Corke | VIC |
| Dr Marian Louise Biddle | VIC |
| Dr Matthew Matto | SA |
| Dr Matthew Nikola Pavicic | QLD |
| Dr Michael O'Donnell | NSW |
| Dr Mina Selim | SA |
| Dr Naomi Eve Abbt | SA |
| Dr Rowan Derrick Ellis | WA |
| Dr Samuel Hanafy | QLD |
| Dr Sarah Ritchie | NSW |
| Dr Seng Wei Ho | QLD |
| Dr Stephanie Louise Jones | ACT |
| Dr Tegan Lee Asser | SA |
| Dr Veronique Anna Molan | NSW |
| Dr Vimoksalehi Lukoschek | QLD |
| Dr Wilson Lai | VIC |

## ORDINARY MEMBERS

| | |
|---|---|
| Associate Professor Damien Finniss | NSW |
| Dr Alan Fung Tuan Lim | QLD |
| Dr Alexander Norman Kippin | QLD |
| Dr Amit Surah | VIC |
| Dr Annabelle Victoria Marianne Harrocks | QLD |
| Dr Anthony Baird | VIC |
| Dr Chloe Butler | QLD |
| Dr Crispin Wan | VIC |
| Dr David Matthew Moniz | NSW |
| Dr Dharshi Karalapillai | VIC |
| Dr Hafiza Binti Misran | WA |
| Dr Julia Hoy | ACT |
| Dr Katarzyna Maria Nowak | QLD |
| Dr Laurent Anthony Wallace | NSW |
| Dr Muhammad Yahya Samin | TAS |
| Dr Richard Sorby-Adams | SA |
| Dr Rosa Meng-Chen Hou | NSW |
| Dr Samuel Robert Fowler | QLD |
| Dr Satnam Singh Solanki | QLD |
| Dr Sophie Anderson | WA |
| Dr Thomas John Shepherd | TAS |
| Dr Yael Katinka Fiebelkorn | WA |

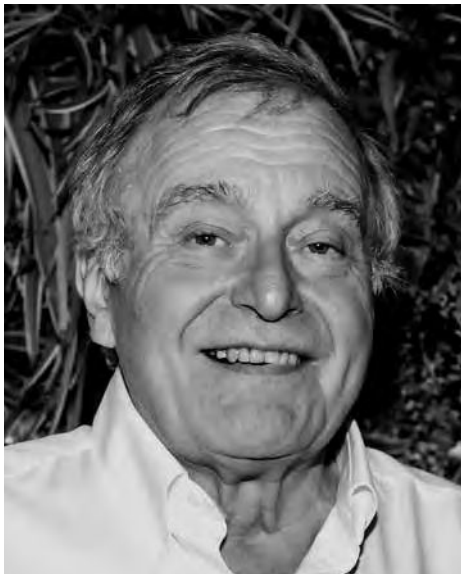
## IN MEMORIAM

The ASA regrets to announce the passing of ASA members Dr Anthony Paul Birrell, NSW; Dr Peter Edgeworth Lillie AM, SA; Dr Choong-Keet Lee, NSW; Dr Glenn Bakyew, VIC and former ASA member Dr Kerry Ronald Delaney, NSW.

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

# INSIDE YOUR SOCIETY

# PETER LILLIE AM 1949-2021



**Dr Peter Edgeworth Lillie passed away peacefully on January 21, 2021, following a long and distinguished career in anaesthesia.**

Friends and colleagues have recently had many opportunities to recognise and honour this legend of a man. In 2019 Peter celebrated his 70th birthday and was made a Member (AM) in the General Division of the Order of Australia for his service to medicine in the field of anaesthesia. In 2020 he retired from Flinders Medical Centre (FMC) after 40 years of dedicated service, which coincided with him receiving an ANZCA Citation, acknowledging him as an outstanding person, clinician and leader.

After commencing his anaesthesia training in Sydney, Peter arrived at FMC as a registrar in 1978. He then worked at the Department of Anesthesiology, University of Washington School of Medicine Hospital Group in Seattle from 1979-1980. Peter returned to FMC as a staff specialist in 1980 and in 2001 was appointed Head of the Department of Anaesthesia and Pain Management which he held until his retirement.

Peter has been instrumental in the lives and careers of an entire generation of anaesthetists through his four decades at FMC, as an ANZCA examiner and his significant contributions as the ASA Federal Treasurer.

During his tenure at FMC, Peter expanded the department to over four times its original size, managed the amalgamation of the Repatriation General Hospital and the implementation of SA Health's 'Transforming Health' program (including the transfer of medical and surgical services to Noarlunga Hospital Service). In addition to playing a key role in the development of the liver transplant and cardiothoracic services, he also provided care to critically unwell and premature neonates and established the Acute Pain Service. Always embracing progress and change in anaesthesia, he was quick to adopt innovations such as transoesophageal echocardiogram in cardiothoracic cases and the implementation of perioperative surgical pathways.

After more than four decades at Southern Adelaide Local Health Network (SALHN), we will remember Peter for his enjoyment of life, intelligence and outstanding ability. His strong leadership and commitment to improving the Department of Anaesthesia attracted a highly skilled and dedicated group of anaesthetists. He fostered inclusive, flexible and fair workplace practices, including gender equity in the hiring of staff, long before this was the norm. His colleagues described him as incredibly loyal and supportive.

"His legacy is most enduring in the department at SALHN, where his commitment to excellence and can-do attitude will be ingrained in its culture for years to come," Dr Rob Padbury.

"Not only was he a wonderful mentor and skilled anaesthetist he was perhaps one of the finest heads of department I have had the privilege to work for in my career. He led from the front and was never afraid to stand up for himself or the department," Dr Aileen Craig.

"Working in his department was a revelation... My life is better because of him," Dr Caroline Lake.

Peter was a committed teacher, serving as an ANZCA examiner for a full 12-year term from 1988-2000 and was a coordinator and teacher on the Adelaide Primary Examination Course. He was a visiting speaker on many international courses and conferences and heavily involved in teaching nursing and medical students at Flinders University. (It's not clear how widely he taught his golden rules of anaesthesia: 1. Never panic; 2. Don't F*^k it up; 3. If you break rule 2 refer immediately to rule 1!)

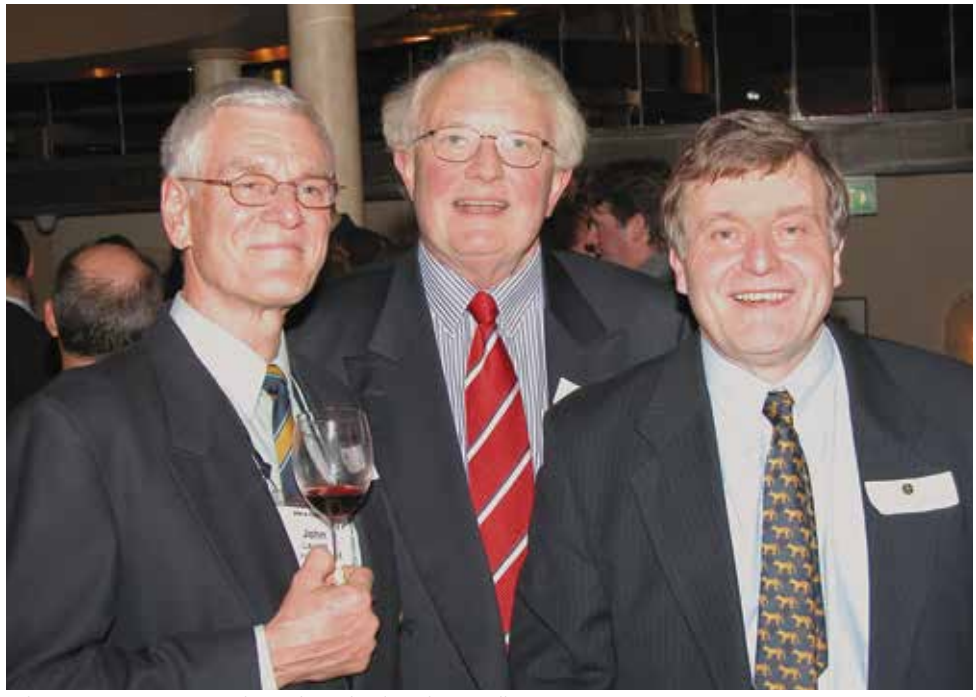
Peter was a great friend of and contributor to the ASA, serving as the Federal Treasurer between 1988 and 2003. He was presented with the President's Award in 1993 and Life Membership in 2004, the most significant award conferred by the ASA. This award was celebrated at

the 2004 AGM where he was thanked for exceptional dedication and guidance in managing the Society's financial direction for over 16 years. Dr Steve Kinnear recalls Peter was characterised as "a fantastic treasurer, a no-nonsense straight shooter and a great leader". He was held in the highest regard by many ASA Presidents and described as a true gentleman.

Peter also served as the Chair of the South Australian Directors of Anaesthesia for 20 years and was a great advocate for anaesthetists, highlighting the importance of anaesthesia in South Australia and ensuring its recognition as an essential perioperative service. As one colleague, Dr Tim Porter, noted: "Peter was a skilled anaesthetist, a great leader, a canny politician, a mentor to many… and a big teddy bear".

Many colleagues have described Peter not only as their colleague and mentor, but also as a trusted friend who provided them with support and guidance during both professional and personal challenges. He has built not only a large anaesthesia department, but one that has become like a family to many of its members.

"He inspired me and supported me the whole way through my career, being instrumental in every aspect," Dr Michael Goldblatt.



John Lauritz, ASA Past President John Richards and Peter Lillie at ASA/NZSA CSC in 2003

"I will not forget his wonderful friendship, and his impish laugh," Dr Rod Westhorpe, ASA Past President.

Peter was forever calm in a crisis and handled every situation with expert skill, both in the operating theatre and in his administrative duties. His proficiency and knowledge of anaesthesia are beyond doubt, however, it was his warmth and dry sense of humour which ensured that there was never a dull moment when he was at work.

He was a wonderful friend and colleague and will be missed by all who knew him.

Dr Brigid Brown
*Chair, ASA SA/NT Committee*
Dr Sophia Bermingham
*Vice Chair, ASA SA/NT Committee*

INSIDE YOUR SOCIETY

# ANTHONY EDMUND 'TONY' WILLIAMS 1939–2020

Tony was born in 1939 in Roseville and grew up in Western Sydney, where his father was a bank manager at Fairfield, then Penrith. He received his secondary education at the Marist Brothers in Parramatta and then commenced his medical studies at Sydney University in 1957, progressing without a failure or a post to graduate in 1963. This success in exams was a forerunner to his passing both Part I and Part II of his Anaesthetic Fellowship, also on his first attempt, a no mean effort in those days, and while being on-call and with a growing family.

In 1963 he was appointed a Junior Resident at St Vincent's Hospital Darlinghurst, where he had been a medical student. It was also in this year that Tony made the wisest decision he was ever to make, he married Mary Rose Dunford who was a nurse at SVH. In 1964 he became a Senior Resident, followed by a year as a Medical Registrar at Concord Repatriation Hospital, which greatly enhanced his medical skills. He then spent three years, 1966-1968, as an Anaesthetic Registrar at SVH which included a six-month rotation to the Royal Alexandra Hospital for Children at Camperdown. He was awarded his Anaesthetic Fellowship in 1968.

By 1969, now with four children, it was time to provide for his present and future family. He commenced private practice and was soon asked to join one of Sydney's main anaesthetic groups, General Anaesthetic Services (GAS).

Appointments to St Vincent's General followed, as did to Concord Repat, Mater Private and a number of smaller private hospitals in the eastern suburbs. Tony would entertain his family and frighten his registrars with stories, always with a safe and successful outcome, of giving anaesthetics, where you had to provide your own drugs, and equipment, with no ventilators and often no ECGs and with oxygen cylinders being delivered in a truck. Oximetry was still two decades away.

By 1970 Tony had also been appointed to St Margaret's Hospital for Women, which had an adjacent Childrens Hospital. There he was able to develop his great skill in the care of obstetric and paediatric patients.

This developed over the 70's, into supervising a Neonatal Intensive Care Unit for both premature newborns and major paediatric surgical patients. In 1981 the St Margaret's Children's Hospital was closed and Tony was asked to join the paediatric anaesthetic staff at the Prince of Wales Hospital.

The Williams' family had by now grown to eight children and would also for many years be the home to a large number of special needs foster children, and these were very lucky children indeed.

How Tony had time for his non-clinical commitments is hard to imagine, but he did.

He was Federal Secretary of the ASA from 1973-75. Then he was elected to the NSW State Committee of the Faculty (College) of Anaesthetists. It was during this time that Anaesthetic Continuing Education (ACE), as it is today, really started. It was thought that registrars were being updated but not consultants. So a small committee chaired by Tony, with representatives of both the NSW Faculty and the ASA began organising regular educational meetings, the first in July 1977. Often up to two per year, these were all day weekend sessions with anaesthetic topics as well as updates on medical issues especially cardiac, respiratory, renal and lots more. These meetings regularly began to attract 300 or more anaesthetists from all over NSW and interstate and are still popular today. We anaesthetists thank Tony for guiding ACE in its early days.

Apart from his clinical associations, Tony had been a member of the Medical Guild of St Luke since his student days and became its Master for the last 20 years. When an Alumni Association of St Vincent's Hospital was formed 10 years ago for all former staff, both medical, nursing and others, Tony accepted the role of initial Chairman and only stepped down two years ago. He was also Chairman of many other hospital organisations, committees and anaesthetic departments, too numerous to list, but all of which benefitted from his skills as a Chairman. He was reliable, responsible and hard working.

Tony was not a man who sought worldly rewards, but after his family two of his proudest achievements were being awarded a Papal Knighthood, and after his ultimate retirement from St Vincent's being made an Emeritus Consultant, for his enormous contribution over a lifetime of dedication and commitment to the hospital.

As he gradually reduced the number of hospitals he worked at, though not his workload, he continued his long association with St Vincent's Private and the Mater Private, and he also began regular tutorials to registrars and to helping supervise the Anaesthetic Simulator at St Vincent's Public Hospital.

He had also by this stage been long involved in palliative care and pain management. His compassion and care for his patients knew no end. His wise opinion was always sought at staff meetings and was greatly missed after he retired.

Tony was not all work, as he found time for golf and he loved his regular Saturday games at Roseville Golf Club where he had been a member for many years. In 2019 he was able to celebrate his 80th birthday there, surrounded by his large family and many friends and those present will always cherish that memory.

However, in recent years he had slowed down with the onset of Parkinson's disease, but he was still alert and still had his impish sense of humour.

Tony and Mary Rose Williams with their family. Back: Matthew, Anthony and Justin
Middle: Sophie, Josephine, Catherine, Dominica and Lucy

After a fall in which he fractured some ribs, he was admitted to Hospital. When the anaesthetist was putting in a thoracic epidural for pain relief, Tony said if he wanted help he was available, as he had done a few in his time. Sadly, he passed away some 12 days later, surrounded by the love of his life, Mary Rose and their children and grandchildren (as many as COVID restrictions would permit).

He will be remembered by all who ever met him as a thorough gentlemen, always softly spoken, whose wisdom and advice was sought after by both surgeons and anaesthetists, and whose skill and care was given to every single one of his many thousands of patients for more than 50 years of total dedication to his profession. His daughter Dominica in his eulogy described him as full of compassion, kindness, humility and love.

All our thoughts go out to Mary Rose, their eight children and 21 grandchildren.

Joe McGuinness
Greg O'Sullivan

INSIDE YOUR SOCIETY

# JOHN PHILLIP MADDEN 1954-2020

Dr John Madden recently passed away in Hobart after a short illness. John was a specialist anaesthetist who served the community of Hobart for more than 30 years and was renowned for his great care for patients and his skills as an anaesthetist throughout his career.

John grew up in Launceston under the care of his aunt and uncle after the loss of both of his parents at a young age. He won an entrance scholarship to the Launceston Church Grammar School where he completed his secondary schooling. He excelled academically and was accepted into the University of Tasmania Medical School in 1972. After gaining his medical degree in 1977, he travelled to Brisbane for his intern year at the Princess Alexandra Hospital. After completing a residency year at the Royal Canberra Hospital in the ACT, John took a year off to go travelling in Europe with his wife Sally. Upon his return to Australia he worked in general practice in George Town before successfully applying for an anaesthetic training position at the Launceston General Hospital (LGH).

During his first year as an anaesthetic registrar in 1982 John became the first anaesthetic trainee from the LGH to pass the First Part exam of the Faculty of Anaesthetists. John continued his anaesthetic training in Hobart at the Royal Hobart Hospital (RHH) as well as at the Royal Children's Hospital and the Royal Women's Hospital in Melbourne. John passed the final exam and became a Fellow of the Faculty of Anaesthetists, Royal Australasian College of Surgeons in 1985.

In 1986 John accepted a position in the Hobart Anaesthetic Group (known universally as 'The Group') and soon after was appointed as a Visiting Medical Officer to the RHH as a Consultant Anaesthetist. John always excelled at successfully completing the challenging academic requirements of his anaesthetic studies and he was subsequently invited by the Faculty of Anaesthetists (and later the Australian and New Zealand College of Anaesthetists) to be an Examiner for the final anaesthetic exam. John undertook his work as an Examiner with pride and absolute dedication and he also assisted many anaesthetic trainees to successfully prepare for their final exams.

As an anaesthetist John was renowned for his excellence, his great knowledge and skills and his absolute calmness in dealing with crises. John possessed all of the attributes of an ideal anaesthetist with the safety of his patients being paramount. He was extremely popular with work colleagues, surgeons and nurses alike, not only because of his skills as an anaesthetist, but also because he had that rare ability to combine those skills with kindness, compassion and humour.

There was so much more to John than his excellence as an anaesthetist. John was a dedicated family man who was devoted to his four children (Sam, Jack, Tom and Alex) and three grandchildren and supported each of them in their individual pursuits throughout their schooling and their adult lives.

John was also an accomplished athlete throughout his life particularly in the fields of long-distance running, bike riding and mountaineering. John was always extremely physically fit and enjoyed competing in many of these activities with his children. John completed several marathon races as well as ultra-marathons and was a stalwart veteran of the 'Cradle Mountain Run the Overland Track' event for many years.

During his short illness John was cared for by his loving family and his devoted wife Ang and passed away peacefully at home with his family present.

Dr Andrew Mulcahy

# RVG 22nd edition

## Exclusive to ASA members

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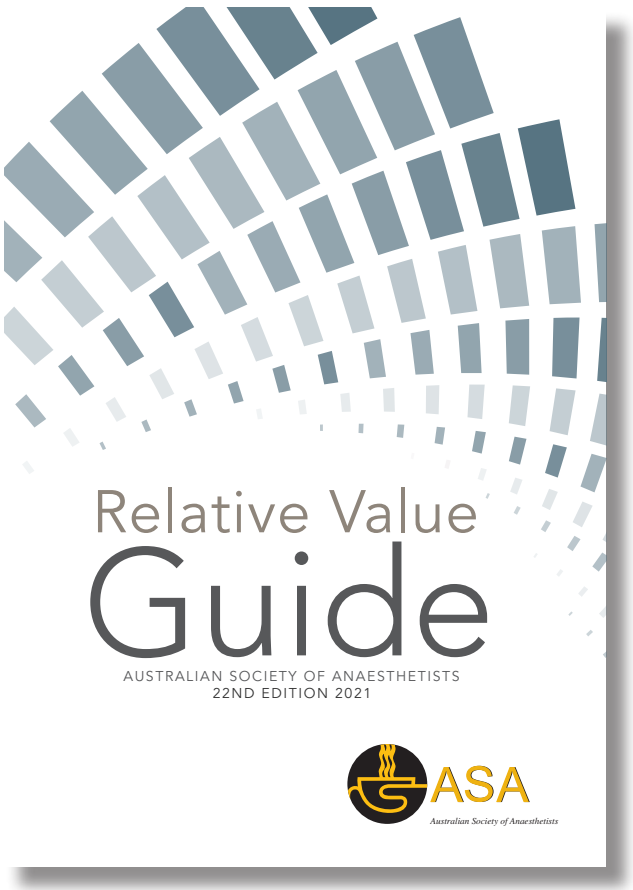


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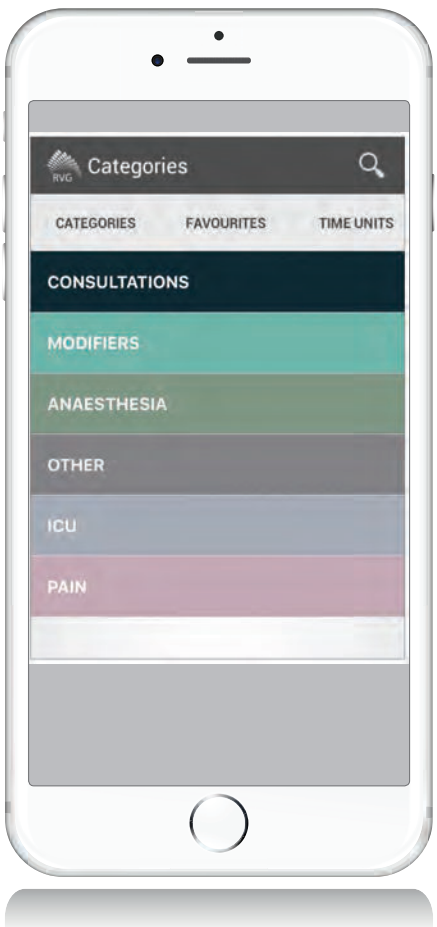


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**23–25 JULY 2021**

# CONJOINT
# ASA NSC & QLD ACE MEETING

## INVITED SPEAKERS

### ASA NSC

**Clinical A/Prof. Andrew (Andy) Lumb**
UNITED KINGDOM

**A/Prof. Kerstin Wyssusek**
BRISBANE

**Dr Viren (Vern) Naik**
CANADA

**Dr Jo Rotherham**
BRISBANE

### QLD ACE

**A/Prof. Laurence Weinberg**
MELBOURNE

**Mr Sean Lowry**
BRISBANE

**Dr Suzi Nou**
MELBOURNE

**A/Prof. John Loadsman**
SYDNEY

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